wait eight weeks from the time of being diagnosed by bronchoscopy as having a lung cancer before being admitted to hospital for thoracotomy. If it had not been for my making a pest of myself by repeated letters and a telephone call, he would probably have waited 10 weeks. In fact, he jumped the queue for admission. Eight to ten weeks is long enough for an operable carcinoma to become inoperable. It is highly unethical for a National Health Service to be organized in such a way that there is a waiting list for cancer of two months' duration.

In Manchester the waiting time for admission for treatment for lung cancer is two months; for iatrogenic abortion several days. Whether this is a local or national phenomenon I do not know, but it seems to be a highly unethical state of affairs.—I am, etc.,

R. N. EBBING.

Collyhurst,
Manchester.

First-aid Training

SIR,—As a person responsible, *inter alia*, for advising on first-aid training policy in the mining industry, I was interested in the paper by Surgeon Rear Admiral Stanley Miles on aspects of emergency care. (22 November, p. 485). I find myself in complete agreement with him, but beg leave to add one or two points.

Were it possible to train everyone up to standard first-aid certificate level this would not necessarily be a good thing. Many lack the necessary intellect, others are disinterested, and quite a lot of people have a horror of blood. The question is, who do we really need to train? Certainly not people in industry, perhaps with exceptions, where there are statutory responsibilities resting with the employers to provide "adequate" first-aid facilities. Not in the cities, towns, villages, and hamlets, where responsibility for medical coverage rests with local authorities, ambulance services, and doctors, and where delays resulting in the deterioration in the condition of the casualties may do no greater harm than could result from bad handling by people who think they are qualified. So, the field is narrowed down to motorists (particularly long distance transport drivers), mountaineers, and underground workers—that is, people not within quick or easy reach of assistance, who should be given a basic training in first-aid commensurate with their needs. Giving everyone some form of first-aid training has real dangers. Such people may be tempted to take action themselves instead of sending for a qualified person, and may cause more harm than good. Even so, I still believe, with Admiral Miles, that a case exists for giving basic training to the people specified, so long as the risks are carefully calculated and great care is taken in the preparation of the syllabuses and lesson notes.

I would specify desirable targets, covered somewhat by the progressive first-aid instruction chart produced by Admiral Miles, to be as follows: people in "at risk" employments should be trained in carefully prepared basic principles of first-aid; the basic training should be made as interesting as possible in order to encourage those taking it to become "certificated" first-aiders;

and that, in industry and schools particularly, a method of "streaming" be evolved so that those who show a marked interest in first-aid may, later, be trained up to a higher standard than the others.

There may be a case for a select committee of doctors and educationists to study these questions, as proposed by Admiral Miles, but I should have thought that it was within the terms of reference of the national voluntary first-aid organizations to examine the case submitted and to place any recommendations before the appropriate Minister(s).—I am, etc.,

DAVID CURTIS.

Industrial Relations Officer,
National Coal Board.

London S.W.1.

Fracture of Curette

SIR,—I was most interested to read Mr. J. M. McGarry's report of a fractured Kerslake curette (3 January, p. 49). In this unit two plastic Kerslake curettes have fractured over the last six months. The first presented no problems, as the end was easily retrieved, but in the second case, on fitting the pieces together, it was apparent that a small piece of plastic about $\frac{1}{2}$ -inch (1.25 cm.) x $\frac{1}{4}$ -inch (0.6 cm.) was missing. A careful search of the uterus and of the aspirated tissues failed to reveal the piece.

We x-rayed a curette and found it showed up on the plate, but when a similar curette was x-rayed in situ in a uterus using a soft exposure, it was impossible to see it, although the uterine outline could be visualized.

I wonder if the manufacturers would consider the possibility of making this plastic radio-opaque, as fracture would seem to be a not uncommon happening and the loss of a small splinter a hazard.—I am, etc.,

JOHN ATKINS.

St. Andrews Hospital
Billericay, Essex.

Open E.C.G. Service

SIR,—The article by Dr. C. M. Morgans and his colleagues (3 January, p. 41) analysing an open E.C.G. service is of much interest, especially to those of us who have been involved in a similar service.

Their article raises several points which are worth comment. Firstly, a delay of seven to ten days between the patient being seen by his family doctor and the latter receiving the report of the tracing seems excessive. My experience¹ has shown that a truly open service at which the patient can be referred without an appointment is a practical and satisfactory solution to this problem. Approximately 14% of the patients referred to Dr. Morgans had tracings compatible with myocardial infarction. It would be of interest to know how many of these tracings were compatible with a recent acute myocardial infarction. We were surprised in our series by the number of tracings compatible with a recent acute myocardial infarction, especially when the conditions of the service lay down that patients suspected of an acute infarction should not be referred.

