

performers up to scratch while not overloading staff already trying hard. The seriousness with which any government takes quality in the NHS will become obvious only when these standards are toughened up and become more encompassing. So the charter should achieve substantial changes, although not immediately. More work will be needed than merely disseminating the charter widely. (Every household will be receiving a copy.)

Some more serious charges may be levelled at the charter in its current form. The first is that it is something of a middle class charter: standards for waiting times and so on are important only if you already have reasonable access to health care. For a substantial number of people from ethnic minorities or with disabilities or who are homeless the charter may seem irrelevant. Despite the emphasis on information nothing in the charter suggests that patients should have a right to written information in a language they understand and personal communication through interpreters if necessary. Respect for religions and cultural beliefs is included, but not the right of women to be examined by another woman in sensitive specialties such as obstetrics and gynaecology.

The other concern is the omission of anything on standards of clinical care, which seems odd given that this is what the NHS is about and that what people want, above all, is the

most effective treatment for their condition. Patients would like a guarantee that standards are being monitored and poor performance is being weeded out.

The charter ends by telling people how they can help—by keeping outpatient appointments, donating blood, carrying organ donor cards, and becoming voluntary helpers. On this point the Welsh charter is more innovative: “Try to be well-informed about your health or condition. Ask questions so you can make decisions based on a better knowledge and understanding.” That begins to sound much more like a partnership between patients and professionals and acknowledges that people have responsibilities for their health care too. At present the charter concentrates on what the NHS should be doing for the patient, but this is only one side of the bargain.

BARBARA STOCKING

Director,
King's Fund Centre,
London NW1 7NF

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Surgical pathology and general practice

Send all specimens for histopathological examination

Under the terms of their new contract principals in general practice may earn up to £1200 a year from doing minor surgery. Fifteen surgical procedures are eligible for payment. General practitioners are paid £100 each session for up to three sessions of at least five procedures a quarter. Only general practitioner principals who have been accepted on to the minor surgical list held by their family health services authority may perform minor surgery, although those who are on the list may take up the quota of those who are not. Departments of histopathology, which will have to finance themselves on the work that they attract, are also affected by the new regulations: contracts with local practices may add 4% to their workload (p 1179)¹ or income.

Opportunities exist for maximising the financial benefits from minor surgery, such as concentrating on quick procedures that do not produce specimens (for example, incising abscesses, injecting joints, and freezing warts). Fundholders may also benefit by not sending—and therefore not having to pay for—any specimens for histopathological examination. If laboratories don't provide collection systems general practitioners are even less likely to send specimens for examination.

Three papers in this week's journal look at the histopathological work resulting from general practitioners doing minor surgery (pp 1177, 1179, 1180).^{1,3} Skin biopsies accounted for most of the specimens submitted for examination. Should all excised tissue be submitted for examination or is it legitimate to discard skin tags and other apparent trivia?

Certainly, death from metastatic melanoma after previous removal of unexamined “moles” is well known. Indeed, pigmented and suspected malignant lesions should probably be off limits to general practitioner surgeons unless they have had dermatological training. Hillan *et al* were worried that,

although they did not know what proportion of specimens general practitioners did not submit, more than two thirds of the specimens removed in their surgical day theatre were not submitted for examination.² Their concern is echoed by many dermatologists who submit every excised bit of tissue because they have been caught too often.

McWilliam *et al* found that in only 41% of cases was there good agreement between general practitioners' clinical impression and histopathological findings (the figure for hospital cases was 62%). For malignant specimens the hospital was right nine out of 10 times; general practitioners were right, however, only three out of 10 times. These rates are based on small numbers but make the point that all tissue, regardless of source, should be examined.

Incomplete excision is another problem. McWilliam *et al* found this occurring in 36% of all specimens excised by general practitioners and in 16% of all specimens excised in hospital. The figures for malignancies were even more worrying: excision was incomplete in 80% of specimens originating from general practice and in 10% of cases from hospital. (No comment was made whether those patients with incomplete excisions were followed up.³) This study also found that the common bleat by pathologists about inadequate clinical data was justified. On this count, hospital doctors were as bad as general practitioners: about two out of five requests from both groups lacked adequate data. (This can usually be remedied by a telephone call.)

