Guidelines on managing stable angina omit important point

EDITOR,—The North of England Stable Angina Guideline Development Group has provided concise and authoritative recommendations for the management of stable angina in primary care.[1] They do not, however, say anything about the importance of advising patients with stable angina on what to do should their pain be prolonged and unresponsive to glyceryl trinitrate.

Patients with stable angina are at greatly increased risk of myocardial infarction.[2] If this occurs it is likely to be fatal in 40-50% of cases, and about three quarters of deaths occur outside hospital,[3] in many cases because patients delay in calling for help. Many deaths could undoubtedly be prevented if patients with stable angina (and indeed the population at large) were advised to telephone 999 for an ambulance in the event of pain of unusual severity or lasting for longer than 15 minutes despite appropriate drug treatment. Should not advice about this be a key aspect of the management of angina in general practice?

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Helping sick doctors

Stress management interventions need to be evaluated

EDITOR,—In their editorial on helping sick doctors Ruth Chambers and Richard Maxwell conclude, "If the job is making the doctors sick, why not fix the job rather than the doctors?"[1] It is not only among doctors that stress has been addressed primarily as a health problem rather than as an organisational problem. Stress management in other professions has similarly emphasised individual health based interventions to deal with the symptoms rather than attempting to modify factors that induce stress in the workplace.[2] Fortunately, research has now begun to address the problem from an organisational perspective. For example, the BMA is currently funding a hospital based project in the midlands. This study uses a risk assessment-risk management paradigm and aims to produce organisational change through audit of stress (M Macafee, University of Nottingham, personal communication).

We support the call for proper evaluation of all stress management initiatives. Evidence of the efficacy of stress management interventions in other professions remains equivocal.[3] Studies among hospital doctors have shown some benefits from stress workshops,[4] but randomised controlled studies are needed. In addition, results obtained among hospital based doctors may not be generalisable to general practitioners, given their pattern of work and self employed status.

Problems to be overcome in conducting controlled trials of stress management interventions include the relatively low uptake of stress management workshops[1] and difficulties in choosing suitable outcome measures. Outcomes measured elsewhere, such as productivity and absenteeism, may not be appropriate for doctors. We agree with Chambers and Maxwell that the cost of stress among doctors in terms of their morbidity and the risk to patients highlights the need for randomised controlled trials of the benefits of any stress management strategy.

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Confidential voluntary scheme has been set up in Britain

EDITOR,—Ruth Chambers and Richard Maxwell mention counselling services to help sick doctors.[1] Canada has had a scheme for years to help chemically dependent doctors. Last November, while at a conference in York on addiction in doctors and dentists, I heard about the physicians support programme in Ontario from Dr Graeme Cunningham, the coordinator. This uses doctors who have recovered from dependence on alcohol and other drugs.

The authors of the editorial state that only 3% of sick doctors use support schemes. Why is this? Doctors (and their families, colleagues, patients, etc) do not seek help because of denial, lack of insight into personal illness, and fear of confiding in non-medical dependent people.

When training elephants, mahouts use older trained elephants to set an example and to overcome the fear of the trainee and act as a role model. The same applies in medical training.

In Britain, as in other countries, there is an extensive informal network of doctors and dentists (800 altogether, with 15 regional groups in the United Kingdom and the Republic of Ireland) who are in recovery from chemical dependency.

Recently, a body called the Addictive Physicians Programme has been formed; it has a helpline (01252 316976), which is advertised in the *BMJ*. This is separate from all officialdom, and absolute confidentiality is guaranteed. The programme works on the same principles as the Sick Dentists' Scheme, and, running on a voluntary basis, has helped 85 doctors since 1 July 1995. The Sick Dentists' Scheme, an intervention scheme for dentists who are dependent on alcohol or drugs, has existed since 1986; it has helped more than 300 dentists to lead a productive life free of alcohol and drugs. The scheme is funded nationally through a trust supported by the local dental committees and by other interested bodies. It uses the skills of recovered chemically dependent dentists.

In the light of the current discussion about stress and the medical profession the Addictive Physicians Programme has the skill to help those who are "coping" with stress by becoming dependent on mood altering chemicals and are not able to face reality. The programme has the organisation, but at present lacks the funding, to develop fully. Can this not be rectified? Why should we be second best to the dentists? Meanwhile, let us use the scheme, which is free and works and is confidential.

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Torture continues in Algeria

EDITOR,—Having recently published the results of a study on Zaïrean asylum seekers,[1] the Medical Foundation for the Care of Victims of Torture has done a similar study on asylum seekers from Algeria. Algeria was chosen because it is a country in which there is a little known civil war[2] and severe abuses of human rights,[3] yet the Home Office is deporting asylum seekers back to the country.

In Algeria civilians are trapped between the security forces and armed Islamic groups.[3] Teachers are targeted, often by both sides: by the Armed Islamic Group for working for the government and by the security forces simply for attending a mosque. Journalists in particular have been targeted. Twenty four of 51 journalists killed worldwide in 1995 were Algerian,[4] as neither side wants information to get out of the country.

In 1994-5, 23 Algerians were seen by the Medical Foundation for the Care of Victims of Torture. Twenty two were male and one female. Nineteen were single, and of the four who were married, one had been able to come with his family. More demographic data will not be given, to avoid these people being identified if they are returned to Algeria.

All but one of the men had been detained in Algeria, 12 once, eight two or three times, and one about 10 times. Of the 40 detentions, 23 lasted a few days, 13 lasted up to one year, and four were longer. Fourteen men said that they were members of the Islamic Salvation Front, but seven were picked up for attending a mosque or just being near one at the wrong time. Two were Berbers. Two had spent periods in prison camps in the Sahara desert, and one was about to be transferred there but was thought to be too ill. Most people in these camps are there indefinitely.[3]

The commonest torture was described by 13. In this the detainees were forced to inhale water (usually contaminated) and then punched in the stomach until vomiting occurred. Most described being left naked or almost naked and complained of suffering from the cold. Seven described electric shocks. Five said that they had been made to sit on a bottle. In this torture a bottle is pushed through the anus and the man is made to put his weight on it, stretching the sphincter very painfully. Four men described rape, and three said that other things had been pushed through their anus. Two mentioned other types of sexual assault, and one described his sister being sexually assaulted in front of him. Six described seeking psychiatric help shortly after their release.

Algeria is a country in upheaval, but, because of intimidation of journalists by both sides, little is heard about it.

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