Doctors with problems in an NHS workforce

Liam J Donaldson

Abstract

***Objectives*—To describe the incidence, nature, and implications of serious disciplinary problems among the medical staff of a large NHS hospital workforce.**

***Design*—Descriptive study with analysis of case records.**

***Setting*—Northern Health Region, an administrative area within the NHS covering a population of three million.**

***Subjects*—Forty nine hospital doctors: 46 consultants and three associate specialists.**

***Main outcome measures*—The nature of the problems encountered within the doctors' practice, and the types of action taken by the employing authority.**

***Results*—Over a five year period concerns serious enough to warrant the consideration of disciplinary action were raised about 6% of all senior medical staff (49/850). Ninety six types of problem were encountered, and were categorised as poor attitude and disruptive or irresponsible behaviour (32), lack of commitment to duties (21), poor skills and inadequate knowledge (19), dishonesty (11), sexual matters (seven), disorganised practice and poor communication with colleagues (five), and other problems (one). Twenty five of the 49 doctors retired or left the employer's service, whereas 21 remained in employment after counselling or under supervision.**

***Conclusions*—Existing procedures for hospital doctors within the NHS are inadequate to deal with serious problems. Dealing with such problems requires experience, objectivity, and a willingness to tolerate unpleasantness and criticism. Because most consultants' contracts are now held by NHS trust hospitals, however, those who had developed skill over the years in handling these complex issues are now no longer involved.**

Introduction

Concerns about the conduct or performance of doctors come to the public's attention in one of two main ways. Cases of alleged serious professional misconduct heard by the General Medical Council usually receive wide coverage in the media. Similarly, when a doctor comes before the courts, at an inquest, in a professional negligence action, or on criminal charges, the public is often given insights into wider issues surrounding standards of clinical practice.

Less prominence has been given in public to discussing doctors as employees of the NHS and how problems arising within their practice are dealt with. Formal procedures exist which allow an employer to deal with issues of professional competence and conduct among hospital medical staff. In the past, comparatively few cases have come to light in this way. Two explanations are often put forward for this—firstly, that there are in fact few serious problems and, secondly, that serious problems are much more common than is officially acknowledged but that employing authorities avoid facing up to them because of the complexity, time, money, and acrimony involved.

I report my experience of a consecutive series of cases over a five year period in which serious allegations were made about the conduct, competence, or performance of NHS hospital doctors within a large medical workforce.

Methods and background

STUDY POPULATION

The Northern region covered a population of about three million. Northern Regional Health Authority, which planned and provided health care for this population, was one of 14 similar authorities into which the NHS in England was divided geographically and administratively.

At the time of the study, regional health authorities held the contracts of employment of hospital consultants, associate specialists, senior registrars, and registrars working in hospitals within their jurisdiction. This role was consistent with a regional health authority's responsibility to plan the size and distribution of the medical workforce within its boundaries in response to clinical and training needs, as well as to changing patterns of care and new developments.

In the future the new statutory entities, NHS trust hospitals, created as part of the NHS and Community Care Act 1990[1] will be the employers of almost all the consultants and associate specialists formerly employed by the regional health authorities and will have the responsibility of dealing with allegations of the kind described here.

At the midpoint of the study there were 790 consultants, 60 associate specialists, 170 senior registrars, and 254 registrars employed by the region. None of the senior medical staff had yet transferred their contracts to NHS trust hospitals.

CASES ASSEMBLED

I have assembled all cases in which serious concerns had been expressed (or existed) about a hospital doctor employed within the period of June 1986 to June 1991. By serious I mean concerns about the doctor's conduct, competence, or performance sufficiently grave to warrant disciplinary or other formal action being considered as an option by the person raising the concern. In most instances, the person reporting the concerns (doctors, managers, or health authority chairpeople) brought the case to my attention with the approval of colleagues and with substantial supporting evidence. Action was never taken precipitately because of concerns expressed by only one person, who may have had antipathy towards the doctor concerned.

