CORRESPONDENCE

- *All letters must be typed with double spacing and signed by all authors.*
- *No letter should be more than 400 words.*
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General practice observed

SIR,—A retired academic physician who elects to comment on general practice either is somewhat foolish or must have a compelling reason. Without ruling out the first of these possibilities, I naturally prefer the second. I believe that general practice is once again at a crisis; and that is something which must concern us all.

The coming of the NHS in 1948 gave each of us the right to access to a family doctor, and through him the specialist services. But in the privation and the reorganisation that came after a great war the provision for meeting the new responsibilities was uneven and sometimes frankly inadequate. Dramatic advances in what was possible in hospital and the progress that was made in the fairly easy task of disseminating specialist services caused an erroneous, but nevertheless damaging, undervaluation of the importance of general practice—so that patients might make unreasonable demands to "see a specialist." Many family doctors worked in isolation with little professional contact or leisure and without support from nurses or secretaries. There were also of course many excellent doctors in family practice; it was their concern as much as general low morale that was to establish the need for and then bring about a true renaissance of general practice.

The formation of the (Royal) College of General Practitioners in the early 'fifties was a tangible sign that the need for changes was recognised; and of course the college was itself to become one of the agents of change. The most critical period, at any rate until the present, was, however, in the 'sixties, which saw the family doctors' charter, negotiated with Jim Cameron and Kenneth Robinson as the leaders; the Nuffield impetus to postgraduate centres, in which family doctors could meet their colleagues; and the development and recognition of teaching and training in general practice as an indispensable component of the medical course. (I am proud of my period as chairman of the governing body of Darbishire House Health Centre, and of my association with Pat Byrne, one of the first professors of general practice and a pioneer in invoking the assistance of educationists in postgraduate training for general practice.) The whole situation is now different from and infinitely better than it was when I qualified, when it was possible and not unknown for a person to qualify on a Monday and enter general practice on Tuesday. Over the same period general practice has been reborn, and people's health has improved—I cannot see these two things as being entirely dissociated.

Then why the worry? Because the achievements of the past 20 years in general practice, which are the fruit of much idealism and hard work, are now threatened by ill considered proposals against which the profession has rightly reacted strongly. It is bad enough that family doctors should be distracted from the job for which they have been trained (better now than ever before) by being induced to concoct advertisements, to negotiate contracts with sundry hospitals, and to be amateur accountants—good doctors will learn how to avoid or neutralise such snares. But just as the essence of good general practice is to have time to talk with patients so anything that strikes at its root is likely to do the greatest damage. Increasing the proportion of remuneration that results from enlarging the lists is using the wallet to reverse the tendency towards smaller lists, which has hitherto been encouraged, has actually happened, and must have contributed to better practice.

Our negotiators deserve sympathy in their difficult task; the narrowness of the recent vote may have reflected that sympathy. Nevertheless, our representatives were right to throw out a package that left untouched the intransigent refusal to reconsider the capitation proposal not simply because that proposal is inherently bad but also because we can continue to resist an imposed contract, which would not be possible with an agreed contract.

Embarrassment of choice makes it hard to pick out the worst feature in the government proposals. But although well aware of the likely damage to hospitals,[1] I would give to the capitation proposal my own vote.

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1 Black D. A Black look at a white paper. *J R Coll Physicians Lond* 1989;23:66-7.

SIR,—I write to express my considerable disappointment at the vote at the special conference of representatives of local medical committees to reject the revised contract. I hope that the profession may yet see the benefits to both doctors and patients of the new proposals negotiated by Dr Wilson and his team and vote in their favour in the forthcoming ballot.

As a singlehanded general practitioner working in a large health centre in inner Nottingham I expect the following benefits for my practice and my patients as a result of the new contract. For the past nine months since my appointment we have been screening opportunistically, checking blood pressure, smoking and alcohol habits, and immunisation state and encouraging cervical cytological examinations. These activities have been expensive in time and resources. The proposed new patient registration fee and inner city allowance will recognise our particular problem and encourage us to continue. We have already achieved 80% targets in immunisation, and we realise that, although a 90% target is difficult to achieve, it is necessary if herd immunity is to develop.

Having inherited many patients aged over 75, we urgently considered how to care for them. We are about to implement a multidisciplinary assessment, which seems to be the best buy approach for anticipatory care for the elderly. The new over 75 capitation fee will provide a method of paying for what we have already decided to do.

The new postgraduate education allowance will provide the incentive to undertake various practice based activities on the basis of learning from others. With regard to audit I shall find this no easier than anyone else, but surely the time has come to stop talking about the good service general practitioners provide and to show what we can do?

The capitation fee is clearly a most contentious issue, but the negotiating team has, in fact, reduced the so called 60% figure by ensuring that the new capitation for registration, child surveillance, and deprived area allowances are all included.

As a general practitioner for 20 years I have been concerned with effective and efficient prescribing. I have not so far either turned a patient away or exceeded the local average, and I do not expect to have to limit the services I provide in future.

