What's potty about early toilet training?

PERSONAL VIEW **Rosemarie Anthony-Pillai**

I have returned to work after eight months' maternity leave following the birth of my daughter. These have been months filled with wishing people would forget that I am a doctor and treat me like any new mother, and wishing that others would remember that I am a doctor and stop treating me like an idiot. With motherhood comes not only a new baby but endless good advice. So it is always a good idea to challenge perceived wisdom. One area I would like to tackle is the issue of toilet training.

In the West, a toddler learns to toilet train any time after 18 months, the average being around two and half years. This has been the case for the past 40 years, following work done in the late 1960s which developed the idea of child readiness—physiological, emotional, and social. This child centred approach was in stark contrast to the parent centred strict toileting of the 1930s, which was felt to have adverse behavioural consequences. My own opinion is that the development of disposable nappies, which also occurred in the late 1960s, allowed the child centred approach to establish itself as the unchallenged standard. "Later is better" may not have been so easy if all you used were terry cloths.

Yet disposable nappies are an environmental disaster; 2.5 billion disposable nappies are sold each year in the United Kingdom (and many billion disposable diapers are sold in the United States). They make up 2-3% (400 000 tonnes) of landfill in the UK. An average child will use more than 5000 disposables in two and a half years. Local councils are desperately trying to reduce their landfill tax bills and are setting up schemes and moneyback offers to encourage parents to use washable cloth nappies. However, the Environment Agency's life cycle report on disposables and washables (2001) failed to show a significant environmental benefit of one over the other (though the study did not look at the impact of disposables on landfill). The main environmental impact of disposables is in their manufacture; for washables it is the energy used in washing and drying.

Little if no work has been done on the merits of getting your baby used to a potty before one year of age. And though for many the idea of putting a baby on a potty seems faintly absurd and rather futile, babies without nappies are the norm in many parts of the world. If you live in the West and are affluent you are more likely to wait till the child is over two and a half to toilet train. This is almost certainly because the longer you leave it the "quicker" the training will be, and this no doubt appeals to busy working parents. Yet there is some evidence that delaying potty training can lead to increased problems of stool holding, potty refusal, and constipation. Early potty training (under 18 months) is advised for infants with bladder dysfunction and ureteric reflux, as getting babies out of nappies improves their bladder volumes and aids full voiding. There are also concerns of possible male infertility through increased scrotal temperature associated with disposable nappies.

When my daughter was four months old, my mother told me I should put her on the potty before it was too late and she became more interested in exploring. I later found out that my mother was describing a technique known as infant potty training or elimination communication. Some mothers do start training from birth. I found it easier to start when my daughter was old enough to be supported on a potty chair. Infant potty training has three main elements:

There is some evidence that delaying potty training can lead to increased problems of stool holding, potty refusal, and constipation

- Look for cues that your baby is toileting—this may be a cry, a grimace, contracting the abdominal muscles, writhing, straining, getting suddenly fretful
- When you see any of these signs, put the baby on the potty. As the baby wees or poos, make an associating sound (for example, a grunt, or "whoosh" noise), and then congratulate them on what they have done
- Keep doing this, but then build in times when you will regularly toilet them—for example, after a sleep, after a meal, before bedtime. Sit them on the potty and make your associating sound, and if they do anything then congratulate them.

Elimination communication is not training as such: it is a method of dealing with a baby's bodily functions. I believe the benefits of allowing a young baby to start associating a potty with elimination as early as possible are vast, not only for their own health but for the environment and their skin. Having soiled, offensive nappies sitting against a baby's skin and then smelling out the bin becomes almost a thing of the past. Allowing this technique to remain the preserve of the poor in the developing world and a few "hippy" mothers in the West now seems absurd. It's time to review the 40 year old theories on potty training, and for more work to be done on the benefits of getting babies out of nappies.

Rosemarie Anthony-Pillai is specialist registrar in palliative medicine, Mount Vernon Hospital, Northwood, Middlesex roseap@doctors.org.uk

RUTH JENKINSON/MOTHER AND BABY PL

"Look—no nappies!"

The complex art of healing, p 1169

REVIEW OF THE WEEK

Straight talking?

Lesbian, gay, bisexual, and transgender issues currently receive little attention in clinical training, writes **Jeanelle de Gruchy**, welcoming a book that challenges the status quo

There's an in-joke that goes: "Which is it better to be, black or gay?" with the answer "black, as you don't have to tell your mother." For those who are gay, the invisibility of their sexuality and the need to take a position on whether you're in—or out—of the closet is a constant. Conversely, being heterosexual is also invisible. As Julie Fish eloquently writes, heterosexuality "rarely has to attest to its existence . . . while homosexuality is silenced, heterosexuality is silent." And it is this routine presumption of heterosexuality and its oppressive privileging over an "inferior" homosexuality that she terms heterosexism.

