during the first year. The outpatient waiting time stands at two weeks, and since it opened the waiting time at the longer established unit has declined steadily to an average of three months.

We believe that providing adequate facilities of this type is a much more satisfactory solution to the problem of delays in fitting hearing aids than the proposal suggested in the Royal National Institute for the Deaf document entitled *Hearing Aids—The Case for Change*.

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1 Watson C, Crowther JA. Provision of hearing aids: does specialist assessment cause delay? *Br Med J* 1989;**299**:437-9. (12 August.)
2 Campbell JB, Nigam A. Hearing aid prescribing—is the specialist opinion necessary? *Clin Otolaryngol* (in press).

SIR,—As general medical practitioner advisor to the Royal National Institute of the Deaf campaign, Breaking the Sound Barrier, I was interested to read the article on provision of hearing aids by Messrs Carl Watson and John A Crowther.[1] I greatly welcome that it highlights the need for greater education of general practitioners in otoscopy and audiometric assessment. But their conclusion that the fact that general practitioners miss some diagnoses means that all people with hearing problems should be referred to an ear, nose, and throat surgeon needs to be challenged.

General practitioners accept responsibility for a wide range of their patients' problems without referral to specialists, and inevitably this entails making decisions about their care with less expertise than specialists. The same should apply to common hearing problems, which, as the article illustrates, are largely unrecognised by the patient. There is a strong case for looking at the elderly population, in which the incidence of hearing loss is high; underlying ear, nose, and throat diseases are less common; and the logistic problems of attending hospital are often considerable.

In our inner city practice I run a three weekly audiology clinic with an audiology technician in the surgery explicitly for people of retirement age. The vast majority of these people have their hearing problem detected by a member of the primary health care team and would not otherwise have presented and would not consider several trips to the hospital worth while or easy—they usually do not possess a car and live in an area with poor public transport services. The local consultant ear, nose, and throat surgeon supervises the clinical notes and audiograms that are taken to approve the prescription of hearing aids. In any cases in which the surgeon is doubtful the patient is called up to the ear, nose, and throat department; in any cases of which I am doubtful I refer the patient to the ear, nose, and throat surgeon for an opinion.

The clinic has been highly successful, with a high attendance rate of about 95% and a high referral rate for environmental aids, which in my experience are too infrequently ordered by both general practitioners and specialists. Given the scale of the problem and the degree of misery caused to elderly people, who suffer alone with depression and arthritis compounded by hearing loss and are poorly motivated to seek help, it seems counterproductive and retrogressive to hamper the efforts of primary health care teams to gain skills to provide basic services to this group. In the same way that physicians have improved the skills of general practitioners in treating patients with diabetes and asthma in shared care schemes and that general practitioners need to be registered for antenatal and family planning care it should be possible to ensure that general practitioners who provide audiological services are adequately trained and supervised in the general practice setting, which, in the foreseeable future, is the only acceptable place from patients' point of view for providing the service.

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1 Watson C, Crowther JA. Provision of hearing aids: does specialist assessment cause delay? *Br Med J* 1989;**299**:437-9. (12 August.)

Cocaine and crack

SIR,—With rerference to the leading article on cocaine and crack by Drs J Strang and G Edwards,[1] we would like to point out our experience in the regional addiction unit in the west midlands.

In the past six weeks we have seen five patients presenting with crack abuse, all of whom used crack as the only drug of abuse. It is interesting that three of the cases were prostitutes who were introduced to it by pimps. Crack abuse does not require injection so it precludes the most common means of spreading HIV or AIDS through shared needles. But prostitutes trying to maintain expensive crack habits may be tempted into unsafe sex practices by the promise of extra money, which in turn may lead to an increase in the spread of AIDS. These three patients told us that crack is widely available in Birmingham and that most of their friends working with them use crack daily.

The other interesting feature in our group of patients is that all of them are women and are from the lower social class. All were using crack daily and were dependent on it.

