We concluded that despite education and high motivation in an organised group of travellers simple preventive measures were not observed. Guidelines, however, are regularly updated,[2] and doctors advising travellers should be aware of current advice.

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1 Miller JH, Byers M, Whiteoak R, Warrell DA. Imported falciparum malaria in British troops returning from Kenya. *J R Army Med Corps* (in press).
2 Bradley D. Prophylaxis against malaria for travellers from the United Kingdom. *BMJ* 1993;306:1247-52.

No documentary evidence of bribery by German hospital directors

EDITOR,—On behalf of the German Chamber of Physicians, I wish to comment on Helmut L Karcher's report on accusations of bribery against German hospital directors.[1] At the end of May the association of all German public health insurance companies said in a statement that directors of 50 out of 51 heart centres in western Germany were to blame for having accepted bribes from producers of artificial heart valves. The news magazine *Der Spiegel* published these accusations.[2]

In fact, no such nationwide scandal exists. When the public health insurance companies had to prove their accusations at a special meeting of the health committee of the German Bundestag on 1 June they claimed only 12 cases of bribery without naming the heart centres of hospital directors. Even three months later they were not able to support their accusations with documentary evidence.

There are no indications that bribery is common in German heart centres. According to the news magazine *Focus*, however, there are indications that the public health insurance companies themselves spent more than DM1m (£421 000) in an attempt to gain information about the alleged scandal from insiders.[3] Karcher's article was written as though the story was true, but the story was a hoax.

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1 Karcher HL. German hospital directors accused of bribery. *BMJ* 1994;309:1588-9. (18 June.)
2 Bares oder einen BMW. *Der Spiegel* 1994;22:92-8.
3 Kowalski M. Herzklappenaffäre: Flop für Krankenkassen. *Focus* 1994;31:18-21.

New treatments for benign prostatic hypertrophy

EDITOR,—Roger S Kirby and M C Bishop's examination of treatment of benign prostatic hypertrophy is timely,[1] given the growing number of methods of treatment that are being advocated and the emerging evidence that the volume of unmet need for treatment in the population is large.[2] We believe, however, that the arguments advanced by Kirby are not supported by the evidence. In the absence of data from randomised controlled trials his conclusions concerning alternative treatments can be only speculative. Unfortunately, depite continued uncertainty about this issue, urologists in Britain have been reluctant to participate in a randomised controlled trial comparing transurethral resection of the prostate with open surgery.

Bishop argues that patients with mild lower urinary tract symptoms are best left alone, a view with which we concur.[3] Apart from consideration of the balance of benefits and risks, the cost implications of advocating any of these innovative treatments for such men is enormous and the treatments should be undertaken only for good reason. There is therefore an urgent need to evaluate them properly. Before this is done, however, several issues that are insufficiently emphasised by Kirby and Bishop need to be resolved. Are the treatments seen as a substitute for transurethral resection of the prostate among patients currently offered treatment? Is it envisaged that they will be offered to patients with less severe disease than those currently being treated? What measure of outcome will be used, given the lack of concordance between symptoms and urinary flow?[4] And as drug treatment may need to be continued for many years, what is the most appropriate time at which to measure outcome?

Kirby may be correct in saying that urologists unprepared to grasp the future will be left behind. The history of medicine is, however, littered with those who rushed to embrace new technologies only to abandon them when the initial enthusiasms proved unfounded.[5] The question of who should pay also arises. At present health authorities and general practice fundholders should purchase these new treatments only if they are part of a randomised controlled trial.

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1 Kirby RS, Bishop MC. Are the days of transurethral resection of prostate for benign prostatic hyperplasia numbered? *BMJ* 1994;309:716-8. (17 September.)
2 Hunter DJW, McKee CM, Black NA, Sanderson CFB. Urinary symptoms: prevalence and severity in British men aged 55 and over. *J Epidemiol Community Health* (in press).
3 Doll HA, Black NA, McPherson K. Transurethral resection of the prostate for benign prostatic hypertrophy: factors associated with a successful outcome at one year. *Br J Urol* 1994;73:669-80.
4 Barry MJ, Cockett ATK, Holtgrewe HL, McConnell JD, Sihelnik SA, Winfield HN. Relationship of symptoms of prostatism to commonly used physiological and anatomic measures of the severity of benign prostatic hyperplasia. *J Urol* 1993;150:351-8.
5 Beeson P. Changes in medical therapy. *Medicine* 1980;59:79-84.

Supervised administration of methadone by pharmacists

EDITOR,—Supervision of the administration of methadone by community pharmacists has benefits beyond the prevention of "street leakage."[1] The risks of loss or theft of the drug, binging, injecting, and overdose are minimised; trust between doctors and patients is enhanced; and as a reward for progress in treatment patients may be given more than one day's supply to take home. A scheme similar to that in Glasgow[1] has run in West Glamorgan since 1991, with 25 pharmacists each supervising up to 15 patients. The anxieties expressed by pharmacists to Robert T A Scott and colleagues[1] have not been justified in practice.