Serious cases entailed a single major incident (or occurrence), a longstanding problem, or a cumulative

Northern and Yorkshire Regional Health Authority, Newcastle upon Tyne NE6 4PY
Liam J Donaldson, *regional general manager and director of public health*

BMJ 1994;308:1277-82

series of incidents. Other cases came to notice with some regularity, which after discussion were not considered to raise serious concerns. They are not described here and were dealt with by informal counselling regionally or locally. Nor are problems of ill health described here. These were dealt with within the region by treatment, care, or retirement if appropriate.

DATA EXTRACTED FOR ANALYSIS

A confidential file on each of the cases was held by the regional medical officer. The following data were extracted for analysis: sex, age, grade, specialty, the details of the concern(s) or allegation(s) and when they first arose, whether there was a history and when it began, a synopsis of the problems and issues which were established after investigation, and the outcome of the case. Great care has been taken in extracting and presenting the data to ensure that individual doctors and patients cannot be identified. This has meant excluding or modifying certain aspects of the case descriptions but not so as to distort their fundamental substance.

FORMAL DISCIPLINARY AND OTHER RELEVANT PROCEDURES

The duties and powers of an NHS employer of hospital doctors in relation to disciplinary matters are set out in various circulars and procedural notes which are linked to terms and conditions of service for medical staff.[2,3] There is thus a formal contractually based framework through which an employer must approach a problem arising from a doctor who is an employee. Broadly, disciplinary problems or allegations must notionally be placed in one of three categories before they are dealt with.

The first category is personal misconduct, which encompasses behaviour unrelated to clinical skills. Examples of personal misconduct would be assault, sexual harrassment of colleagues, fraud, or theft.

The second category is professional misconduct, which is behaviour which arises during the exercise of clinical skills. Examples would be breaches of confidentiality, sexual intimacy with a patient, rudeness and insulting behaviour towards patients, or disruptive or seriously uncooperative behaviour towards colleagues.

KOBAL COLLECTION

The figure of dictatorial Sir Lancelot Spratt in the series of "Doctor in the House" films may have been a figure of fun, but in reality such a figure can completely destroy the teamwork of a department

The third category is professional incompetence, which is inadequate or poor performance in exercising clinical skills or professional judgment. Examples of incompetence would be failure to examine patients properly, neglecting to carry out proper investigations before initiating treatments, persistently poor record keeping, or making technical errors in carrying out operations.

Personal misconduct is dealt with by the employer's internal disciplinary procedure, which also applies to other groups of staff; such cases may involve the police from an early stage and later the General Medical Council. Professional misconduct and incompetence are dealt with by procedures unique to medical staff. Again, some cases of this kind may involve the General Medical Council.

The most serious cases in the latter category are those in which the regional medical officer judges that the issues of professional conduct or competence, if proved, could result in the doctor's dismissal and on which he or she gives advice to the regional health authority chairperson accordingly. In such cases, the procedure is a modified form[3] of that described in a circular which was first issued in 1961.[4] It entails the presentation of evidence to a form of tribunal at which there is legal representation of the doctor and the employing authority. Until 1989 there was no formally defined method for dealing with less serious cases involving concern about a doctor's professional conduct or competence or for those in which a doctor was failing to fulfil contractual obligations. New procedures were introduced in 1990,[3] however, which entailed peer review-type mechanisms, one of the outcomes of which was advice to the employing authority about how to proceed.

Another procedure exists for doctors in whom the concerns about their professional conduct or competence seem to arise from ill health or related factors. This procedure is set out in a circular dealing with the prevention of harm to patients, often colloquially referred to as "the three wise men" procedure.[5] Cases of this kind are not included in this report.

Results

The cases of 49 career grade doctors came to my attention as possible serious breaches of conduct during the five year period. Forty three doctors were men and six were women; 46 were consultants and three were associate specialists.

At the time of referral six doctors were aged under 40 years, 18 were 40-49 years, 19 were 50-59 years, and six were 60 years and over. Table I shows the specialties in which they worked at the time the problems arose. The age and specialty of the consultants in the study was not significantly different (χ^2 test) in either case from what would have been expected given the distribution of age and specialty of all such doctors employed at the time.

Table II shows the types of problems. There were more problems than individual doctors because in most cases there was more than one reported incident or area of concern.

