of pressure, liquefied phenol should be rubbed into the nail matrix and bed.

Dr Cameron does not state for what periods patients are followed up after angular phenolisation, as opposed to the simple treatment, but a long-term view must be taken. Chiropodial experience is that phenol can inhibit nail-germinating cells so that they do not divide for months or a year or more, but eventually they become active again and produce a troublesome degree of cornification. Adequately applied phenol will always destroy, but, certainly, it is as easy to fail to eradicate the matrix by phenolisation as it is for a surgeon not to dissect it out completely.

Accepting Dr Cameron's point that the current medical methods for treating ingrowing toenails are generally unsatisfactory, might I suggest that chiropodial approaches be considered and that reference is made to our literature when the problem is reviewed.

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[1] Anonymous. *Lancet* 1826-7;**12**:702-3.
[2] Dagnall JC. *Chiropodist* 1981;**36**:315-24.

SIR,—Following my article (26 September, p 821) on the treatment of ingrowing toenails, I would like to draw the attention of interested readers to an excellent article on the phenol techniques which appeared in the September issue of the *Chiropodist*.[1] This article draws fully on the early American papers appearing in chiropody and podiatry journals, which are difficult to obtain over here.

With regard to the "simple" treatment, I agree that it is crude. I had no chiropody training, had never seen a nail chisel, and was self-taught. However, in my hands it works well in these early infected cases and the pain caused is minimal and acceptable.

It is interesting that no voices have been raised in defence of surgical ablation despite its prevalence in orthopaedic and casualty practice. Is there any reason to continue this form of treatment in view of its inefficiency and expense? A good case could be made out for diverting the majority of cases of infected and gryphotic toenails to a hospital chiropody clinic run under medical supervision.

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[1] Dagnall JC. *Chiropodist* 1981;**36**:315.

Sex and physical disability

SIR,—What a welcome article by Dr Wendy Greengross (24 October, p 1089) on sex and physical disability. She discussed a wide spectrum of problems which surely deserve the attention of doctors from all disciplines. Patients will retain the right to choose which doctor they approach with such delicate problems—but with the advance of modern medicine one wonders whether, for instance, a general surgeon is right to derive pleasure from prolonging life by carrying out a mastectomy and then to deny that patient and her spouse any practical advice. The number of men with now irreversible secondary impotence I see whose wives died from breast cancer is increasing.[1]

The problems of male sexual dysfunction are being complicated by some modern drugs and a very real dilemma exists. If we ask patients questions we are liable to receive answers and the task of discovering whether secondary impotence is drug induced is onerous and time consuming—also it would be quite wrong to open the floodgates that way as it would create problems for some patients rather than solve existing ones for others. Perhaps a question such as "Have you any other particular problem?" might be beneficial in some clinics. It now seems almost routine that patients being discharged from coronary care units are given practical advice about when love making can be safely resumed and this is always greatly valued.

I am forced to disagree with Dr Greengross that "few textbooks discuss the sexual implications of disease and none mention the effect of drugs on libido." One of Kaplan's textbooks has a very comprehensive appendix on the entire subject.[2]

In this International Year of Disabled People my personal contribution has been an endeavour to take more interest in those less rewarding patients—everyday problems for me which I cannot resolve—like the diabetic last week who was helped to feel masculine again after some explanation of the neuropathy causing his organic impotence. How much pleasanter was the inner glowing satisfaction inevitably obtained from sending off the previous patient for good—as her marriage had at last been consummated. But we are in medicine to treat patients and not ourselves.

Could we change our attitudes a little and realise that if we cannot make people better we may still be able to help them? Psychosexual problems should not be too solemn. Currently I am treating a mature spastic couple—he has the problem but his wife acts as interpreter as his ghastly speech difficulty is too much for me, and together we laugh our way through consultations and they are most grateful. It has not taken long to help to add a little fun to otherwise very dreary and difficult lives.

For doctors, however, it is not always easy: we can cope emotionally only by leaving ourselves out—but we cannot do this with sexuality. Thus we might avoid facile assumptions and may not miss the occasional secret cause of a patient's greatest sadness. As innately sexual beings not one of us can claim to have absolutely no knowledge of this subject.

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[1] Ford GP. *Br Med J* 1981;**283**:501.
[2] Kaplan HS. *The new sex therapy*. Vol 2. New York: Brunner and Mazel, 1979.

Simple technique for measuring serum or plasma viscosity with disposable apparatus

SIR,—Dr R C F Leonard in his report "Simple technique for measuring serum or plasma viscosity with disposable apparatus" (31 October, p 1154) compares his method with that using the Ostwald apparatus. The published results, however, show no evidence of correlation between the two methods. The graphical presentation used allows comparison only of the between-individual variation, the between-individual mean, and the variation with temperature of each method. The information missing could be most easily provided by between-method correlation statistics and single-temperature scattergrams.

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SIR,—I wish to point out some important omissions in Eleanor Moskovic's American-English vocabulary (7 November, p 1242). When I visited the Massachusetts General Hospital last summer, I found the following abbreviations were de rigueur: Dx—diagnosis; Bx—biopsy; Sx—symptoms; Hx—history; ABs—antibiotics; OOB—out of bed; a line—arterial line.

A cardiac arrest involved a "code call," but if the patient could not be resuscitated the resident would say "OK, let's call this one." The term WACU refers to the white acute care unit, which is the recovery area for the 40 operating theatres (the ORs), with a few beds for intensive care.

The widespread use of nouns as verbs includes such horrors as to party, to parent, to gift, and to Foley. To handbag is not to strike someone, but to ventilate the patient manually.

My favourite notice is the sign outside the chapel, which declares that the minister is the Revd X of the department of pastoral care. I feel sure that this will soon be renamed the eternal care unit.

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SIR,—Eleanor Moskovic's vivid description of her student elective at the Massachusetts General Hospital (7 November, p 1242) has brought back to me some memories of my own medical residency at the Boston City Hospital 10 years ago. One cannot fail to be impressed by the striving for excellence and by the dedication to hard work in American teaching hospitals. Young European doctors especially admire the eagerness with which their American contemporaries seek responsibility and the zeal with which they apply themselves, sometimes to the point of physical and emotional exhaustion. The report contains, however, some alarming observations, and these cause me to question whether excellence is not bought too dearly and at the expense of the patient.

One hears, for example, much about malpractice litigations in the United States. Is this still surprising when we now read that behind closed doors a doctor calls his patient a "dirtball" or "son of a bitch"? I admit that professional work of any kind tends to strain and narrow the mind, but this is no excuse for moral perversion.

The finest qualities expected from a physician are still a clear head and a loving heart for those entrusted to his care. I do not believe that "autognosis sessions" will help to acquire these qualities, nor do I believe that zoological analogies will help to repair a broken relationship between the physician and his patient. Instead, I would recommend reading or rereading of Francis W Peabody's famous address to the students at the Harvard Medical School,[1] where he says: "The treatment of a disease may be entirely impersonal, the care of a patient must be completely personal. The significance of the