by general practitioners has not been broken down into two separate questions: are general practitioners able to certify fitness for work? should the patient's own general practitioner certify fitness for work?

Prolonged certification is the chief problem and gives rise to most perceived pressure on general practitioners to continue certification. No one wishes to provoke confrontation (and the potential loss of the patient to the practice) when fitness for work is so subjective. There are so many illnesses and so many jobs—and so much unemployment. General practitioners have become almoners, even if they do not determine the size of the alms. At present the rules encourage collusion between a claimant and his or her general practitioner to avoid being assessed as fit for work. This is good neither for the doctor, who feels obliged to err on the side of diagnosing incapacity, nor for the patient, who may become truly disabled and demoralised by the "sick role." It is possible to avoid the conflict between being a doctor and being an almoner only by separating the functions.

Incapacity for work lasting longer than six months, which triggers invalidity benefit, should not be decided by the claimant's general practitioner. There are organisational difficulties in changing current procedures, but the potential savings would be large enough to fund a system possibly based on the regional medical service. This answers our two questions earlier: general practitioners are able to certify in most cases, but after six months the decision should be made by an independent examiner. General practitioners could thus avoid tangling themselves in knots, professing themselves to be incapable of certifying fitness to work when in fact they are trying to avoid conflicts of interest.

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1 Handysides S. GPs are unhappy to police invalidity. *BMJ* 1993;307:644. (11 September.)
2 Resolutions passed by the annual representative meeting 1993. *BMJ* 1993;307: facing p 669 (clinical research edition), facing p 666 (general practice edition), facing p 681 (other editions).

Writing a departmental handbook

EDITOR,—Having developed a handbook for my hospital's paediatric department over the past six years, I believe that some additional points to those mentioned by Janet McDonagh and colleagues[1] are important in ensuring the longer term success of such a handbook. Our handbook covers three wards with different functions as well as the outpatient department and several maternity wards. Each clinical area has its own folder of guidelines incorporating those elements relevant to it. The full handbook is produced in house in an A5 format and costs about £1 a copy. Forty two copies of the full handbook are required each year. It is reprinted annually, whereas the ward guidelines are updated as often as required.

Guidelines developed from departmental audit sessions are incorporated into the handbook and printed in bold when there is agreement that they represent departmental guidelines. The role of the consultants in the department is crucial. One consultant, with the help of middle grade staff, should be responsible for ensuring that the handbook is kept up to date, but the commitment of all the consultants in the department is important.

McDonagh and colleagues mention that one benefit of compiling the handbook on a word processor is that this facilitates amendments. There are other important benefits. Our departmental handbook now runs to 178 pages. The word processor allows us to produce an index, which is five pages long, and a table of contents: without these it would be difficult to use the handbook. It is crucial to keep a record of when each amendment to the handbook is made, otherwise it may prove impossible to know what the guidelines were several years previously. This may be important for medicolegal reasons. A word processor allows unprinted comments and the dates of changes to be inserted into the document, and a separate file is kept of all previous guidelines.

I believe that departmental handbooks have an important role in education and audit. The main investment is in consultant and middle grade doctors' time.

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1 McDonagh J, Clarke F, Veale D. How to write a departmental handbook for junior staff. *BMJ* 1993;307:553-5. (28 August.)

Complaints to the GMC

EDITOR,—T G Barrett comments on statistics published in the General Medical Council's annual report relating to its disciplinary work.[1] Barrett suggests that the council is less concerned with potential harm to patients than with doctors' personal conduct, citing as evidence the fact that, in 1992, 86 complaints about the personal conduct of doctors were referred to the preliminary proceedings committee, compared with 38 complaints relating to the standard of the medical treatment provided by doctors.

Barrett's letter illustrates the dangers of looking at one or two figures from a statistical report in isolation. Among all the types of complaints referred to the preliminary proceedings committee the largest category, in all recent years, has been complaints about the standards of medical care. Last year these amounted to 38 cases out of 124. The 86 cases mentioned by Barrett are the combined total of all the other categories of misconduct, including, for example, misuse of alcohol or drugs by doctors, violence or indecency towards patients, false claims to qualifications, falsification of research data, and dishonesty. A high proportion of those 86 cases therefore related to conduct that was potentially damaging to the health and welfare of patients and the general public.

In addition, the annual report points out that the General Medical Council has other procedures for acting on complaints besides referring them to its preliminary proceedings committee. Many cases are considered and resolved by sending letters of advice about their future conduct to the doctors concerned. Forty five cases relating to medical treatment were dealt with in that way during 1992.

These figures therefore show that the council is indeed concerned with protecting patients through its disciplinary procedures.

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1 Barrett TG. General Medical Council. *BMJ* 1993;307:628. (4 September.)

