

operations from GPs book patients in to clinics before placing them on a waiting list.

As part of an initiative programme to reduce waiting times at King's College Hospital in London, GPs were given an opportunity to book patients with eyelid pathology directly onto the minor operations list over a 6-week period. We audited this data retrospectively.

There were 85 subjects (50 males and 35 females) with a mean age of 41.6 years (range 16–75 years). The referring diagnoses were divided into three categories: chalazion/cyst (80% of referrals); skin tag/papilloma (16%); and unknown aetiology (4%). When compared with the diagnoses made by the senior attending ophthalmologists, there was a 34% diagnostic discrepancy. The main discrepancy (65% of cases) occurred in the skin tag/papilloma group (referred initially as cysts). The unknown group contained skin tags/papillomas (66%), and cysts (34%).

Analysis of the final outcome revealed that 26% of patients did not require (or want) surgery; these patients were discharged. The proportion of those discharged was directly related to the length of time between referral and the appointment, which averaged about 3 months.

The clinical diagnosis of benign eyelid lesions at ophthalmic departments has been shown to be fairly accurate when compared to histological samples,<sup>1</sup> in particular for chalazia (up to 94%). However, where discrepancy occurs the lesions often have a premalignant or malignant aetiology.<sup>2,3</sup>

The accurate diagnosis of ophthalmic conditions is clearly in the best interests of all parties involved, and would optimise the use of resources in the treatment of conditions considered suitable for management as 'minor ops'. Improvement in this arena has been demonstrated by organising workshops in some units. Furthermore, it appears that including ophthalmology as part of vocational training is the best way of achieving this aim.<sup>4</sup>

The direct-access pilot scheme was not shown to be an efficient way of conducting the minor operations service.

A picture of the lesion may help the ophthalmologist decide where and when to list the patient. In addition, targeted training/workshops for GPs, and a telephone interview with the patient a week prior to their visit in order to confirm the continued presence of a troublesome lesion, may reduce the day-of-surgery discharge rate.

#### SHAHRAM KASHANI

Senior House Officer in Ophthalmology  
Normanby Block Level 2, Kings College  
Hospital, Denmark Hill, London SE5 9RS.  
E-mail: shahdoc@hotmail.com

#### MOHAMMAD MUHTASEB

Senior Registrar in Ophthalmology

#### FIONA ROBINSON

Consultant Ophthalmic Surgeon

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## The problems with choice

Mike Fitzpatrick<sup>1</sup> is correct. The perverse truth is that inequity is a necessary precondition for choice to be meaningful.

The choice evangelists try to repel their critics by quietly conflating consumer choice with moral choice and rights talk. It is important, therefore, to distinguish between consumerism (the preoccupation with, and increase in, consumption), and moral choice (the patient's inalienable authority to give and withhold consent).

If patient choice drives quality and empowerment, to where is it driving it? A state of equity, and satisfaction for all, by way of the necessary evil of market forces. Who said Marxism was dead?

#### JOHN MAGUIRE

General Practitioner  
Wibsey Medical Centre, Wibsey, Bradford  
BD6 1TD. E-mail: johnp.maguire@virgin.net

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## The stethoscope and cross-infection revisited

Jevons first reported methicillin resistant *Staphylococcus aureus* (MRSA) in 1961<sup>1</sup> and it has now become a serious cause for concern in UK hospitals. Indeed, it has even entered the political arena.<sup>2</sup> In 2003, a search for MRSA using www.yahoo.com yielded 153 000 results; this has now risen to 329 000 references.

Last year, a letter of mine was published here; it detailed a bacteriological examination of my practice stethoscope, which showed that it did not carry MRSA bacteria over a 2-week period.<sup>3</sup> I have since examined 50 stethoscopes chosen at random. They were in daily use by doctors in general practice in the London area drawn from the membership of the Independent Doctors Forum. Their stethoscope bells and diaphragms were imprinted on blood agar medium plates, which were then incubated for 24 hours at 37°C. The Doctors Laboratory examined those culture plates that grew bacteria and identified these bacteria, further testing staphylococci to establish if they were MRSA species.

Of the 50 stethoscopes examined, 13 carried no bacteria at all, 15 carried mixed skin flora, and coagulase negative staphylococci were isolated in 22. Not one of these 50 stethoscopes carried MRSA. This can be contrasted with previous studies, and particularly with a paper by Smith *et al.*,<sup>4</sup> which showed that in 1996 in the hospital environment, MRSA frequently colonised stethoscopes used on medical and surgical wards. They found 68 out of 200 stethoscopes (34%) to be positive for MRSA; comparing this with my results, a <sup>2</sup> test gives  $P < 0.001$ , which is highly significant.