No contract would offer an employee all that he or she would like. I recognise the need to discuss in detail topics such as target populations and criteria for inner city and rural payments. As a member of a team looking after nearly 2000 patients and providing some 35 hours of consultation time a week, however, I welcome this revised contract as a reasonable compromise between the state and the wishes of the profession and look forward to improving patient care as a result of its implementation. I have no wish to be part of a campaign that on occasion has seemed to take on a macho image.

On the wall of my surgery is a quotation from one of Churchill's speeches: "Give us the tools and we will finish the job." We have been saying this to the government for some years. The time has come to put our words into action and agree to accept this revised new contract, which, although not ideal, is probably the best we can get.

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Use of stents for treating obstruction of urinary outflow

SIR,—As the original workers who permanently implanted stents in the urinary tract we wish to comment on the report from Mr G Williams and colleagues.[1] Our initial experience with the implanted urethral stent (the Wallstent) suggested that it is successful in treating recurrent urethral

strictures over a short term follow up (now three years).[2] Subsequent work in our unit has investigated its potential to replace sphincterotomy in managing patients with spinal injuries and, in particular, as an alternative non-invasive treatment for prostate obstruction. We reported our first series of 15 patients earlier this year.[3]

As this is a new treatment, not yet fully evaluated, we have confined its use to those patients for whom conventional surgery would be hazardous and those with large glands in whom retropubic prostatectomy would be preferable to transurethral prostatectomy. The technique used is as described for urethral strictures,[4,5] but the procedure is carried out under local anaesthesia. We believe that retrograde urethrography is inaccurate in identifying the urethral sphincter mechanism. Instead we carry out the procedure under continuous monitoring with transurethral ultrasonography, confirming the position of both the bladder neck and distal sphincter mechanisms visually with a flexible cystoscope.

Our experience of 15 cases supports the report of Williams and colleagues. The mean age of our patients was 69·6 (SD 2·4) years and incorporated the following clinical groups: acute retention (five patients), acute on chronic retention (six patients), chronic retention (one patient), and severe outflow obstruction (three patients). All patients were satisfied with the procedure except one, in whom troublesome detrusor instability after relief of the obstruction resulted in great frequency and urgency. All patients were continent and were emptying their bladders well; mean postoperative flow rate was 14·88 (1·21) ml/s. We reviewed eight of the early cases endoscopically and found at six month follow up that the stent was nearly completely epithelialised, confirming our observations with the use of this prosthesis in the urethra. The follow up of these patients is still too short (4·1 (0·5) months, range 1-7) to allow definitive comment, but the technique seems to have potential as an alternative to conventional surgery.

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1 Williams G, Jager R, McLoughlin J, *et al.* Use of stents for treating obstruction of urinary outflow in patients unfit for surgery. *Br Med J* 1989;**298**:1429. (27 May.)
2 Milroy EJG, Chapple CR, Cooper JE, Eldin A, Seddon AM, Rowles PM. A new treatment for urethral strictures. *Lancet* 1988;i:1424-7.
3 Milroy EJG, Chapple CR, Eldin A, Wallsten H. Permanently implanted urethral—2 year experience and new indications. *J Urol* 1989;**141**:314A.
4 Milroy EJG, Chapple CR, Eldin A, Wallsten H. A new stent for the treatment of urethral strictures. A preliminary report. *Br J Urol* 1989;**63**:392-6.
5 Milroy EJG, Chapple CR, Eldin A, Wallsten H. A new treatment for urethral strictures: a permanently implanted urethral stent. *J Urol* 1989;**141**:1120-2.

SIR,—Dr G Williams and colleagues' use of a prostatic stent (Wallstent, Medinvent),[1] which once embedded cannot be removed without an open operation, must be questioned in patients who are unfit for surgery. The concept of prostatic stenting for outflow obstruction has been reported.[2-4]

We have used the Fabian Urospiral Endoprosthesis (Porges) for the past nine months. This is a flexible spring which keeps the prostatic urethra open and is connected by a straight portion across the external sphincter to a further helical element. This allows spontaneous sphincter control to be preserved. The device (22 French gauge) is smaller than the Wallstent and does not permit catheterisation or endoscopy of the bladder when in situ. These disadvantages are compensated for by the ease with which it can be moved or removed at will. For critically sick patients we therefore believe that endoprostatic helicoplasty (the term used to describe spring placement) is a safer option.[5]

The procedure is performed under local anaesthesia or sedoanalgesia,[6] and the springs are positioned endoscopically by direct vision without radiographic control; the procedure takes from five to 10 minutes. Of 15 patients treated to date, eight patients subsequently voided normally, and seven with chronic retention or dementia, or both (four), failed to void satisfactorily; three of these subsequently had a transurethral prostatectomy but were still unable to void satisfactorily. Our results indicate that patients who are mentally alert who have reasonable bladder function do very well; those with severe dementia and chronic retention of large volumes of urine do rather badly (as commonly occurs after conventional prostatic resection).

