Of 200 consecutive children or young adults with nocturnal enuresis I found only 2 who appeared not to have had a single dry night. In other words, true "primary" enuresis is exceedingly rare and the usual situation is one of "intermittent" nocturnal enuresis.

I agree with Mr Hindmarsh that the term "recent-onset enuresis" or "secondary" enuresis is not very helpful. Its incidence, association and management will depend on the period of dryness that is demanded before the person is labelled as having "onset" enuresis. For instance, if a period of 12 months' absolute dryness is demanded the number of persons with onset enuresis will be small. If a period of only three months is demanded, the number with such onset enuresis will be quite large.

ROY MEADOW

Department of Paediatrics,
St James's University Hospital,
Leeds

"Lecture Notes on Medical Statistics"

SIR,—The point that has got lost in this "wordy warfare" (23-30 December, p 1783; 13 January, p 123; and 27 January, p 263) is the nub of my criticism (9 December, p 1631), which was contained in the words "the statistics needed by the intending clinician or medical researcher [is] different from that required by the intending statistician." Incidentally, reviews are signed because they are only the *opinion* of their authors.

May I cite two examples of the increasing concern with what statistics doctors and other medical writers do know? Firstly, there was a meeting last year in Lexington, Kentucky, organised by the Biometric Society under the title "Should there be Statistical Guidelines for Medical Research Papers?"¹ Secondly, this coming April a meeting is to be organised by the Royal Society of Medicine's section of medical education, in conjunction with the Association for Medical Education, under the title "Teaching and Learning Statistics in Medicine," at which your associate editor is delivering the first paper.

My opinion is that rehashing first-year statistics courses and spreading a few medical examples around the text is not the right way to educate medical students statistically. But it is only my opinion.

IAN CLARKE

London W6

¹ *Biometrics*, 1978, **34**, 538.

Phantom limb pain and propranolol

SIR,—Your excellent and comprehensive leading article (9 December, p 1588) has prompted me to share my observation with your worldwide readership.

Case 1—In August 1977, a 69-year-old man was admitted with diabetic ketoacidosis, diabetic angiopathy and neuropathy, coronary heart disease, and Gram-negative septicæmia. He underwent below knee amputation for gangrenous toes of the right foot. He was discharged home after a stormy and eventful stay in the hospital. He was then plagued with "phantom limb" pain. Analgesics prescribed by his family physician did not improve this condition. Propranolol 40 mg/day was added in his regimen to control his hypertension and angina. From that time not only did his cardiovascular status improve but the phantom limb pain also disappeared. After propranolol had been withdrawn because of cardiogenic shock and

heart blocks following recent myocardial infarction, he started having severe phantom limb pains.

Case 2—In October 1977 a 69-year-old man underwent below knee amputation because of gangrenous toes of the left foot. He had survived two myocardial infarctions (1957 and early 1977) and was diabetic and a heavy smoker. He developed attacks of stabbing and lightning pains in the stump lasting for hours and days. Analgesics offered no solace. Propranolol 40 mg daily was added in the regimen for angina pectoris. He never complained of this "wretched pain," as he called it, while on propranolol.

These two patients were incapacitated with pain but lived happily after taking propranolol. The second was very happy that he could manage to use his artificial leg. I feel it is worth reporting the usefulness of propranolol in these two "mentally and physically crippled" patients who managed to cope better with their lives.

Further investigation of this observation should be undertaken because anything which mitigates the lot of the patient with phantom limb pain is very much worth while.

SAEED AHMAD

Department of Medicine,
Fairmont General Hospital,
Fairmont,
West Virginia, USA

1918 influenza epidemic

SIR,—I remember as a house physician in Queen Alexandra Hospital, Cosham, during an influenza outbreak in, I think, 1957, seeing a middle-aged man, admitted in a moribund condition from his general practitioner's surgery, with a stench so fearful that I could only examine him for some seven minutes at a time. At the subsequent necropsy one lung was green and gangrenous with multiple small abscesses forming.

I do not know if similar pathology occurred in the 1918-8 outbreak, but if it did it might account for the stench referred to by Minerva (16 December, p 1722).

J A MOSS

St John's Lane Health Centre,
Bristol

"Helping with Health"

SIR,—Your reviewer TS in "Medicine and the Media" (13 January, p 118) appeared puzzled by the intended audience for "Helping with Health," yet he diagnosed it quite correctly. The series was intended for all professional health workers and this was clearly announced at the beginning.

It will be repeated in July (Sunday afternoons, Radio 4, VHF) and will be followed early next year by a related series on health education, on the prevention of illness, which, like the recent series, has been developed in consultation with the Health Education Council (and many others).

