General Practice Observed

General-practitioner Hospital Beds: A Review

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British Medical Journal, 1971, 1, 452-456

Summary

This paper reviews literature related to general-practitioner hospital beds. In England and Wales 21% of all maternity beds are controlled by general practitioners rather than consultants, and the proportion has increased considerably since 1955. Nearly one in five of these 21% are sited in the wards of a consultant hospital. General-practitioner beds, other than maternity, represent 3% of all hospital beds (excluding psychiatric beds) and this proportion has remained constant over the past 15 years. Only about 1% of these general-practitioner beds are located in a consultant hospital.

In the discussion three questions are raised: Will general-practitioner inpatient care have a useful function in the future? What might that function be? Where should the care be located? The broader issue of the future role of the general practitioner needs to be considered before these questions can be satisfactorily answered. Unless a "hospital orientated" role of the general practitioner prevails there seems little place for practitioner inpatient care in urban areas. In the more rural areas, however, whatever the role of the practitioner becomes, certain groups of patients might advantageously receive inpatient care from their practitioners. Firmer answers to the questions raised cannot be given until a co-ordinated programme of research and development concerning different patterns of care is started.

Introduction

A division between medical care practised inside and outside the large general hospital became increasingly marked in the United Kingdom during the first half of the twentieth century. The National Health Service continued this division, and in recent years, as the schism became more noticed, the search began for ways to unify the system and to improve the collaboration between different parts of the Health Service.

One important interface is that between the primary physician or general practitioner and the specialist service operating from the district general hospital. This paper reviews published data on one aspect of this practitioner-hospital relationship—namely hospital beds for which general practitioners have responsibility, now a subject of lively interest in the United Kingdom partly as a result of the Hospital Plan (Ministry of Health, 1962), which envisaged the closure of smaller hospitals, where most such beds are situ-

ated.* Other related aspects, such as access to hospital diagnostic facilities and general practitioner hospital appointments, raise equally detailed questions but are not covered here.

It is realized that examining the functioning of hospitals in terms of information relating to beds rather than to patients and services has its limitations. Nevertheless, at present the bed is still the main unit used in published statistics.

Extent of Use

General-practitioner beds are designated "maternity" and "other medical" in Department of Health statistics and are contrasted with the other main types of N.H.S. acute bed for which consultants are responsible.

MATERNITY BEDS

In 1969 there were 4,950 maternity beds specifically designated for use by general practitioners in National Health

Average daily number of occupied beds, general-practitioner maternity and non-maternity beds, and consultant maternity beds, England and Wales, 1955 to 1969. (Department of Health annual reports.) Data refers to "occupied" beds and not to the total number of beds designated.

*A full bibliography on general-practitioner beds may be obtained from S.I. on request.

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Service hospitals in England and Wales, an increase of 85% since 1955. Practitioner maternity beds now total 21% of all maternity beds, compared with 14% in 1955. The number of consultant maternity beds has remained almost constant since that time (see Chart). The proportion of general-practitioner maternity beds to all maternity beds shows wide variation between the hospital regional boards. The figures for 1968 range from 2% in the North-West Metropolitan Region to 51% in the South-Western Region. The average length of stay is slightly shorter in general-practitioner maternity beds—6.3 days, compared with 7.7 days in consultant beds. An untested hypothesis suggests that this difference may result from the higher proportion of patients with obstetric abnormalities in the latter type of bed.

Since 1955 almost all additional hospital maternity beds have been general-practitioner beds. However, 235,000 more births took place in hospital in 1968 than in 1955 of which only a little over a third were delivered in general-practitioner beds. The reduction of home births by 88,000 in absolute terms and an increase of a similar number in general-practitioner maternity units has clear implications in respect of the domiciliary maternity services.

NON-MATERNITY BEDS

The Hospital Plan (Ministry of Health, 1962) suggested that the number of general-practitioner beds would probably be reduced; the number of such beds has, however, remained almost constant since 1955 (see Chart). They numbered 7,338 in 1969 and were 3% of all non-psychiatric beds. This average conceals a regional variation from 1% in the Liverpool Regional Hospital Board to 10% in the South-Western Region. There is evidence to suggest that occupancy rates are lower in general-practitioner beds than in equivalent consultant beds, though average length of stay may be similar. Occupancy rates alone give little indication of "productivity." These need to be related to the number of patients occupying a bed in a given time period and the medical and nursing needs of the patient. In an analysis of 1960 data from the Hospital In-Patient Enquiry it was found that the average length of stay was 15.1 days in general-practitioner beds compared with 15.8 in approximately equivalent beds in district hospitals (Ministry of Health, 1960). Since 1955 the average length of stay in most hospital departments has fallen while that for general-practitioner non-maternity beds has risen to 16.6 days. An explanation could be that they are now treating a greater proportion of the chronic sick than formerly, though there is no direct evidence of this, and specific studies are needed before the significance of these figures can be fully understood.