Fish, a research fellow at De Montfort University, shows how heterosexism distorts the health and social care that lesbian, gay, bisexual, and transgender (LGBT) users receive. Take, for instance, the account of one woman's attendance for a cervical smear: "I was asked when I last had sex—I said my last experience of penetrative sex with a man was nine years ago—she said never mind, I'm sure you'll find someone soon. With an instrument in place and my legs at 10 to 2 I didn't feel comfortable telling her I was a lesbian!" Or then there's the woman who "mentioned my girlfriend to the nurse and she bolted—and got a male nurse to come and do [the cervical smear]." Lesbians' accounts of their experiences of cervical screening and breast cancer provide graphic illustrations of how they have to negotiate disclosure and non-disclosure about their sexuality. In each interaction with a health professional, the closet is in the room, and they have four choices to make—active non-disclosure (pretending to be heterosexual); passive non-disclosure (not actually claiming to be heterosexual); passive disclosure (dropping hints); and active disclosure (a verbal assertion of sexual identity).

Obliged to negotiate a range of barriers to good care, including ignorance of their needs and moral disapproval, users from the LGBT community are more likely to report adverse rather than positive experiences of health care. Currently LGBT issues receive little attention in clinical training—and when they do, they are predictably confined to issues sexual and psychiatric. It is perhaps unsurprising, therefore, that the health sector is also uncomfortable for LGBT health professionals—in a recent survey, only 1% were "out" to their superiors.

So who are the LGBT community? Fish details what little information there is, and provides a clear, accessible description of diverse groups within this community: young and old, black and disabled, bisexual and transgendered, those living in rural areas, and those who are working class. She discusses these groups' particular positioning within heterosexist society, their social and healthcare needs, and their access to services.

Of course the other aspect of the in-joke is the implied hierarchical positioning of different oppressed groups—gay or black—and the assumption that they're mutually exclusive: "Black LGB sometimes feel they are required to make an either/or choice to identify with either their race or their sexual identity in order to fit in with black heterosexual or white LGB communities." Yet "not only is it impossible to distinguish between multiple identities, but when people are obliged to compartmentalise their identities, they often experience alienation." And of course there are large differences within black and minority ethnic groups—in one UK study, only 27% of Asian respondents had come out to their mother, compared with 61% of African-Caribbeans.

Given this diversity, how do we know who is a lesbian or a gay man? This question is fundamental to measuring and studying their needs, and whether these are being met equitably. Fish raises many of the inherent difficulties, such as what's an accepted definition of this community, is it acceptable to the funders, or to those you're studying—and if they haven't disclosed to their mother, will they to you? In an infamous example, the US Center for Disease Control researching HIV/AIDS accepted as lesbian only those women who had had sex exclusively with women in the previous 13 years—and unsurprisingly found a low risk of transmission.

Fish quite rightly situates heterosexism within the broader diversity agenda, with its starting point the acknowledgement that inequity and discrimination exist in public services, and the imperative that we change policy and practice to ensure equity. This book challenges us all to examine how our skin colour, nationality, religion, class, abilities, and sexuality may be a privilege, "an invisible package of unearned assets which can be cashed in daily."

Jeanelle de Gruchy is consultant in public health medicine, Nottingham City PCT **jeanelle@degruchy.co.za**

Heterosexism in Health and Social Care
Julie Fish
Macmillan, pp 248, £45
ISBN-13 978-1403941237
Rating: ★★★

Lesbians' accounts of their experiences of cervical screening and breast cancer provide graphic illustrations of how they have to negotiate disclosure about their sexuality

Madeleine McCann

FROM THE FRONTLINE
Des Spence

At the time of writing Madeleine McCann is still missing. I became vaguely aware of the story of the 4 year old girl who disappeared while on holiday in Portugal from a crackling radio bulletin. I had an odd sense of unease, but it wasn't until the phone rang—"That's Gerry's daughter"—that the penny dropped. I was at university with Madeleine's father. The next day I pulled into a local garage. After sifting through all the banal birthday cards I eventually found a card I felt I could send. Half an hour later the card was still blank: what possible words of comfort could I offer to Gerry and his wife in such plight? I wrote four words. Since then I have stayed silent, partly out of respect and partly through a desire not to intrude on the family's grief. Last week an old friend emailed me and asked if I would write for Madeleine, but I am a hack and do not feel worthy.

Little is made of Gerry and Kate McCann being doctors, because above all else they are simply parents. Despite all the generous offers of support, the pain etched on their faces says it all: there is nothing that they would not sacrifice to have her back.