POOR ATTITUDE AND DISRUPTIVE OR IRRESPONSIBLE BEHAVIOUR

The commonest problems encountered concerned doctors' behaviour or attitudes towards patients or professional colleagues. This category was diverse and difficult to deal with. It included many examples of consultants who were aggressive or rude to both patients and staff. For example, one consultant regularly arrived late for clinical sessions and then was abrupt and unsympathetic to patients as well as rude, demanding, and condescending towards the nursing staff concerned. There were other cases in which one

TABLE I—*Specialties of senior hospital doctors about whom there were serious concerns*

Specialty	No of doctors (n=49)
Anaesthetics	7
General medicine	2
General surgery	4
Geriatrics	4
Obstetrics and gynaecology	5
Other medical (including paediatrics)	6
Other surgical	9
Psychiatry	11
Radiology	1

TABLE II—*Nature of problems among senior hospital doctors*

Problem	No of problems
Poor attitude and disruptive or irresponsible behaviour	32
Lack of commitment to duties	21
Badly exercised clinical skills and inadequate medical knowledge	19
Dishonesty	11
Sexual overtones in dealings with patients or staff, or both	7
Disorganised practice and poor communication with colleagues	5
Other	1
Total	96

doctor's behaviour led to a complete breakdown of relationships within the clinical team, in one instance preventing discussion and planning of leave arrangements let alone clinical matters. As a result at certain times of the year the clinical workload could not be covered because no previous arrangements had been made with the hospital management or clinic staff to cover annual leave. In other situations, personal animosity was such that abusive comments were made to other doctors, managers, nursing staff, and even patients by one consultant about another. Other doctors in this category caused a great deal of disruption by repeatedly refusing to participate in any team development plans or persistently failing to comply with decisions or policies that had been democratically agreed.

There were also cases of grossly irresponsible behaviour. For example, in one instance a doctor had compromised hospital standards and possibly placed a patient in jeopardy by contaminating a clinical area in pursuance of a purely personal objective. The incident necessitated the service being closed for a time. In another case a surgeon was in the habit of leaving his patients during operations to demonstrate to staff the use of theatre instruments which were unrelated to the procedure in hand.

Many of these problems were long standing, and we were often surprised by the willingness of the doctor's professional colleagues to tolerate the difficulties that ensued for such long periods of time. In these cases the judgment about when behaviour becomes so unreasonable that it should form the basis for disciplinary action is a difficult one. Sadly, we did not encounter many serious problems of this kind which could be resolved by counselling or informal means. Behaviour that is persistently disruptive or apparently stems from immature attitudes and reactions proved almost always refractory to such interventions. Of this group, six out of 15 stayed in post after counselling, with varying degrees of monitoring or supervision being required. The remainder opted for early retirement or left the authority's employment.

LACK OF COMMITMENT TO DUTIES

The issues found in this category were varied, but three cases illustrate the kinds of problems encountered. One consultant's pattern of work meant that he started and finished work earlier than any of his colleagues, he exceeded his annual leave entitlement, he refused to respond to emergencies while on call at home, and saw far fewer patients than other consultants in the same specialty in the same hospital. Another consultant missed clinical sessions without notice or explanation or was persistently late for them, refused to handle extra work while colleagues were on leave, and systematically took the busiest on call days as annual leave or to attend professional meetings out of the area. A third consultant was never available in the hospital during one half day paid session a week and recorded above average amounts of time each week as devoted to administration. In 10 cases the lack of commitment to duties was explicitly linked to private medical practice. For example, one consultant carried out extensive private work during the normal working day, but NHS work was undertaken only at the beginning and end of the day, at times which were inconvenient for junior staff and disruptive to hospital ward routines. Another consultant continued to undertake private practice while on sick leave from the NHS.

Just under half (six of 14) of these doctors opted to take early retirement or left. The remainder stayed in post, and their work programme and commitment was kept under review.

POOR SKILLS AND INADEQUATE KNOWLEDGE

The third largest category of problems were those of poorly exercised clinical skills or inadequate medical knowledge. These included high levels of complications after surgery, displaying a lack of knowledge of the effects of drugs currently being prescribed therapeutically, and the incorrect use of clinical instruments. In one case the clinical practice and opinions of one consultant were so distrusted by junior medical staff (having been found on many occasions to be in error) that they were reluctant to approach him when a problem arose with which they needed help, preferring instead to seek help from any of the other senior medical staff.

