ity to both employee and employer and an ethical duty to put the interests of their patients first.[2] In the case of an NHS trust, the occupational physician's obligation to the employer is to ensure that an employee does not have a medical problem that poses a health and safety risk to the employee, patients, or other members of staff. When assessing an individual's fitness to work the physician must also consider the level of skill and physical and mental capacity required for effective performance of the work, as well as any possible adverse effects of the work, or the work environment, on the employee's health.[3]

An audit of all 700 pre-employment questionnaires completed by doctors starting work at Southmead NHS Trust between 1 July 1993 and 30 June 1996 showed that 16 doctors declared a history of mental health problems. Of these, seven were contacted by an occupational health nurse by telephone or seen in person, six were contacted by the consultant occupational physician by telephone, and three were seen by the consultant in person. Strategies for preventing or reducing the work related element were discussed with the nine doctors who indicated that their problems were work related. All 16 of the doctors were assessed as medically fit to work in the job that they had applied for. One doctor had a relapse of her condition, but after a month off work she returned to her post. Two doctors referred themselves back to the occupational health department. One of them, at his request, was referred for counselling, and the other requested detailed careers advice and an appointment was made for her to see the postgraduate dean.

Job applicants should be encouraged to declare relevant medical problems on occupational health questionnaires. By providing confidential, independent medical advice and support, occupational health departments can work in the best interests of all members of staff, the general public, and, most importantly, individual employees with health problems.

Ira Madan *Consultant occupational physician*
Southmead Health Services NHS Trust, Westbury on Trym, Bristol BS10 5NB

1 The danger of an honest admission. *BMJ* 1997;31:195-6. (19 July.)
2 Faculty of Occupational Medicine of Royal College of Physicians. *Guidance on ethics for occupational physicians.* 4th ed. London: RCP, 1993.
3 Royal College of Physicians of London and Faculty of Occupational Medicine. *Fitness to work: the medical aspects.* 2nd ed. Oxford: Oxford Medical, 1995.

Career guidance for doctors

RCSE is doing much to help surgical trainees and medical students

Editor—Carnall says that career advice for doctors can be hard to come by.[1] He may be correct, but I can assure him that the situation is improving.

It is unusual to find surgical trainees disillusioned, but many are confused about the changes in training, and they are often uncertain about how they should proceed. The Royal College of Surgeons of Edinburgh has taken the need for career advice seriously. For final year medical students we have written and distributed the booklet "Becoming a Surgeon," which describes the pathways to becoming a trained surgeon. We exhibit at the medical school career fairs and have developed a career advisory service, which responds to the needs of medical students as well as surgical trainees. Each year more than 1000 surgical senior house officers receive a brochure from the college describing the new training. Those who register with us receive not only advice and help on structured learning but have the opportunity to correspond with and visit the college for help. Our booklet "Choosing a Surgical Specialty," which explains the higher surgical specialty options, also assures our trainees that a departure from the traditional career path is not a disadvantage and that interview committees appreciate candidates with diverse range of talents.

Carnall is correct that not all consultants are skilled in appraisal or in counselling. Our course "Educating consultants" is designed to help trainers improve these qualities. All our fellows in the United Kingdom recently received literature on how they can make the most of their training opportunities. We say that one of the motivations for a lifetime of enjoyable surgery is to see confidence grow in young doctors as skills develop and a career begins to blossom. We try to make sure that career information is accessible where it is needed. It is available on the internet (http://www/.rcsed.ac.uk) and also by post.

R W Porter *Director of education and training*
Royal College of Surgeons of Edinburgh, Edinburgh EH8 9DW

1 Carnall D. Career guidance for doctors. *BMJ* 1997;315:6. (5 July.)

Career counselling has to be part of appraisal

Editor—Carnall's editorial on career guidance and recent letters in response to Smith's editorial on problem doctors show the wide range of advice and support that doctors currently need.[1-4] As part of this support, the Standing Committee on Postgraduate Medical and Dental Education has recommended the introduction of appraisal for doctors and dentists in training. Its 1996 working paper for consultation clarified the purposes of, and distinctions between, appraisal, assessment, and performance review.[5] There is still tremendous confusion about the meaning of these terms and unhelpful variability in their use.

In the standing committee's view, supported by the vast majority of those responding to the consultation, appraisal for doctors and dentists in training should be primarily educational, totally confidential except in defined eventualities, and designed to help the trainee to progress. In contrast, assessments, which are also an important part of postgraduate education, are needed to inform the regulatory process about career progress. They should be objective and open and subject to appeal. Both appraisal and assessment contain elements of performance review, but they need to be kept separate. This presents challenges to hard pressed consultants and trainees, who must find protected time to carry them out.