Preparing for retirement

Go on a course

EDITOR,—People in England who would like advice about their retirement, which Harold Jacobs thinks he has lacked, have far more opportunity than he seems to have in Canada.[1] Courses are run by the NHS (as an employer), the Pre-Retirement Association, the Workers' Educational Association, and other bodies: arrangements vary from area to area. One thing that I have found fascinating when taking part in many of these courses over many years is the similarity between the questions raised by doctors, other hospital staff (professional or unskilled), and people of all sorts outside hospital work. Thus special courses for doctors are probably not necessary.

Jacobs also suggests, reasonably, that the subject should be approached earlier: five to 10 years earlier has been shown to be a good time. The trouble is that if "management" tells you when you are in your 50s, "It's time you prepared for retirement," you fear the worst.

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1 Jacobs H. Facing the future backwards. *BMJ* 1993;307:689. (11 September.)

It's easier for women

EDITOR,—I agree with Harold Jacobs that men can find retirement from a busy, useful professional life a shock.[1] Women may find retirement easier for several reasons. Many continue to run a house, which requires an established routine to be maintained. Many will have experienced a change in their work pattern earlier in their lives when moving from full time work to part time work or not working while their families were young; thus they will already have coped once with loss of professional status.

Perhaps men would adapt better if, instead if changing abruptly from full time work to not working, they were allowed a phase of part time work. This would make part time schemes more fairly distributed—early in women's careers, late in men's careers.

Helping people adapt to retirement might also save them from the indignity of hanging on beyond their span of competence.

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1 Jacobs H. Facing the future backwards. *BMJ* 1993;307:689. (11 September.)

Junior surgeons lack practical experience

EDITOR,—Minimal access surgery has resulted in an increasing number of procedures that were previously performed by juniors being performed by senior surgeons. Surgical skills are gained by "hands on" experience, and the reduction in opportunities to acquire these skills is causing concern among surgical trainees. To assess the effects of minimal access surgery on surgical training we questioned 89 trainee surgeons about their experience of cholecystectomy, the most commonly performed laparoscopic procedure. Before laparoscopic cholecystectomy was introduced the mean number of open procedures performed by the trainees in their first year was 19. The number is now 0·5.

This highlights the difficulties experienced by juniors in training. Not only are more procedures being performed laparoscopically but a considerable proportion of open procedures are also being performed by consultants. This is because some are converted laparoscopic procedures while other cases are not considered to be suitable for laparoscopic surgery because they are likely to prove technically difficult. Other procedures such as appendicectomies and hernia repair are similarly affected, although to a lesser degree.

Though we accept that when any new technique is introduced the number of procedures performed by juniors will fall, a cohort of trainees is gaining

little practical experience in either laparoscopic or open surgery. In future, laparoscopic methods may be taught as the primary technique, but until then juniors must obtain some practical experience both to maintain their interest and to improve their surgical skills. Senior staff must address this problem now.

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Jewish law permits treatment on the sabbath

EDITOR,—In the first paragraph of her report on the first international meeting on Jewish medical ethics in Jerusalem Judy Siegel-Itzkovich misquoted the Halacha (Jewish law).[1] She states that Jewish law allows medical treatment to be given on the sabbath only if a person's life is at risk. The authoritative Slulchan Aruch Harav (code of Jewish law)—chapter 328, paragraph 19—clearly permits treatment for people who are not dangerously ill.

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1 Siegel-Itzkovich J. Rabbis and doctors sort out medical ethics in Jerusalem. *BMJ* 1993;307:404. (14 August.)

Different kinds of meeting

EDITOR,—Bernard Dixon is right to extol the virtues of the special form of scientific meeting adopted for several years by the organisers of the Dahlem Konferenzen.[1] It is a considerable advance on the design of the usual symposiums, in which much time is wasted with presentations followed by a brief period of off the cuff questions from the audience, resulting perhaps in education for some of the audience but little scientific advance.

Another format is used by the Ciba symposiums. In these, presentations are still made but in private, before a small, highly selected group of participants, who have the opportunity for free and open discussion. This is then edited and published with the original papers as a book.

Having attended both of these meetings, I was led to devise yet another form, which I believe is superior to either for some purposes, principally to make scientific advances. There have been 15 such meetings, and they have become known as the Dobbing workshops. Briefly, each of about a dozen participants writes a paper about three months before the workshop, and this is sent to each of the 11 others. Each person then writes a considered, referenced commentary on each paper to a deadline of six weeks before the workshop, and this in turn is also circulated to all the others. We all then meet for three days, during which no presentations are made, no projectors used, and no recordings made. At the rate of about two papers per half day, the proceedings consist entirely of discussion.

The chairperson calls on the author to spend about 10 minutes responding to the written commentaries on his or her paper, and this gives rise to discussion long before he or she has finished. The authors, as well as the writers of commentaries, can modify their work in the light of the discussion, and often new issues are raised which give rise to additional paragraphs written by appointed participants on the spot. The main stipulation is that by the end of the three days all has to be ready for publication. The chairperson-editor spends the next fortnight arranging both the papers and the surviving commentaries into a book, which is usually published within six months.

