in the whole period of 10 years, but this is statistically strongly influenced by the results in the first three years, which are open to selection bias. The authors do not present a separate analysis restricted to follow up after the first four years. The pattern of results shown in the graphs comparing height and weight at different times since birth suggests little difference between the two groups. The study design is an ingenious one, but the analysis of the results is problematic.

One must conclude, therefore, that this trial provides no evidence of any benefit of screening. The pattern of results after four years weighs against a material benefit, but the number of cases is small, so failure to find a significant difference does not exclude a small benefit. Longer follow up (beyond the 10 years of age in this study) may be informative. When the children are older the key outcome measure should be lung disease because it is this above all that causes the severe disability and premature death in cystic fibrosis. This is not covered here, but with longer follow up the rate of hospital admissions for respiratory illness in the two groups could be reported.

Although we cannot say at this stage whether neonatal screening is worth while, the present evidence is not encouraging and does not warrant any change in policy from that suggested by the National Institutes of Health consensus development statement,[3] which concluded: "Offering cystic fibrosis genetic testing to newborn infants is not recommended."

Nicholas J Wald *Professor*
Joan K Morris *Senior lecturer*

Wolfson Institute of Preventive Medicine, St Bartholomew's and the Royal London School of Medicine and Dentistry, London EC1M 6BQ

1 Farrell PM, Kosorok MR, Laxova A, Shen G, Koscik RE, Bruns T, et al. Nutritional benefits of neonatal screening for cystic fibrosis. *N Engl J Med* 1997;337:963-9.
2 Dankert-Roelse JE, te Meerman GJ. Screening for cystic fibrosis—time to change our position? *N Engl J Med* 1997;337:997-9.
3 National Institutes of Health. *Genetic testing for cystic fibrosis. NIH consensus development statement.* Bethesda, MD: NIH, 1997.

# Missed problems and missed opportunities for addicted doctors

*We need a special service for doctors addicted to drugs or alcohol*

Every few days another addicted doctor comes to light in Britain. A report from an alliance of health professional bodies, led by the British Medical Association and published last month,[1] highlights the risk posed by such doctors to the general public and calls for better preventive education and awareness. It fails, however, to prioritise the need for improved treatment for addicted doctors.[2] This need arises from the special problems facing addicted doctors compared with other addicts and their special treatment needs, which ordinary addiction services do not serve well.

Doctors are at special risk of developing addiction problems,[3–5] owing to the strain of medical practice, erosion of the taboo against injecting and opiates, and, particularly, access to supplies.[6] Once addicted, they pose a particular risk to the general public, forcing consideration of whether they need urgent removal from their work. Ordinarily, many patients with drug or alcohol problems receive outpatient treatment while continuing to work, but the same level of disability may be incompatible with medical practice. In addition, since most doctors who become addicted to drugs misappropriate them from work, removing the doctor from his or her work environment may be necessary to protect both the doctor and the public.

Membership of the medical profession normally enhances access to treatment, through knowledge of providers and the old boy network, but addicted doctors face major problems in accessing effective treatment. Addiction fosters isolation and denial: when present in a medical culture that prizes self reliance and has deficient mechanisms for intervention and treatment, the paradoxical consequence is impaired access to health care. Doctors find it particularly difficult to access help for stigma bound problems, fearing breaches of confidentiality and jeopardy to their reputation, professional accreditation, and employment. The NHS reforms have further aggravated the problem with their requirement for identifying patients referred outside normal contracts.

The identification of addiction problems is often characterised by crisis—perhaps following removal from the operating theatre or surgery after being deemed intoxicated, complaints from patients, or discovery stealing drugs from the workplace. The problem may be chronic, but the circumstances around public exposure give the condition an acute on chronic character. Internal investigations are often inefficient, protracted, and inhumane for a doctor who essentially has a health problem. It is easy to see why addicted doctors feel they cannot seek treatment. Nevertheless, such crises provide excellent opportunities for healthcare intervention.

Providing treatment to the addict-doctor also poses challenges. Doctors have difficulty accepting the role of patient. Clinical staff may deal with addicted doctors differently—for example, treating them more as colleagues and holding higher expectations for recovery, compliance, and participation in treatment. Nevertheless, despite these complications, when addicted doctors are comprehensively treated the outcome is good.[3 5 7]

Thus addicted doctors are deflected from obtaining help by numerous obstacles and eventually come to light through distorted routes of referral—via distraught colleagues, friends, or family seeking secret consultations or informal opinions. Existing provision, as listed in the BMA report,[1] falls far short of an accessible and appropriate and adequate service. A

*BMJ* 1998;316:405–6

dedicated service for addicted doctors is now long overdue.

Three distinct components of care are essential. Firstly, entry routes into treatment should be simple and well publicised and must include crisis intervention. Responding to a crisis such as police proceedings or exposure at work with a distant appointment is manifestly inadequate. Not only is it compassionate to offer urgent admission; it is also valuable to capitalise on the motivation generated by the crisis.

