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