General practitioners can treat hospital inpatients under two administrative arrangements within the National Health Service in England and Wales. In 1968 there were 2,112 doctors working on a payment-per-bed basis, often in cottage hospitals where they normally admit and treat their own patients. This was 11% of the total number of general practitioners in England and Wales. There were 3,886 (19%) practitioners working as part-time medical officers on a sessional basis. In addition, 832 (4%) were employed in both ways. Thus, in all, one-third (34%) of general practitioners in this country have a formal engagement to treat patients in hospital beds. The number working under the first arrangement has fallen considerably over the past 10 years and the number working under the second has risen.

In a recent survey in the Oxford Region (a region with a comparatively high ratio of general practitioner to specialist beds) 65% of practitioners were able to admit their patients to maternity beds under their own care if they wished and 28% could admit to other beds. The authors commented that only doctors in rural areas have real opportunities of admitting patients to non-maternity beds (Oxford Regional Hospital

Board, 1969). This comment seems applicable nationally, for though the quantity of hospital maternity work for which general practitioners are responsible is substantial, the amount of their non-maternity work is small. (It should be noted, however, that though a substantial quantity of maternity work is conducted in general-practitioner hospital beds the practitioners are not necessarily in attendance at delivery. Butler and Bonham (1963) found that in general-practitioner units family doctors conducted or supervised only 28% of deliveries). In England and Wales there is, on average, one non-maternity general-practitioner hospital bed for every three practitioners.

Siting of General Practitioner Beds

MATERNITY BEDS

The Royal College of General Practitioners (personal communication, 1970) sent a postal questionnaire to senior administrative medical officers in the United Kingdom to ascertain data about general-practitioner beds and their administrative setting. The results are shown in the Table.† Most (76%)

General-Practitioner Hospital Beds by Location, U.K., 1969 (Royal College of General Practitioners, personal communication, 1970)

	Maternity Beds		Non-maternity Beds	
	No.	%	No.	%
In wards of a district general or general hospital	489	8.1	88	0.9
In wards of a maternity hospital	617	10.2	N.A.	N.A.
In separate units attached to a district general, general, or maternity hospital	353	5.8	32	0.3
In general-practitioner units/hospitals or cottage hospitals	4,612	75.9	9,705	98.8
	6,071	100.0	9,825	100.0

N.A. = Not applicable.

general-practitioner maternity beds were found to be in units or hospitals completely separate from "consultant" hospitals. A further 6% were in separate units but attached to a district general or specialist maternity hospital. There are now a little over 300 general-practitioner maternity units and Hobbs (1967) found that 44% of them were more than 10 miles (16 km) from the nearest consultant unit and a further 24% were between 5 and 10 miles (8 and 16 km).

Some general-practitioner maternity beds are located within a cottage hospital, and Cavenagh (1966) described a rural unit so sited which was 40 miles (64 km) from consultant cover, and Jameson and Handfield-Jones (1954) described maternity work in a rural cottage hospital. How far the development of "flying squad" cover compensates for large distances is not known.

General-practitioner maternity beds can be also sited in the wards of a specialist hospital and in 1969 there were 1,100 beds of this kind (see Table). Specific schemes have been described by, for example, O'Sullivan (1961) at Kingston Hospital, Oldershaw and Brudenell (1968) at Dulwich and St. Giles Hospitals, and Rhodes (1968) at Lambeth Hospital. In recent years, following the ideas described by Sluglett and Walker (1956), a few general-practitioner delivery units have been opened where the unit is situated near to or within a consultant maternity department and is used for delivery only—the mother is discharged in less than one day (Sluglett, 1968). These interesting developments provide hospital care with fewer of the usual drawbacks, such as the risk of cross-infection to the infant.

†Data in the Table differ significantly from those shown in the Chart. Beds in the Table refer to the U.K. in 1969 and are "total" beds; those in the Chart relate to England and Wales in 1968 and are "occupied" beds. In addition, the data were collected by two different methods.

