When she was admitted to hospital from school with abdominal pain a few days later the teacher divulged this information to the admitting doctor. As the child was depressed she was seen by a psychiatrist, who advised that she should not be questioned about the alleged sexual abuse because of the risk of suicide. She was started on amitriptyline and sent home. Her genitalia were not examined. A few days later she was readmitted after an overdose of amitriptyline and recovered after intensive care. The psychiatrist, in whose opinion the girl had attempted suicide for fear of her parents coming to know about the sexual abuse, broke the news to her parents after obtaining her permission. They insisted on absolute confidentiality and insisted that the girl should not be seen by any doctor other than the psychiatrist and her general practitioner (who did not know about the alleged abuse).

This case raises important issues. Can a 14 year old tell a professional person about sexual abuse and insist on absolute confidentiality? If this girl's confidentiality had been broken and a case conference held against the psychiatrist's advice she might have attempted suicide—which indeed she did for fear of her parents learning of the sexual abuse. In the attempt to keep the child's confidentiality it is possible that other young girls have been put at risk from a sexual abuser. As her genitalia were not examined it is also possible that the allegation of sexual abuse was false. Furthermore, she may now be denied proper medical care.

Cultural and social factors make the management of sexual abuse in Asian children particularly difficult. In each case all factors should be carefully considered and a decision taken in the child's best interest—in this case the prevention of possible suicide—and the hope that the child comes to no further harm.

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Plastic surgery

SIR,—Mr D M Davies's statistics and the need for more plastic surgeons are beyond dispute (12 December, p 1502). The implication that an expansion of the specialty would enable a reduction in waiting lists consisting largely of cosmetic cases is, however, wide of the mark for regional plastic surgery units. I do not decry the importance of the "surgery of appearance," but cosmetic surgery—which is the elevation of the normal to the supernormal—does not form a part of our workload.

Our present long waiting list—of non-cosmetic cases—is largely due to general difficulties within the health service that affect all specialties and an increased ability to perform and therefore greater demand for major reconstructive surgery using newly developed methods of tissue transfer. Both these pressures are exemplified by our past week's operating, when two whole day lists of congenital, rheumatoid, and post-traumatic hand and arm surgery had to be cancelled to perform (*a*) wide excision and flap reconstruction of carcinoma of the chest wall, (*b*) flap coverage of an infected knee prosthesis, (*c*) major excision and flap repair of an open knee joint and trochanteric pressure sore, (*d*) excision and flap repair of radionecrosis of the hand, and (*e*) attempted repair and later mid-thigh amputation of a completely degloved leg.

All these cases were referred as emergencies or urgent cases by other specialties. Expansion is desperately needed to enable us to provide the required "urgent" service while avoiding postponement or cancellation of waiting list cases. The solution to the problem does not lie in the DHSS declaring some operations "no longer available." This would transgress clinical judgment, as restoration of normality is the right of everyone who contributes to the NHS.

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Privatising water: implications for health

SIR,—The leading article by Dr James Dunlop (21 November, p 1294) is mischievous.

The standards of public water supply in Britain are high. It is a paramount concern of the water authorities, and also, we understand, of the government, that they should remain high and indeed continue to improve.

The terrible toll of waterborne disease world wide is caused by bad sanitation—not by metering. Charging according to what people use is commonplace among our neighbours in Europe and they do not suffer ill health in consequence. A feature of the metering trials which are currently being planned is that customers will be able to obtain the basic public health element of their water at a lower cost than is available under the present system of fixed charges based on rateable values.

Also it is simply not true to say that "Britain has no defined standards for drinking water." The fact is that the European Community drinking water directive lays down standards for over 60 separate aspects of drinking water. That applies equally to water undertakers whether they are in the public or private sector.

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Vitamins and dialysis

SIR,—Unfortunately many of the patients we see would not have the motivation to follow a regimen as rigorous as that followed by Dr Peder K Knudsen (26 September, p 767). We would like to comment on his use of vitamin supplements.

Mr Knudsen is taking water soluble vitamins at doses ranging from 3 to 500 times the Food and Agriculture Organisation-World Health Organisation recommended dietary intakes. While some losses occur during haemodialysis and restricted food intake may lead to inadequate dietary vitamin consumption, it must be remembered that the clearance of vitamins normally excreted by the kidney will be retarded in chronic renal failure. Water soluble vitamins are generally regarded as non-toxic but this assumption is based on the fact that excesses are excreted in the urine. The potential toxicity of large doses of water soluble vitamins is now being illuminated, and patients undergoing haemodialysis are a very susceptible group.[1-3]

Our studies show that patients taking 5 mg folic acid (after dialysis, three per week) had raised plasma and red blood cell folate values. We also found raised plasma ascorbate concentrations in patients taking 1000 mg (three times per week). Such raised plasma concentrations of ascorbate are not possible in normal healthy people. Dr Knudsen was taking only 100 mg; our studies suggest that 50 mg daily is sufficient. Dr Knudsen is taking a dose 500 times greater than the requirement for vitamin B_{12}. Our patients took only 4 mg and had normal plasma values.

