The authors claim that factors other than clinical judgment should not affect our decision to do a rectal examination. It is, however, impudent for surgeons, with no apparent input from general practioners and no training on the interaction of the physical, psychological, social, and spiritual aspects of patient care, to comment on doctors' attitudes or the attributes of practices. They should focus on their own responsibility—namely, teaching rectal examination to undergraduates.

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1 Hennigan TW, Franks PJ, Hocken DB, Allen-Mersh TG. Rectal examination in general practice. *BMJ* 1990;**301**:478-80. (8 September.)

Importance of ovulation in ovarian cancer

SIR,—Dr Derek J Cruickshank reports that ovulation is the prime aetiological factor for the development of epithelial ovarian cancer and that ovarian cancer seems to arise predominantly on the right side because ovulation occurs mainly in the right ovary.[1]

Interestingly, germ cell tumours are also more common in the right ovary, although the ovarian surface epithelium, which is subjected to regular episodes of rupture and repair through ovulation, is not affected in this condition. Dysgerminomas are reported to be unilateral and right sided in over half the cases, and only roughly one third are in the left ovary.[2,3] Endodermal sinus tumours also have a predilection for the right ovary.[4] In our department we have seen five germ cell tumours (four dysgerminomas and one endodermal sinus tumour) during the past four years, and all were right sided.

Both dysgerminoma and endodermal sinus tumour are malignant and are often observed in children and adolescents, but in this age group ovulation occurs infrequently. A direct relation between the right sided ovulation and epithelial ovarian cancer therefore seems to be purely coincidental and may depend on the different vascularisation of the two ovaries.

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1 Cruickshank DJ. Aetiological importance of ovulation in epithelial ovarian cancer: a population based study. *BMJ* 1990;**301**:524-5. (15 September.)
2 Mueller CW, Topkins P, Lapp WA. Dysgerminoma of the ovary. An analysis of 427 cases. *Am J Obstet Gynecol* 1950;**60**:153-9.
3 Talerman A, Huyzinga WT, Kuipers T. Dysgerminoma. Clinicopathologic study of 22 cases. *Obstet Gynecol* 1973;**41**: 137-41.
4 Kurman RJ, Norris HJ. Endodermal sinus tumor of the ovary. A clinical and pathologic analysis of 71 cases. *Cancer* 1976;**38**: 2404-19.

New review group will monitor NHS changes

SIR,—Ms Linda Beecham reported that a working group has been set up to monitor the effects of the NHS reforms on contracts, fund holding, and self governing trusts.[1] One aspect of the new general practitioner contract that the group should review is the confusion over its health promotion requirements.

The *Statement of Fees and Allowances* and the amended terms of service for doctors provide limited guidance on how health promotion is to be organised, assessed, or paid for. Total discretion is given to family health services authorities over what constitutes a qualifying clinic both in terms of clinical content and of organisation. Examples of health promotion and illness prevention are given that are a mixture of screening activities and continuing surveillance of existing conditions such as diabetes mellitus. The *Statement of Fees and Allowances* calls for clinics to be organised so as to last a minimum of only one hour, but, paradoxically, they are to attract a minimum of 10 patients.

Family health service authorities are obliged to consult local medical committees when considering whether to recognise a clinic, and this has produced a dilemma. Good clinical standards are best established by preparing a clinical protocol outlining the minimum standard to which doctors would be expected to conform to claim a fee. Given the lack of central direction and the uncertainty over what aspects of health promotion merit an item of service fee and what should be paid for through the capitation fee, local medical committees must ensure that their local constituents are being treated the same as doctors in other areas.

The Secretary of State for Health promised that there would be no ceiling on payments from this source. Nevertheless, there will be a ceiling in the form of the pool of money available for paying the generality of fees and allowances. Average net remuneration will not change, and those doctors who capitalise on this payment will do so at the expense of colleagues. If there was equality of opportunity for these fees among doctors this arrangement might be acceptable, but doctors in leafy suburbs will find it easier to attract patients to health promotion clinics than will their colleagues in deprived inner city practices. Furthermore, big partnerships can attract groups of 10 patients to a clinic more easily than can doctors with small lists, especially those in rural areas.

