active treatment compared with 30 of 60 on placebo. We question the need for run in and washout periods in a crossover trial which simply compared the state of the patient at the end of two treatment periods. It did not compare the changes which occur during those periods. There was no evidence of a carryover effect; if it had occurred it would, of course, have invalidated the study design and underestimated the efficacy of active treatment. Lack of space prevented the inclusion of baseline data, which are available on request.

We do not accept that the medication was inadequately standardised. It was produced according to the French homoeopathic pharmacopoeia, which forms part of the French national pharmacopoeia and is legally enforceable. Chemical and spectroscopic tests for active principles are specified. A standard chromatogram must be run on every batch of tincture and retained for inspection. The medication is thus as reproducible as is practical for material of this type.

Finally, we heartily agree that the way is open for further research.

PETER FISHER
E C HUSKISSON
PAUL TURNER
PHILIPPE BELON

Department of Rheumatology,
St Bartholomew's Hospital,
London EC1A 7BE

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Referrals to general practitioner maternity units

SIR,—Drs A Prentice and S M Walton suggest that general practitioner maternity units integrated within the specialist obstetric units of district general hospitals may offer better prospects for continuity of care for women at low risk than "alongside" units, and they cite the general practitioner maternity unit at the John Radcliffe Hospital, Oxford, as an example of the "integrated" variety.[1] This unit has existed and been audited annually since the hospital opened in 1972. The transfer rates are shown in the table.

There may, of course, be considerable demographic variation between the female populations of Stockton on Tees and Oxford, but the contrast in transfer rates, with the single exception of that for nulliparas in labour, is evident. Furthermore, in Oxford general practitioners are autonomous regarding the booking and management of patients. There is no booking committee or subsequent review by specialists or midwives unless the general practitioner formally refers the patient. Booking requirements are based on the Cranbrook criteria,[2] which are interpreted flexibly. In the delivery room general practitioners and community midwives have access to facilities such as electronic fetal monitoring and augmentation of labour when necessary, and advice or assistance from the obstetric or paediatric specialist teams is freely asked for and freely given, with or without transfer of care.

Drs Prentice and Walton also refer to the difficulty of predicting risk in obstetric care and refer to our recent study.[3] Numerous papers have been written on this topic, but no definitive system has yet been devised that will ensure that a normal pregnancy will be followed by a normal delivery. However, if transfer rates are to be utilised as performance indicators for general practitioner obstetrics, there is one other important factor that is perhaps not widely acknowledged: the annual caseload (and thus, by inference, the confidence) of the practitioner concerned. In over 2500 bookings for our unit in 1983-5 the mean transfer rate of patients (both before and during labour) for general practitioners booking fewer than 10 women a year was 37%, whereas the rate for doctors booking 10 or more was 29%, a significant difference ($p<0.05$) (M J V Bull, report on general practitioner maternity unit, John Radcliffe Hospital, 1986).

Another survey in 1987 showed that the greater the number of women a general practitioner attended at delivery the more likely were his or her patients to receive his or her personal attention during labour (M J V Bull, report on general practitioner maternity unit, John Radcliffe Hospital, 1987). Women booked by doctors with an annual caseload of less than 10 had a chance less than 50% of being attended by their own doctor, whereas if the general practitioners attended 10 or more deliveries each year the probability of attending their own patients (rather than a colleague's) was nearly 80%. This fact assumes increasing importance here since a recent internal review of community midwifery services in the Oxford Central district showed that only 38% of women were attended in labour by the midwife who had originally booked them. If the option for personal and "low tech" maternity care is to remain available the onus will be not only on the midwife but increasingly on the general practitioner to provide it. Encouraging younger practitioners to engage in intranatal as well as antenatal and postnatal care is thus one of the principal aims of the recently formed Association for General Practice Maternity Care.[4] Doctors interested in the association should write to Dr Gavin Young, Barncroft Surgery, Temple Sowerby, Cumbria CA10 1RZ.

