Analyses of this kind are beset by problems of colinearity, particularly of variables pertaining to practice organisation. "Female partner in the practice" is the only such variable entered into the multiple regression model of Majeed and colleagues. This variable is, by virtue of its construction, highly correlated with partnership size. Our data suggest that both these variables have an independent effect of similar magnitude.

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Thalidomide may be a mutagen

EDITOR,—On the basis of two men accepted as damaged by thalidomide who fathered babies with similar defects, W G McBride raises the hypothesis that thalidomide may be a mutagen.[1] Andrew Read quite rightly dismisses this as "almost certainly unfounded."[2] In addition to the reasons given by Read, it is important to recall that many children were accepted as thalidomide damaged on the basis of a clinical opinion and in the absence of any evidence of exposure to thalidomide in utero during the sensitive period of embryogenesis.

The father's defects in McBride's case 1 are quite atypical for thalidomide, which affects the digits from the radial to the ulnar side—that is, the thumb is the first to be affected. The father's defects in case 2 are neither illustrated nor adequately described to allow an opinion.

Approximaely 350 children have now been born to beneficiaries of the UK Thalidomide Trust, of whom two have limb defects. McBride's hypothesis is without any scientific foundation and should not be allowed to stir up inappropriate anxieties among those who believe themselves to have been damaged by thalidomide.

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Snoring and sleep apnoea

EDITOR,—Ian Mortimore stated that "operative treatment for snoring by uvulopalatopharyngoplasty . . . may be associated subsequently with appreciable morbidity and death" as the surgery may prevent the effective use of nasal continuous positive airway pressure in the future.[1] We dispute this.

We agree that many simple snorers probably progress over the years to sleep apnoea; there is evidence to support this.[2] We do not currently know whether surgical intervention has any beneficial or harmful effect on this progression but it does reduce snoring and daytime sleepiness in snorers, whether or not they have apnoea.[3,4]

We know of no anecdotal or other evidence to support Mortimore's claim that previous uvulopalatopharyngoplasty may prevent the effective use of nasal continuous positive airway pressure, though some doctors have used this theoretical argument against surgery in the treatment of simple snoring. We intend to test this theory by using nasal continuous positive airway pressure in some of our patients who have had uvulopalatopharyngoplasty.

In Bristol we have taken another approach to surgery for snoring and use a punctate diathermy of the soft palate. This procedure works well, reducing snoring by provoking fibrosis within the soft palate and stiffening it. Its main advantage over uvulopalatopharyngoplasty is that normal anatomy is maintained so that "failure of nasal continuous positive airway pressure" is not possible. We are currently reviewing our series of patients treated this way and hope to publish our results soon.

Douglas advised against referral to ear, nose, and throat surgeons for snoring "unless the patient has gross abnormalities of the upper airway."[5] Many "simple" snorers with only subtle airway abnormalities can benefit from surgery and seem quite willing to cope with the relatively short term cost of pain and potential voice and regurgitation problems referred to by Douglas.

If the patient is referred to an ear, nose, and throat surgeon only when the physician detects gross anatomical abnormality or not at all on the basis of an unproved theory that it might affect the use of nasal continuous positive airway pressure in future, many patients will be denied effective treatments for this surprisingly debilitating condition.

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Training in medical emergencies

EDITOR,—R J Burden and J Handel voice fears felt commonly by junior medical staff, particularly by newly qualified doctors undertaking their first post as a preregistration house officer.[1] I agree that formal training in the management of common medical emergencies would improve the quality of medical training and should be encouraged. But "all new trainees" starting jobs in which "emergencies regularly feature" surely include all preregistration house officers.

The final year of undergraduate medical training is the time to equip trainee doctors formally with the skills and knowledge to deal competently with all common emergencies. As a newly qualified doctor about to enter my preregistration year, I know that this aim is not achieved in many cases. This is especially so with cardiopulmonary resuscitation, a skill in which training is still inadequate[2] despite the skills of junior medical staff having repeatedly been shown to be poor.[3,4]

Hopefully, the General Medical Council's recommendations on undergraduate medical training[5] will go some way to ensuring that all new doctors are adequately prepared to deal with common medical emergencies. The keys to this are sufficient formal teaching (preferably by an accident and emergency specialist), proper practical training (for example, in cardiopulmonary resuscitation by a resuscitation training officer), and good exposure to clinical emergencies (on attachment to an accident and emergency department and while shadowing a house officer). These steps might go some way to ensuring that all doctors are better prepared for emergencies at a more appropriate stage of training.

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Practice nursing

EDITOR,—In reply to Mark R Williamson's suggestion that practice nurses should be freed from having to take blood,[1] I would point out that many of the seemingly routine tasks carried out in general practice allow staff to form relationships with patients; this bond will be of particular benefit at times of severe illness, trauma, or emotional distress. Furthermore, routine tasks done by practice nurses often give patients the opportunity to clarify earlier discussions with their doctor, and several studies have suggested that patients use nurses to explain what has been said by the doctor.[2,3]

For patients with chronic diseases who receive hospital based care but whose condition is monitored by a general practice, the practice nurse may be the only health professional they see for three months or more. Such chronic diseases may cause problems with everyday living on which an experienced nurse can offer care and advice, thus contributing towards an improved quality of life.

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New start dates for medical posts

EDITOR,—Graham Winyard[1] claims that the directive[2] to change start dates for house officers will not result in departments having a two day shortfall in senior house officers unless current postholders choose to leave their posts on 31 July.

This is correct, but he fails to realise that many senior house officers are obliged to leave their posts on 31 July. Senior house officers entering general practice are not covered by the directive (BMA, personal communication). Consequently they are obliged to start their new posts on 1 August and therefore leave their current posts on 31 July. An