Five of these 12 cases were resolved by the doctor concerned opting for early retirement. The remainder stayed in post after counselling, with close monitoring of, or restriction to, parts of their practice.

DISHONESTY

The cases of apparent dishonesty included a number of false claims for expenses and the non-declaration to the NHS hospital of private patients seen within the hospital. In other cases some of the doctors were less than honest in their work practices. One consultant had falsified work returns about the number of patients seen to conceal a clear shortfall in workload, while another had knowingly given incorrect data to a drug company during a drugs trial.

Three of the five doctors in this group took early retirement or resigned. Cases were referred to the General Medical Council or the police as necessary.

SEXUAL BEHAVIOUR

In a few cases the problems raised about the doctor's practice concerned sexual matters. In this group the history of incidents was long standing, ranging from two to 20 years.

The behaviour of one consultant had repeatedly distressed his female patients. He regularly took an inordinate amount of time to carry out internal examinations. Lengthy pelvic and breast examinations were carried out on patients with conditions such as varicose veins in which arguably such procedures would normally be omitted. The doctor concerned also questioned such patients in detail about their sexual histories and proclivities. One one occasion (observed by nursing staff) the doctor carried out a lengthy vaginal examination with his head under a blanket. He

justified this approach as dulling all perceptions except that of touch.

Another doctor regularly insisted on examining female patients with upper abdominal symptoms by palpation through their breast tissue. The manner in which the breast was massaged and manipulated caused distress to patients and to the nursing staff who observed the examinations. The same doctor was reported to use a great deal of sexual innuendo in history taking with female patients. As a result nursing staff never left him alone with female patients, and additional staff were deployed in outpatient clinics so that he was never without a chaperone.

In each of these cases there were also complaints about conduct in relation to female members of staff—for example, suggestive comments or a physical approach.

In all such cases the patients were convinced that the doctor's actions had sexual overtones, and the nursing staff also considered that the practice or behaviour was improper. In some cases of this kind complaints were made initially by the patients, relatives, or staff, but when this happened none would pursue them formally because when it was explained that they may have to appear before a hearing and possibly be asked questions, they were unwilling to take the matter further.

All but one of the doctors in this group took early retirement.

DISORGANISED PRACTICE

Some doctors ran their practices in a disorganised way. Their record keeping was extremely poor, and letters about patients referred for consultation were never sent or were too late to be of help to the general practitioners. All the doctors in this group remained in post after counselling.

OUTCOME OF THE CASES

Table III shows the outcome of all the cases described in the previous sections. Over half of the doctors (25/49) whose performance or conduct had been a cause for concern either retired or resigned, some presumably to work elsewhere. Most of the others continued in post after counselling and were kept under observation.

Discussion

My experience of dealing with the most serious problems of conduct and performance among hospital doctors in NHS employment in a health region provides, to the best of my knowledge, the first published report which has attempted to quantify such problems in a large medical workforce in Britain.

I must anticipate and accept the criticism that I have identified only a proportion of the cases which actually existed. I have made no mention of junior hospital doctors. We only occasionally became aware of problems in these grades. My strong impression was that such problems were not always properly dealt with locally or reported to the regional authority. The attitude taken was often that the problem was best resolved by the junior doctor concerned leaving at the end of the contract. As far as the consultants and associate specialists were concerned (who formed most of the cases reported here), however, my extensive contacts with senior doctors, health authority chairpeople, and health service managers in the region at that time meant that almost all the names of doctors that eventually arose formally were already known to me through this informal network as people who had been giving rise to concern over a period of time. Thus, I believe that the number of cases involving senior medical staff reported here, which represented 6% of the workforce, is a reasonable estimate of the size of the problem.

TABLE III—*Outcome of cases of disciplinary action against doctors*

Outcome	No of doctors (n=49)
Remained as employee after counselling or under supervision	21
Retired	16
Left to work elsewhere	9
Other	3

CLOSING RANKS

Among managers I found general resentment arising from the perception that doctors are so heavily protected and that they seem to be privileged compared with other groups of staff. On many occasions I was told by those making the referral of their reluctance to report problems because they thought that nothing could or would be done or because of the tendency in such cases for early involvement of defence societies and their lawyers. Moreover, whereas doctors' colleagues were often willing to report concerns confidentially and informally they were extremely reluctant to go on the record. Some considered that this would amount to disloyalty; others feared giving evidence in a hearing or believed that defamation actions would be launched against them.