Apart from giving the maximum opportunity for in depth discussion, the book will have been peer reviewed by the workshop process like no other—and much more extensively than any published original paper. It displays all the points of view of the experts chosen to take part since no attempt is made to arrive at a consensus. Consensus may be desired by the readers or by politicians and policymakers, but far more useful in the long run is that everyone should be made to think for himself or herself in the light of what he or she has read of the conflicting views.

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1 Dixon B. A different kind of meeting. *BMJ* 1993;307:629. (4 September.)

War in Bosnia

Disabled children in the pink zone

EDITOR,—Sir Donald Acheson condemns the systematic targeting of hospitals in the war in former Yugoslavia,[1] but the suffering of vulnerable groups has become the hallmark of this conflict. Even children with learning and physical disabilities are victims.

On 25 August 1991, during a Serbian attack on the town of Vrlika, residents of the town's only home for disabled children were forced to evacuate. The children made for Split, 76 km away. Nineteen of the 303 children died as a result of the journey.[2,3] As many as possiible were transferred to other facilities, but 262 remain in Split. They come from Croatia, Bosnia-Herzegovina, and Montenegro; 181 are Croatian, 44 Serbian, and 37 of unknown nationality.

Facilities for disabled children are hopelessly inadequate. For nearly two years some have lived in two welfare institutions, while 60 others live in a gymnasium. These children cannot return to their home in Vrlika because it is in the so called pink zone—an area of Croatian territory outside the zone protected by the United Nations but still under occupation.

This war is distinguished by its cruelty and insensitivity. These children, brutalised and homeless, now have little chance of experiencing the brighter side of life.

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1 Acheson D. Health, humanitarian relief, and survival in former Yugoslavia. *BMJ* 1993;307:44-8. (3 July.)
2 Donadini M, Čikeš L. The wartime trauma of the inmates in the Vrlika Institute. *Arh Zašt Majke and Djeteta* 1992;36:119-22.
3 Pintarić I, Sapunar D, Gudelj I, Andelinović S, Kuzmić I. Remember they are humans. *Croatian Medical Journal* 1992; 33(war suppl 2):34-5.

Lessons from Vietnam

EDITOR,—Eric Freedlander's remarks on return from Tuzla about the inappropriateness of the airlifting of a small number of patients to Britain nicknamed "Operation Irma"[1] make me wonder why Britain does not use some taxpayers' money to provide medical teams for trouble spots such as Bosnia. In the middle and late 1960s medical teams from many countries, ostensibly funded by their governments (though probably subsidised by the Americans), treated large numbers of sick and wounded civilians in South Vietnam without the hype in the media about the techniques, drama, and petty quarrels within officialdom that has accompanied recent evacuations to Britain of highly selected patients.

These teams helped a civilian population tormented by war. Eric Freedlander is right. Putting a team in place is far more effective than evacuating people with complex problems, which may have resulted from an inability to provide primary treatment. The very presence of a team has great meaning for the community, even if the team stays for only a short time. Teams experienced in surgery, acute medicine, and paediatrics are needed: people are less concerned with chronic illness and hygiene when they risk death from a mortar round daily.

Perhaps the government thinks it is politically incorrect to go into a foreign country except under the auspices of the United Nations, whose role seems not to include providing the type of medical care that the teams provided in Vietnam. Is it too dangerous? War without front lines surrounded the teams in Vietnam but they suffered no physical casualties in six years despite some narrow escapes. Leaving it to the marketplace of emotion and media hype and taking credit for achievements is probably the simplest solution, but it fails to exploit experience gained the hard way in Indo-China and looks pretty sorry from the medical angle.

What the public does not understand is the agony out there. There is an enormous load of surgical and other disease and disorder that we can scarcely imagine. Organisations such as Médecins sans Frontières tackle this on the ground and by sacrificing the personal freedom of their members. We need the government's commitment to underpinning surgical care at the point of injury and identifying disease in places such as Sarajevo. I was a surgical specialist to the Australian teams in Vietnam. We benefited from good logistic and social support because our care was seen to be impartial. In Bosnia this neutrality has been obscured by political considerations. We in Britain could be more prepared—given material support—to take an active role. Surgical teams will never change the course of history but they will, as my Vietnamese interpreter said to me, "be remembered in the marketplace."

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1 Butcher T. Doctors dismiss Operation Irma as "theatre." *Daily Telegraph* 1993 Aug 18:8.

Whistleblowers

To keep quiet would be worse

EDITOR,—K Jean Lennane's article on "whistleblowing" describes the psychological traumas suffered by those who expose malpractice in their organisations.[1] It does not, however, raise a reciprocal of this issue: how potential whistleblowers might have felt had they failed to act in accordance with their conscience. Some of those who blew the whistle will have done so because they judged that the emotional effects of keeping secret (and so colluding with) an unjust practice would be more unbearable than those caused by exposing it.

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1 Lennane KJ. "Whistleblowing": a health issue. *BMJ* 1993;307: 667-70. (11 September.)