Ministers have rejected "opportunistic" consultations as qualifying for health promotion payments on an aggregated basis over a week. When a practice follows a protocol approved by the health authority and local professional representatives it is surely unjust to refuse payment when the work is being carried out in the only way practicable for most rural doctors and those with small lists. Doctors may accept a redistribution of income that rewards those who do extra work but not one that benefits doctors just because they are in a large practice. The profession is entitled to look to the government to fulfil its promise that extra services for patients would be properly rewarded.

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1 Beecham L. New review group will monitor NHS changes. *BMJ* 1990;**301**:670. (29 September.)

Eye protection in the metal working industry

SIR,—It is highly unlikely that as many as 99 of Mr Ashis Banerjee's 164 patients with foreign bodies were wearing protective spectacles at the time of injury.[1] Those who regularly see patients with eye injuries rightly treat patients' assertions that they were wearing protective spectacles with some scepticism.

The reasons for scepticism are clear. Patients' feelings of guilt are compounded by the pejorative implications of the question "Were you wearing safety glasses?" The Protection of Eyes Regulations 1974 are not, as stated by Dr Banerjee, guidelines, but an act of law. Employers and employees have a duty to adhere to them, and many employers will also issue safety regulations. Failure to comply with these regulations often results in disciplinary action, and repeated offences may lead to dismissal. That patients do not admit to their failure to wear the appropriate safety spectacles, even to an apparently disinterested party, is hardly surprising.

There is little evidence that the range of industrial eye protectors is inadequate. A wide range of devices for different activities already exists under the provisions of British Standard 2092, including BS 2092(1) for high velocity impact, BS 2092(C) against chemical injury, BS 2092(G) against toxic gases, and BS 2092(M) against molten metal. The most widely used (and readily available for the do it yourself market) is BS 2092(2), which is available in a wide range of styles and fittings. There are also separate standards for protection against various forms of electromagnetic radiation. Inadequate safety spectacles is an uncommon cause of eye injury. The problem is that people do not wear them.

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1 Banerjee A. Effectiveness of eye protection in the metal working industry. *BMJ* 1990;**301**:645-6. (29 September.)

Consenting patients

SIR,—I am concerned about the new consent form described in the news item by Dr Tony Delamothe.[1]

The doctor who consents a patient for a surgical operation is asked to sign a single sentence declaration: "I confirm that I have explained the operation investigation or treatment, and such appropriate options as are available, and the type of anaesthetic . . . proposed, to the patient in terms which in my judgement are suited to the understanding of the patient and/or to one of the parents or guardians of the patient."

In most British hospitals the preregistration house surgeon generally obtains consent for surgery. No houseman—and, I venture, no one doctor of any seniority—could sign that declaration. The houseman can neither explain "such options as are available" (a task for the consultant surgeon), nor, without postgraduate training in anaesthesia, the "type of anaesthetic."

The declaration could be improved if it were divided into two sentences: a consent for surgery (signed by a surgeon of registrar status or above) and a consent for anaesthesia (signed by an anaesthetist). Even if this were done there might still be problems for departments of anaesthesia. The patient is asked to agree "to the use of the type of anaesthetic that I have been told about." Anaesthetists sometimes need to change their minds (there could be anatomical problems with a regional block, for example), but the wording does not seem to allow for this.

The joint consultants committee, which took part in discussions with the Department of Health about the form to achieve a national consensus, was not asked to comment on the final version. As it stands the model consent form seems to be unworkable.

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1 Delamothe T. Consenting patients. *BMJ* 1990;**301**:510. (15 September.)

SIR,—Dr Tony Delamothe described the new model consent form to be issued by the NHS Management Executive.[1] This form requires the single doctor who obtains consent, usually a surgeon, to detail and obtain consent for a specific type of anaesthesia.

The only appropriate person to explain the type of anaesthetic proposed is the anaesthetist