M J V BULL

East Oxford Health Centre,
Oxford OX4 1XD

1 Prentice A, Walton SM. Outcome of pregnancies referred to a general practitioner maternity unit in a district hospital. *Br Med J* 1989;**2991**090-2. (28 October.)
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SIR,—Messrs A Prentice and S M Walton quite rightly pointed out that the "alongside" general practitioner unit provides a safe alternative to delivery in a consultant unit for "low risk" women.[1] They found that complications requiring transfer to consultant care could largely not be predicted by the Cranbrook committee recommendations,[2] a finding supported by the work of Reynolds *et al*[3] and Campbell and Macfarlane.[4]

When applied as a screening test at booking the Cranbrook criteria have both poor specificity and poor sensitivity in predicting antenatal and intrapartum complications. They can therefore have little effect on fetal outcome. Perhaps the time has come to relax some of the booking criteria that have to be fulfilled before a general practitioner is permitted to book a pregnant women under his or her sole care for delivery. This might be allowed for general practitioner obstetricians who work in "integrated" units. Then if an intrapartum problem did occur expert obstetric help should be quickly available and if transfer were required there would be no need for physical transfer of the mother and the midwife might well not change, allowing continuity of care. This arrangement would enable more women at least to have the chance of the "low tech" delivery that many seem to desire[5]; it might also prevent the further decline in the number of general practitioner obstetricians[6] by increasing their clinical caseload and thus preserving their obstetric skills.

LINDSAY F P SMITH

General Practice Unit,
University of Bristol,
Bristol

1 Prentice A, Walton SM. Outcome of pregnancies referred to a general practitioner maternity unit in a district hospital. *Br Med J* 1989;**299**:1090-2. (28 October.)
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Workload of general practitioners

SIR,—Dr Tim Carney's editorial on the workload of general practitioners referred briefly to the time required for preventive medical checks on the elderly.[1] We report the findings of studies carried out in two teaching practices in September 1989 to assess general practitioners' contact with patients aged 75 or over and the implications of the Department of Health's new general practitioner contract on workload.[2]

Samples of patients were identified from the age-sex registers of a rural and commuter practice in Kegworth and an urban practice in Nottingham, and their notes were reviewed. The main results are summarised in the table. For comparison, 6·7% of the national population are aged 75 or over[3] and our patient contact figures broadly agree with those of previous studies.[4,5]

Of the patients seen in the urban practice over the previous year, 59% always attended surgery, 31% were seen both at home and in the surgery, and only 10% were exclusively visited at home. District nurses visited 14% of patients over 75 in

Deliveries in consultant care and general practitioner (GP) units in 1987

	North Tees General Hospital			John Radcliffe Hospital, Oxford		
	Nulliparous	Multiparous	Total	Nulliparous	Multiparous	Total
No (%) transferred to consultant care unit						
Before delivery	123 (39·0)	79 (23·9)	202 (31·3)	101 (22·2)	58 (10·7)	159 (16·0)
During labour	71 (22·5)	25 (7·6)	96 (14·9)	97 (21·3)	21 (3·9)	118 (11·9)
No (%) of deliveries in GP units	121 (38·4)	226 (68·5)	347 (53·8)	257 (56·5)	461 (85·4)	718 (72·2)
Total	315	330	645	455	540	995

Contact with the elderly patients in two general practices

Practice characteristics	Rural	Urban
List size	6700	10 600
No (%) of patients aged ≥75	449(6·7)	806(7·6)
Sample size	98	79
Average consultation rate per year	5·3	3·9
No (%) consulting GP:		
Over previous year	81(83)	61(77)
Over previous 3 years	92(94)	75(95)
No (%) visited by GP in previous year	42(43)	25(32)
% Of total consultations occurring at home	50	29

GP = General practitioner.

the city practice. In the rural practice a nurse practitioner visited 23% for monitoring and surveillance of chronic diseases. All but one patient in each of these groups was also visited by a general practitioner.