Following on from the above remark, Dr. Morgans does not state when the E.C.G.s are read or initially scanned. I found it pre-

ferable that the record be seen, not necessarily fully reported, before the patient was permitted to leave the cardiac department. The referred patient was only seen by the hospital medical staff when the initial scanning of the tracing suggested the need for immediate admission to hospital. This occurred in 15 of my patients—I am, etc.,

KENNETH P. DAWSON.

Stobhill General Hospital,
Glasgow N.1.

REFERENCE

- 1 Dawson, K. P., *Practitioner*, 1969, 203, 70.

Chlormadinone Contraceptive Withdrawn

SIR,—We regret to announce the suspension from the market of Verton, the low dose, oestrogen-free preparation containing chlormadinone acetate. Doctors have already received letters making this announcement.

This decision is taken in view of over-reaction to any adverse reports associated with oral contraceptives in the light of certain reported findings of breast nodules in dogs. Long-term toxicity tests on such animals are required by the Food and Drug Administration of America but not by the Committee on Safety of Drugs in the United Kingdom.

The significance of these reported findings is unclear, and it is known that the metabolism of certain sex steroids in the dog is significantly different from that in man and monkey. In addition, the reaction of dogs to progestins is markedly different from that in man, and the natural history of these nodules, which appeared in a significant proportion of dogs by the age of 6, bears little resemblance to that of breast cancer in the human. The Committee on Safety of Drugs required long-term toxicity studies in rats and mice, and in these species no similar effects have been shown. Further, no similar findings have been observed in monkeys treated for a little over a year.

Nevertheless, because of the recent alarmist publicity in relation to chlormadinone acetate, we have decided to suspend it from the market. This decision is taken in consultation with the Committee on the Safety of Drugs, with whom we have been in almost daily contact over the past few weeks.—I am, etc.,

G. R. DANIEL

Medical Director,
E. R. Squibb and Sons Ltd.

Twickenham.

**Normenon, another preparation of chlormadinone acetate, has also been suspended from the market. A leading article appears at p. 252.

SIR,—The decision by the manufacturers to suspend marketing of chlormadinone acetate seems regrettable. The grounds on which this has been done appear to be the experiments in the U.S.A. on beagle dogs. The precise relevance to man and the validity of these experiments is open to question.

Against the hypothetical risk, on the other side of the balance sheet must be set the proved danger of thromboembolism with conventional preparations. Chlormadinone

acetate appears to be the only available oral contraceptive which does not produce rises in blood clotting factors and increased platelet aggregation.^{1,2} Abnormal levels of clotting factors and platelet aggregation arising from the taking of combined preparations do in fact return to normal when chlormadinone acetate is substituted. The harmful element in all the other oral contraceptives appears to be oestrogen, and we found no difference in clotting response between the high and low dose oestrogen combinations. Inman and Vessey⁴ showed a mortality of 3.4 women in the 35 to 44 year and 1.3 per 100,000 in the 20 to 34 year age groups resulted from conventional oestrogen-progestogen contraception. To this must be added the much greater numbers of non-fatal thromboembolisms.

Though chlormadinone acetate in some respects may not be ideal, it does appear to represent a considerable advance. The correct procedure, surely, for the manufacturers

should have been to report the experimental findings to the Committee on Safety of Drugs. Doctors could then have been made aware of a possible hazard and the ultimate decision on the advisability of withdrawal could then have been left in the hands of Professor Scowen's committee.

By wishing to be seen to do "the right thing" the manufacturers may, from the clinical standpoint, be making a tragic mistake, as it must of necessity be a considerable time before other progestogen preparations are developed for clinical use.—I am, etc.,

L. POLLER.

Withington Hospital,
Manchester.

REFERENCES

- 1 Poller, L., Thomson, J. M., Tabiowo, A., and Priest, C. M., *British Medical Journal*, 1969, 1, 554.
- 2 Poller, L., Priest, C. M., and Thomson, J. M., *British Medical Journal*, 1969, 4, 2.
- 3 Poller, L., Tabiowo, A., Thomson, J. M., *British Medical Journal*, 1968, 3, 218.
- 4 Inman, W. H., and Vessey, M. P., *British Medical Journal*, 1968, 2, 193.

Consultant—By Any Other Name

SIR,—I would request the use of your columns to reply to the letter of Dr. I. M. Librach (10 January, p. 113), which takes me to task concerning the so-called "subconsultant grade."

This letter so astonished me that I for the first time read the report of the last meeting of the C.C.H.M.S. (*Supplement*, 27 December, p. 79) and found that, no doubt owing to the inevitable element of *précis* in this report, my remarks on this subject have been misreported.

I did not, in fact, suggest a grade for "drops outs" but for those who, some at a quite early stage of their career, chose to opt out of the race for consultant appointment. I think I made it clear that I was referring to those doctors who, though deciding that a consultant career was not for them, would nevertheless, prefer to work in hospital rather than in general practice or the public health service. I suggested, and now repeat, that I believe that such doctors can perform a useful role in the hospital service, and I therefore consider that there should be an appropriate career for them.

