an increase in milk supply; the mother of a hungry baby is often advised to start complementary bottle-feeds.

Inevitably the free booklets are peppered with advertisements for artificial foods; and, though some of these point out that breast-milk is better, this reminds me of the Government health warnings on cigarette advertisements. Similarly, while there may be a single photograph of a mother breast-feeding her baby there will be numerous ones of bottles and bottle-feeding; this, together with the prominence of bottles and the other equipment related to artificial feeding in the shops and the absence of mothers seen breast-feeding in public, will tend to reinforce the impression that breast-feeding is unusual.

Early days

In the early days after a hospital delivery a mother needs help and encouragement as she learns about her baby. In those early days when one feels tired, ignorant, and insecure most mothers appear to be bottle-feeding by the clock—with peaceful nights while the nursing staff give the 2 am feed and leisurely days with bottles of ready-mixed milk brought to the bedside. This may be enough to push the mother hesitant about breast-feeding to switch to those bottles already placed at the end of her bed by a thoughtless nurse. The hospital routine may not help either with the lack of privacy and almost constant interruption by drug trolley (not more iron pills . . .), drinks, domestics (didn't they once respect closed curtains and doors?), and meals that just get cold and more unappetising while the baby finishes his. It can be difficult to establish a faultless let-down reflex under these conditions despite the advantage of being free from one's own domestic responsibilities.

Fatigue was the one factor in the early weeks that might have made me give up breast-feeding if I had not been determined to continue. Demand feeding can be very demanding in the first two or three months. We doctors think that we are working hard on a one in two rota, but the breast-feeding mother cannot have a night off, her responsibility cannot be delegated. She may be disturbed two, three, or more times each night for several weeks, and by day there is little time for anything else but feeding and changing nappies. In the days of the extended family sharing of housekeeping duties was taken for granted, but with the current trend for nuclear families that ideal is not so easily attained; a stranger who constantly needs instructions may provide more work for the mother than doing the chores herself.

The calorie-consuming nature of breast-feeding is another aspect inadequately publicised. Once the baby is born and is being breast-fed the physiological fat stores laid down for this purpose in pregnancy are mobilised, with easier return to pre-pregnant weight and figure. If no extra fat has been laid down the lucky mum can eat for two. I believe that too little attention is paid to maternal diet throughout. It is not much use getting dietary advice at antenatal classes in the third trimester when it is needed from the first.

So we pay lip service to the benefits of breast-feeding as we do to many things, but we fall over backwards to reassure mothers who want to bottle-feed, or who have had to give up breast-feeding, that artificial milks are as good. Even if they are, the incidence of errors in making up the feeds[2] lends more support to the view that Nature's way is best. We are frightened of causing these mothers to feel inadequate, but this ambivalent attitude does little to promote breast-feeding.

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Letter from . . . Oregon

Friends of Medicine*

RALPH CRAWSHAW

British Medical Journal, 1979, **2**, 372-373

Fortunately, the humanity of doctors is more often recognised in their strengths than in their weaknesses. The doctor is looked to for leadership, forbearance, intelligence, and wisdom, but, unhappily, the expectation is not always fulfilled. The doctor who displays appetites where he is expected to abstain, ignorance when he should know, or weakness when he should be strong, is a persistent problem. The experience of Oregon's doctors in meeting this problem by forming the Friends of Medicine may be valuable to other medical communities in dealing with the disabled doctor.

*Based on a presentation at the VI World Congress of Psychiatry, Honolulu.

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Beginnings

The Friends of Medicine began in 1968 with a letter from a local doctor to our county medical society. He wrote of his deep concern for a colleague of many years who appeared to be steadily deteriorating. He gave examples of his colleague's poor medical judgment, incompetence, and loss of friends and staff privileges. He wondered if a committee existed within the government of medicine to help this man before he took his final plunge into professional oblivion. The letter stirred deep feelings in the doctors and administrative staff of the medical society. Ths miserable and sometimes terrifying experience of standing by and watching a colleague fray his life to shreds is too common; but what can be done? How can we protect him and his patients from his destructive behaviour? The letter's clear plea to help the doctor and protect his patients was the beginning of the Friends of Medicine.

The initial group formed, the Committee of Concern, was led by a doctor who knew well the desperate problems that illness and poor judgment had brought down on the heads of fellow doctors. He had spent years as a member of the state board of medical examiners, that window on personal and professional tragedy, and was aware that one in ten doctors in Oregon will appear before the board during their

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professional life. He had heard doctors' wives pleading that their alcoholic husbands be given yet another chance. He knew the dilemma of choosing between depriving isolated rural communities of their only direct medical care, and exposing them to the danger and misery of incompetent care. Having lived through all this, he wanted more than discipline for disabled doctors, and the committee crystalised around this wish.

The backgrounds of the members was diverse: a professor of family medicine; a former president of the state medical association; a radiologist; a general practitioner who had served as president of the local medical society; a psychiatrist with the state board of medical licensure; a general practitioner who was the chairman of the state committee on professional care; a psychiatrist interested in the special problems of the medical profession; the executive officer of the medical society; an internist interested in developing new modes of communication within the government of medicine; an internist interested in the future planning of the state medical society; a retired ophthalmologist who had served on the professional care committee for a number of years; and a surgeon with wide experience in rural medicine.

After considerable discussion a consensus developed within the group. There was strong agreement that no additional medical regulatory bodies were needed in Oregon, because the present state board of medical licensure and the emerging peer review committees in hospitals and county medical societies appeared to be enough. To a man, the group declined any punitive role.