Unlike Smith,[4] the Standing Committee on Postgraduate Medical and Dental Education considers that career counselling has to be part of appraisal because appraisal is a tool to help career development. Appraisal should therefore not just be confined to feedback on performance in a particular post. Doctors will draw on many inputs when making decisions about their careers and professional lives, a process that the committee has termed continuing professional development. This and other forms of support, including mentoring, are the subject of inquiries by the standing committee, and reports will be submitted shortly to the secretary of state for health.

Barbara Clayton *Chair*
Standing Committee on Postgraduate Medical and Dental Education, 1 Park Square West, London NW1 4LJ

1 Carnall D. Career guidance for doctors. *BMJ* 1997;315:6. (5 July.)
2 Bennet G. All doctors are problem doctors. *BMJ* 1997;314:1908. (28 June.)
3 Noble BA. All doctors are problem doctors. *BMJ* 1997; 314:1908. (28 June.)
4 Smith R. All doctors are problem doctors. *BMJ* 1997;314:841-2. (22 March.)
5 Standing Committee on Postgraduate Medical and Dental Education. *Appraising doctors and dentists in training.* London: SCOPME, 1996.

Payment of financial incentives to GPs may invalidate informed consent process

Editor—The fraud committed by Dr John Anderton[1] was not academic fraud, as in other recent cases, but financial fraud inspired by the large payments now made by drug companies to doctors to enter patients in trials. Within hospital departments this income is usually put into research funds, but in general practice the doctor is often personally remunerated. This is now sufficiently lucrative that some general practitioners have reduced their clinical work and set up companies to administer trials and the proceeds. The ethical issues involved, particularly relating to informed consent, have yet to be properly debated by the profession.

Although drug company trials are often of high quality in terms of design and scientific method, their primary purpose is commercial. The companies design the trials, collect the data, analyse them, and (sometimes) publish the results. The doctors entering patients have no scientific input, gain no professional credit, have no knowledge of the results or their interpretation, and play no part in the publication process. The only interest they have is financial. Effectively the doctor's status is bought by the company to legitimise the trial to the patient.

When consenting to a trial patients believe that their doctor is personally involved in scientific inquiry for the com-

mon good, which could not be further from the truth. They believe that the doctor is their advocate and will act in their interest. But often there is not even a potential benefit to the patients, and sometimes there is considerable risk. They frequently have their normal drug treatment changed, and the treatment is often withdrawn at the end of the trial even if benefit was evident. That they do consent is testimony to the strength of the relationship and trust they have in the doctor and their desire to enhance this relationship. In these circumstances the ethics of informed consent are clearly compromised.

If it is unethical to offer patients financial incentives to participate in trials then the same should apply to doctors. I would suggest that the doctor's remuneration must be part of the information required for consent to be valid. Local ethics committees should consider whether excessive financial incentives invalidate the informed consent process when they consider study applications.

Colin Ferguson *Consultant general and vascular surgeon*
Morriston Hospital, Swansea SA6 6NL
cfergu7880@aol.com

1 Dyer C. Consultant struck off over research fraud. *BMJ* 1997;315:205. (26 July.)

Humanitarian issues

Young people affected by HIV must be supported year in, year out

EDITOR—The increase in cases of HIV infection worldwide is reported to have included 600 000 new cases in children in 1997[1]; the theme of the most recent World AIDS Day was children. The danger with this theme, and the day, is that we may isolate both—as if HIV matters on only one day a year and children with HIV infection are separate from the rest of the population.

The truth is that HIV infection is with us all year round, across the world. The UN report shows that, worldwide, over 30 million people have HIV infection. Most do not have access to clean water, adequate housing, or the basic health care that might be taken for granted in developed countries. Children live in households where whole generations are being wiped out by starvation and war. People fleeing from such situations may find themselves ostracised and penniless on the streets of richer countries such as our own, seeking asylum while benefits are removed.

In Britain, children and young people living in households in which somebody is infected with HIV are not immune to all the other pressures. Such households may, for example, experience poverty, unemployment, injecting drug use, and poor housing and are then subject to the pressures on community care budgets and unequal access to new treatments for HIV infection. We have to overcome the inequalities in the provision of health and social care, in Britain and worldwide, if people with HIV infection are to receive equal care to that received by everyone else.

At the same time, the messages given to children and young people by politicians and the press need to encourage equality and a positive outlook on life. In Britain we need to see positive moves: the introduction of an equal age of consent at age 16, repeal of section 28 of the Local Government Act (which forbids the portrayal of homosexuality as "normal"), and withdrawal of the proposal to make the transmission of HIV a criminal offence (which would discourage young people from coming forward for HIV testing, advice, or treatment).

