their needs in an attempt to improve on the present situation, delay "suspension," prevent disasters, and make things less traumatic for the doctor patient. The integrity of purpose, the many talents, and the broad experience of the GMC make it the body which must be in control. However, my concern is the lack of any specified arrangements for caring for and advising ailing doctors before things reach the GMC stage. There is no early warning system. There is a limbo where the sick doctor drifts "unsuspended" while deliberations proceed, often in his absence or the absence of his representative.

The absence of routine medical check-ups for all doctors perhaps creates the problems we would all so much like to solve. There are no "centres" where doctors can go away from their work or home area to obtain expert medical advice in a sympathetic and *confidential* atmosphere. One is certain that doctor passengers flying over the oceans of the world feel reassured because the pilot and his crew are fit men with the advantage of regular medical examinations to prove this, so far as is possible. We should consider the reasons for the profession's obsession to be different. Is it apprehension that something sinister will be discovered, or likely loss of status or job, or the fear of "letting the side down"? (Traditionally doctors are tough and resilient—they rarely have a cold, much less a behavioural deviation.) A doctor who is fit has nothing to fear; if unfit, for his sake and his patients' sake he needs treatment. This is the code of conduct for a noble profession. Loss of status or job would follow only a misdemeanour or fatal error of judgment; but this circumstance should be prevented before it arises. Furthermore, it should be natural for an aging doctor, or one about to pass his prime, to ease up from his more exacting work and pass into other spheres of the NHS *without* loss of pay or status, taking with him his experience. Many senior medical administrative posts should be reserved for such people.

If there is any virtue in these ideas, how can they be made respectable and acceptable? It must all start at the medical schools, where perhaps the last lecture could be—"Fitness to practise—a continuing assessment *and* obligation."

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[1] Committee of Enquiry set up for the Medical Profession in the United Kingdom. *Competence in Practice*. London: Committee of Enquiry into Competence to Practise, 1976. (Alment Report.)

SIR,—It was surely the ironic hand of chance that in the week that my fellow authors and myself received a rejection slip from your journal of an article based on our study of the health of doctors and problems concerning their medical care, in which 1044 doctors participated, you should have written so persuasive a leader on the health needs of doctors. While I would not suggest that our study made a great contribution to the understanding of this problem, it was at least an honest and unique endeavour to probe towards a factual basis of the problem—and facts, as is not unusual, are in short supply.

The prime difficulty which has to be recognised is that doctors who have not been ill have little interest in the misfortunes of those who have and this takes the form both of ignoring the problem and of rejecting practical suggestions to correct it. This indifference is not because doctors are selfish, ignorant, or unkind, which as a group self-evidently they are not; but probably is a protective mechanism enlisted against the stresses of life. It is, however, a lethargy difficult to overcome.

You rightly question the role of the new Health Committee of the GMC and, while events may prove me wrong, I suspect that in its present form its contribution will be insignificant; for most doctors will choose the obvious benefits of voluntarily accepting informal care and management and consequently will never appear before it. The essential dilemma is whether this committee should act as a purely disciplinary body, as does the Professional Conduct Committee, or whether it should assume a wider responsibility, like that of the Education Committee. If it chooses the second alternative its contribution to the care of sick doctors could be considerable and would justify the GMC's claim to special responsibility within the profession.

Finally, Sir, you urge the need for a confidential and informal system and confirm that such a system has worked in the United States and among anaesthetists of the United Kingdom. Our study shows that many doctors and their wives believe that they and their families benefited from the "formal" management of their health care; we argued that this might be achieved if a "medical care system" was developed for doctors and their families using the facilities of the Health Service and that this might overcome the difficulties of delay, self-treatment, and the problem of the "addicted" doctor. I am sure that the key to success is that, firstly, doctors' illnesses should be made respectable and, secondly, that doctors and their families should enjoy a common service.

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SIR,—Where an occupational health physician with postgraduate training in that specialty is employed within the Health Service, it would seem that he should have some responsibility for the sick doctor, although no reference was made to him in your leading article (3 January, p 1).

There are only a few of us employed full time within the Health Service, but non-medical staff are frequently referred to us by management when they are considered to be unfit to continue in post, whether the problem is psychiatric or physical. After investigation through colleagues or our own examinations (or both), we sometimes report that with treatment the employee ought to improve sufficiently to continue in the post; and then we refer him back to his own practitioner. Sometimes we recommend alternative work or retirement on health grounds. Sometimes we consider that there is no health problem, and that the matter needs to be dealt with along other lines.

There is no real difference in kind between the sick doctor and any other sick employee within the Health Service, but there will clearly be a vast difference in the method of handling. Even so, I believe that occupational health physicians should be involved at some stage with a sick doctor. The Association of Anaesthetists' scheme described in your article sounds good, and it would appear to be sensible to introduce a similar scheme into each district or perhaps region of the National Health Service, with the occupational health physician as the contact man. If he feels that there is prima facie evidence for further investigation, he ought to be able to call on two other experts (one from the specialty of the sick doctor and one from the specialty related to the alleged illness), and together the three should proceed from there.

I agree that the problem with this scheme is that there are still only a few areas within the Health Service where occupational health does anything other than pre-employment screenings of nurses and others, but where a more developed service exists I am sure that it should be enlisted in some way to help with the thorny problem of the sick doctor.

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Female sterilisation—no more tubal coagulation

SIR,—We were interested to read the letter about the failure rate of Hulka-Clemens clips by Mr M Sutton and Mr R D de Vere (6 December, p 1564), quoting a failure rate of 2·1% in every 300 cases, and inviting comments from other units.

One of us (MFB) has carried out 200 clip sterilisations with only one pregnancy. From a review of our figures, our conclusions are that this clip is the safest, most effective method of female sterilisation available, provided that two clips are accurately and closely applied to each tube. Our one failure occurred when only one clip was applied to each tube. Subsequent examination of clip and tube demonstrated a well-applied clip and patent lumen. In our series of 200, only 30 had one clip on either side. We had no pregnancies in the 170 other cases, where two clips were routinely applied. We had, however, very early in the series one example of tubal patency due to the clips being crossed and interlocked with each other, allowing the tube to remain open. This type of technical incompetence is avoidable as experience grows. In our experience, failure will occur only if the metal spring is faulty. There is no good evidence that the clip is capable of forming a tubal fistula.

The prospects of two clips being faulty must be negligible, unless the whole batch of clips is at fault.

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SIR,—The almost simultaneous arrival of a pregnant patient, previously sterilised with Hulka-Clemens clips, and the letter (6 December, p 1564) from Mr M Sutton and Mr R D de Vere, prompted a review of the records of this unit.

We have used Hulka-Clemens clips since May 1977, although bipolar diathermy has been the most frequently performed procedure. My personal experience of the clip method is based on 252 patients—those operated on by my senior or junior colleagues have not been included. There have been two pregnancies to date, including the one mentioned above. In both cases the clips were applied in the luteal