A new scheme in Mid Glamorgan has been straightforward to implement. The local pharmaceutical committee agreed the protocol and circulated it to all pharmacists. In both schemes scripts to be supervised are stamped to be easily identifiable. All patients newly prescribed methadone have their consumption supervised daily, Monday to Saturday. Pharmacists do not enforce the scheme but telephone the prescriber regarding non-compliance so that appropriate action can be taken.

P D Thomas's criticisms seem misplaced.[2] Both sets of guidelines referred to by Scott and colleagues emphasise the need for treatment and contact with a doctor over and above the prescription of methadone.[3,4] It is perhaps surprising that neither refers to supervised consumption. The suggestion that prescribers should be responsible for supervision ignores both the unwillingness of many general practitioners even to prescribe and the number of patients per doctor seen by specialist services. Similar concerns over confidentiality and privacy were expressed when pharmacists first provided needle exchange, but pharmacists are now generally seen by drug misusers as "drug user friendly." The reasons for a prescription of methadone are understood by the pharmacist irrespective of where the drug is consumed. Three pharmacists in our schemes have rearranged their premises with privacy in mind, and others may follow. We would emphasise that pharmacists undertake supervision because they recognise the benefits for patients and the public; they receive only the dispensing fee.

Community pharmacists' supervision of consumption of methadone has many advantages. With collaboration between professional groups it can be straightforward to implement. It should be considered wherever centralised methadone maintenance clinics with supervised dispensing on site are impractical.

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1 Scott RTA, Burnett SC, McNulty H. Supervised administration of methadone by pharmacists. *BMJ* 1994;308:1438. (28 May.)
2 Thomas PD. Doctors should supervise administration of methadone. *BMJ* 1994;309:53-4. (2 July.)
3 Advisory Council on the Misuse Of Drugs. *AIDS and drug misuse update*. London: HMSO, 1993:42-9.
4 Department Of Health, Scottish Home and Health Department, Welsh Office. *Drug misuse and dependence: guidelines on clinical management*. London: HMSO, 1991.

Computer training for doctors and students

EDITOR,—We agree with the comments by Ronald LaPorte and colleagues[1] and Ray Jones and Sue Kinn.[2] The information superhighway, an important technical development of immense potential impact in clinical medicine, will not fulfil its potential if doctors do not, will not, or cannot use it because they do not know how. Education is clearly the key—a fact recognised by the General Medical Council, which has stated that "a working knowledge of modern medical information technology will be essential to the doctor of the future."[3]

For some years our unit has run a course in information technology as part of the first year curriculum at Leeds University Medical School, teaching skills necessary to use computers and networks (accessing network information, word processing, use of spreadsheets and databases) and emphasising the use of computers as a source of information for help with practical problems.

Testing after the course shows that 95% of students possess (under examination conditions) the relevant skills and also shows considerable changes in the students' attitudes towards computers and information technology.

Such a course is not, however, without problems. Firstly, a course in computing for medical students is unlikely to be popular. A course will succeed best if it is practical (that is, it teaches skills) and clinical (that is, preclinical students are presented with clinical scenarios and problems that they can solve only with the aid of the computer and a minisuperhighway). Secondly, the course must be "streamed," reflecting mixed ability. Incoming students range in ability from being completely ignorant about computers to having held a computer consultancy. It is impossible to teach the same course to every medical student: the high flyers get bored and the neophytes become terrified. Finally, the course needs appropriate resources. We are fortunate in respect of hardware at Leeds University. The course is also, however, labour intensive. If one wishes neophytes to acquire computer skills rapidly and effectively then appropriate demonstration (sometimes on a one to one basis) is necessary.

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1 LaPorte RE, Akazawa S, Hellmonds P, Boostrom E, Gamboa C, Gooçh T, *et al.* Global public health and the information superhighway. *BMJ* 1994;308:1652-3. (25 June.)
2 Jones R, Kinn S. Global public health and the information superhighway. *BMJ* 1994;309:736-7. (17 September.)
3 General Medical Council. *Tomorrow's doctors. Recommendations on undergraduate medical education.* London: GMC, 1993.

Sick doctors

Workaholics harm families also

EDITOR,—I am disappointed that Liam J Donaldson's editorial on sick doctors makes no mention of workaholic doctors and the peer pressure that results in doctors seeming to take pride in workaholism.[1] This "respectable addiction," as it has been described, seems not to be recognised in Britain. Doctors who do not subscribe to such an ethos may often be criticised by other colleagues as being lazy, lacking in motivation, or unambitious, whereas they may be showing a healthier balance of concern for themselves and their families.

As Donaldson states, doctors have a high mortality from suicide, self injury, poisoning, and cirrhosis. This may well be the visible tip of the iceberg. It would be interesting to see the profession have the courage to investigate the effect of doctors' working patterns on their families. The current political concern for the importance of family life is not widely put into practice by doctors with families.