NON-MATERNITY BEDS

Official policy has been to close as many peripheral beds as possible and to site general-practitioner beds within the district general hospital (Ministry of Health, 1962). At present most non-maternity practitioner beds are located outside towns in small cottage hospitals or convalescent homes (see Table). A few schemes for general-practitioner beds within a specialist ward or hospital have been described, and one such is a ward within the East Birmingham Hospital (Wilkinson, 1968). Many reports have suggested further experimentation along these lines, and a pilot scheme is beginning at the Radcliffe Infirmary at Oxford, the first teaching hospital to have practitioner beds (E. J. R. Burrough, personal communication, 1970).

In an attitude survey among practitioners within the Wessex Region, not surprisingly those in the urban areas tended to favour beds in a general-practitioner unit in a district general hospital and those in the more rural areas favoured beds in a cottage hospital (Wessex Regional Hospital Board, 1964). Evans and McEwan (1969) reported on five surveys of doctors within the Birmingham Region and found that 95% of young doctors wanted to work in district hospitals in association with consultants. What was meant by "association" was not made explicit in the report.

Function of General-practitioner Beds

This section confines itself to non-maternity beds. Many, but not all, agree on the type of case suitable for general-practitioner maternity beds, though Hobbs and Acheson (1966) showed that in the Oxford area a proportion of patients were being poorly selected for care in such beds.

Two statistical analyses of relatively large scale have been made of patients in non-maternity practitioner beds, but neither has ascertained information relating to the function of such beds. Both have been concerned with demographic and diagnostic data and not with information relating to patients' nursing and medical needs. The Chief Medical Officer (Ministry of Health, 1960) reporting on an analysis made from the 1959 Hospital In-Patient Enquiry showed that general-practitioner hospitals dealt with a higher proportion of the aged. For men 31% of the patients discharged were aged 65 and over, compared with 19% for all hospitals; for women the proportions were 35% and 15% respectively. Warren (1962), in a survey of 13 general-practitioner hospitals, found that 36% of patients were aged 65 and over. The Hospital In-Patient Enquiry found, in general-practitioner hospitals compared with similar departments in general hospitals, a higher proportion of patients suffering from vascular lesions of the central nervous system, diseases of the circulatory system, pneumonia, and bronchitis. Warren (1962), surveying patients in 13 general-practitioner hospitals in one regional hospital board, found similar results and noted that surgical cases included hernias, varicose veins, tonsillectomies, dilatation and curettage, appendicectomies, and biopsies. Overall he found 30% of beds were surgical, 45% medical, and 25% obstetric. (Nationally, 40% of practitioner beds are for maternity work). It is not clear from the report, however, how much of the surgery performed on patients in general-practitioner beds was conducted by specialists.

Though it is often suggested that practitioner beds are used extensively for geriatric and chronic cases, the Report of the Chief Medical Officer (Ministry of Health, 1960) found no evidence of this, and the recorded length of stay in general-practitioner beds is still, on average, only 16.6 days.

Discussion

The data suggest that only a small proportion of general practitioners are administratively allowed to treat non-maternity

cases in hospital. The debate on general-practitioner beds centres on whether this proportion should be altered, where such beds should be sited, and which patients could be so cared for.

Those who argue for an increase in general-practitioner beds do so on three main grounds: (a) that the patient benefits from care given by his own doctor in a local hospital, (b) that it is a more economic use of resources, and (c) that it is necessary for the future well-being of general practice.

PATIENTS' WELFARE

It is argued that patients receive as good, if not better, care in general-practitioner hospitals as in specialist hospitals. It seems undesirable, however, for general-practitioner beds to be used as a substitute for specialist inpatient care. The data described above give little information on either the severity of illness or its outcome for those treated in practitioner beds. The absence of relevant studies is striking and prevents rational arguments. The only evidence on the comparative effects of care by alternative "agencies" concerns maternity beds. Hobbs and Acheson (1966) showed that where separate general-practitioner maternity beds exist they come to be used as alternatives for specialist care, with deleterious effects. They found that the presence of a local practitioner obstetric unit greatly reduced the proportion of mothers booked for consultant care—mothers in the "high risk" category as well as those considered as "low risk." Perinatal mortality was significantly higher in practices with access to general-practitioner units (28 per 1,000) than in those without access (19 per 1,000).

For patients who do not need specialist inpatient care the trends are towards increased use of domiciliary care, care on an outpatient basis, and hospital day care. There is also the possibility of large health centres providing some diagnostic and assessment facilities at local level along the lines suggested for community care units (Draper, 1967).