The indications for endoprostatic helicoplasty are therefore the same as those for transurethral prostatectomy. However, owing to lack of long term follow up (the longest a spring has remained in situ is six years) selection of patients is advisable.

We believe that the procedure is indicated in five groups of patients. These include patients who are medically unfit for surgery (for example, with myocardial infarction or receiving anticoagulant treatment), those with concurrent local or systemic malignant disease who have a short life expectancy, and those in whom the outcome of a transurethral prostatectomy is uncertain (for example, patients with dementia, Parkinson's disease, severe diabetic neuropathy, and small volume obstructed unstable bladders), when the procedure can be used to evaluate the effect of a transurethral prostatectomy. If the procedure is unsuccessful the spring can be removed. In addition patients who require catheterisation for a few weeks before operations would also benefit from this procedure, which permits normal micturition and sexual function. The final group is perhaps more controversial, comprising young patients who have outflow obstruction but are keen to avoid any of the permanent sexual complications that may be associated with conventional transurethral prostatectomy (such as retrograde ejaculation and impotence).

The use of endoprostatic stents is an important topic for research and a major advance in treating outflow obstruction. Many patients have already benefited from this procedure. Long term follow up and careful study of failures and complications are, however, required before the procedure can be regarded as a standard alternative to conventional transurethral prostatectomy.

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1 Williams G. Use of stents for treating obstruction of urinary outflow in patients unfit for surgery. *Br Med J* 1989;**298**:1429. (27 May.)
2 Fabian KM. Der intraprostatische partielle Katheter. *Urologe [A]* 1980;**19**:236-8.
3 Garbit JL, Blitz M, Bomel J, Pin P, Paillot J. La prothese endoprostatique spirale de Fabian. *J Urol (Paris)* 1988;**94**:265-7.
4 Roth ST, Rathert P. La spirale urologique: une possibilité therapeutique dans le traitement du carcinome prostatique. *J Urol (Paris)* 1988;**94**:261-3.
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Egg donation and medical ethics

SIR,—An anonymous letter indicating a possible ethical transgression[1] must be a rarity in the *BMJ*. The accusation was that a patient had been coerced into donating oocytes in return for a speedy sterilisation. If true this inducement must be condemned, but the lack of specificity in this letter stigmatises all units performing oocyte donation. We welcome the opportunity to relate our practice concerning the recruitment of egg donors.

The success of donating eggs for managing formerly untreatable causes of infertility such as premature menopause has led to a shortage of eggs. In our unit 82 patients on our waiting list telephone each month to inquire whether eggs are available. This is a severe stress to add to the problem of infertility.

From January 1988, 100 patients have received eggs from 64 donors, resulting in a clinical pregnancy rate of 28%. Six babies have so far been born. Of these donors, 20 were patients already receiving treatment in our assisted conception programme, who had agreed to donate a maximum of six eggs in excess of 12 produced during their treatment. The 44 other donors were all volunteers recruited from patient contact or through the media.

The Voluntary Licensing Authority has stated that donors of eggs should remain anonymous and that sisters or friends of potential recipients should not be used. When our potential recipients have indicated that friends or relatives would be prepared to donate for them they have been informed of the ethical objections; we have suggested that these potential donors might wish to donate eggs for other recipients and have thus been able to find 10 donors while still maintaining anonymity.

The 34 other volunteers resulted from publicity from press articles and television programmes. Thirty contacted our unit directly to donate eggs, and four contacted their local gynaecologist or general practitioner, booking for sterilisation and expressing a willingness to donate eggs at the same time. As there were no facilities for donating eggs at their local hospital they were directed to our unit for both procedures. None were private patients offered a free procedure, and none came from NHS hospitals with long waiting lists for sterilisation.

All donors were extensively counselled about the risks of induction of ovulation, the anaesthetic, the operative procedure, and also their views about bonding or identification of any offspring. We have surveyed the first 35 donors about their attitude to the procedure and are reassured that 27 would like to donate again; 28 thought that any type of payment would be inappropriate, although another 2 thought that it would be acceptable only if it encouraged other women to donate. It is also reassuring that 47% (7/15) of the infertile patient donors became pregnant in their donor cycle and 87% (13/15) had frozen embryos left for future use; thus the donation of eggs should not limit the success of their own endeavours to become pregnant.

Volunteer donors accept a small extra risk from ovarian stimulation, general anaesthesia, and the surgical procedure, which would be unnecessary if recruitment was entirely from infertile patients during the process of assisted conception. Nevertheless, although the incidence of minor side effects reached 60% in all 100 patients serious hyperstimulation did not occur and 60% (12/20) of volunteer donors indicated that they would be willing to donate again.

Finally, 55% of all our donors have resulted from publicity; if the public is made aware of the possibility of donating eggs more women would volunteer. There is no need for any sort of inducement.

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1 Anonymous. The GMC and medical ethics. *Br Med J* 1989;**298**:1380. (20 May.)