graph.[1] A one pence coin was removed during rigid endoscopy, but when the authors went back to inspect the site of coin impaction they were surprised to find a second coin (a five pence piece). We are advised that "a second look (endoscopy) is mandatory after removal of a foreign body from the oesophagus."

It is appropriate to make an extensive inspection whenever endoscopy is performed. The second coin would almost certainly have been detected before endoscopy had a lateral soft tissue radiograph of the neck been obtained in addition to the anteroposterior view. As small children are unreliable historians, any child under the age of 5 being assessed for foreign body ingestion should have plain radiography from the base of the skull to the anus.[2] The lateral radiograph of the neck will show whether the coin is in the upper respiratory tree (sagittal orientation) or in the oesophagus (coronal orientation).

Another picture concerns a 28 year old woman who attempted suicide by ingesting concentrated sodium hydroxide. She had blisters on the lips but her pharynx was normal to inspection. She was eating and drinking normally 72 hours later and dicharged home after six days. She was readmitted after a further two days with dysphagia and in hospital vomited a 15 cm cast of her oesophagus. Subsequent endoscopy showed "severe oesophagitis from 20 cm to the cardia." Physicians managing caustic ingestion need to know that the appearances of the mouth and pharynx in such cases are notoriously unreliable. Severe oesophageal and gastric injury may be present with no evidence of burns in the mouth. It is standard practice, at least in the United States, to perform endoscopy within 24 hours of caustic ingestion to assess the degree of injury.[3] Had this patient undergone endoscopy soon after caustic ingestion, extensive oesophageal necrosis would have been apparent and it is unlikely that she would have been allowed home. Some endoscopists are nervous about performing endoscopy in acute oesophageal injury, but this is the most accurate way to determine the severity of the lesion, predict outcome, and plan management. Patients who ingest concentrated acid or alkali require early endoscopy, even if they seem to tolerate the initial insult without obvious complications.

JOHN BAILLIE
MALCOLM S BRANCH

Duke University Medical Center,
Box 3189,
Durham,
NC 27710,
USA

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Minor surgery in general practice

EDITOR,—Adam Lowy and colleagues conclude that the increase in minor surgery done by general practitioners since the introduction of the new contract in April 1990 has had no effect on reducing referral to hospital outpatient departments for these procedures.[1] The quality of data on referral activity before 1990, however, made it difficult to perform a true "before and after" analysis. Nevertheless, it is surprising that the pattern of referral remained unchanged.

In Chichester Health Authority departments of accident and emergency, plastic surgery, and maxillofacial surgery undertake some of the minor surgery while chiropodists deal with some ingrowing toenails. These hospital based locations were not mentioned in the study, and data on referrals by general practitioners would not normally include these options as referral locations. Patients with abscesses and ingrowing toenails are two groups who may not be referred to the outpatient locations mentioned in the study. In the quarter April to June 1991 general practitioners dealt with 43 ingrowing toenails and 23 abscesses, conditions that might have been referred to accident and emergency or chiropody departments. Although Lowy and colleagues might be correct in assuming that general practitioners' activity has had little effect on the work of some outpatient departments, whether this applies to all hospital departments is questionable.

Dermatology accounted for 42% of all outpatient minor surgery. General practitioners refer patients with skin lesions to dermatologists for a diagnosis, which in some cases may lead to excision or cautery. The decision as to which patients require surgery is left to the dermatologist, and changes in dermatological practice would also influence the volume of minor surgery undertaken in hospital.

Waiting times are short and the costs to the NHS lower when minor surgery is performed in general practice. Patients' sastisfaction is also high. Is this not sufficient health gain? Before accepting the authors' conclusions that minor surgery in general practice fails to influence hospitals' outpatient workload we need to look more critically at the procedures performed in general practice. Aspiration of a breast cyst may prevent one or more attendances as a surgical outpatient. Similarly, joint injections may prevent one or more referrals to a rheumatology or orthopaedic clinic. They would have failed to register as a health gain in this study.