When professionals talk to professionals jargon sometimes crops up as a form of shorthand, though we don't encourage it.

MICHAEL TOTTON

British Broadcasting Corporation,
London W1

Abortion and the NHS

SIR,—The impression gained from the paper by Dr F G R Fowkes and his colleagues (27

January, p 217) is that the writers are in favour of abortion on demand. It suggests that the NHS figures show "discrimination" against applicants who are single; surely many of these are not covered by the terms of the Abortion Act?

One of the most emphasised recommendations of the Lane Report was the need for better facilities for counselling. No comment is made on this in the article.

Does not the low rate of sterilisation in the private sector suggest that there is no incentive to kill the goose that lays the golden eggs?

MARY BELTON

London E11

Who does the surgery?

SIR,—I was delighted to read Professor Douglas Roy's "Who does the surgery?" (25 November, p 1474). The approach to the training, role, and career structure of the "specialist" district physician outlined is admirable, and could be adopted in my own country with great benefit to our various peoples.

However, I believe the programme errs in excluding anaesthesia (suggested as optional) as an essential component. Even if anaesthesia is given by specially trained assistants, I believe the knowledge and expertise gained during three to six months' intensive training in anaesthesia could be of great benefit to the district physician, not only in supervising his "anaesthetist" but also in providing valuable education and experience applicable to other fields—for example, the use of regional or conduction anaesthesia, neonatal resuscitation, management of acute cardiopulmonary failure, etc.

Also, would he not consider the role of the specially trained surgical assistant in dealing with routine surgical procedures (for example, herniotomy, circumcision, setting of fractures), as employed with success in other African countries, such as Malawi?

J W DOWNING

Department of Anaesthetics,
University of Natal,
Durban, South Africa

Clinical medical officers

SIR,—Those who have been concerned about the status, role, and training of those clinical medical officers who carry out so much of the work involved in preventive child care and developmental surveillance will welcome the letter from Drs Gwynne Lewis and others (13 January, p 128) suggesting that they might in future work within general practice without necessarily being trained as principals. This was the solution that many of us hoped that the Court Report would recommend and it would have avoided the disagreements that have resulted in the report's being shelved rather than implemented.

Community physicians have the information and resources to identify those children needing immunisation or assessment, but this need not mean that the clinicians who do the field work should come under their jurisdiction: instead they should tender the work to general practices by contract, using only those practices which can deploy principals or assistants (who will often be married women

with paediatric training) or attached clinical medical officers with the necessary interest, experience, and qualifications. Such physicians would normally also act as school medical officers and would then belong by right to the paediatric division in their district, which by including them would justify its independent existence.

JOHN A DAVIS

Department of Child Health,
University of Manchester

Part-time contracts for women doctors

SIR,—In response to Professor Philip Graham's letter (13 January, p 128) asking women doctors to provide models to the community of ways in which family lives can be combined with rewarding and contributing careers, may I make a plea to all doctors working in community paediatrics to encourage their regional health boards to consider providing a number of specific school-term-only contracts? The number of such contracts to be drawn up would depend very much on local requirements.

These contracts would serve a need to both the employing authority and the doctor concerned. Within the nature of the clinical medical officers' commitment in paediatrics, the work complement varies between school term and school holidays. At present, this alteration in work force needed is often met by the wide use of sessional doctors who lack the security of a contract.

JILL FYFIELD

Chairman,
North Lothian Clinical
Medical Officers' Subcommittee

Community Health Service,
Lothian Health Board,
Edinburgh

The Warnock Report and medical confidentiality

SIR,—I have been following the correspondence concerning community child health doctors with great personal interest. It has been most encouraging to see support for our oft-maligned service coming from eminent paediatricians. I was therefore most concerned to read in the GMSC report (13 January, p 142) that, in the name of medical confidentiality, the dissemination of information should be at the discretion of the general practitioner.

The main concern of the Warnock Committee was for children with a continuing disability not amenable to medical treatment. The parents, as they begin to recover from their grief, and later the child need continual support and encouragement from a competent team of professionals. I have worked in the child health service for ten years and, sadly, could report many instances where "needless distress to the child and his parents" has been unwittingly caused by GPs unaware of the educational implications of such things as developmental delay, hearing impairment, and minor neurological incompetence. It is so easy to give a bland general reassurance in the midst of a busy surgery.

In the mid 1950s I served a tough four-year apprenticeship as a hospital resident. I later spent five years as a GP principal in a busy urban practice. I enjoyed both and viewed my later entry into "school medicine" as a sacrifice willingly made for the sake of my

young family. I now realise, after much further training, that this field of medicine is as worthwhile and demanding as any other. Of course medical confidentiality must be maintained at all times but I fail to understand why medical colleagues in the hospital and general practice should assume it is not safe in our hands?

