radiologist. The addition of clinical examination would increase the yield of cancers and minimize instances of false reassurance.

Clowes and Varlow concede that the effects of the NHS breast screening programme on mortality are not yet certain. Bearing in mind that it is 10 years since the inception of screening and more than £200 million will have already been spent, women continue to be invited without the benefit of balanced information that would explain candidly the pros and cons of screening.

Our critics find many of our arguments unhelpful: unhelpful in what way? Would they prefer not to obtain informed consent for screening? Would they wish every woman who is invited and all those who have a cancer detected at screening to believe they will be certain to benefit? We are not alone in arguing that informed participation in screening is essential.  

References

Minor surgery and general practice

Sirs,

Although agreeing with Finn and Crook that standards of infection control in primary care should be rigorous and enforced as such, I do not agree that the standards applied in secondary care settings can simply be transferred to primary care.

The types of procedures carried out in secondary care day surgery are very different from those carried out in most of primary care. The Statement of Fees and Allowances (SFA) clearly defines the types of procedures that can be carried out under the ‘minor surgery’ arrangements. Clearly, the standards required of a general practitioner (GP) to remove a minor benign skin lesion are different from those required of an outpatient surgeon to carry out a vasectomy.

The new guidance (HSG (96)31) allows for the transfer of services that were previously carried out in secondary care to be carried out in primary care, and for GPs to be remunerated for doing those new procedures. The guidance states specifically that this is nor an extension of minor surgery and GPs cannot simply claim for more minor surgery repayments under HSG (96)31. If GPs wish to undertake additional and different procedures then they have to be measured against their capacity to provide these new services. This includes appropriate infection control.

There is, to my knowledge, no published evidence that patients are more at risk from minor surgery carried out in general practice compared with the same procedures being carried out in hospital settings. Given the prevalence of organisms such as MRSA in hospital settings, the opposite may in fact be true.

If, as the authors suggest, minimum national standards are drawn up, then they must be sensible, and different standards will have to be drawn up for different procedures. The key issue is that infection control procedures are commensurate with the level of risk involved. It is neither necessary nor practical to expect GPs to don protective clothing and to have a separate minor surgery room simply to remove a wart.

Reference

Yours faithfully,

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Reply

Sirs,

I welcome the opportunity to reply to Dr Scanlon’s comments, as important issues need debate. I am pleased that he agrees that ‘standards of infection control in primary care should be rigorous and enforced as such’. Sadly, the literature supports our findings that this is not always the case.

Dr Scanlon makes the point that there is no published evidence that patients are more at risk from minor surgery carried out in general practice compared with the same procedures being carried out in hospital settings but, until well-conducted randomized controlled studies are undertaken, assumptions regarding risk cannot be made.