Finally, it is misleading to suggest that the money targeted for minor surgery is priority funding. There was no new money—it was merely redirected from other allowances within the general medical services pool. At a cost of £20 per procedure this represents outstanding value compared with the cost of a hospital outpatient procedure (£50-100) or a minor procedure in hospital (£200-300).

ANDREW FOULKES

Yew Tree Surgery,
Yapton,
West Sussex BN18 0DU

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Dispensing in general practice

EDITOR,—David Smith says, "in Lincolnshire recently two suppliers of generic medicines have gone into liquidation; under these circumstances the dispensing doctor assumes full product liability."[1]

Section 2 of the Consumer Protection Act 1987 imposes liability to pay damages primarily on the producer of the product. A prescribing or dispensing medical practitioner (unless engaged in the manufacturing process) cannot be regarded as a producer.

Under the act, the only circumstances in which a supplier may be liable for a claim arising from a defect in such a product is if he fails to comply with a request made under Section 2(3), which reads as follows.

(3) Subject as aforesaid, where any damage is caused wholly or partly by a defect in a product, any person who supplied the product (whether to the person who suffered the damage, to the producer of any product in which the product in question is comprised or to any other person) shall be liable for the damage if—

(a) the person who suffered the damage requests the supplier to identify one or more of the person (whether still in existence or not) to whom subsection (2) above applied in relation to the product;

(b) that request is made within a reasonable period after the damage occurs and at a time when it is not reasonably practicable for the person making the request to identify all those persons;

(c) the supplier fails, within a reasonable period after receiving the request, either to comply with the request or to identify the person who supplied the product to him.

Accordingly, a supplier would become liable for a defect only if he failed to comply with a request made under the above section. No chain of liabilities is established in the act whereby, if the producer goes bankrupt or into liquidation, liability for damages automatically moves down the line from producer to supplier.

A clear reference to this point is contained on page 8 of the Medical Defence Union's booklet, *Product Liability*.

J A A WATT

Hempsons Solicitors,
London WC2E 8NH

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The new NHS

Very peculiar practice

EDITOR,—I found Neil G M Beattie's letter outlining the now unrealistic expectations of a general practitioner's role refreshing.[1] Equally, I have to concur with R J Rabbett's observation that our present day aspirations for the NHS have to be rationalised.[2] I still believe, however, that we should speak out as the answer cannot lie in general practitioners being forced increasingly to jump through unsubstantiated governmental hoops. Moreover, with financial incentives this practice is verging on the unethical: would we happily accept payments from pharmaceutical companies for interventions that we know to be unfounded at the expense of others (are governments really above ethics?)

General practitioners' role pivots on their unparalleled doctor-patient relationships and local knowledge. This is the fundamental advantage that necessitates general practice in addition to hospital based care. Unfortunately, as we increasingly devolve responsibilities to pursue the rising non-medical job commitments we increasingly lose contact with patients and lessen continuity of care.

We are now past the thin edge of the wedge. Minor ailments, including eczema and peptic ulcer disease, are to be treated by pharmacists over the counter, while pharmacists are also claiming responsibilty for repeat precriptions with the full backing of the National Audit Office; diabetes and asthma are already the responsibility of protocol driven practice nurse clinics, with other chronic diseases surely to follow; maternity care is soon to be wholly the midwives' responsibility; child health surveillance is increasingly the health visitors' domain; social problems are apparently best dealt with by citizens' advice bureaus; geriatric problems belong to the practice nurse or district nurse; and psychiatric problems are increasingly left in the hands of the community psychiatric nurse. In many ways this is not a bad thing, but we need to maintain an input—otherwise, as we distance ourselves further from the clinical picture, we may disappear from the scene altogether or, more realistically, have to accept a far more limited managerial, rather than medical, role.

Times change and so should general practitioners, but above all we must remember that we