becomes a useful research tool for comparing analgesic drugs double-blind. We believe this method can bring us closer to the much desired goal of effective postoperative analgesia.

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¹ Rosen, M, in *Pain—New Perspectives in Measurement and Management*, ed A W Hargreaves, R Smith, and B Whittle. Edinburgh and London, Churchill Livingstone, 1977.

Altered bile in diabetic diarrhoea

SIR,—I was interested to read the article by Anne M Molloy and Dr G H Tomkin (25 November, 1978, p 1462), in which they report increased faecal bile acid excretion in diabetic diarrhoea. This finding is at variance with our study using the ¹⁴C-glycocholate test as an indicator of bile acid malabsorption.¹ We found increased faecal ¹⁴C excretion in only one of seven patients with diabetic diarrhoea. In contrast, in a similar study of postvagotomy diarrhoea all the patients had increased faecal ¹⁴C excretion and responded to cholestyramine.²

In the present series the daily faecal volume is not given. Clinically important bile acid malabsorption is unlikely when the stool output is less than 200 g.³ It would also be interesting to know whether cholestyramine was used in these patients. I have found it to be generally disappointing in diabetic diarrhoea.

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¹ Scarpello, J H B, *et al*, *British Medical Journal*, 1976, **2**, 673.

² Scarpello, J H B, and Sladen, G E, *Lancet*, 1977, **1**, 646.

³ Fromm, H, Thomas, P J, and Hofmann, A F, *Gastroenterology*, 1973, **64**, 1077.

Prophylactic co-trimoxazole in biliary surgery

SIR,—The study "Prophylactic co-trimoxazole in biliary surgery," by Dr C Morran and others (12 August, p 462), raises many more questions than it answers. Possibly the most important observation from their paper is that the majority of their wound infections grew staphylococci, an unusual organism in the biliary tract, as their bile cultures show. The authors state that wound sepsis is more common in patients with infected bile yet the data in their paper can scarcely be said to support this claim since of the nine patients in each group with a positive bile culture only three of the controls and none of those treated with co-trimoxazole had wound infections. We have no dispute with the central thesis of the paper that perioperative single-dose co-trimoxazole reduces the incidence of wound sepsis in elective biliary surgery. However, it seems to us that the effective prophylaxis has been against staphylococci, most of which have not been introduced from infected bile.

Two further matters are worth a comment. The first is that 10 of 47 patients undergoing elective cholecystectomy without antibiotic cover developed a wound infection (could it be that Dr McNaught did the surgery and Mr McArdle the bacteriology?). This infection rate of 21% is far too high and preventive measures are certainly justified. Nevertheless,

the cause of this high infection rate needs to be established and dealt with; on the data presented infected bile is not the culprit.

Wound infection rates in elective biliary surgery without antibiotic prophylaxis appear to be very high (16.9-22%) in recent studies reported from the United Kingdom.¹⁻³ Studies reported from the United States indicate a lower wound infection rate (1.4-11%)⁴⁻⁶ and in this hospital the wound infection rate in 200 consecutive patients undergoing elective cholecystectomy was 6%. It is interesting to speculate on the reasons for these differences.

We are also surprised at a mean duration of stay of 10 days in patients with an uncomplicated postoperative course when this is 6 days in this hospital (200 patients) whether or not their course was complicated. There are obviously many reasons for these discrepancies and it would be useful for comparative purposes if papers of this nature could include data on patient characteristics, especially that of age distribution, so that useful comparisons could be made.

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¹ Keighley, M R B, *et al*, *British Journal of Surgery*, 1975, **62**, 275.

² McLeish, A R, *et al*, *Surgery*, 1977, **81**, 473.

³ Strachan, C J L, *et al*, *British Medical Journal*, 1977, **1**, 1254.

⁴ Stone, A M, *et al*, *American Journal of Surgery*, 1977, **133**, 285.

⁵ Stone, H H, *et al*, *Annals of Surgery*, 1976, **184**, 443.

⁶ Cunha, B A, *et al*, *Lancet*, 1978, **1**, 207.

Function of the community physician

SIR,—I refer to your leading article "Epidemiology and the Potteries" (9 December, p 1590), in which certain remarks attributed to Professor E D Acheson may be misconstrued by those who are not familiar with the specialty of community medicine and the role of the community physician.

In order to clarify the issue it is vital to distinguish between the "administration" and "management." Administration is the day-to-day running of established services, usually the responsibility of non-medical administrators, whereas management is concerned with the planning and development of future services. While it may be true that some community physicians may be involved with some administrative duties, in general community physicians are neither interested in nor concerned with administration. Their training and orientation is in relation to their management function—that is, intimate involvement in planning and policy making in the field of health service development.

Planning services requires epidemiological studies and epidemiology is that science which, although not exclusive to the specialty of community medicine, occupies a large part of the training curriculum. Because of this the community physician has a unique depth of knowledge and expertise in this field. Clinicians must, of course, concern themselves with trends and developments in their own field of practice, but judging by continuing correspondence in medical journals the majority of today's clinicians are far too busy dealing with an ever-increasing case load to have either the time or the energy to cope with the exacting intricacies of accurate and effective epidemiological methodology.

It is in the field of epidemiology that the community physician and the clinician may most usefully combine their joint skills in furthering the understanding of the aetiology and prevention of disease processes. It would be a pity if the skills of community physicians in this important field were to be dismissed through a misunderstanding of their role and function in the Health Service.

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Opportunity in health visiting

SIR,—We, health visitors of the future, take exception to Dr Michael Hall's letter (9 December, p 1646). Our own experiences over the past year in trying to enter the health visiting profession have proved that it is extremely difficult to obtain selection: motivation is strongly questioned as well as academic ability and suitability for health visiting.

Concerning the review of training requirements of those working in the health professions, we feel the Briggs Report has either been misinterpreted or read with bias by your correspondent. The historical reference is relevant but incorrect, as medical and nursing qualifications have long been required for entrance to this profession.

We refute the implications about motives for moving from nursing to health visiting. Many of us entered nursing in order to become health visitors, and the increased interest in health visitor training has resulted in the combined course. Many health visitors in training bring a wealth of experience from their years in all branches of nursing, which also enables them to appreciate fully the value of preventive medicine.

We should be grateful if Dr Hall could suggest an alternative course for school leavers which would provide them with the expertise in human relationships, development of powers of observation and detection which are gained through nursing training, as well as, of course, a knowledge and understanding of other health professionals, which Dr Hall seems to lack.

1974 saw the integration of health visiting with the National Health Service. Gilmore found then that a high proportion of health visitors' functions were misunderstood and not fully appreciated by general practitioners. It appears, sadly, that this may still apply.

We agree that the role of the health visitor has never been so important as it is today in our stressed society.

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and 34 other health visitor students

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Staffing of accident and emergency departments

SIR,—It is sad to think that we are as far from solving the problem of medical staffing in accident and emergency (casualty) departments as we were in the early 1950s, when senior casualty officers like myself were first forced on to a reluctant profession, and, if Dr D M Bowers (9 December, p 1648) is right, there is not going to be much improvement in the next 25 years.

At least 75% of the work presenting in the