Clinically we have not yet come across anyone with a transient cocaine psychosis. Four of our patients have been treated successfully with desipramine, but it may be too early to comment on relapse rates; relapses have been reported in 35 out of 253 people in a study in America.[2]

It may be too early to make predictions about an impending crack epidemic (as does the national press) following America's experience, as the history of drug abuse in Britain, with the possible exception of LSD and ecstasy, has had its own course. We hope to carry out an extensive study of crack abuse in our drug addict population in the near future.

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1 Strang J, Edwards G. Cocaine and crack. *Br Med J* 1989;**299**:337-8. (5 August.)
2 Wallace B. Psychological and environmental determinants of relapse in crack cocaine smokers. *J Drug Abuse* 1989;**6**:95-106.

Twenty four hour care in inner cities

SIR,—Drs J A and P G N Main's comments on the Jarman index and the related issue of deprived area allowance[1] will find an echo elsewhere in the country.

I work in a south Wales valley practice. Only 60% of the adult male population is at work, and 40-50% of children attending our local comprehensive school receive free school meals. The local standard mortality rate is 127, the proportion of patients permanently sick and disabled is three times the national average, and the proportion of "low birthweight babies" four to five times higher than the national average. The 1988 consultation rate was 5·5, 25% being home visits. I work a one in two night duty rota and have a night visit rate (11 pm-8 am) of 33/1000 patients. The practice will not get any deprived area allowance.

The Welsh General Medical Services Committee has already agreed details of the deprived area allowance with the Welsh Office. By the use of a modified Jarman index just over 5% of Welsh electoral wards have been designated as deprived. Considering that the scale of deprivation is greater in Wales than England, one cannot expect that more than 5% of English electoral wards will be similarly designated.

At a district health authority level the Jarman index seems to be too oriented to London and inner cities. Though the Northern region has the highest levels of mortality and morbidity in England and Wales, not one of its health districts features in the top 10% on the Jarman index.

If the deprived area allowance is to address the problems highlighted by Drs Main and Main it must be extended to more than 5% of electoral wards, and the identifying variables need further empirical verification.

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1 Main JA, Main PGN. Twenty four hour care in inner cities. *Br Med J* 1989;**299**:627. (2 September.)

SIR,—I present data from my own practice for comparison with that presented by Dr A E Livingstone and colleagues, calculated in exactly the same manner (table I). All data refers to face to face consultation; I do not include figures for telephone advice.

TABLE I—*Out of hours consultation workload and rates (per 1000 patients per year) for 1988*

	Plymouth		London	
	No of consultations	Rate	No of consultations	Rate
Emergency surgery	732	61·0	496	34·6
Visits	1822	151·8	1888	131·5
Night visits	295	24·6	271	18·9
Total	2554	212·8	2384	166·1

Some background information is relevant. The practice operates a personal list system in a building improved through the cost rent scheme and is staffed by five full time male partners, one part time female partner, one full time practice nurse, and virtually the full complement of ancillary staff. We are not a training practice but are computerised, run a well man clinic, and see all new patients on registration. The list size is reasonably constant at about 12 000, although, as for the London practice, in 1988 the patient turnover was 20%. The daytime workload is also similar to that of the London practice with an overall consultation rate of 3·7 per 1000 patients per year.

Two partners staff the emergency surgery on Saturdays from 0900 to noon, and the rest of the out of hours work is shared between the full time partners. The deputising service does all night visits. Most of the remainder is done by the duty doctor until 2300 (including weekends). One partner uses the deputising service full time.

The practice serves a wide area of a relatively prosperous city, but most of the workload is generated by a small area that we would call deprived. Nevertheless, I estimate a Jarman deprivation index[2] of only 10–20 for this area. There is no ethnic problem.

Table II shows a comparison of the Plymouth and London data in terms of out of hours workload per doctor and the related rates per doctor. This probably represents an accurate index of the workload any doctor can expect when on call. This