This is essentially no different from the situation obtaining in other specialties, and has been the method of climbing the ladder used by those of us who started as part timers but who have been willing to invest both time and money in our training and qualifications.

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Points

Method of healing diabetic forefoot ulcers

Mr FRANK I TOVEY (Basingstoke District Hospital, Park Prewett, Basingstoke, Hants RG24 9NA) writes: We have used metatarsal bars, as suggested in the letter from Dr Adolf Singer (16 April, p 1284), and also rocker soles in the management of forefoot ulcers in both diabetic patients and patients with leprosy. There is no doubt about their efficacy in preventing recurrence of healed ulcers, but they introduce problems. Metatarsal bars catch on objects when the patient is walking, and rocker soles are thick and clumsy. The cushioned cradle insoles which we described (5 March, p 805, and 19 March, p 984) are equally effective and more versatile and are more acceptable to patients.

Letters to a young doctor

Dr P D O DAVIES (Department of Medicine, Llandough Hospital, Penarth CF6 1XX) writes: I was interested in Dr N Berlyne's dilemma over whether to let a candidate know that he or she had been vetoed on account of a single damning reference (2 April, p 1143). On one occasion after an unsuccessful interview for a job I was approached by the secretary coordinating the candidates and told that Dr X, one of my referees, was "not a good doctor from whom to receive a reference." This, of course, left me wondering whether it was because he had given me a poor reference or because he was not considered highly by his colleagues that he was not a good doctor to give me a reference. The practical outcome was, of course, helpful: I have never since approached him for a reference. I am not sure whether Dr Berlyne would consider such advice ethical, but should I find myself in a similar situation of having to turn down a candidate because of a damning reference I would have no hesitation in acting along the lines of the above mentioned secretary.

Professor F A JENNER (Department of Psychiatry, Royal Hallamshire Hospital, Sheffield S10 2JF) writes: Dr N Berlyne's letter (2 April, p 1143) on the applicant repeatedly turned down because of a damming reference caught my eye. Recently we offered to recommend an appointment subject to the receipt of an outstanding referee's report, and we were shocked when we received it. The applicant was not given the job, and the referee approached his medical defence society as we had, albeit inadvertently, revealed his views. We survived to tell the tale, but I decided that in future if someone is turned down because of his referee to write personally to the referee in confidence suggesting that he tells the candidate of his views.

Candidates are still in difficulty if they cannot get their last chief's approval, but they can then comment themselves, and doctors should write damaging comments only after having had the courage to warn the applicant.

Use of blood in elective general surgery

Mr IAN FRASER and Mr D E OSBORN (Urology Unit, Leicester General Hospital, Leicester LE5 4PW) write: Mr J A Smallwood (12 March, p 868) highlights the lack of blood transfusion policies in the Portsmouth area. As he correctly points out, a variety of previous studies have already established a case for grouping and saving serum only before certain major surgical procedures. More useful information would be the published experience of the implementation of such policies. We have just completed a prospective series of 250 transurethral prostatectomies using this type of plan without appreciable problem (to be published), and we believe that current practice will be modified only by this type of study.

Yes, no, and maybe

Professor M J R HEALY (Department of Medical Statistics and Epidemiology, London School of Hygiene and Tropical Medicine, London WC1E 7HT) writes: Dr T D R Hockaday's view (19 March, p 915) that users of t and χ^2 tests are restricted to qualitative questions answerable only by "Yes" or "No," though widely shared, requires qualification. A statistical hypothesis test of whatever kind asks the question: "Are my data compatible with the null hypothesis?" and this seems to demand the answer "Yes" or "No"; the answer it receives, however, is "Maybe," along with a quantitative measure of the degree of compatibility in the form of the significance value. It is a common misapprehension, reinforced by the use of the meaningless abbreviation "NS," that the 5% level of significance is some kind of absolute dividing line; it is, of course, wholly conventional and its popularity is mainly due to its near equivalence to the computationally simple ± 2 SEs. More importantly, the t and χ^2 distributions can (and usually should) be used not merely for testing but also to assess the quantitative range of hypotheses with which the data are compatible at any desired level of confidence. Such analysis helps to answer Dr Hockaday's preferred "How much?" questions.

Flour and eggs as stiffening for bandages

Dr AMIN RAHEMTULLA (Hospital for Tropical Diseases, London NW1 0PE) writes: Minerva (2 April, p 1151) mentions the use of egg white and flour as stiffening for bandages in the treatment of fractures before plaster of Paris came into use. My mother used a similar method until quite recently in Uganda. The fractured limb was wrapped in cotton wool and on this was applied a mixture of egg and plain flour. A second layer of cotton wool was then applied and a bandage tied over it. This successfully immobilised the bone. Usually only one application was required, but sometimes the plaster developed cracks and had to be reapplied. Of the many cases that my mother treated in this way there was not a single case of mal-union or delayed union. Though plaster of Paris is more convenient to use and easier to handle, flour and eggs have the advantage of being universally available.

Doxapram and diazepam

Dr R H HARDY (Accident and Emergency Department, General Hospital, Hereford HR1 2PA) writes: This interesting article by Dr C J Allen and Dr K R Gough (9 April, p 1181) reached the same conclusion as a previous article,[1] and the same information has been widely publicised in successive editions of *Accidents and Emergencies*.[2] It is described under the headings "Diazepam" and "Narcanalgesia." The recent development of midazolam (Hypnovel) has lent a further dimension to this excellent narcanalgesic method for fractures and dislocations. Doxapram is just as effective in reversing the central effects of midazolam as of diazepam. The method has our full approval, but the usefulness of doxapram in reversal of the benzodiazepine component is certainly not new.

[1] Beesley JR, Bowden G, Hardy RH, Reynolds TDR. Intravenous diazepam narcosis in the treatment of injuries, with doxapram for recovery. *Resuscitation* 1975;**4**:255-63.
[2] Hardy RH. *Accidents and emergencies*. 3rd ed. Oxford University Press: Oxford, 1981.

Alpha blockers and converting enzyme inhibitors

Dr M P FARRELL (St Luke's Hospital, Guildford, Surrey GU1 3NT) writes: Dr P C Rubin and Professor J L Reid (9 April, p 1192) omitted to mention acute renal insufficiency as an adverse reaction to captopril. They note that it is particularly useful in hypertension associated with renal artery stenosis.

A recent report of captopril induced functional renal insufficiency in patients with bilateral renal artery stenosis or renal artery stenosis in a solitary kidney[1] emphasises the necessity to monitor renal function closely when starting treatment with this drug in patients with low renal perfusion. This may have important implications for the role of captopril in congestive cardiac failure.

[1] Hricik DE, Browning PI, Kopelman R, Goorne WE, Madias NE, Dzau VJ. Captopril-induced functional renal insufficiency in patients with bilateral renal artery stenosis or renal artery stenosis in a solitary kidney. *N Engl J Med* 1983;**308**:373-6.

Simple and effective breast pump for nursing mothers

Dr CATHERINE ROYCE (University Surgical Unit, Southampton General Hospital, Southampton SO1 6HU) writes: I was amused to read about Dr William Sponsel's somewhat Heath Robinson breast pump (9 April, p 1180). Expressing breast milk really need not be so complicated. May I, as a breast feeding mother working full time, suggest the Robbins hand breast pump? It is a simple device, which has a bicycle pump type of action and doubles as a feeding bottle. It is easy to assemble, clean, and can be carried to work in a lunch box. It costs about £6 and is available from chemists and the National Childbirth Trust.