

ward transmission of the card with the medical record is recommended, and conforming to the standard system leaves less room for errors in interpreting other practices coding.

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Care of the foreskin in infancy

Sir,

A survey has recently been performed at Southampton on the instructions given to mothers about the care of the foreskin. This showed that only 29 per cent of mothers were given the correct advice, 33 per cent were given incorrect advice and the rest received no advice. Only 66 per cent of those giving advice — both doctors and nurses — knew what the correct care should be.

It is now generally accepted that the optimal management of the infant's foreskin is masterly inactive until the child is out of nappies and that by the age of three, 80 per cent of foreskins will be retractile.¹ Thereafter, gentle retraction while washing in the bath will allow separation of the normal preputial adhesions. Premature retraction causes radial splitting of the foreskin, with healing by fibrosis and subsequent development of a phimosis. This results in an avoidable circumcision.² It is worrying that there are so few mothers who receive the correct advice, considering the large number of medical and nursing staff they see. In addition, it is sad to see that one-third of mothers were advised to prematurely retract the foreskin.

The advisers themselves were confused about both the correct management and who should be responsible for ensuring that mothers were correctly instructed.¹ The health visitor has a statutory duty to visit the mother and child at 10 days, and then is available during the first 13 months while the child is immunized. She should also review the child at about 18 months and three years. She is therefore perfectly placed to insure that mothers learn the correct management of the foreskin and thus reduce maternal anxiety and the numbers of avoidable circumcisions, together with ensuring a lifetime of routine penile hygiene.

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References

1. Gairdner D. *The fate of the foreskin*. *Br Med J* 1949; 4: 1433-1435.
2. Twistington-Higgins T, Williams DI, Ellisln-Nash DF. *The urology of childhood*. London: Butterworth, 1951.

Fluoridation update

Sir,

Since the article by Mr G. Smith (June *Journal*, p.350) was restricted to the medical aspects of fluoridation — some of which, to me, seemed misleading — it would have been inappropriate to have introduced an entirely different topic 'The moral issue' into my reply, which was a simple statement of scientific fact.

Replying to Dr Juby's letter (November *Journal*, p.626), much of the river and spring water in the world is drinkable in its natural condition, provided one is prepared to risk contracting cholera. The water authorities, however, without reference to the freedom of choice of the individual, who could add chlorine tablets to his natural drinking water if he so wished, add free chloride ions to the water supply at source.

Similarly, the individual, who could add fluoride tablets to his artificially chlorinated drinking water or to his natural spring water if he so wishes, may choose to feed fluoride deficient water to his children, provided he is prepared to risk their contracting dental caries.

Just as water authorities provide protection against microbial enteritides by default so they wish to provide protection against dental caries by default. There is no 'moral' objection to the principle of extending a service which is already accepted by society. There is only an emotional repugnance at what might seem to be 'Big Brother' who is removing our freedom to make our children suffer if we so choose.

The anti-fluoridationist is surely one of the greatest 'friends' of the dentist's bank manager since he is ensuring that there will always be plenty of disease for him to treat.

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Doctors and nuclear war

Sir,

Dr Watts raised a most important matter in his letter (November *Journal*, p.628). As a profession we are totally unprepared for nuclear war, and the RCGP adopts an uncharacteristic head-in-the-sand attitude to the whole question.

At the Annual General Meeting on 10 November, after an eloquent address from the Chairman of Council in which members were exhorted to 'anticipate medical needs, rather than await events and then respond if we have to', a motion asking the College to produce a booklet for general practitioners and a leaflet for patients on the medical problems arising from nuclear war was so mutilated by amendments that in its final form it was virtually meaningless. This was a shameful exercise which did the College no credit.

Where else should we turn for guidance if not to our own academic body? For, make no mistake, guidance is sorely needed, and our present concern with matters like deputizing, prescribing habits, record-keeping and so on pales into insignificance compared with the almost unimaginable changes in the doctor's role which would follow a nuclear exchange, however small. How many of us are ready to work under military command, with few or no resources, and certainly without such luxuries as professional freedom or individual conscience? It seems likely that the major task facing any surviving doctors will be to choose those few casualties likely to benefit from what little treatment is available, and separate them from the majority who must be left to die. Simple humanity will impel us to offer some form of euthanasia to those we cannot help in any other way, but precious drugs and ammunition cannot be used up in this non-productive manner. What then shall we do?

Unless we begin to prepare now, to plan and to explain our plans to the public, we shall fail in our duty. Let wiser councils prevail than those which were heard on 10 November.

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