Are there, however, any groups of patients who do not require specialist care and yet need medical inpatient care and cannot be treated at home? At least two groups are often suggested: (a) those who could not be treated at home because of domestic circumstances, the "social" (including "holiday") cases, and (b) those who require hospital inpatient facilities but not necessarily specialist medical care—that is, those requiring continuous skilled nursing care and some medical supervision, frequent laboratory tests, assessment, etc. In urban areas the benefits of separate provision seem unproved even for patients in these two groups. Apart from arguments related to general practice dealt with below, the case rests on the advantage of the patient receiving continuous care from his general practitioner. Last (1967) suggested that familiarity may lead to some diagnoses being overlooked and that therefore continuity of care may not always be the best care. Patients for whom continuity of care may, however, be particularly important include those who are dying though information relating to terminal care is still sketchy. Some research is now being conducted in this field.

For those of the above-mentioned patients who live in less densely populated areas some distance from a district general hospital it is clearly more convenient (and incidentally if many visits by patients and relatives are entailed perhaps less costly to the community as a whole) to be treated in a local hospital by their general practitioner. Such hospitals would, by their nature, be small and might carry with them psychological advantages. They also give rise to local employment opportunities.

To divide patients into those living in urban and those living in rural areas is crude, and there are inadequate data to refine this division. It is clear that more emphasis needs to be placed on a concept of different medical care systems for different locations with a programme of careful research and development.

ECONOMIC USE OF RESOURCES

In the era of the large, complex specialist hospital it is probable that on economic grounds, as well as others, patients should, wherever possible, be cared for in their own home. Where this is not possible are there any economic advantages for patients to be treated in a general-practitioner bed? The answer seems more equivocal than some of those for or against the use of small hospitals recognize. In terms of the capital costs there may be little saving in building both a specialist hospital and a separate less intensively equipped general-practitioner hospital rather than one larger (heterogeneous) specialist hospital. In terms of the running costs expenditure on medical supervision remains relatively unchanged where the practitioner replaces the consultant, since average incomes are similar. If the remainder of the care is assumed to be similar wherever the patient is treated, then other staffing costs will be similar. Of course, any saving is better than none. Such savings remain conjectural until the exact costs of treating similar patients under different systems of care are known (assuming the quality of care received is the same). More information is also needed on the number of patients who might be suitable for treatment in general-practitioner beds, in order to calculate any overall saving or loss.

ROLE OF PRIMARY PHYSICIAN

Perhaps the most important aspect of general-practitioner beds involves the wider issue of the future role of the general practitioner and the place of primary care in the total system of health care.

At present about one-third of practitioners work in hospital, though a very much smaller number have access to beds. Are the reasons for hospital work primarily those of status or primarily a concern to practise a particular type of medicine and to gain access to certain hospital facilities? These reasons are, of course, all interrelated. Some of the attitude studies so far conducted suggest a smaller proportion of practitioners emphasizing the importance of bed access than was hitherto thought—for example, Mechanic (1968)—and it is probable that in the future access to some hospital services without access to beds would become widespread.

It is becoming increasingly clear that two aspects of the role of the general practitioner are pulling in opposite directions. On the one hand there is the concept of a practitioner who carries out some curative and preventive care himself (and according to this view a practitioner will need more psychosocial training to benefit from recent knowledge) and also selects and co-ordinates other services on behalf of his patients—that is, including a managerial, interpretative, and ombudsman function. The B.M.A. Planning Unit (1970) suggested that the next 25 years would see this role becoming the dominant one, with the practitioner emerging as a specialist in his own right. On the other hand there is the concept that general practice is an activity made up simply of parts of the various specialties. At the risk of oversimplifying, the latter role can be considered as a doctor performing technical medicine similar to that practised in the modern hospital but treating cases outside, most of whom are not normally admitted. This latter concept is strongly bound up with ideas for rehabilitating the primary doctor in the hospital.

If the role suggested by the B.M.A. Planning Unit prevails the need for acute medical beds in a specialist hospital diminishes, but the need for local general-practitioner beds for "social" cases, terminal cases, etc., will remain important. The necessary integration of primary and secondary care can be built up by the practitioner entering the hospital as a "consultant" and being requested to give advice at any stage of his patient's illness, especially at the later stages where his aid should be sought in relation to rehabilitation and aftercare. Also, closer consultant-practitioner liaison can be achieved by

consultant outpatient work at health centres, as, for example, exists at Kilsyth (Thomson, 1969).