Secondly, though immediate admission for assessment and detoxification is desirable, existing addiction units often have major difficulties in providing this care. Doctors who have committed crimes and other acts shameful to their professional standing may have difficulty sharing these episodes with a non-medical peer group. Other patients may express outrage at a fellow patient who is a doctor. The addict-doctor may therefore need treatment in a dedicated unit—probably alongside other addicted healthcare professionals.

Thirdly, special arrangements for supervision and post-treatment monitoring are essential, especially if the recovering addict-doctor returns to work. Progress may need to be "policed" by a supervising consultant in liaison with the recovering doctor's employer or senior colleagues. Support systems such as peer groups[8] and counselling are pivotal factors in maintaining recovery.[9] Monitoring should include random collection of supervised urine or hair samples for analysis[10] and should generally continue for some two years.

The phenomenon of the addicted doctor may shock and offend. Nevertheless, it must be addressed by both the profession and employers as an important cause of impaired performance through ill health. In America, state level "impaired physician" schemes[7 11 12] ensure that addicted doctors are confronted, receive adequate treatment, and return to work under supervision. Other countries may feel less comfortable with such interventions, but, as the BMA report illustrates,[1] greater professional awareness at all levels and visible dedicated services will enable many doctors to avoid the tragic consequences of drug and alcohol dependence that can so affect their patients, their family, and their careers. The current lack of a dedicated service leaves many addicted doctors unchallenged, untreated, and abandoned: the BMA report's failure to deal with comment on this point is an important shortcoming in an otherwise excellent document. With good outcomes from treatment of this group (on whose training so much has already been expended), there are compelling grounds for such a development. The addicted doctor, the profession, and the general public would all benefit.

John Strang *Professor of the addictions*

National Addiction Centre, Institute of Psychiatry, London, SE5 8AF

Michael Wilks *Chairman*

Medical Ethics Committee, British Medical Association, London WC1H 9JP

Brian Wells *Medical director*

Riverside Mental Health Trust, London W6 8DW.

Jane Marshall *Consultant psychiatrist in the addictions*

National Addiction Centre, Institute of Psychiatry, London, SE5 8AF

1 Working Group on the Misuse of Alcohol and Other Drugs by Doctors. *The misuse of alcohol and other drugs by doctors*. London: British Medical Association, 1988.
2 British Medical Association. *Chemical dependence in the medical profession*. London: British Medical Association, 1995.
3 Vaillant GE, Brighton JR, McArthur C. Physicians' use of mood-altering drugs: a twenty-year follow-up report. *N Engl J Med* 1970;282:365-70.
4 McAuliffe WE. Nontherapeutic opiate addiction in health professionals: a new form of impairment. *Am J Drug Alcohol Abuse* 1984;10:1-22.
5 Brooke D, Edwards G, Andrews T. Doctors and substance misuse: types of doctor, types of problem. *Addiction* 1993;88:655-63.
6 Winick C. A theory of drug dependence based on role, access to, and attitudes towards drugs. In: Lettieri DJ, Sayers M, Pearson H, eds. *Theories on drug abuse: selected contemporary perspectives*. Rockville, Maryland: National Institute on Drug Abuse, 1980.
7 Talbott GD, Gallegos KV, Wilson PO, Porter TL. The Medical Association of Georgia's impaired physicians program: review of the first 1000 physicians, analysis of specialty. *JAMA* 1987;257:2927-30.
8 Chappel JN. (1991) The use of alcoholics anonymous and narcotics anonymous by the physician in treating drug and alcohol addiction. In: Miller NS, ed. *Comprehensive handbook of drug and alcohol addiction*. New York: Marcel Dekker, 1991:1079-88.
9 Coombs RH. *Drug-impaired professionals*. Cambridge, Mass.: Harvard University Press, 1997.
10 Strang J, Black J, Marsh A, Smith B. Hair analysis for drugs: technological breakthrough or ethical quagmire? *Addiction* 1993;88:165-8.
11 Shore JH. The Oregon experience with impaired physicians on probation: an 8-year follow-up. *JAMA* 1987;257:2931-4.
12 Pelton C, Ikeda RM. The California physicians diversion program's experience with recovering anesthesiologists. *J Psychoactive Drugs* 1991;23:427-31.

# Turbulent future for school nursing and health visiting

*Change the bathwater—but hang on to the baby*

The government is attempting to reduce inequalities in health by public health measures rather than by a fundamental redistribution of wealth.[1] Primary prevention and health promotion will be encouraged and health action zones will "provide more integrated care … better housing, healthy schools, and healthy workplaces."[2] In the light of this, the recent proposal by Cambridge and Huntingdon Health Authority to move resources from health visiting and school nursing into acute care may seem perverse. Of course, health authorities must consider cost effectiveness, but it seems shortsighted to sacrifice primary prevention and health promotion to pay for technology and acute services.

What do health visitors and school nurses do, and how effective is it? The health visitor's first task is to identify health care needs. Together with general practitioners, they provide the child health surveillance programme of immunisations, screening, and advice. They aim to identify those important conditions that parents might overlook and, for the rest, to help parents access professional expertise, voluntary agencies, and local facilities.[3] Britain's child health surveillance programme is already the leanest in the

*BMJ* 1998;316:406–7