they have cancer may "go to pieces," by which is usually meant that they weep in the presence of their doctor, is to do with the doctor's difficulty in coping with his patient's grief. Because patients have reason not to believe their doctors, there are many who have difficulty in believing their doctor when he *truthfully* denies the presence of serious disease.—I am, etc.,

EMANUEL LEWIS

London N.W.3

Surgery on Day Patients

SIR,—Mr. A. B. Cassie raises some important issues about outpatient surgery (8 September, p. 542). We have recently reviewed the results in 300 patients undergoing major outpatient operations in this hospital. An account of the series will shortly be published, but in the light of Mr. Cassie's letter some preliminary observations seem warranted.

Operations for which outpatient surgery is appropriate, in selected patients, can include inguinal or femoral herniorrhaphy, stripping and multiple ligations of varicose veins, and other procedures of equivalent severity. We find it a highly satisfactory system with a complication rate which compares favourably with inpatient surgery.

The above statements require some very careful qualifications. The essential ingredients for a satisfactory outpatient surgery system are as follows. A consultant surgeon must be interested in the method and prepared to supervise the hospital part closely. General practitioners must be prepared to support the project and assume responsibilty for postoperative supervision. In this context Mr. Cassie's point about the deputizing service is well made. District nurses must be well trained and should, ideally, be employed in individual practices. The hospital outpatient facilities must be geared to a thorough medical assessment and investigation of each patient before selection is made. After the operation hospital facilities and the surgeon's support (by domiciliary visit if necessary) must be readily available should the G.P. or district nurse have any cause for anxiety. Patients must live within a few miles of the hospital. The local ambulance services must co-operate fully. A day-bed unit is valuable but not essential. There are many areas, many hospitals, and many surgical practices for which outpatient surgery of this type is contraindicated.

Mr. Cassie stresses the importance of careful hour-by-hour monitoring of postoperative patients. In our experience patients of the type we have defined[1] require this grade of monitoring only while they are recovering from the anaesthetic. Thereafter the intensity of supervision which the staff of an acute surgical ward are trained to provide is not required.

Nor, in our experience, does an expansion of day-care surgery solve the problems of the waiting list. In fact it may create as many difficulties as it solves. Despite a busy programme of day-care surgery our waiting list continues to rise. This is partly because the removal from the ward of the relatively young, mobile, and independent patients slows down the turnover, increases the proportion of disposal problems, and has marked repercussions on the nursing, medical, and laboratory load. Day-care surgery must not be viewed simply as a means of relieving the pressure on hospital resources and certainly not as "a second class standard of patient care." No such justifications are required. It can and should be developed on its own merits as a first-class method for well-chosen patients. At the same time there must be a greater concentration of staff and resources to provide better care for the increasing proportion of ill patients who now populate the surgical ward. Without this any pressure on surgeons to develop day-care surgery should be resolutely resisted.—We are, etc.,

C. V. RUCKLEY
A. J. ESPLEY
C. M. LUDGATE

Western General Hospital,
Edinburgh

1 Ruckley, C. V., MacLean, M., Smith, A. N., Small, W. P., and Falconer, C. W. A., *Lancet*, 1971, **1**, 177.

Promotion of Research on Deafness

SIR,—Drs. L. Fisch and R. Hinchcliffe (6 October, p. 46) have returned to their attack on Dr. Annette Rawson and her report.[1] I had discussed their views with them and their colleagues after their latest letters were written out before they were published. They have also written a joint letter to *Hearing* to which I have replied as it repeats the suggestion that I repudiate the report.

The letters from Drs. Fisch and Hinchcliffe which you published seem to be aimed at Dr. Rawson's report and her competence to review the subject. I have a high regard for both and have made that clear in discussion with the two authors. I hope that anyone interested in this dispute will read the independent, detailed, and devastating comment on the joint letter of these same gentlemen which follows it on pages 320-323 of *Hearing* for October 1973.—I am, etc.,

G. E. GODBER,
Chief Medical Officer

Department of Health and Social Security,
London S.E.1

1 Department of Health and Social Security, *Deafness: Report of a Departmental Enquiry into the Promotion of Research*. London, H.M.S.O., 1973.