Though it seems unlikely and undesirable, what are the implications if the "hospital orientated" role prevails? Firstly, local hospitals treating "social" cases, etc., would not fulfil this function. Secondly, urban practitioners can increase their hospital role by clinical assistantships. If they also require the more widespread use of hospital beds to treat some acute medical cases it might well be necessary for them to accept the greater restrictions on clinical freedom imposed in countries such as Canada and the United States and to accept some form of measurement of the standard of their hospital work—for example, the medical audit. If the practitioners have full clinical responsibility for their patients on a par with consultants they would also require some means of adjustment to the corporate responsibility of working within a hospital. Finally, the effect of an increase in general-practitioner beds to care for patients previously cared for by specialists would have important implications for manpower resources (including recruitment to general practice), for the financing of general practice, and for the future training, particularly vocational training, of the general practitioner.

MATERNITY BEDS

Most of this discussion has been concerned with non-maternity general-practitioner beds, and a word must be set aside for relating it to obstetrics. To examine all the implications of who looks after maternity cases, and where, requires more space than this paper allows and therefore only a few points will be touched on. Firstly, general-practitioner maternity beds constitute a sizable (21%) and growing proportion of all maternity beds, and for this reason alone the future of general-practitioner maternity beds is an important issue. The B.M.A. Planning Unit (1970), however, sees the role of the general practitioner as diminishing in this area, and thus the future roles of the domiciliary and hospital midwife, the general practitioner, and the specialist need careful re-examination.

The largest single question affecting the obstetric service in this context is the quality of care given in general-practitioner maternity units. Hobbs and Acheson (1966) showed how the presence of general-practitioner units led to poor case selection, and there is consequently a strong argument to be made for such units to be near to or within a district general hospital wherever possible. In less urban areas, however, the arguments for the existence of local units are particularly valid, though problems of transport to the nearest specialist hospital are still largely unknown. On the one hand, improvement in the ambulance service and other transport may lessen the need for local units. On the other hand, advances in technology may improve the practitioners' case selection, and, together with a possible improvement in some of the shortcomings of the local units which Hobbs (1967) outlines (such as the lack of equipment and poor antenatal consultant liaison), could strengthen the case for local units.

It may be that, as Ashford and Fryer (1970) suggest, a cost-effectiveness study on the whole of the maternity services might point to the need for a radically different balance between, say, home and hospital deliveries such as exists in Holland. It is certain, for example, that domiciliary midwives are at present underutilized in some areas. By reorganization and reducing the intensity of services slightly, wider coverage and overall improvements might be obtained. This strategy applies of course to other fields.

CONCLUDING COMMENTS

In summary, the position of general-practitioner maternity beds is still unclear and depends greatly on decisions about the roles of the specialist, general practitioner, and midwife,

and on research into the quality of care given in different types of maternity units. These are pressing problems, for the number of general-practitioner beds is comparatively large. There seems little case to be made for the widespread use of non-maternity beds in urban areas, particularly if the trend in primary medical care follows the arguments outlined above. In certain situations, however, the case is stronger—for example, some groups of patients living in certain geographical areas—but greater clarification of bed function and siting is needed. Some of these problems are dependent for solution on basic ideas and political philosophies, some on research. Research and experimentation is required to evaluate properly and comprehensively how different patterns of care can work—many of the present differences are haphazard rather than part of a planned policy of research and development.

This paper is part of a research project being conducted at the Department of Community Medicine, Guy's Hospital Medical School, sponsored by the Department of Health and Social Security. We should like to thank Dr. J. A. D. Anderson, Director of the Department of Community Medicine, for his interest and encouragement; Miss N. Phelps, research assistant, for her help; and the many colleagues who have given us advice and supplied comments on earlier drafts. We should also like to thank the Royal College of General Practitioners for making available data relating to general-practitioner beds.