If we want to support children and young people affected by HIV we have to make sure that we don't make them a separate issue, special just for one day. We must end the discrimination associated with HIV; a good start would be to remove the barriers, such as those related to gay sexuality and represented by the cuts in benefit brought in by the Asylum and Immigration Act 1996.

John Nicholson *Secretary, HIV Alliance***on behalf of the seven member organisations of HIV Alliance**
HIV Alliance, 75 Ardwick Green North, Manchester M12 6FX

Neil Gerrard *Chair, All Party Parliamentary Group on AIDS*
Evan Harris *Liberal Democrat spokesperson on health*
House of Commons, London SW1A 0AA

1 UNAIDS/World Health Organisation. *Report on the global HIV/AIDS epidemic.* Geneva: UNAIDS, 1997.

WMA wants medicines and foods to be excluded from economic sanctions

EDITOR—Delamothe rightly points out that economic embargoes, some of which are based on United Nations policies, are having a devastating effect on the health of many people in affected countries.[1] Children are particularly vulnerable to the shortage of medical supplies—including vaccines—and food. Starvation is life threatening; long term food deprivation affects physical development, including that of the brain. The young people in Iraq, Cuba, and other countries clearly show the devastation that sanctions can cause. It was for this reason that the World Medical Association, at its assembly last November, passed the following resolution, which had been prepared by the BMA:

"Recognising that all people have the right to preservation of health and that the Geneva convention (article 23, number IV, 1949) requires the free passage of medical supplies intended for civilians, the World Medical Association urges national medical associations to ensure that governments employing economic sanctions against other states respect the agreed exemptions for medicines, medical supplies, and basic food items."

The BMA has already written to the secretaries of state for international development and for foreign affairs over this matter. We shall be asking colleagues from other national medical associations what responses they have had from their governments.

W James Appleyard *Chair, World Medical Association medical ethics committee*
BMA, London WC1H 9JP

1 Delamothe T. Embargoes that endanger health. *BMJ* 1997;315:1393-4. (29 November.)

Paediatrician needed in Kabul

EDITOR—Following Vivienne Nathanson's editorial calling for doctors to become more involved in humanitarian issues,[1] we write in the hope of finding a paediatrician to address a tragic consequence of war on children.

Extreme poverty induced by 18 years of conflict in Afghanistan has led some families to place children in the state orphanage in Kabul. This institution contains 396 boys and 52 girls aged 3-15 years; 78% of the children have at least one living parent, 14% have close relatives, and 8% are without a family. They exist in a partially destroyed building with one outside hand pump for water and no sewerage system; faeces litter the floors. The children wear little more than rags and few have shoes (usually the plastic kind worn by our children when on the beach). Hygiene is poor, with five children sharing one towel. Serious and recurrent infection is common and results in children being admitted to the Indira Ghandi Children's Hospital, where similar conditions prevail. There is no heating and during the winter the temperature inside the building reaches −20°C. Access of girls to the open air is restricted to the roof (which has a 1 m ledge around it and is their open toilet). Eighteen girls have recently "fallen" 20 m to the ground below. In bedrooms 6 m by 7 m there are 23 beds.

Maliha, aged 13, has written: "When I was eight my father was on his way to work when a rocket hit him and he died. We cried a lot, but no hope. Three years after his death my mother was also martyred by a rocket. We were with our uncle; he is a very kind man. He is taking care of us much. After one year of the death of our mother he put all four of us (two brothers, one sister, and me) in the orphanage. We suffer a lot, but what to do. Our uncle is coming on the weekend and taking us home for two days."

The Department for International Development[2] has provided funds to Children in Crisis and Child Advocacy International to return as many as possible of these children to their families or to foster homes. A paediatrician is needed (see paediatrics section, classified supplement) to examine the children, treat illnesses, monitor growth and development, and educate local nurses and social workers to sustain the programme.

This is an opportunity not only to address an issue of human rights but also, if it succeeds, to highlight a way of helping the many thousands of other children within similar institutions around the world.

David Southall *Professor of paediatrics*
Charles Shepherd, *Consultant paediatrician*
Child Advocacy International, Academic Department of Paediatrics, North Staffordshire Hospital, Stoke-on-Trent ST4 6QG
cai_uk@compuserve.com

1 Nathanson V. Humanitarian action: the duty of all doctors. *BMJ* 1997;315:1389-90. (29 November.)
2 Secretary of State for International Development. *Eliminating world poverty. A challenge for the 21st century.* London: Stationery Office, 1997.