These doctors would not have taken degrees qualifying them for a post in the consultant grade and would not therefore, as with the S.H.M.O.s of the past and many of our present medical assistants, regard themselves as "failed consultants."—I am, etc.,

H. M. BENNETT.

Altnagelvin Hospital,
Londonderry.

SIR,—I am sorry that Dr. I. M. Librach (10 January, p. 113) should take exception to my remarks on the sub-consultant grade at the meeting of the Central Committee for Hospital Medical Services (*Supplement*, 27 December, p. 79). It is not that I am maintaining that it should be regarded as "Junior," but despite its permanence it is classified as "Junior." The medical assistant grade is represented through Hospital Junior Staff machinery by constitution. Only consultants and senior hospital medical officers

are directly represented through the senior committee. Therefore an incumbent of whatever vintage would appear to be permanently "Junior" by reason of the fact that he is unable to assume full clinical responsibility and is thus debarred from falling into the senior category. The Platt Report instituted this grade of medical assistant purely to fulfil service needs and to be clearly distinguishable from the consultant grade in responsibility, status, and name.¹ I fail to see, in view of the foregoing, how my comments can be construed as naive or unrealistic. They are simply factual.

As a past secretary, Birmingham Hospital Junior Staffs Group, I have ensured that an invitation is extended to all medical assistants in this area to attend the frequent group meetings and that the interests of these doctors are safeguarded. Dr. Librach has every right and indeed must ensure that his regional H.J.S. Group adequately represents medical assistants in his area. I welcome paragraphs 5 (b) and 12 of the progress report on discussions between representatives of the Health Department and the Joint Consultants Committee (*Supplement*, 6 December, p. 53). Medical assistants who are already carrying out consultant duties should be regraded to consultant status; those that are not are covered in the report. It is most important that a just and humane solution should be found, and I recently spoke to this effect in the H.J.S.G. council meeting of Friday 16 January.

I cannot speak for Mr. H. M. Bennett, but by "drop-outs" I took him to mean those doctors who for one reason and another fell off the training ladder but who wish to continue to practise their skills under full supervision in the hospital service. As to the desirability of applying for a medical assistant post it is entirely up to the individual concerned. In view of the lack of responsibility and status, to say nothing of the financial incentive, it would seem difficult to advise a trained doctor to apply for such a post.

It is timely for Dr. I. McD. G. Stewart (3 January, p. 52) to remind the profession that

it is not just the Joint Consultants Committee which is firmly opposed to the medical assistant grade but the Representative Body as well. These wise people have not reached their decision hastily and no doubt bear in mind the historical disaster of the senior hospital medical officer grade.

Finally, it is not helpful, however, to introduce surmise and inaccuracy concerning hospital junior staff representations. Examination of the minute book of the Birmingham H.J.S.G. over a period of a decade shows categorically that almost without exception all the past officers are now of consultant status. I am sure that Dr. Stewart would like to join me in congratulating Dr. J. F. G. Pigott, to whom the hospital junior staff owe a real debt of gratitude, on his recent consultant appointment.—I am, etc.,

I. MCKIM THOMPSON.

Birmingham 13.

REFERENCE

- 1 Ministry of Health and Department of Health for Scotland *Report on the Medical Staffing Structure in the Hospital Service*. London, H.M.S.O., 1961.

Chairman's Resignation

SIR,—At its meeting last December, (*Supplement*, 10 January, p. 9), the Hospital Junior Staffs Group Council reaffirmed by 30 votes to one its determination to achieve the status of a standing committee within the British Medical Association. When I accepted the honour of being the chairman, I was thus committed to make a final attempt to secure the agreement of the executive committee of the Central Committee for Hospital Medical Services. This was not forthcoming, and as there is thus no prospect of achieving our policy within the foreseeable future I had to resign. *Supplement*, p. 36.

I could not continue as Chairman while the B.M.A. remained unwilling to allow the hospital junior staff a full and equal part in formulating the policies of the Association and seems content to play lip service to its "juniors" by appointing a few to selected committees and negotiating teams. Without the actual (or promised) secure political platform within the Association that a standing committee would provide the juniors' views can easily be out-voted, suppressed, or lost within the complex committee system. At this critical time, when the control of the profession is at stake and the future planning of postgraduate education and careers in the National Health Service are being decided, it is vital that the hospital junior doctors are allowed to play their full part.

The recent events which have overtaken the leaders of the Association reveal with what contempt the "junior" views and even those of the Representative Body are held. The official B.M.A. policy towards the annual retention fee is that "While appreciating the necessity for instituting an annual retention fee by the General Medical Council it is felt that those doctors who have paid a life registration fee should not be asked to pay an annual fee in addition." (*Supplement*, 19 July 1969, p. 73).

On 18 October the Council of the B.M.A. resolved (*Supplement*, 18 October 1969, p.