The most difficult and time consuming cases to resolve were those in which a doctor's attitude and behaviour were disruptive or highly unreasonable. So serious did this become in some of the cases I describe that clinical departments were almost brought to a standstill. The resulting poor communication, the absence of teamwork, the atmosphere of hostility, and the poor morale could not, in my view, have been other than detrimental to patient care.

During the course of handling these cases, on numerous occasions I have heard doctors' colleagues ask, "Why can you not just get rid of him?" A similarly pragmatic approach was often advocated by newly appointed non-executive directors of health authorities, who, seeing the problem for the first time, were incredulous that the delivery of a service could be allowed to be so severely damaged for so long by the behaviour of one or two individual people working within it. Judgments about poor attitude and unreasonable behaviour are difficult to convert into evidence which could sustain an action for professional misconduct or incompetence. In several cases the problems remained and were little improved by the process of investigation and counselling.

PROBLEMS OF DEFINITION

It might be thought that apparent failure to fulfil work commitments would be a more straightforward issue to resolve. On the contrary, in my experience establishing precise contractual responsibilities within the aegis of terms of conditions of service for hospital doctors, even with the advent of job plans introduced as a component of the 1990 NHS reforms,[6] is extremely difficult in practice. It often proved impossible to overcome the counterarguments of the doctors' trade union or legal representatives that the actual commitment being made technically fell within the scope permitted by the minimum requirements laid down nationally. Yet the cases concerned were regarded as particularly serious and blatant by the doctors' peers. Without a more explicit form of contract for hospital doctors it will not be possible to deal with problems like this simply and effectively.

The cases that particularly concerned me was the small but worrying minority in which there were sexual connotations to doctors' relationships with patients. The behaviour concerned never presented itself as

conventional sexual assault and was construed by the doctor as a variant of clinical practice and justified as such. These doctors had continued with unconventional practices for long periods of time, with staff often going to extraordinary lengths to protect patients —for example, by providing double chaperones. Most of these problems were resolved by retirement of the doctor concerned. Trying to deal with them within a purely disciplinary framework repeatedly broke down because patients and staff did not wish or were afraid to give evidence in a formal hearing, given the distasteful and distressing nature of the complaints.

UNSATISFACTORY PROCEDURES

Present employment procedures dealing with conduct and performance of doctors introduced in the early 1990s[3] are unsatisfactory in two main ways. Firstly, the procedures for dealing with contractual and other problems (not judged serious enough to result in possible dismissal) involve quasi peer review mechanisms. These call on doctors to perform a part that would be carried out by the employer for other grades of staff (or senior professional staff in many other sectors). Secondly, the procedure for dealing with cases of professional misconduct or incompetence which could result in dismissal is legalistic, time consuming, expensive, and intimidating to those who might wish to report a problem or who might have something relevant to say on the matter.

My health authority did not conduct such inquiries on the type of cases in which this was a possible option. Unless there was an immediate danger to patients, suspension was seldom used. It introduces an immediate stigma, increases the degree of confrontation, and makes informal and agreed solutions much more difficult. Most cases that were resolved ended in early retirement under the regulations. Without retirement packages, particularly those introduced under the *Achieving a balance* medical staffing plan.[7] I would inevitably have left more doctors in practice who should not have continued, with consequent implications for the quality of patient care. Even retirement was not an easy route for resolving problems. It was usually reached after months or sometimes years of difficulty. Although at the time it clearly represented the only realistic solution to serious and intractable problems, it must be asked whether this is the right way for such matters to be dealt with, by using what is essentially an informal mechanism.