Hillan *et al*'s study found that 16% of specimens from general practitioners came in the wrong fixative or were unfixed—all, however, were interpretable. On all these counts Shrank asks whether patients would not be better dealt with by one visit to the experts in the dermatology clinic.⁴

General practices may earn the extra payment for minor surgery only after investing in suitable space, equipment, and

staff. Zoltie and Hout, of the Leeds Family Health Services Authority minor surgery inspectorate use 14 criteria to approve a practice for minor surgery, one of which is a follow up policy.⁵ Whether general practitioners think that minor surgery is worth doing must depend not only on the balance of cost and benefits (in which being a fundholder is certainly weighty) but also on the enthusiasm of the practice to provide a complete service for its patients, on the patients' satisfaction with the results, and on the doctors' own ethical sense that they are not taking unreasonable risks with their patients for whatever motive. Pringle *et al* have looked at training for minor surgery, which is still in its infancy, but training in dermatology, potentially more important, has not been addressed at all.⁶ In both disciplines training seems woefully inadequate.

General practitioners will find themselves competing with hospitals offering day surgery, but as patients' main advisers they will usually control whether they do the job themselves or refer it to a day surgeon. Fundholding general practitioners will also decide which accredited histopathology laboratory they should contract with for the specimens they excise. Their choice will depend not only on where they have good relationships with histopathologists but also on the speed of service—although in histopathology speed is usually less important than accuracy. The accreditation of NHS and private laboratories, which, after pilot studies, is now set to go ahead, should reassure general practitioners that the competi-

tion for their histopathological specimens is at least between acceptable services (handbook available from Clinical Pathology Accreditation (UK) Ltd, (a company set up by the Royal College of Pathologists and the main pathology societies), Project Office, Department of Haematology, Children's Hospital, Sheffield S10 2TH).

The minor surgical component of the new general practitioner contract has therefore introduced new twists into the practice of both general practice and histopathology. Their full financial and clinical ramifications may not be entirely what the begetters of the scheme intended.

WILLIAM F WHIMSTER

Professor of Histopathology,
King's College School of Medicine and Dentistry,
London SE5 8RX

ROSEMARY A LEONARD

General Practitioner,
Group Practice,
Paxton Green Health Centre,
London SE21 8AU

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Preventing AIDS now

Treating other sexually transmitted diseases could help

At the VIIth international conference on AIDS held in Florence in June this year, James Chin, of the World Health Organisation's global programme on AIDS, outlined sobering figures about the worldwide AIDS pandemic. Over 16 000 cases of AIDS had been reported in Brazil by the end of last year. In Thailand the prime minister's office recently estimated that 400 000 people are already infected with HIV. Thousands of prostitutes in Bombay and Madras are infected, portending a disaster in India. Nowhere is the problem worse than in sub-Saharan Africa, where, Dr Chin estimated, there are currently 5 million to 6 million people infected with HIV with half a million cases of AIDS expected each year over the next decade—even without new HIV infections. Recent figures indicating that the prevalence has plateaued among sentinel populations (for example, blood donors and pregnant women) in some parts of Africa¹ do not signal an end of the epidemic. They indicate only that the number of new infections is roughly equal to the number dropping out of such pools because of illness and death.

About the only good news is that the HIV epidemic in North America and Europe probably peaked—with over one million people infected—in the mid-1980s (PS Rosenberg *et al*, 1991 meeting of the American Statistical Association, Atlanta, 1991).² Because of the long latent period between HIV infection and the development of AIDS numbers of new cases of AIDS will not fall until the mid-1990s. Even this decline will not signal an end to concern about HIV. Those who get sexually transmitted diseases or who use intravenous drugs—the young urban poor being most at risk—will continue to become infected with HIV.

Treatment, vaccines, and prevention are the only ways of controlling this pandemic. But treatments for HIV infection and the associated opportunistic infections are of no practical importance in limiting the spread of HIV, and preventive vaccines will not be available until at least the end of this century. By that time Africa alone may have 15 million to 20 million people infected with HIV, according to Dr Chin. Prevention is therefore the only realistic immediate approach to the control of HIV.

HIV is spread by well defined sexual, parenteral, and vertical routes. Of these, heterosexual spread accounts for more than nine in 10 new infections worldwide. Although modifying sexual behaviour is the most effective approach to prevention, it may also be the most difficult. In many Third World cities, especially in Africa, young men outnumber young women, creating a demand for the services of prostitutes. Single urban women may have few other opportunities for employment. With up to 1000 clients a year these prostitutes are at high risk of exposure to HIV and serve as reservoirs of infection for their partners. But if female to male transmission of HIV occurred in one in 1000 acts of unprotected vaginal intercourse³ the epidemic would not have spread with the astounding speed that has been observed in Africa and other places where homosexuality and intravenous drug misuse are rare.⁴

One important cofactor increasing transmission of HIV may be the presence of sexually transmitted diseases, which are spreading almost unchecked in many groups that are at high risk of sexually acquired infection. The relation between sexually transmitted diseases and transmission of HIV needs