Knowelden were members of this small group, and we adopted two firm principles. These were: (*a*) that the quality of the existing community health services must not be compromised; (*b*) that as in other branches of medicine control of training and accreditation must lie largely in the hands of senior practitioners of that specialty. We did not consider it our responsibility to protect existing career structures since that is not a function of colleges or faculties.

I believe that the current draft embodies our two principles, but it is not yet finalised—although a preliminary draft has been shown to the chief medical officer. The report can never, however, be more than the considered opinion of its authors, and it will be no more than one of the documents that the chief medical officer will have available to him when he advises his ministers.

I am sure that Sir Raymond is as grateful as I am to Dr Dalzell and to other community health doctors for the advice they have given us. I also entirely understand how frustrating it must be for a specialty that is insecurely represented in the establishment that is officially charged with advising on education and training. I hope that the present discussions will help towards remedying that problem.

ALWYN SMITH
President

Faculty of Community Medicine
of the Royal College of
Physicians of London,
London W1N 4DE

Points

Medical education

Dr CHRISTOPHER D MITCHELL (Children's Hospital of Philadelphia, Philadelphia, PA 19104 USA) writes: I agree with many of the points raised by Professor F Harris (7 July, p 53) about medical education and the preregistration year. I would add that there must be better systematic education throughout the postgraduate years. In July 1983 my fellow registrars and I at the Queen Elizabeth Hospital for Children in London started a daily morning teaching session based on the North American model suggested by Dr Harris. The previous day's admissions were presented and diagnostic and management problems were discussed. A survey of the junior staff at the hospital six months later showed that this meeting and an evening teaching ward round with the duty registrar were thought to be the two most useful educational events available.

Violence and psychosis

Dr PAMELA J TAYLOR and Dr JOHN GUNN (Institute of Psychiatry, De Crespigny Park, London SE5 8AF) write: Dr S E Josse (28 July, p 249) appears to have misunderstood the data in our second article about violence and psychosis (7 July, p 9). Mental hospitals do tend to reject mentally abnormal offenders. It is also undoubtedly true that when the police find a grossly emotionally disturbed person in a public place they sometimes charge then remand him or her in custody, mainly because it is the only way left to them of getting assistance for that person. The patient does not, however, need to show particularly violent behaviour for this to happen.

Our description of police ratings of violent behaviour was based on the exceptional risk forms (618) which the police may complete. These forms have nothing to do with the legal proceedings against the offender but are for the assistance of the prison authorities in safely managing such people. Our tables show that most of the mentally disordered in our sample received no police rating of violence. Nevertheless, the mentally disordered groups were more likely to be rated as potentially dangerous to others than their non-disturbed peers.

What price psychotherapy?

Dr DE WET S VORSTER (Plymouth Nuffield Clinic, Plymouth PL4 8NQ) writes: Many studies support the view presented by Steven Hirsch (4 August, p 316) concerning the economic value of well done psychotherapy, especially intervention before adverse circular intrapsychic and interpersonal habits are formed and the "correct type of psychotherapy for the correct patient."[1 2] Concerning the effectiveness of psychotherapy, Langley refers to the West German study, the results of which showed an 85% reduction in average number of hospital days a year for the five years after mental health treatment.[3] The results of the Kaiser Permanente study showed reductions of 62% in outpatient medical visits and 68% in the number of hospital days by the fifth year after psychotherapy, and those of the Blue Cross of Pennsylvania showed a medical and surgical reduction of 57% when the two years after psychotherapy were compared with a similar period; thus psychotherapeutic intervention improved, removed, or decreased functionally caused medical illnesses.

[1] *Psychotherapy research*. Washington DC: American Psychiatric Association, 1982.
[2] Vorster D. Psychotherapy and the results of psychotherapy. *S Afr Med J* 1966;**40**:934-8.
[3] Langley D. Primary care and psychiatry. *Soc Psychiatry* 1982;**17**:289-94.

