tested for HIV antibodies in Africa, despite donor and government plans to implement voluntary testing centres. In Zambia, for example, international donors are funding the testing of up to 5% of the adult population of Lusaka. If preventive treatment for tuberculosis proves efficacious, it will be the first major medical intervention that can be offered to the thousands of people found to be HIV seropositive and the costs of counselling and testing will already be being met for reasons other than to provide preventive treatment. As Lucas and colleagues conclude, "outcome in skeletally wasted patients is likely to be unfavourable whatever the cause."¹ Early diagnosis and better management of tuberculosis will eventually reduce the burden of tuberculous infection in the community but cannot be expected to make much immediate impact on the incidence of and associated mortality from slim disease. To define the efficacy and to find innovative ways of delivering preventive treatment and monitoring its cost and impact should be among the priorities of nations where the distributions of HIV infection and tuberculosis overlap.

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Catholic beliefs about contraception

EDITOR,—Dorothy Logie's concern for suffering women and children is fully shared by those of us who are Catholics.¹ Catholic teaching throughout the centuries has been to "love your neighbour as yourself," and this has been manifested by the many hospitals, hospices, orphanages, and schools that Catholics have founded throughout the centuries.

Catholic objections to abortions, condoms, etc are objections not to the laudable end of relieving suffering but to the means of achieving it. For us, killing the unborn is not a legitimate means. Our objection to artificial contraception is based on our belief in the dual purpose of sex—that it is for pleasure and procreation, just as eating is for both pleasure and nutrition so that to eat purely for

pleasure with no need of food is gluttony. In addition, I see artificial contraception as the soft option. Natural methods of contraception require men to respect women and their natural cycles by maintaining a monogamous relationship and practising periodic abstinence.

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Waiting times in an ophthalmic outpatient clinic

EDITOR,—The problems facing ophthalmologists in busy units trying to meet the patient's charter have recently been highlighted.¹² It seems that the blame must lie with the hospital if the conditions of the charter cannot be met, but this may not always be justified.

Around the time that the charter was introduced I conducted a survey of three general ophthalmological outpatient clinics over three weeks. These were representative morning clinics for a busy, specialised teaching hospital. Overall, 216 elderly patients attended; the most notable finding was that 84 arrived an average of 46 minutes late for their booked appointment time. Trying to fit these patients into the clinics resulted in long delays, with the allotted schedule being overrun. Although a small proportion of the patients were late as a result of ambulance delays, many were late because they were unable to use their reduced fare passes on public transport in the early morning. Because the eye hospital is in a busy city centre, parking problems were also partially responsible. Patients may also be late if they have had to wait many hours to be seen at previous appointments.

The standards in the patient's charter do not take into account factors that may be outside a hospital's control, yet it is the hospital that will be penalised. Perhaps we should impose stricter regulations by informing patients that they will not be seen if they turn up late. This may allow us to meet the standards of the charter but could also result in a number of patients becoming blind unnecessarily.

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Laser treatment of palate results in severe postoperative pain

EDITOR,—Anthony Hinton and Victoria Moore-Gillon write that the recently developed operation of palatal stiffening by laser is less painful than conventional uvulopalatopharyngoplasty.¹ The evidence for this is uncertain as no controlled studies have been carried out, but laser operations on the soft palate are extremely painful, the critical factor possibly being the cutting of muscle with the laser. The pain usually takes two or three days to develop postoperatively but lasts for up to two weeks. Any surgeon planning to perform such procedures must counsel patients about the severe nature of this pain, particularly because patients commonly undergo treatment to benefit others

(spouses or partners), with only indirect benefits to themselves. It is therefore advisable to include the partner in such discussions. It is also important that the patient's general practitioner is aware of the severity of the likely postoperative response as he or she will almost certainly be approached for continuing analgesia. Non-steroidal anti-inflammatory drugs are usually most effective, although opiate analgesics may be necessary. Antibiotics are commonly prescribed, but probably only a few patients specifically benefit from them.

Laser treatment of the palate for snoring is likely to increase and holds the promise of relieving severe snoring in a considerable proportion of sufferers. We must be aware, however, of the short term consequences of our surgery.

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GPs' opinions about provision of intrapartum care

EDITOR,—David J Brown's study of general practitioners' opinion on intrapartum care confirms the declining interest in the service.¹ Why is this so when a movement from hospital to community based care is being encouraged² and women are apparently demanding a choice?³ The reasons listed—workload, fear of litigation, and disruption of personal life—undoubtedly provide some explanation. Less is known, however, about women's desire for choice. Does the average woman not demand a choice? Does the typical general practitioner perceive that demand for intrapartum care is insufficient to justify the extra time, commitment, and resources required?

Intrapartum care provided by well motivated general practitioners is undoubtedly safe.⁴ These general practitioners, however, are in a minority. Studies of populations of general practitioners include many who claim to offer intrapartum care but assist at few deliveries and perform even fewer procedures. This may jeopardise safety. Women booked for delivery by their family doctor may in practice find themselves delivered by an attached midwife or a midwife they have not met before.⁵ This is not the continuity of care that many perceive to be an attraction of delivery assisted by a general practitioner.

The commitment required to provide a good standard of intrapartum care may be unattainable for modern general practitioners. If more intrapartum care is to be based in the community is there not a role for specialist community obstetricians trained by the Royal College of Obstetricians and Gynaecologists? Enthusiastic general practitioners could, with further training, also participate in this service. Provision of intrapartum care by all general practitioners could then take a respectable place in medical history.

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