BROADER REMIT FOR GENERAL MEDICAL COUNCIL

It is far too simplistic to imply, as some have done, that misconduct or incompetence should be tested by using the formal procedures and if not found to be present, then no problem exists. I fully accept that concerns have been expressed by some members of the profession, notably Wendy Savage,[8] that doctors should have the right to be "tried" under existing procedures (ideally in public), and to deny them this, whether by prolonged suspension or other means, could be unjust and amount to victimisation. This position fails to acknowledge that existing procedures which could result in a doctor's dismissal are, however, a deterrent to action by employing authorities, potential witnesses, and others. Intolerable situations are thus allowed to prevail rather than being dealt with. Many of the cases described here in which competence was at issue were among doctors in the latter phases of their careers. Many had not been able to keep pace with modern developments or their existing limitations had been allowed to go unchallenged over a long period of time. To try them for incompetence would have been humiliating and surely not the right way to deal with such matters. Yet patients must be protected.

Over the period of the study we referred only a small proportion of the cases to the General Medical Council, notably those dealing with dishonesty, which were on the whole much more straightforward. The council has been concerned about the apparently low rate of referral of cases from hospitals and has tried to encourage regional medical officers to report more.[9] My experience of the General Medical Council was that it was not used to dealing with cases of the kind described here and took too long to process them given the pressing needs of the employment situation. The categories exemplified in the General Medical Council's definition of serious professional misconduct[10] in theory could be regarded as covering the kind of issues I dealt with. It is obvious, however, from reading the council's reports[11] that the population of problem doctors I saw as an employer was essentially different from that dealt with by the council. This is not surprising because the council's approach is governed by the definition of serious professional misconduct enshrined in the Medical Act 1983.[12]

The General Medical Council has proposed the introduction of a new performance review procedure.[13] The emphasis in the proposed new procedures is on remedial measures, not punishment, and thus great store is put in retraining. I strongly support the council's wish to broaden its remit into issues of performance, but my experience described here is consistent with the observations made by Richard Smith that cases of poor performance may be more common than the council anticipates and that retraining is unlikely to be an effective solution for the kinds of problems encountered.[14] Nevertheless, the council's proposed wider involvement represents a step of major importance in finding the ultimate solution to these problems.

FUTURE ACTION

My experience of dealing with problem doctors over many years leads me to reflect that it is difficult, distasteful, time consuming, and acrimonious work. For these reasons the temptation to avert one's gaze from these problems is at times very great. Add to this the nature of the present NHS disciplinary procedures and I have no doubt that many employers do look away when they should not. I fear for the position of the NHS trust medical directors. They are taking on this work for the first time, but they will be dealing with their peers who work in the same institution. They will not be at an appropriate distance to sustain objectivity as were their predecessors, the regional health authority medical officers and chairpeople. There are, however, certain pointers to dealing with these problems based on my experience for these new employers and in particular their medical directors (box).

A solution must be found which introduces greater

Dealing with disciplinary problems among doctors: some guiding principles

- Be familiar with and generally adhere to policies and procedures for handling disciplinary problems, fully establish the facts, and document the approach scrupulously
- Avoid precipitate action on apparent disciplinary matters; things are often not always as they first seem
- Remain non-judgmental—do not be drawn into expressing preliminary opinions or making gratuitous observations
- Beware of manipulation by those who have axes to grind
- Never opt for a quiet life by avoiding dealing with problems—this may be to the serious detriment of patients or the effective functioning of a clinical department

flexibility, less confrontation, and more openness, as well as striking an appropriate balance between professional self regulatory and employer based mechanisms for dealing with problem doctors. Moreover, more varied retirement and other exit options must be created to enable doctors with problems to depart with dignity when the circumstances are appropriate. Without all this patients and the quality of their care will suffer as they have done in the past because of a reluctance to face up to difficult issues.