ABC of poisoning

Dr JOHN PRING (Penzance, Cornwall TR18 4PG) writes: I enjoyed the articles by Dr John Henry and Dr Glyn Volans (7 July, p 39) but disagree with their statement that "Oxygen should not be given to the patient whose severe respiratory depression is known to be due to drugs or chemicals causing depression of the central nervous system. . . ." Oxygen administration to a patient with chronic obstructive lung disease may result in ventilatory depression with a further rise in P_{CO_2} (removal of hypoxic drive via peripheral chemoreceptors). Hypoventilation due to "respiratory depression known to be due . . ." will also be associated with CO_2 retention. The alveolar gas equation $P_{AO_2} = P_{IO_2} - P_{ACO_2}/R) - F$ shows that by the administration of only 28-30% oxygen (which could easily be achieved in the ambulance on the way to the hospital) the alveolar P_{O_2} may rise by 6·6-7·98 kPa (50-60 mm Hg). I agree that once in hospital the patient's ventilation can be carefully assessed, and endotracheal intubation and artificial ventilation started if necessary.

Hidden dangers of sliced bread

Mr ALAN D WELLS and Mr DEREK PACKHAM (King's College Hospital, London SE5 9RS) write: Aside from the dangers reported by Mr G Sutton (30 June, p 1995) of the ingestion of plastic bread wrapper clips, finding one of these clips unexpectedly at operation may cause diagnostic difficulties. At a recent radical nephrectomy for a hypernephroma preliminary laparotomy showed an easily palpable mass in the small bowel. The bowel looked essentially normal apart from one area where the wall appeared puckered, and examination showed a small well defined mass. Although rare, a small bowel metastasis from the hypernephroma was considered, as was a primary small bowel tumour. Further careful palpation defined the edges of a small flat object that appeared to be embedded in the mass and a diagnosis of an intraluminal foreign body was queried. After the nephrectomy a small enterotomy was performed to show a white plastic bread clip embedded by its open ends into the wall of the small bowel and surrounded by an inflammatory mass. The clip was removed and the enterotomy closed. After the operation the patient had a wound infection, which we would not normally expect to see after a radical nephrectomy and which may have been related to opening the small bowel. The patient admitted to eating bread packaged with these clips but denied having knowingly swallowed one. In addition to Mr Sutton's suggestion of enlarging the clips to help prevent accidental ingestion, perhaps it would be prudent to suggest banning white clips in the hope that the brightly coloured clips would be more easily recognisable in one's sandwich!

Writing a thesis on a word processor

Mr R M KEANE (Royal United Hospital, Bath) writes: Word processing is a godsend when used efficiently (28 July, p 242). I recently prepared my thesis as follows. I carefully dictated my first draft, with accurate punctuation instructions and spelling of technical terms, on to microcassette tapes. A professional typist, experienced at both thesis preparation and word processing, then typed the text directly from microcassettes into a word processor. I then corrected the printout and returned it for editing on the word processor. This took far less than a year and my word processing bill for over 200 thesis pages was only £300, far less than the figure quoted by Mr McDonald.

Is routine episiotomy necessary?

Dr E FRITZ SCHMERL (Samuel Merritt Hospital, Oakland, California 94609 USA) writes: Mr R F Harrison and others (30 June, p 1971) have had the courage to revive the question but their attempt to answer it with a statistical model left some questions still open. Thus, the value of routine episiotomy is still not clearly definable. Neither is there a rule for its length. It is surprising that textbooks such as Wilson and Ledger do not indicate it.[1] In a diligent search I found not a single instance in which the proper length of the incision is discussed. Apparently, it is left to the discretion of the accoucheur. Yet, to qualify as a routine episiotomy a perineal incision is often more than 5 cm long.

Dr Ludwig Kochmann, who practised family medicine in a Berlin suburb for 42 years (1895-1937) and who had over 2000 home deliveries to his credit, did routinely a 1 cm mediolateral incision that one could call a routine miniepisiotomy (personal communication). It was sufficient in almost all primigravids, and it hardly ever required suturing. It did protect the tissue where the pull and pressure is most severe—that is, at the vulva's rim. It was rarely necessary to extend the cut subsequently. The routine miniepisiotomy would offer a compromising third alternative. Although coming from the grassroots it deserves scientific scrutiny and, perhaps, wider application. Unfortunately, Dr Kochmann has never reported his experience. In his days the work of the busy generalist remained quite remote from the ivory tower of investigative academia. Yet Dr Kochmann's voice deserves to be heard.

[1] Wilson, Carrington, Ledger. *Obstetrics and gynaecology*. London: C V Mosby, 1983:539.

Correction

Treatment of oesophageal cancer: proposal for a national society

We regret that an error occurred in the letter from Mr A Watson and Mr L R Celestin (11 August, p 379). The sentence in the 16th line of the third paragraph beginning "Survival at one year was 5% . . ." should have read "Survival at one year was 51% . . .".