Although the contract requirements continue to change, the 1989 draft regulations recently laid before parliament by the Secretary of State for Health require general practitioners to offer to make a domiciliary visit annually to each patient over 75 for functional assessment.[6] If our figures are extrapolated to include all patients over 75 on the lists, visiting those who had not been visited would require an extra 256 home visits a year in the rural practice and 548 in the city practice. If 40 minutes (including travelling time) is allowed for each visit and assessment an additional 7·6 hours a week would be required in the city practice and 3·6 hours in the rural practice (assuming a 48 week working year). If all patients in this age group receive a home functional assessment, however, the time required will be 11·2 hours a week in the city practice and 6·2 in the rural practice. This takes no account of administrative time, follow up visits, or resources required to meet the needs discovered.

We doubt that an annual home visit to every patient aged over 75 represents an effective use of health professionals' time. Selective visiting of patients not seen within a year may be useful, but for most patients over 75 who attend surgery opportunistic assessment there seems more appropriate.

HELEN BROMHEAD
JULIET HALL
CAROLINE ANDERSON
JOHN TEMPLE

Department of General Practice,
University of Nottingham,
Nottingham NG7 2UH

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Survival of patients with cancer

SIR,—It will come as no surprise to oncologists or surgeons that entry into clinical trials improves survival and survival without relapse.[1] Most clinicians are only too willing to enter patients into local and national trials, but there are practical difficulties.

Firstly, it takes about two to three times as long to see a new patient with a view to entering them into a trial. This time is required to explain the nature of the trial and the treatment options, for signing of the consent forms, and for randomisation by telephone. The knowledge that no treatment is superior to another may induce anxiety and require further explanation.

Secondly, completing registration and follow up forms, and particularly collecting the necessary data, adds considerably to both doctors' and secretaries' time. Pathologists and radiologists also need to participate sending sections or radiographs for review.

Personally, these difficulties preclude me entering more than a small number of my patients into randomised trials each year. The difficulties could be eased by having a local trials coordinator within each district, available to all specialties. This person would become the focus of all trials for the hospital and be responsible for all of the collection of data. It is unlikely that funding would be forthcoming from district or regional funds, and I suspect that support from charities would be required. It is gratifying that the new national trial on managing ductal carcinoma in situ is making financial provision for administrative help at a local level.

STEWART COLTART

Kent and Canterbury Hospital,
Canterbury CT1 3NG

1 Stiller CA. Survival of patients with cancer. *Br Med J* 1989; **299**:1058-9. (28 October.)

"Operation Cataract"

SIR,—"Operation Cataract"[1] deserves plaudits for being innovative and well organised and gaining the commitment of staff and patients alike. Certainly, as a one off means of clearing a backlog of non-urgent (as opposed to urgent or semiurgent) cases it was successful.

The problem with such a project is that there are real additional costs (said in the article to be £60 000) in addition to tying up existing work areas, theatre facilities, and staff. The only means of cost saving are if there are closures (beds, theatres, etc) of greater value to the district than the additional outgoings for hotel expenses and so on. Such a project also fails to solve the fundamental problem of why these elective cases had been on the waiting list so long. Apart from the general financial constraints, the problem is that urgent and semiurgent cases will always take clinical precedence over non-urgent cases, pushing the non-urgent cases to the back of the queue. Unless the bed allocation system has changed in Canterbury, Operation Cataract will probably be needed again in a couple of years' time.

Also, cataracts are just one of a number of non-urgent surgical cases in the same boat: hips, hernias, arthroscopies, varicose veins, and other operations often have similarly lengthy waiting lists. Finally, such a project inevitably displaces other patients, unless additional facilities are being used, and increases their waiting time (and that of others behind them in the queue).