The cod liver oil supplement will provide fat soluble vitamins. We found that all our patients had raised plasma concentrations of vitamin A (retinol); most took no supplements. The toxicity of vitamin A is well documented.[4] About half of our patients had raised plasma vitamin E (α tocopherol) values and no patient took supplements of this vitamin.

Thus we suggest that supplementation with vitamins A and E is unnecessary and may be harmful. Water soluble vitamins should be given at doses as near as possible to the recommended dietary intake to avoid potential toxicity.

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A test for manpower planning

SIR,—I agree with Dr Cynthia Marvin (14 November, p 1281) that the issue of research in training and career progression needs more study, and I am sorry that my leading article (10 October, p 868) did not give scope for more than a fairly superficial comment.

If a specialty has 40 NHS senior registrar posts recognised for higher training and there are an additional 10 research posts as "honorary clinical assistant," or whatever, without training recognition then, if the requirement for accreditation is four years in recognised posts, there will be on average 10 training posts a year available and 10 people a year eligible to compete for consultant appointments. Some of these competitors will, however, have prolonged their "training" to do their research. Raising the number of non-recognised research posts to 20 or 30 or 40 will increase the average total length of higher "training," in that a larger proportion of trainees will spend extra time doing research but there will still only be the same average of 10 people a year able to gain accreditation. On the other hand, if in addition to the 40 NHS senior registrar posts there are 20 research posts recognised for higher training this pool of 60 posts will increase the average number of competitors for consultant or other senior appointments by 50% a year. So much for a hypothetical steady state.

If the pool of research posts which are non-recognised or occupied by doctors who already have accreditation expands while the number of NHS senior registrar posts remains correctly related to the number of expected consultant vacancies, the additional take up of research posts will temporarily remove candidates from the NHS. Both trainees and consultant vacancies will tend to stack up unless a better outflow is available into more permanent senior academic posts, in which unhappily improbable case the NHS will lack consultant recruits. If there is imbalance either way it is the number of NHS senior registrars which needs adjusting. It is easy, as Dr Gary Butler (24 October, p 1067) has pointed out, to make assumptions which are inadequately supported by data about the ultimate career aspirations and prospects of researchers. What matters to the NHS

career structure is that the more commonly research becomes incorporated within higher training, so that such experience can be gained with little or no prolongation of senior registrar or equivalent tenure, the more control has to be held over the number of available posts.

Geographical spread of senior registrar training and research is another related issue, and I should hate to think that I had made any suggestion which might lead to a perpetuation of the present disparity.

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Primary care and the small practice

SIR,—The leading article by Dr Robin Hull concerning the white paper on primary care (5 December, p 1436) touches on the problems which could beset small practices with the proposed increase in patient numbers and committed hours that will be needed to qualify for the full basic practice allowance.

If these proposals are implemented small practices which are small by design (because of other commitments, husband and wife units, women doctors, health) or small by circumstance (starting up, in area of heavy competition, location) will be penalised by reduction in income at the same time as being forced to accept a higher commitment. Such practices already receive less proportionally than their colleagues (no group practice allowance and higher expenses with locums), and many of these will become untenable.

Small practices are not commensurate with low standards as is implied in the white paper. Many such practices in this area outshine in service and standards their larger counterparts, some of which hide behind the anonymity of "the health centre." Small practices are an important part of community medical care. Pricing them out will do nothing but harm.

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Acupuncture as an antiemetic

SIR,—Dr W M Weightman and his colleagues (28 November, p 1379) are to be congratulated on the design and execution of their study, which failed to show any beneficial antiemetic effect of acupuncture with their particular anaesthetic technique. Their claim that the findings were contrary to those reported by us[1] is untrue, however, as our anaesthetic technique differed fundamentally from theirs. Using a similar technique (alfentanil-methohexitone, nitrous oxide, oxygen) with electro-acupuncture given during the operation, we likewise failed to find any benefit from acupuncture.[2] In groups of 20 patients undergoing minor gynaecological operations eight in the acupuncture group were sick during the first four hours after operation compared with six in the control group.

