General practitioners are slow, however, to change their practice. Little careful research is done in general practice and many new developments are introduced without being evaluated. Vocational training, health centres, and practice teams have all been introduced without any work showing that standards are raised, morbidity and mortality reduced, and the service improved. "Most of these changes are very expensive and their value should be shown. Nobody knows what goes on in general practice," summed up Dr Primus.

Running costs of practice

"I could run a practice with only a stethoscope and a roof over my head. I'm not advocating such minimal conditions but pointing out that receptionists, nurses, electrocardiographs, typewriters, and such like are by no means essential." Dr Primus's practice employs a practice manager, five receptionists (most of them part time), and a nurse; a second nurse and a health visitor are also attached to the practice. When Dr Primus first started in practice many years ago he looked after exactly the same number of patients as now but without any ancillary helpers apart from the district nurse. Of course, he says, people will say that the work load has increased, but he thinks that much of the increase may be due to the doctors themselves: by enlarging the capacity for treatment they have created more illness.

The senior receptionist keeps the accounts and regards it very much as her role to save money—the doctors have complete confidence in her. Because the doctors have to meet the surgery costs they are all "eagle-eyed" to prevent waste—lights and heating are always switched off, and people are not careless with equipment. Dr Primus does wonder, however, if disposables are as essential as in hospital practice. "Infection is not a serious problem in general practice. We don't have much need to be obsessive about aseptic techniques and I think we could easily return to boiling up our syringes and scalpels. But then it would be only a small saving."

The parsimony over surgery costs does not extend to prescribing, for which the doctors bear no financial responsibility. Each general practitioner receives information on his prescribing costs, but Dr Primus wonders whether some interesting thoughts might be provoked if each group of general practitioners received a comparison of how much each individual doctor spent on different categories of drugs. Few doctors underprescribe, and one doctor might usefully ask himself why he prescribes four times as many antibiotics as one of his colleagues.

Limited prescribing suggests to Dr Primus not so much a restriction of, for example, the kind of beta-blockers that can be prescribed but rather removing things like cough linctuses and liniments from prescription. "I don't take cough linctus if I have a cough, nor do I rub on liniments for aches and pains; so what is the logic in my prescribing these for others? I resist whenever I can, and I would find it easier to resist if patients had to pay for such items."

"If stringent economies were forced on us, I think one of the first things we would do would be to abandon the appointments system," adds Dr Primus. Running the appointments system creates a considerable amount of work, and thus expense, and the rewards are doubtful. "Some patients prefer to come and just wait knowing that they will see the doctor at that surgery—and some deliberately choose practices without an appointment system."

Domiciliary visits by consultants

I asked Dr Primus if he had experienced trouble having patients admitted to hospital. "Never for medical, surgical, or obstetric emergencies," he replied. "But waiting lists for non-emergencies are getting larger and I blame this at least partly on the increasing number of consultant domiciliary visits." Originally, domiciliary visits were intended only for those who could not possibly get to hospital, but now any patient is entitled to a domiciliary visit. And if Dr Primus calls out a consultant to see a patient then that patient will be promptly investigated and admitted if necessary. The alternative is to wait weeks or months for an outpatient appointment, and then the patient will have to wait longer still for an operation. "Consequently I am under great pressure sometimes to call out a consultant, who will come that afternoon if asked," says Dr Primus. "This is clearly an uneconomic way for consultants to use their time."

References

1 Marsh, G N, *British Medical Journal*, 1977, **2**, 1267.
2 Ryde, D, *Journal of the Royal College of General Practitioners*, 1978, **28**, 752.

Is a symptomless, painless massive haematuria an indication for immediate cystoscopy?

This is an extremely interesting problem in urological education. As a student myself I well remember being taught that painless haematuria should demand an emergency cystoscopy, but in practice this is rarely if ever done. The reason is simply that in by far the majority of cases the cause of the haematuria will be shown clearly, either on intravenous pyelogram or on subsequent cystoscopy. The quality of excretory urography today is such that a neoplasm in the kidney or ureter is unlikely to be missed. Just occasionally bleeding from nephritis may prove to be consistently from one kidney, or even from a particular part of a kidney. Even so, it is unlikely that surgery would be attempted unless the amount of bleeding from one part of one kidney was exsanguinating the patient. In 30 years of urological practice I have never seen a case of painless haematuria in which the diagnosis could have been better made if an emergency cystoscopy had been carried out during the haematuria.

Are eyes accepted from donors with long-standing myopia of moderate degree?

There is no reason why corneal grafting material should not be taken from an eye which in life has suffered from a moderate degree of myopia for many years. The maintenance of clarity in a corneal graft is essentially concerned with the function of the corneal endothelial cells, which pump excess fluid from the corneal stroma into the anterior chamber of the eye. If the corneal endothelial cells are present in adequate numbers and are healthy then the graft should remain clear and free of oedema. The number of viable endothelial cells decreases throughout life, and the rate of fallout is increased in various degenerative conditions and after intraocular operations. The endothelium may be somewhat unhealthy in cases of long-standing degenerative myopia, particularly if complicated by glaucoma, but this is not so with simple myopia. The cell count is greater in younger patients, so that the more "long standing" is the myopia the older the patient, and therefore the less the chance of producing an ideal grafting result.

Inhalation of formaldehyde and xylol

The second reference to this Any Question (29 September, p 778) should read: Porter, J A H, *Lancet*, 1975, **2**, 603. The third reference (to cover slipping) should read: Bush, C L, and Nelson, G E, *Laboratory Medicine*, 1977, **8**, 16.