They have been criticised for leaving their children unattended, but I too have taken my family on a Mark Warner holiday. We did exactly what Gerry and Kate did: left the kids and checked them regularly while we ate. This was a type of holiday promoted as brief respite from the constant onslaught of caring for preschoolers and, above all, considered "safe." The McCanns merely did as thousands of other parents have done. Any blame or guilt is grossly misplaced and unkind, for they are victims of a random act of malevolence. No one has the right to question the McCanns' parental commitment.

Our profession can relate directly to Madeleine's disappearance. Yellow ribbons have been widely worn and beautiful Madeleine innocently gazes from posters on every surgery waiting room in Glasgow. Medicine can seem a disparate profession, as we scurry along pursuing our careers, but Madeleine's abduction reminds us that the professional veneer of coping with anything is just that—a veneer. We are ordinary people too, and this story reminds us that without family and friends life has little meaning.

Kate and Gerry have been dignified and resolute. They should know that they carry the best wishes and thoughts of the whole profession. We hope they find Madeleine soon. They rightly seek to maintain Madeleine's media profile (www.findmadeleine.com).

Des Spence is a general practitioner, Glasgow **destwo@yahoo.co.uk**

Barefoot doctor

OUTSIDE THE BOX
Trisha Greenhalgh

Nothing is more flattering to the precious academic ego than being asked to be the subject of someone's dissertation. I have had walk-on parts in several MSc theses—chiefly in the role of (assumed) "opinion leader" in some topic or other, and an enlightened PhD student from the Netherlands once gave me a star part in her study of female role models in medicine.

Here's the latest request. My brother in law has signed up for a distance learning course on horticultural design. His thesis must describe the makeover of a garden along a theme of the candidate's choice. My garden (*our* garden, reminds spouse, who keeps the weeds at bay) has been selected on the sole criterion of "room for improvement." The theme, announced the brother in law, will be medicinal plants that will help me in my practice.

He came round for tea, armed with a pair of jumbo-sized tape measures, his soil analysis kit, and some grandiose ideas. The dampest and dingiest corner could be devoted to cardiology ("perfect climate for digitalis"). Over here, perhaps, the respiratory section (sage, garden myrrh). A raised bed against the back fence could be the dermatology department—lemon balm, camomile. And we'd need some neurological cures over here: nettles (*really?*), feverfew, angelica.

Quaint, isn't it? Every morning, before setting off to the surgery, I would refill my set of little brown bottles with fresh, scented leaves. Instead of worrying whether a borderline cholesterol level justifies an expensive statin, I could offer garlic, one clove t.d.s. Who needs topical non-steroidal anti-inflammatory drugs when I can formulate Tincture of Arnica in my trusty pestle and mortar? And all those stamped addressed envelopes from sedentary old people requesting "something for constipation" could be filled with a generous handful of senna pods.

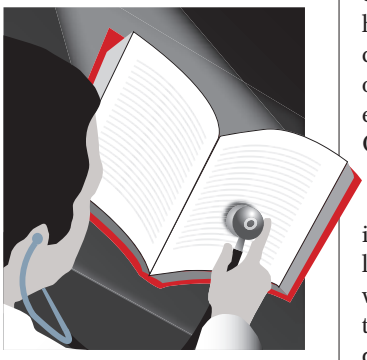
I hate to admit it, but the project has got me thinking seriously about home grown remedies. Has anyone ever done a randomised controlled trial of Gaviscon versus peppermint tea for non-specific dyspepsia, or dock leaves versus chlorpheniramine for hives? Someone has certainly shown significant benefit over placebo for St John's wort in depression, and for ginger in hyperemesis gravidarum—and that was without the additional therapeutic benefit of nurturing the plant.

We're talking early days here. The thesis is yet to be written, and the kids are protesting against anything that might "stink." But maybe, just maybe, I'll junk the *British National Formulary* and go barefoot for a while.

Trisha Greenhalgh is professor of primary health care, University College London
p.greenhalgh@pcps.ucl.ac.uk

Exercising restraint

BETWEEN THE LINES
Theodore Dalrymple



If Dr Ostermark's principles were put into practice, there would be whole areas of Britain denuded of males, and an increasing number of females

Everyone is agreed that the Swedish writer August Strindberg was a strange chap, although exactly where he fits on the Procrustean bed of modern psychiatric diagnosis is uncertain. His misogyny is not yet a formal illness, though it might be made one at some time in the near future, complete with ICD (International Classification of Diseases) number; he had a variety of strange beliefs, including that he could communicate with his third wife by telepathy. He studied chemistry, at one time thought of taking up medicine as a career, and later in his life conducted alchemical experiments, particularly with sulphur (which he did not believe to be an element), and thought he could transmute base metals into gold. But the oddities notwithstanding, he was extravagantly gifted. He learnt enough Chinese to be for a time a librarian of Chinese manuscripts, wrote one of his books in French, and was no mean painter. His dark seascapes suggest a very turbulent, unquiet mind.