We do not know how acupuncture works as an antiemetic but its timing in relation to the use of an opioid appears to be crucial. Given before or with intramuscular nalbuphine premedication it is very effective (our current figures for sickness in the first six hours after operation are 38/56 with no acupuncture compared with 13/56 when acupuncture was used), but given after the opioid becomes "fixed" it is not effective.

There is much we do not know about the mode of action of alternative medicine techniques, but, as with orthodox medicine, like has to be compared with like. Even minor differences between our anaesthetic technique and that of the New Zealand workers can be very important and we must be careful to use the same methods when trying to verify the findings of others.

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Promoting better health

SIR,—The proposals in the government's white paper on primary care (5 December, p 1497) suggest a shift in general medical practice from the treatment of the sick and handicapped to preventive medicine.

I suspect that there are many practitioners both fully occupied and fulfilled by their present commitment to the management of illness who are apprehensive about this proposed extension of service. It would appear that much of the present personal interpretation of professional responsibility enjoyed by general practitioners will be replaced by directives from outside agencies, in many cases enhanced by the offer of extra remuneration. This may be attractive for some but it will dismay others who have cherished professional independence.

The new concepts of preventive medicine could have provided an honourable career structure for a limited number of doctors who have both the training and inclination for such work, leaving those who still think general practice means supportive and curative medicine free to continue as before.

What is likely to happen is a competition for time between these equally necessary medical activities to the detriment of both.

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Hyperglycaemia and porphyric attacks

SIR,—The case recently reported by Dr A G Yalouris and Professor S Raptis (14 November, p 1237), although most interesting, contains a conceptual flaw. While there is evidence that a high carbohydrate intake can curtail porphyric attacks there is no proof that this approach also works prophylactically. The four references quoted by the authors in support of their assumption that "a high intake of glucose or carbohydrates offers protection from porphyric attacks" do not contain this evidence.

The difference between the assumed prophylactic and the proved therapeutic effectiveness of carbohydrates for porphyric attacks is not trivial but clinically important. I have seen patients who in the hope of preventing porphyric exacerbations consumed large amounts of carbohydrates, with obesity the only result.

While there is little doubt that starvation can indeed induce a porphyric crisis, carbohydrate loading should be used only early in an attack, quickly to be supplemented by haematin if the symptoms do not abate rapidly. All diabetics should strive for normoglycaemia at all times, even when they have an inducible porphyria.

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The death of Oscar Wilde

SIR,—Dr J B Lyons's letter (12 December, p 1567) on the terminal illness of Oscar Wilde is both timely and judicious. The encylopaedic nature of Professor Ellman's recent biography may lead to uncritical acceptance of his conclusions by reviewers and literary historians.[1] The evidence that Wilde had been infected by syphilis is sketchy and based on gossip rather than any professional facts that have come to light.

Three days before Wilde died a report dated 27 November 1900 and signed by his attending physicians, Dr Paul Claisse and Dr A'Court Tucker, stated clearly that their patient had a meningoencephalitis due to a chronic suppuration of the right ear; there was no mention of any underlying luetic process.

Wilde's symptoms comprised unilateral deafness dating from his imprisonment, fever, and intense headache, which required repeated opiates and local applications of leeches and icepacks. We are not told whether or not the deafness was progressive or whether it was accompanied by otorrhoea. Intractable headache does not suggest syphilis but favours a septic infection. The late Sir Terence Cawthorne was of the firm opinion that Wilde's death was the outcome of an intracranial complication of otitis media.[2,3]

In the terminal picture there was also an obstinate skin irritation, attributed by Wilde—rightly or wrongly—to mussel poisoning. It suddenly cleared up, only to return. The nature of the rash is debatable.

We are often told that Wilde had a medical clearance before his marriage to Constance Lloyd. Up to now no supporting evidence has emerged. His doctor was Dr Charles de Lacy Lacy of Grosvenor Street, Mayfair, but no records appear to have survived his death in 1932.

At present I am writing another paper on this subject. Has any *BMJ* reader further data bearing upon Wilde's medical history?

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Time to start changing the time?

SIR,—Greenwich Mean Time is a standard by which the whole world sets its clocks. Dr J G Avery (19 December, p 1586) contends that this is no longer in harmony with the British times of starting and finishing work and school and supports changing the clocks. Why not change the times: there is no magic, for example, in starting school at 0900.

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Correction

Potassium citrate mixture: soothing but not harmless?

An error occurred in this letter by Dr Roger Gabriel (5 December, p 1487). The values for urinary potassium should have been expressed as mmol/day and not μmol/day.