References

- Ashford, J. R., and Fryer, J. G. (1970). In *In the Beginning*, ed. G. McLachlan and R. Shegog. London, Oxford University Press.
- British Medical Association (1970). *Primary Medical Care* (Planning Unit Report No. 4). London, British Medical Association.
- Butler, N. R., and Bonham, D. G. (1963). *Perinatal Mortality*. First Report of the 1958 British Perinatal Mortality Survey. London.
- Cavenagh, A. J. M. (1966). *British Medical Journal*, 1, 533.
- Draper, P. (1967). *Lancet*, 2, 1406.
- Evans, E. O., and McEwan, E. D. (1969). *British Medical Journal*, 1, 172.
- Hobbs, M. S. T. (1967). *British Medical Journal*, 4, 287.
- Hobbs, M. S. T., and Acheson, E. D. (1966). *British Medical Journal*, 1, 499.
- Jameson, J. E., and Handfield-Jones, R. P. C. (1954). *Lancet*, 1, 665.
- Last, J. M. (1967). *Medical Journal of Australia*, 1, 780.
- Mechanic, D. (1968). *Medical Care*, 6, 245.
- Ministry of Health (1960). *On the State of the Public Health: Annual Report of the Chief Medical Officer*. London, H.M.S.O.
- Ministry of Health (1962). *Hospital Plan for England and Wales*, Cmd. 1604. London, H.M.S.O.
- Oldershaw, K. L., and Brudenell, J. M. (1968). *British Medical Journal*, 3, 112.
- O'Sullivan, J. V. (1961). *British Medical Journal*, 2, 1349.
- Oxford Regional Hospital Board (1969). *General Practitioner and the Hospital Service in the 1970s*.
- Rhodes, P. (1968). *British Medical Journal*, 4, 509.
- Sluglett, J. (1968). *Proceedings of the Royal Society of Medicine*, 61, 1027.
- Sluglett, J., and Walker, S. (1956). *Lancet*, 1, 684.
- Thomson, W. (1969). *The Medical Officer*, 122, 128.
- Warren, M. D. (1962). *Lancet*, 2, 601.
- Wessex Regional Hospital Board (1964). *What Do They Really Want?*
- Wilkinson, B. R. (1968). *British Medical Journal*, 1, 436.

Any Questions?

We publish below a selection of questions and answers of general interest

Cervical Erosion

What is the best method of cauterizing a cervical erosion, and is it the treatment of choice?

A simple cervical erosion is frequently seen in nulliparous patients and in patients taking oral contraceptives. Macroscopically there is a reddish granular area around the external os with no evidence of infection or mucopurulent discharge. These simple erosions represent an overgrowth of columnar epithelium from the endocervix and are hormonally produced. It is doubtful if they ever produce symptoms, and probably treatment does more harm than good.

Cervical erosions, however, also occur in association with chronic cervicitis. Here the problem is of a parous patient, and the erosion is associated with varying degrees of cervical laceration, mucopurulent endocervical discharge, and the presence of nabothian follicles. Chronic cervicitis may give rise to a variety of symptoms, the commonest being vaginal discharge, backache, and dyspareunia. It is possible that in some cases the chronic cervicitis also gives rise to infertility, perhaps because the mucopurulent discharge represents a hostile environment to spermatozoa. However, many women with an intense chronic cervicitis seem to conceive with remarkable ease. Occasionally, patients may present with symptoms of frequency of micturition and dysuria suggesting urinary tract infection.

The treatment of chronic cervicitis depends, firstly, on accurate diagnosis and, secondly, on tailoring the treatment to meet the individual requirements. It is always necessary to exclude malignancy by cytological examination and, when the patient comes to operation, by biopsy. The majority of cases are best treated by deep linear cautery or diathermy. Adequate treatment usually involves admission to hospital and diathermy under general anaesthesia. Cauterization in an out-patient department is usually inadequate in extent and associated with a high rate of recurrence.

When the cervix is particularly bulky conization is probably preferable to linear radial cautery. Extensive cautery may be associated with a small but significant incidence of heavy secondary haemorrhage, and if the cervix is badly infected at the time of cautery antibiotic cover for the operation should be considered to minimize the chances of a spreading parametritis. When there is a heavy endocervical discharge obvious causes for this, such as a trichomonal infection or acute neisserian infection, should be excluded before surgical treatment.

Resort to Hearing-aid

Does early resort to a hearing-aid in conduction deafness in the elderly slow the rate of increase in deafness or should the use of an aid be postponed as long as possible?

The danger in using a powerful transistor type of hearing-aid is of greater damage to a cochlea which may already be diseased. There is some objective evidence to support the contention that this may indeed happen in perceptive deafness.

In conductive deafness, on the other hand, wearing a hearing-aid has everything to commend it, particularly in the elderly. The pathological process responsible for conductive loss of hearing forms a protective barrier against too loud sounds reaching and causing possible damage to the cochlea. Furthermore, intelligibility for amplified speech is good with this type of deafness, and any possible mental slowing up due to age which may be retarding the easy interpretation of speech is compensated for by amplification. This is likely to be of untold benefit to both the patient and his family and may prevent his becoming a social outcast.