Further agreement centred on the need for confidentiality. Success depended on the members understanding their relationship with the group, and knowing it would remain inviolate. It was thought particularly important that any records should not be accessible to other medical groups of any kind. Cross-checking within the profession and, worse, gossip would undermine an already weak man. The committee decided it would stand independently of all other medical and governmental organisations and carefully examine its membership for conflicts of interest and information. At this point, the member who was also a member of the state board of medical licensure resigned, promising to resume when he no longer had a conflict of interest.

Growth

In the last eight years the organisation has grown and its work unfolded as an educational institution fostering an enlightened consideration of the plight of the disabled doctor among all doctors by conferences, lectures, and research. The general problem of the doctor's reluctance to act as his brother's keeper has been the subject of articles and lectures. Persistent emphasis is placed on ensuring that the disabled doctor is not condemned out of hand but understood as someone in need. Special attention is given to detecting and treating the drug and alcohol dependent doctor, including a statewide conference on alcoholism to which doctors of national prominence in treating these problems were invited.

The state medical society's auxiliary, the spouses' organisation, has been encouraged to develop their own techniques in detecting and helping from the family standpoint the disabled doctor. At present, they are undertaking an extensive and confidential investigation of the family life among the state's doctors, touching on the time spent at home, satisfactions and dissatisfactions, the consumption of alcohol, and the presence of recognised yet unresolved problems.

Present aims

A forthcoming conference on the disabled doctor sponsored by the Oregon Medical Association serves as an example of our present degree of skill in educating ourselves. The conference will run for three days, over a weekend, focusing on physician support systems. The first day will be limited to members of the Friends of Medicine, who will prepare themselves to lead small group discussions, in which about 150 doctors and spouses will participate over the next two days.

The first task on the second day will be to define the incompetent physician, including intellectual, moral, and emotional incompetency. We hope that through discussion a series of criteria for judging all doctors will emerge.

Then sources of support for the disabled doctor will be reviewed. We suggest that all the following should be able to help: (1) Oregon Board of Medical Examiners; (2) medical school; (3) hospital staffs; (4) hospital administrators; (5) medical societies—general and specialty; (6) professional service review organisation; (7) Friends of Medicine; (8) other health professions (nurses, psychologists); (9) the doctor's family; and (10) medical society auxiliaries.

We hope that the conference will lead to: (1) an increased awareness among professionals of the problems of the disabled doctor, and an improved referral system; (2) increased co-ordination of support systems; (3) research into specific problems; and (4) improved quality of care for patients.

In addition to education, research is an aim of the Friends of Medicine, and a study of an epidemic of suicides among a discrete group of doctors is now underway. In the last two years from this small fraction of the doctors in the state ($<0{\cdot}1\%$) eight have committed suicide, and two have made serious suicidal attempts. This is an exceptionally high death rate, about 150 times the expected figure, and a team of psychologists, psychiatrists, and medical sociologists are now attempting to discover the cause or causes.

The Friends of Medicine also act directly to help a disabled doctor through an informal network of senior doctors. When a doctor considers himself in trouble, or sees another doctor struggling with an overwhelming personal problem, he may confidentially contact anyone in the "network." The message is passed to the leader of the Friends of Medicine, who decides on the best form of approach, often by discussing with a small group of the Friends. Then, working with the disabled doctor himself, and his friends and family, the organisation attempts to use constructively the professional and financial resources of the community.

Sometimes securing a change of position for an overextended doctor and giving him a chance to work under supervision in an understanding and less threatening job will make the difference. Helping a senior doctor on welfare to find sustaining work commensurate with his ability may restore dignity and self-esteem to an unfortunate man. In other cases directly offering psychiatric help to an emotionally disturbed doctor is the beginning of a recovery.

Certainly not all doctors follow the recommendations, but the disabled doctor is usually grateful that someone is interested. The Friends of Medicine have been repeatedly successful in making the doctor aware of his problem before a disaster occurs. The disabled doctor is relieved of professional loneliness, a common condition as he slips down hill, and he is much less likely to deny his problem.

Because of the confidential nature of the direct work with disabled doctors, the Friends of Medicine maintain no records. Consequently there is no written experience to evaluate statistically. The general impression over a period of years is, however, that the effort of the Friends of Medicine has resulted in a discernible improvement in the doctors' service to patients in Oregon.

Conclusions

Increasingly controls are placed on the practice of medicine to ensure the quality of health care. Most of these controls are intended to detect, and rehabilitate or eliminate the disabled doctor. Unfortunately, most of these controls are formal and coercive rather than informal and trusting.

The Friends of Medicine is an organisation of doctors that attempts to detect, in an informal and confidential way, the disabled doctor at an early point in his disability. It then aims to rehabilitate him with minimal loss of self-esteem, professional status, and service to his community. The Friends of Medicine has had some success, both through direct service and by increasing the profession's awareness of the social and psychological problems of the disabled doctor.

STRANGE ENCOUNTERS

References to published work

A medical editor of my acquaintance had to ask some of the authors who sent him work for publication to reduce the high proportion of incorrectly quoted and inaccurately cited references to published work. More than one replied to the effect that if the editor could spot the errors—and, by implication, trace the correct references and the original text—so in due course could the reader.

If a rough guide to a reference is enough for such writers, are rough figures enough for them to base a statistical analysis on, and are they satisfied with roughly accurate results from the path lab, or prepared to prescribe treatment when they have a rough idea of what is wrong with their patients?—WILL MACREDIE.

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