account should be taken of research in a relevant basic science. We recognize that a flexible system must operate. Some investigators will undoubtedly follow unorthodox paths and we do not wish to discourage this. Their accreditation could be considered on merit suggested in the heavy type on p. 8 of the First Report of the J.C.H.M.T. This reads as follows: "It is not intended, nor is it possible, to lay down rigid prescriptions for the training of specialists. Any suggested framework in the following schedules should be interpreted flexibly, allowing for variations in time, for the special needs of individuals, and for local circumstances."—I am, etc.,

J. HALLIDAY CROOM

Chairman,

Joint Committee on Higher Medical Training

Royal College of Physicians,
London N.W.1

Clinical Experience with the Dalkon Shield

SIR,—With reference to the paper by Mr. R. W. Jones and others (21 July, p. 143) I agree wholeheartedly with the statement that independent study of the Dalkon Shield's effectiveness is desirable. Such a study has been under way for some 30 months, controlled by the Family Planning Research Unit at Exeter University, who have accumulated data from some 10-12 family planning clinics. The initial results for one year up to September 1972, compiled by the life table method, have now been published.^{1,2} These data, from a variety of clinics and involving many doctors of varying grades of experience, produced event rates as follows: pregnancy rate 3.8%; expulsion rate, 3.9%; bleeding/pain removal rate, 4.6%. You will see that in each case these multi-centre rates were better than those produced by Mr. Jones and his colleagues.

Now why should this be? Close examination of these authors' paper discloses the following points: (1) Twenty insertions were performed by doctors who are described as "learning the technique." (2) Thirty-one insertions were performed at the time of pregnancy termination. It is surely important that we have some more information about this group, because it is well known that the insertion of an intra-uterine device in this situation depends on the duration of the pregnancy at termination, the type of technique employed, and the success of the evacuation procedure. (3) Only two small shields were used and yet there were 18 nulliparous women in the series. I would expect that there would be a much higher chance of complications when a standard-size shield was inserted into a nulliparous cervix and I would postulate that some of the Dalkon Shields at least that were expelled or were removed probably fell into this category of inappropriate choice of device. (4) The data appear to have been analysed not by the life table method, but presumably with the Pearl formula, which is now accepted as being an out-of-date method of analysis which invariably produces poor results from the event rate point of view in the early stages of a study, but much better rates as time goes on.

I do feel, however, that this paper helps to support the suggestion that the use of

national, multi-centre data for I.U.D. assessment is obligatory. I consider that the data from Exeter are more meaningful, as being representative of the future I.U.D.-using doctor in general, than those from any single-centre study.—I am, etc.,

J. S. TEMPLETON
Medical Director,
A. H. Robins Co. Ltd.

Horsham, Sussex

- 1 *The Dalkon Shield*, Family Planning Research Unit, Report No 2, September 1972. University of Exeter, 1973.
- 2 Snowden, R., and Williams, M., *Contraception*, 1973, 7, 91.

SIR,—With reference to the paper by Mr. R. W. Jones and others (21 July, p. 143) I would like to report the following case.

A 28-year-old para 1 was fitted with a Dalkon Shield eight weeks after the birth of her baby. She attended for follow-up two months later and the shield was satisfactorily in place. Two weeks later she attended complaining of suprapubic pains and backache and requested removal of the shield.

The shield was still in place. When the tail attached to the shield was pulled the patient experienced severe pelvic pain and felt faint. It was decided to remove the shield under general anaesthesia. This was achieved easily and curettage was also performed. Because of the severe pain at the initial attempted removal of the shield laparoscopy was performed to exclude a uterine perforation. This showed a left tubal pregnancy with an intact uterus. Laparotomy was performed and the left tube removed, following which the patient made an uneventful recovery.

This illustrates that pain on removal of the shield may be associated with ectopic pregnancy.—I am, etc.,

J. D. O'DONOVAN

King Edward Memorial Hospital for Women,
Subiaco,
Western Australia

Surgery on Day Patients

SIR,—Those who have read HM(73)32, "Arrangements for the Care of Persons Attending Hospital for Surgical Procedures as Day Patients," have justification for a deep sense of unease derived from this superficial and naive document. Profoundities in regard to the "significant and continuous contribution" which day surgery may make "to the reduction and control of surgical waiting lists and . . . demand on in-patient facilities" are bandied about, as are references to its being "welcome both to patients and staff." What then have we surgeons been playing at in the light of such revelations from the Elephant and Castle? Might there be another side to the coin? Have we not sufficient arithmetical ability to deduce that waiting lists would shrink if large numbers of operations were done as outpatient procedures? Why then do many of us reject a material expansion of this procedure? The answer is simple and in its simplicity so complex—safety and quality of care. Where these are not prejudiced such arrangements are generally already implemented and based on an understanding which has grown up between

the hospital team, the general practitioner, and the ancillary services thereby related. Early discharge has already encouraged this liaison and has in no way prejudiced the patient's safety when the time for monitoring has passed.

There can be little place for expansion of the group of cases judged suitable for day operations if selection is made on clinical grounds. The careful hour-by-hour monitoring of postoperative patients by those with experience and skill cannot be safely replaced by the diffuse and intermittent care of home circumstances, by staff variable in skill, in personage, and in enthusiasm. Nor does a deputizing service provide a suitable source of supervision on the nights of the practitioner's relief or compare with the vigilance of house surgeons on the spot. One can only deduce that quality, facilities, and safety are to be sacrificed for statistics. It is readily understandable that the Department of Health is only too happy to seize upon such an easy way out of the waiting list situation which they have failed to solve in the past by the provision of the necessary resources.

What of the consultant's responsibility? The law might well consider his field of responsibility expanded through his operative commitment to cover the care of his patient by those or their deputies whom he has never seen. The free access of patients to legal aid might deter many surgeons from such a commitment. What of the general practitioner's responsibility? All is well that ends well, but that which does not end well may be a very invidious chapter indeed.

Reduction of waiting lists at the price of a second-class standard of patient care is unacceptable and should be rejected at any level. In the opinion of many of us, those concerned should think very hard and think again before materially changing their selection of patients suitable for day surgery.—I am, etc.,

ALISTAIR CASSIE

Burnley General Hospital,
Burnley, Lancs

Deputizing Services

SIR,—Two valuable surveys of G.P. deputizing services have recently been published. Using calculations based on indirect evidence, Dr. B. T. Williams and others (10 March, p. 593) estimated that the Sheffield service handled between 0.4% and 2.0% of all calls for those G.P. who subscribed to it and between 1% and 17% of their home visits. They concluded that "at this level of activity the concept of 'personal doctoring' was not threatened." In Nottingham the same authors¹ found that the outcome of referral of patients to hospital by deputizing services and by G.P.s was the same—as estimated by the proportion actually admitted, their length of stay, the proportion operated on, and their mortality. They concluded that "familiarity with patients' past medical histories and general circumstances does not appear to be crucial in determining the proper use of hospital resources for emergencies."

Little has been written of the views of patients and deputizing doctors themselves. I have worked for a large deputizing service and for several years in hospital. Perhaps I