Strindberg once attempted to commit suicide by trying to contract pneumonia. This is something I have in common with him, but it is easier said than done. I tried it when I was a child of about 10, for reasons that I cannot now recall but must have seemed important to me at the time and must have involved a large dose of self pity. I had heard that you caught pneumonia from sudden changes in temperature, and one night put my head in the freezer for a few minutes and then sat on a radiator. I discovered that my theory of causation of pneumonia was mistaken. I was no more successful than Strindberg had been.

In his play *The Father*, one of the main characters is a doctor, Dr Ostermark. His part is not particularly glorious, and he seems to be a man of no very defined personality or even views. Such people exist, of course; perhaps too great a concern with the lives of others has led to the effacement of Dr Ostermark's own self.

At any rate, he is easily manipulated by Laura, the wife of an army captain. Laura wants to drive her husband mad, and hits upon the idea of putting doubt into his mind about the paternity of their only child, Bertha. These days, of course, a DNA test might swiftly have brought the drama to an end; but in those days, as the captain realises, no man could be quite certain of the paternity of his child, or of the child that his wife tells him is his. He cross examines Laura, and the logic of the situation is that he will be satisfied only with a confession of her infidelity to him.

Such arguments are still common, of course, though not about paternity, which seems to be a matter of indifference to the modern mind, to which fatherhood is so trifling a matter. But, just as in *The Father*, the arguments often end in violence.

The captain throws a lamp at his wife, and Dr Ostermark resorts almost at once to the straitjacket. (In real life, Strindberg's then wife had a doctor check on her husband's sanity.) The captain then has a stroke almost immediately, and will die from it. People do sometimes die after the mere application of restraint.

If Dr Ostermark's principles were put into practice, there would—by the application of the straitjacket—be whole areas of Britain denuded of males, and an increasing number of females. I can't quite make up my mind whether or not this would be progress.

Theodore Dalrymple is a writer and retired doctor

MEDICAL CLASSICS

Awakenings By Oliver Sacks

First published in 1973

In 1969 levodopa (L-dopa) was hailed as a miracle drug that would cure parkinsonism. Sacks's book *Awakenings* is a series of extraordinary case reports describing how patients trapped by parkinsonism were re-awakened by levodopa after decades of stupor and inertia.

After the first world war, an epidemic of encephalitis lethargica started in Vienna and spread across the world. Many of those who survived developed a range of postencephalitic syndromes. Oliver Sacks worked at Mount Carmel, an institution outside New York, which had 80 patients with intractable, post-encephalitic parkinsonian syndrome. It affected all aspects of behaviour and trapped patients within themselves, often for decades. For patients such as Miriam H, who developed parkinsonism at the age of 12, levodopa was a miracle drug that released her from physical immobility at the age of 49.

Levodopa had dramatically different effects between patients and within the same patient. Despite being titrated slowly, the effects of levodopa were unpredictable and random. Leonard L, when started on levodopa, returned to a happiness he "had not felt for thirty years." Yet six weeks later he developed exaggerated sensitivity to the drug and even with tiny doses had uncontrollable side effects. Even when the drug was prescribed carefully, the complexity of the brain made taking it anything but straightforward, and for some patients it was a nightmare rather than a fairytale awakening.

Humanity: Oliver Sacks

REX FEATURES

For many patients psychological, environmental, and emotional factors seemed to have a profound effect on the efficacy of levodopa. Miron V initially had an excellent response, but then became violently unstable. However, when he resumed work at a cobbler's workshop, his mood stabilised; he became cheerful and continued to be well while taking levodopa. Even when the responses to the drug were positive, patients were not always able to cope with the consequences. Rose R was struck by sleeping sickness at the age of 21 and awoke in 1969 to find her world of 1926 had vanished. She remained rooted in the 1920s and, as if the time gap was beyond her comprehension, stopped responding to levodopa.

Sacks talks with humanity and a deep sense of concern about all his patients. He makes clear that treating them required far more than giving them a new drug. Although levodopa was not always successful, the long term relationship Sacks had with his patients was crucial for them and their families. *Awakenings* is an important reminder that healing is a complex art and that the notion that one pill can cure disease remains a fantasy.

Awakenings captures readers' imagination with the fairytale notion of returning to life after decades blighted by parkinsonism. The book has also inspired a radio play, a stage play, and a film.

Charlotte Allan, foundation year 1 doctor, Leeds General Infirmary **charlotteallan@nhs.net**