The editorial views the problem of sick doctors in terms of the relatively well defined threat to patients and perhaps the profession. The wider aspect of the damage to the health of the doctors, their families, and society as a whole is more intangible and insidious. Work may never be seriously enough affected for the problem to be a threat to patients or colleagues, and it is easy for colleagues to minimise problems as being due to poor judgment, poor interpersonal communication, or poor management. The costs to the families is professionally invisible; the true cost to them and ultimately to the health service and society may not be apparent till many years later. Several American books have been published on the subject,[2-4] which warrants serious consideration. A branch of Workaholics Anonymous has recently started in Britain; its address is c/o 9 Maunsel Street, London SW1P 2QL

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1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)
2 Killinger B. *Workaholics: the respectable addicts.* London: Simon and Schuster, 1991.
3 O'Neill J. *The paradox of success: when winning at work means losing at life.* New York: Putnam, 1994.
4 Fassel D. *Working ourselves to death: the high cost of workaholism and the rewards of recovery.* San Francisco: Thorsons, 1992.

Existing services need to be coordinated

EDITOR,—Liam J Donaldson's concern for sick doctors is welcome[1] as he and his colleagues in management are responsible for the care and wellbeing of staff and for the quality of the occupational health services provided. The problem of sick doctors is not new: in 1832 Thackrah described not only the risks of infection but "anxiety of the mind."[2] The relentless changes taking place throughout the NHS are taking their toll on doctors at all levels, as well as other occupational groups, including management. The effects may be shown by absence due to sickness or early retirement, and finding a senior doctor who wants to work until normal retirement age is difficult now.

Health care workers make up about 5% of the national workforce and are exposed to a wide range of occupational hazards, yet many do not have access to consultant led occupational health services. Provision has improved recently, though many advertisements put great emphasis on income generation, and the conclusion reached in a major review in 1990—that "management attitude to occupational health is frequently primeval compared with their counterparts in private industry"[3]—is, with some notable exceptions, still valid.

Where competent occupational health services exist doctors use them, but neither party is likely to advertise the fact. Trained occupational physicians are required to work to strict ethical standards, and revised guidelines have recently been issued by the Faculty of Occupational Medicine.[4] Confidentiality is paramount, and separate records should be maintained in the occupational health department. Doctors, who receive little undergraduate training in occupational medicine, may not be aware of the services that are available, and so consultations with colleagues in a corridor, self administration, and poor follow up continue.

Sick doctors need clear information on access to help, a prompt and high quality service, and competent advice on rehabilitation available within occupational health departments. The existing services—general practice for all, consultant occupational physicians for some, and "three wise men" and helplines for sick doctors for others—need to be coordinated and developed into a comprehensive and high quality service. The Faculty and the Society of Occupational Medicine are willing to advise on appropriate levels of provision and competence.

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1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)
2 Thackrah CN. *The effects of arts, trades and professions on health and longevity.* 2nd ed. London: Longman, 1832.
3 Harrington JM. The health of health care workers. *J R Coll Physicians Lond* 1990;24:189-95.
4 Faculty of Occupational Medicine. *Guidance on ethics for occupational physicians.* London: FOM, 1993.

Develop existing occupational health services

EDITOR,—Liam J Donaldson calls for "the creation of a new and cohesive national framework" for the management of sick doctors.[1] An effective service is certainly needed,[2] but surely we should use and build on the existing skill in occupational health services rather than develop a new system in parallel. Indeed, Donaldson describes features of the sort of service that could and should be provided by occupational health units throughout Britain.

We accept that the present provision is patchy. The Department of Health called for the development of properly staffed occupational health services in all districts as long ago as 1982,[3] yet there are still fewer than 50 full time consultant occupational physicians in post. More recently the BMA has recommended the provision of a consultant led occupational health service as a prerequisite for approval of trust status.[4] Resources are needed to develop existing departments and attract fully trained and competent staff into them.

The management of sick doctors raises many sensitive and ethical issues. Anecdote suggests that many sick doctors are not referred to occupational health departments, but occupational physicians see other health professionals such as nurses, ambulance crew, and laboratory staff regularly, and there are many issues in common. Specialist occupational physicians have in depth knowledge of the local situation and have built up relationships with managers and clinicians. They work to a strict and well defined code of confidentiality.[5] They are experienced in liaising with local treatment services. Many have developed reciprocal referral arrangements with colleagues in neighbouring districts. This is especially important for psychiatric problems, when staff are often reluctant to consult a colleague in their own institution. To ensure the best use of services we need to encourage a culture in which doctors feel more able to seek early help and advice for health problems. This needs to begin during the training years.

The Association of NHS Occupational Health Physicians is well placed to liaise with interested bodies at a national level and to coordinate a uniform approach to the management of sick doctors. We agree that more needs to be done to help such doctors. But to ignore the framework and skill that already exist in occupational health services and instead develop a parallel system would be expensive and inefficient.

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1 Donaldson LJ. Sick doctors. *BMJ* 1994;309:557-8. (3 September.)
2 Nuffield Provincial Hospitals Trust. *The provision of medical services to sick doctors: a conspiracy of friendliness?* London: NPHT, 1994.
3 Department of Health and Social Security. *Health services—management. Occupational health services for NHS staff.* London: HMSO, 1982. (HN(82)33.)
4 British Medical Association. *Environmental and occupational risks of health care.* London: BMA, 1994.
5 Faculty of Occupational Medicine. *Guidance on ethics for occupational physicians.* London: FOM, 1993.