1 *NHS and Community Care Act 1990.* London: HMSO, 1990.
2 National Health Service. *Hospital medical and dental staff (England and Wales). Terms and conditions of service April 1986.* (Revised.) London: HMSO, 1986.
3 Department of Health. *Disciplinary procedures for hospital and community medical and dental staff.* London: DoH, 1990. (HC(90)9.)
4 Ministry of Health. *Disciplinary proceedings in cases relating to hospital medical and dental staff.* London: MoH, 1961. (HM(61)112.)
5 Department of Health and Social Security. *Prevention of harm to patients resulting from physical or mental disability of hospital or community medical or dental staff.* London: DHSS, 1986. (HC(82)13.)
6 Secretaries of State for Health, Wales, Northern Ireland, and Scotland. *Working for patients. NHS consultants: appointments, contracts and distinction awards.* Working paper 7. London: HMSO, 1989.
7 UK Health Departments, Joint Consultants Committee, and chairmen of Regional Health Authorities. *Hospital medical staffing—achieving a balance.* London: HMSO, 1986.
8 Savage W. Disciplinary procedures and secrecy. *BMJ* 1991;**303**:52.
9 Smith R. Profile of the GMC: the hordes at the gates. *BMJ* 1989;**298**:1502-5.
10 General Medical Council. *Professional conduct and discipline: fitness to practice.* London: GMC, 1993.
11 General Medical Council. *Annual report of the General Medical Council 1992.* London: GMC, 1993.
12 *Medical Act 1983.* London: HMSO, 1983.
13 General Medical Council. *Proposals for new performance procedures: a consultation paper.* London: GMC, 1992.
14 Smith R. The GMC on performance: self regulation on the line. *BMJ* 1992;**304**:1257-8.

(Accepted 25 January 1994)

Treating childhood asthma in Singapore: when West meets East

G J Connett, B W Lee

Though Western medicines and ideas about asthma have become popular in many Asian nations, local beliefs about treatment prevail. The multiracial society of Singapore shows a variety of beliefs about causes of asthma attacks (for example, the balance of yin and yang) and types of treatment—herbal remedies, inhaled versus eaten medicines, the influence of Ramadan. Many of the cultural practices mentioned are probably preserved among south east Asian minorities residing in the United Kingdom. Eastern treatments typically take a holistic approach to asthma and do not ignore the psychosomatic component of the disorder.

Department of Paediatrics, National University of Singapore, Singapore 0511
G J Connett, *overseas fellow*
B W Lee, *associate professor*

Correspondence to:
Dr Lee.

BMJ 1994;**308**:1282-4

As in most Western countries, asthma is increasingly common in many Asian nations. Its prevalence during childhood (5-17 year olds) in Singapore is 12% among Chinese communities, 19% among Malays, and 15% among Indians (unpublished data). In recent years Western medicines and ideas about asthma have become popular, but despite this trend local beliefs about treatment prevail. Some of these sound implausible, but others hint at underappreciated differences in the pathogenesis of asthma between Asians and white people.

Singapore is a multiracial society, consisting mainly of Chinese (76%), Malays (15%), and Indians (6%). These main racial groups are culturally diverse, as are their beliefs in traditional medicine. The Chinese in Singapore originate from southern China and belong mainly to the Cantonese, Fukien, and Teochew dialect groups. These dialect groups share the same written language and have common traditional beliefs about illnesses and their cures. The Malays in Singapore are also a heterogeneous community, with main origins from Javan and Bawean provinces of Indonesia. Like the Chinese, they share distinct beliefs about diseases and their cures.

This article reviews some of the local beliefs about asthma reported by the parents of children attending the respiratory clinics of the National University Hospital of Singapore. Although this report is based on our experience with childhood asthma, these local beliefs apply to asthma as a disease entity and are not unique to childhood asthma.

SPRAGUE/PANOS

Inter-racial differences in food induced symptoms of asthma suggest unexplored processes that cause changes in bronchial reactivity and the expressionm of atopy

Causes of asthma attacks

Central to understanding on how to treat asthma in our cosmopolitan community is to realise that eating is the most important national preoccupation. Beliefs about what foods should or should not be taken during illness are often held with great conviction and are considered just as important for recovery as the doctor's prescription. Although some families' concern with food becomes obsessional, it would be counterproductive to dismiss such ideas on the grounds that medical evidence is lacking or because they are difficult to explain.

Whereas many Western people with asthma identify pollens, grasses, and moulds as important precipitants of symptoms, aeroallergens are less frequently implicated in equatorial climates where exposure is often perennial. Although viral infections are often recognised as precipitants of wheezing, the most common answers to "what makes your child's asthma worse?" are cold fruits, cold drinks, ice cream, and chocolate from the fridge. It is difficult to understand the basis for this purported effect of all things cold on asthmatic