DOROTHY SELL

Gloucester

Pathologists' work load

SIR,—While I sympathise with Dr G S Andrews (13 January, p 130) in his wish for a higher salary, I do hope that the BMA is not now going to make it a policy matter that GPs should no longer have open access to pathology services.

If it is the genuine wish of the DHSS that more patients are to be treated in the community, and if we are to maintain a high calibre of recruitment into general practice, it is essential that these facilities remain. Finally, whereas many investigations in hospital are purely routine, requested by a newly qualified houseman, such are the difficulties of getting the specimen or patient to the laboratory that GPs, who are for the most part experienced doctors, generally only request investigations when they are really needed.

STELLA PARRACK

Liverpool

PPP plan for BMA members

SIR,—Your notice (13 January, p 146) about Private Patients Plan's scheme for BMA members prompts me to mention my recent experience as an outpatient. I needed the help of three consultant colleagues, one of them a radiologist who looked after three items of diagnostic radiology. I then discovered that, although the maximum inpatient benefit payable in one year was as high as £12 500 the maximum aggregate annual amount payable for outpatient treatment was only £25, which did not come near to paying for my x-rays, and left nothing for my colleagues. If there was any fault, it was mine for not reading the table of benefits sufficiently closely before joining; but I believe in insurance, and I believe in properly rewarding my colleagues for their services—and I now think the PPP provision for outpatients in the BMA plan is niggardly.

JOHN DOBBING

Department of Child Health,
University of Manchester

Nursing at a crossroads

SIR,—Dr H A Talpur in his letter (3 February, p 348) states that in his view the root of the problem of staffing hospitals with sufficient nurses of the right calibre lay with the educational requirements for entry to nurse training. He implies that the demand for five or six O levels is too high and that people possessing such educational attainments are unlikely to want to work long unsociable hours, with poor pay and no promise of a post at the end of training.

Does this mean that Mr Talpur is suggesting the answer to the problem is not to improve the appalling pay and conditions under which nurses are employed, but simply to lower the

educational standards required? If this is so, he cannot be aware that nurses do not only look after the general well-being of the patient but are involved in the use of complex treatment and machinery and the assessment of a patient's condition. It is essential that State registered nurses are able to use initiative and intelligence and assume responsibility. Reasonably high educational standards are imperative to ensure wards are staffed by nurses with such qualities.

I suggest that the problem of nurse staffing is almost solely due to successive governments' continued exploitation of the nursing profession. I, for one, would not have left the profession had the working conditions and salary been adequate compensation for all that nursing involves.

VANESSA A GREENWOOD

London W11

Taxation of consultants' emoluments

SIR,—The distribution of the DHSS Circular (HL(78)39) regarding taxation of allowances seems to have passed with very little comment in spite of the fact that it was issued as far back as last November. I can understand why the authorities have kept this very quiet indeed, having now at last managed to have a look at a copy. The implications for hospital staff are alarming, especially in view of the already grossly inadequate reimbursement of motor car expenses. The document clearly states that home-to-base hospital mileage allowances will in future be taxable, and although they will at present allow tax relief on such mileage if the car has to be used to travel to other places in the course of duty it is noted that discussions are proceeding and further advice will be issued when appropriate. Mileage allowance paid for attending emergencies, even in the middle of the night, is apparently taxable, and if one takes the only appropriate action that really seems to be open to us, and insists on a taxi being provided for emergency calls, then for consultants certainly the taxi fare is taxable. This would introduce the ludicrous situation where a consultant is financially penalised for attending an emergency at the hospital, and indeed, the more emergency calls that he attends the poorer he will be.

As a young consultant, I have been expected to endure the indignity of earning less than people junior to me, and indeed took a reduction in income for the privilege of becoming a consultant. One has accepted the situation because of the desperate financial situation of the country—a decision which the Prime Minister has called "rough justice." It would seem that the adjective "rough" is highly appropriate but there is clearly no longer any justice. To claim that this is a strict interpretation of the law is totally laughable as it seems that those below an arbitrary income level are not subject to the same tax as those above that level.

I feel that it is time that the Association takes a completely firm stand with the Department of Health and the Inland Revenue about these matters and states that the proposals are totally unacceptable. I feel that there is enough strong feeling about the inadequacy of mileage allowances already for it to be feasible to take nationwide action if these proposals are implemented, and I personally would be more than happy to insist on a taxi for all emergencies even if I have to pay tax on those taxi fares.