Is Co-trimoxazole Bactericidal in Sputum?

SIR,—We have read the correspondence between Dr. S. R. M. Bushby (7 July, p. 50), and Professor J. R. May and Miss Judith Davies (18 August, p. 407) with interest and support the view of Professor May and Miss Davies that co-trimoxazole should be considered a bacteriostatic rather than a bactericidal drug in the treatment of lung infections. The following points are relevant.

(1) We have found that, on in vitro testing in Oxoid nutrient broth no. 2 containing 5% lysed horse red cells, two out of three strains of *Haemophilus influenzae* were not killed within six hours by co-trimoxazole (1·6 µg trimethoprim and 32 µg sulphamethoxazole/ml).

(2) Thymidine antagonizes any bactericidal action of co-trimoxazole in vitro.[1] However, mutants isolated in vitro which are resistant to co-trimoxazole require added thymidine (or thymine) for growth.[2] Such mutants also arise in vivo, having been isolated from infected urine[3 4] and from pus[4] after co-trimoxazole therapy. The isolation of such thymidine-dependent mutants suggest that considerable levels of thymidine are found in the body tissues and that any bactericidal action of co-trimoxazole would be impeded. We have recently isolated a thymidine-requiring (but not thymine-requiring) strain of *Staphylococcus aureus* from the sputum of a fibrocystic child who had previously received co-trimoxazole. Thus there must be significant quantities of thymidine in the sputum, at least in this patient.

We have already demonstrated the absence of bactericidal activity of co-trimoxazole for urinary pathogens,[5 6] and we agree with the views of Professor May and Miss Davies concerning its activity in lung infections.—We are, etc.,

R. W. LACEY
EVELYN LEWIS

Department of Bacteriology,
Bristol Royal Hospital for Sick Children,
Bristol

1 Bushby, S. R. M., *Medical Journal of Australia*, 1973, **1**, Supple., 30 June, p. 10.
2 Pinney, R. J., and Smith, J. T., *Journal of Medical Microbiology*, 1973, **6**, 13.
3 Okubadejo, O. A., and Maskell, R. M., *Journal of General Microbiology*, 1973, **77**, 533.
4 Barker, J., Healing, D., and Hutchison, J. G. P., *Journal of Clinical Pathology*, 1972, **25**, 1086.
5 Lewis, E. L., and Lacey, R. W., *Journal of Clinical Pathology*, 1973, **26**, 175.
6 Lacey, R. W., Anderson, J. D., Lewis, E. L., and Gillespie, W. A., *Lancet*, 1973, **2**, 509.

Confidentiality

SIR,—As the first medical director of the Oxford Record Linkage Study, I hope I may be permitted to add my comments to the correspondence on confidentiality.

It is ironical that the study came into being as a result of the favourable response to a letter published in your correspondence columns deliberately to test opinion.[1] Subsequently, following a grant from the Nuffield Foundation, the consent for the release of identified information was sought and obtained unanimously from all the consultant staff in all the hospitals in the original study area through the respective medical staff committees. Plans of the study were put to the Central Ethical Committee of the British Medical Association, and received its approval. From the beginning, therefore, the study has had the full consent of the appropriate representatives of the profession. When it was exended to the Reading area in 1965 the consent of the various medical staff committees was again sought and was obtained. So far as I know no patient has come to harm as a result of the study's work, which has been continued under stringent security precautions over a decade. I hope colleagues will take these points into account when they consider Mr. R. R. L. Pryer's call for non-cooperation (15 September, p. 588).

As far as the general issue of the ethics of the use of confidential medical information is concerned, I should like to make the following points. Rights are seldom absolute, and the right to privacy must be balanced against the right to health. This was clearly seen in the nineteenth century, when the notification of certain infectious diseases, whether or not the patient's prior consent was forthcoming, was made compulsory.