Mr J T Snow's point is valid[2] but administratively difficult. If it was easy to just add one patient to each list that, no doubt, would already have been done. As always, it is not just a matter of theatre space or surgeons' availability. Beds, support staff, and finances are all part of the jigsaw.

Overall "Operation Cataract" was undoubtedly useful and points the way forward in two ways: firstly, in the innovative use of non-hospital preoperative and postoperative accommodation (à la Mayo Clinic); and, secondly, in the use of special projects aimed at the "forgotten" people at the end of long queues. Similar projects could and should be adopted by districts whenever a certain number of patients have been waiting longer than a specified time. These variables could easily be determined for each procedure.

M P STANFORD

Directorate of Public Health and Service Development,
South East Thames Regional Health Authority,
Bexhill on Sea TN39 3NQ

1 Thames HF, Darvell RHJ, Hicks C. "Operation Cataract": a means of reducing waiting lists for cataract operations. *Br Med J* 1989;**299**:961-3. (14 October.)
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SIR,—I agree with Mr J T Snow[1] that Operation Cataract[2] is a high profile alternative to proper routine surgery. Many patients have advanced cataracts in both eyes at their first presentation to the ophthalmologist. Conventionally one eye is operated on at a time, and after a lapse of anything up to a year the second eye is operated on. At any given time the number of "second eyes" on waiting lists forms a big proportion. Such patients are elderly, and two separate operations put extra strain on them as well as on the hospital's resources. In some selected patients simultaneous bilateral cataract surgery can be performed under one general anaesthetic.

During the past 19 months I have performed simultaneous bilateral cataract extractions with intraocular lens implants in 19 patients. The results of these 38 cataract operations have in no way been different from those of operations that have been performed during separate operating sessions. All of these patients have expressed great satisfaction and relief at being treated at one time, thus avoiding another spell in hospital. If this approach becomes more widespread then there will clearly be a beneficial impact on waiting lists and patient satisfaction as well as resources.

NIKHIL C KAUSHIK

Wrexham Maelor Hospital,
Wrexham,
Clwyd LL13 7TD

1 Snow JT. Operation Cataract. *Br Med J* 1989;**299**:1167. (4 November.)
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Demarcation disputes in surgery

SIR,—Minerva drew our attention to the demarcation dispute about head and neck surgery developing in the United States between general surgeons and otolaryngologists.[1] We should like to reassure your readership that in the United Kingdom a somewhat more amicable and complementary relation exists among the specialties with an interest in this subject.

Head and neck surgery covers benign and malignant conditions of the upper aerodigestive tract (including the nose, nasopharynx, mouth and salivary glands, oropharynx, hypopharynx, larynx, and upper oesophagus) as well as the cervical lymphatic region and the thyroid gland with its related structures. It does not include the central nervous system, the eye, or the spinal column with its musculature. These anatomical regions are well served by the specialties of neurosurgery, ophthalmology, and orthopaedics. Disorders of the carotid arteries lie within the remit of the specialist vascular surgeon.

Friedmann[2] stated that in the United States, "most head and neck surgery . . . is still being done by the general surgeons." In the United Kingdom this is simply not true. This is perhaps best illustrated by the composition of the meeting of the Association of Head and Neck Oncologists of Great Britain in London earlier this year: the specialties of ear, nose, and throat, oral, and plastic surgery were equally well represented but general surgeons were in the minority. The role of general surgeons is becoming more complementary but is none the less valuable in the team approach to major head and neck procedures—for example, in the provision of stomach, jejunum, or colon for reconstruction after pharyngolaryngectomy.

Thyroid surgery, however, remains controversial. In some centres it is performed by general surgeons while in others by ear, nose, and throat surgeons. We suggest that it matters little whether the surgeon is a general or ear, nose, and throat surgeon, provided that he or she has wide experience of thyroid disorders and their management, can manage acute upper airway obstruction, can examine the larynx to assess the recurrent laryngeal nerves, and is willing to cooperate with endocrine physicians in the preoperative assessment and postoperative management.