improve "academic achievement." Supportive evidence for the effectiveness of treatment in definite cases of hypothyroidism was later provided.[5]

Neonatal screening for hypothyroidism is now widely accepted because hormonal supplementation prevents adverse physical and neurological sequelae of the disorder. We have postulated that intrauterine hypothyroidism of early onset may result in irreversible brain damage and be one of the underlying causes of mental handicap in infants with chromosomal abnormalities. If this is the case short term intrauterine hormone supplementation during a critical stage of development may reduce impaired neurological development.

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Community obstetric care in West Berkshire

SIR,—The paper by Miss Patricia Street and colleagues raises several issues that are central to the provision of obstetric care and merit further discussion.[1]

The authors are to be commended for reorganising the obstetric care in their health district such that women have fewer visits to the hospital. It is disappointing that two isolated units had to be sacrificed to finance the changes in the consultant unit when there are fewer than 70 in England and Wales in total.[2] Such closures of local general practitioner units reduce women's choice and increase their inconvenience and the expense of travelling. This increase in expenditure by women and their families is unlikely to be taken into account in health authorities' decisions.

The viability of alternatives to consultant care depends on high numbers booked and low transfer rates. Therefore I was pleased that the criteria for non-consultant booking have been relaxed (such criteria have remained essentially unchanged for 30 years[3]), that women are no longer required to attend hospital for the "routine booking visit," and that all women were permitted access to an epidural service whether they were booked with a consultant or not. The paper documents yet again that such policies result in safe non-consultant care and is consistent with reputable scientific evidence.[4]

The transfer rate under the new policy is disturbingly high, being 50% higher than that under the old policy owing to the high percentage of antepartum transfers (30·6%), which compares badly with the median value of 16·7% for integrated units in a recently reported national study.[2] The high transfer rate could be due to midwives being unfamiliar with a range of antenatal problems and thus transferring women more readily than general practitioners, who historically have requested transfer. After referral it is appropriate that women whose suspected abnormalities are not confirmed are returned to community care; otherwise the transfer rate is artificially high.

We are told that the changes have benefited hospital staff but are not told of the effects of the new policy on community midwives and general practitioners, whose workload must have changed greatly; some will now be travelling many miles. What are the views of the primary health care teams?

Communication improved between community and hospital midwives, but it may fall between general practitioners and community midwives because they are now doing separate clinics. Most experienced general practitioner obstetricians and community midwives agree that joint clinics can be an excellent forum for two way communication and education. The paper also states that "regular short labour ward attachments are an excellent catalyst to uniformity of practice within the area." This seems to imply that the community staff need to work in the hospital to be brought up to standard. I contend that in many areas it is only midwives working in isolated units or providing domiciliary care who are true midwives; many hospital "midwives" are in danger of becoming obstetric nurses.

My most important point is that the paper presents no data on whether the new policy has increased or decreased the number of general practitioners providing antenatal and, in particular, intrapartum care. If West Berkshire is similar to the rest of the country then, most probably, the general practitioners who used to use the isolated units will not transfer their care to the new integrated unit.[2] Under the new policies the midwives are doing most of the antenatal care alone. Perhaps in the not too distant future general practitioners in West Berkshire will no longer provide any obstetric care.

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Increasing the uptake of cervical smear testing among Asian women

SIR,—Personal visits have proved effective in increasing the uptake of cervical smear testing among Asian women in Leicester who have never been tested previously. In Professor Brian R McAvoy and Rabia Raza's study only 159 of the 482 women visited either declined to participate or could not be contacted.[1] Before a policy of making personal visits is adopted for other groups, however, the availability of the target population and the accuracy of their recorded addresses should be considered.

In Liverpool community nurses or support workers have been visiting the addresses of all women who have not been screened at any venue, even after one letter of invitation and two reminders have been sent as part of the computerised cervical cytology call and recall service. In an evaluation of this service first visits to 1273 addresses were analysed. Altogether 58-68% of these visits resulted in no access and an additional 12-13% of addresses visited were found to be incorrect. The true percentage of incorrect addresses could be higher because some of the addresses where visits resulted in no access were probably incorrect. Only 3-5% of first visits resulted in women attending for smears. Even when contact was made with the correct women only 23-26% of such visits resulted in them attending for a smear.

The Department of Health and Social Security's circular on cervical cancer screening points out that "the coverage achieved by a screening programme is likely to depend on the efforts made to follow up women who do not respond to call and recall invitations."[2] The results described here indicate that in Liverpool the resources used for these personal visits should be deployed in other ways to increase coverage.

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Avoidable blindness

SIR,—Undoubtedly there is agreement that more cataract surgery is required, but there is controversy over how this should be achieved and by whom. In his editorial Dr Andrew R Potter suggests using intracapsular extraction with spectacle correction, and I agree. Other ophthalmologists favour the modern extracapsular approach with intraocular lens implantation. They argue that it is safer, provides better visual rehabilitation, and has fewer long term side effects. Taylor and Sommer wrote that disposable packs are being developed.[2] This technique does produce better results in skilled hands but is more time consuming and expensive and requires greater skill and more sophisticated equipment. Moreover, it is tempting to operate on those with unilateral cataract or relatively early disability. As Dr Potter points out, most ophthalmic surgeons in Africa work in cities, where the richer middle class demand this approach. The risk is that, by emphasising the technique and offering training in it, we are in danger of ignoring the plight of the blind among the 85% who do not have access to such facilities.

Intracapsular extraction, with a standard +10 spectacle correction, provides good vision for the vast majority. Experience has shown that this type of surgery can be mastered by ophthalmic assistants. Surely the way forward is to promote appropriate technology to reach the majority.

Having worked in west Africa, I can appreciate the frustration at having facilities underused. It is not enough to provide a service—superstition, fear, and the expectations of old age must be countered with education and, in particular, literacy campaigns.

So what can we do, both as individuals and as a profession? Obviously, training posts in the United Kingdom will benefit only few and almost inevitably provide inappropriate surgical training. Ophthalmologists should be trained locally. The College of Ophthalmologists could help in setting up and supporting postgraduate schools and, in particular, providing examiners and recognising diplomas. Doctors who decide to interrupt their training to work for a limited period in the developing world should not be disregarded. Such electives foster a greater appreciation of the predicament of the blind in the Third World and benefit both parties. Recognition should be given to them, as it is to electives in the United States or Australia.

Finally, one notable omission from Dr Potter's list of useful addresses is that of the International Centre for Eye Health, 27-29 Cayton St, London EC1V 9EJ. The centre runs MSc courses in preventive ophthalmology. Through this and other