acute diverticular disease. This is of great practical value.—I am, etc.,

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¹ Shepherd, J. A., *Surgery of the Acute Abdomen*, Appendix, p. 1204, 1st edn. Edinburgh, Livingstone, 1960.

Breast-milk Jaundice and the Pill

SIR,—Drs. Y. K. Wong and B. S. B. Wood (13 November, p. 403) purported to show a relationship between maternal oral contraception ("the pill") and subsequent jaundice in breast-fed infants—confusingly referred to as "breast-milk jaundice" (a term best reserved for instances where there is evidence that the breast milk does indeed contain a factor inhibiting conjugation of bilirubin).¹ They gave no time relationships between cessation of pill-taking and conception; the implication was that previous pill-taking, however distant in time and of as short a duration as one month, was related to the subsequent neonatal jaundice. The authors have not set out their data for the mothers of non-jaundiced infants. Other centres were invited to record their data and we would like to do so.

Records for the four years 1968-71 inclusive were used to obtain the names of all neonates clinically considered to be jaundiced during the first 10 days of life; each such infant had had a serum bilirubin determination routinely performed and the results were available to us. A serum bilirubin in excess of 10 mg/100 ml was chosen for inclusion; infants of low birth weight (<2 kg), sick infants, and those with a positive direct Coombs test were excluded. One hundred and twenty fulfilled these criteria. Questionnaires were then sent to the mothers concerned, asking about prior oral contraception, and in particular its duration and the time lapse between cessation and conception. Eighty-two replies were received. An identical questionnaire was completed by 82 mothers of comparable but non-jaundiced infants born sequentially during early 1972. The results are shown in Tables I and II.

TABLE I—Jaundiced Infants

Mother/infant	Breast-fed	Bottle-fed	Total
Pill	15	9	24
No pill	23	35	58
Total	38	44	82

TABLE II—Non-jaundiced Infants

Mother/infant	Breast-fed	Bottle-fed	Total
Pill	8	12	20
No pill	25	37	62
Total	33	49	82

The incidence of breast feeding and previous maternal oral contraception (15/82) within the group of jaundiced infants does not differ from that expected by chance (χ^2 (Yates correction)=2.07; $p>0.13$). Similar results were obtained in the non-jaundiced group (χ^2 (Yates correction)=0.06; $p>0.80$). When the two sets of data were compared directly no significant difference was found between the distributions in the four categories—that is, there was a similar incidence of breast feeding and pill-taking in the jaundiced and non-jaundiced groups. Like-

wise no significant difference was shown if data were used only from mothers who took oral contraceptives within six months of conception.

However, the incidence of pill-taking by mothers of jaundiced infants who were breast-fed in the Birmingham series (33/47) is significantly greater ($p<0.01$ than that in this series (15/38). The explanation for this finding is obscure, but it may reflect a greater overall incidence of pill-taking in Birmingham.

We have, therefore, been unable to substantiate the authors' claim to have established a relationship between prior maternal oral contraception and jaundice in breast-fed neonates.—We are, etc.,

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¹ Gartner, L. M., and Arias, I. M., *Journal of Pediatrics*, 1966, 68, 54.

Unplanned Pregnancy

SIR,—Your leading article on this subject (8 April, p. 65) recommends still further education in sex. When will we ever learn? For never in the whole field of human history has so much been spoken so freely and so openly, or for so long, on so singular a subject as sex is now. To deny this is merely foolish.

Yet in spite of this unwanted pregnancies continue not to decline but to escalate. Clearly there is something wrong somewhere. It seems to me that education itself may well be one of the factors, especially if it is wrong education, as much of the current propaganda would seem to be. A big rethink of the whole of the physiology of sexual behaviour in man and animals would seem to be indicated.—I am, etc.,

T. RUSSELL

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Deputizing Arrangements

SIR,—I shall be grateful if you will allow me to correct some mistaken impressions which may have been conveyed by the remarks of some of the young doctors who took part in the conference of the Junior Members Forum of the B.M.A. (*The Times*, 10 April).

General practitioners in the National Health Service are independent contractors who have agreed to provide a service to their patients 24 hours a day for 365 days each year. Unless they arrange with a fellow principal on the medical list of the executive council to provide care during their periods off call they carry the full responsibility for everything that is done on their behalf.

The majority of doctors in London subscribe to a deputizing service, but they can only use this after they have obtained permission to use a particular service from the executive council, and this is normally given

to a single-handed practitioner for a maximum of up to two nights a week, half days, and alternate weekends. Of the 1,461 doctors in Inner London who have the council's consent to use a deputizing service only 17 have, because of illness, been given consent to use the service in excess of the normal maximum, and my impression is that the majority use a service with responsibility and discretion.

Each of the medical directors of the three services in London is interviewed at intervals by members of the executive council and it is then decided whether or not permission will be given to doctors to use the service he offers.

Because practitioners themselves bear the full responsibility for the advice that a deputizing doctor gives on their behalf the local medical committee regards it as one of its prime responsibilities to maintain a high standard in deputizing services, which now in London compare very favourably with those provided—in the name of the B.M.A.—in other parts of the country. Each service now has a medical advisory committee elected by subscribers which meets regularly and inquires into any complaints which have been made and makes suggestion for the improvement of the service. Every member of the medical advisory committee is invited to visit the service at any time to observe the way in which it is being conducted.

Members of the local medical committee attend the meetings of all the medical advisory committees. I have attended—perhaps more recently than Mr. F. J. Bramble—interviews of applicants to serve with deputizing services, and I have been impressed with the high standards which are required. Further convincing rebuttal of the allegations made at the young doctors' meeting is provided by the fact that of 50 complaints considered by the Inner London Executive Council last year only one—which was dismissed—concerned deputizing arrangements.

The person best qualified to assess the quality of a deputizing service is the family doctor who visits the patient the next morning and carries responsibility for what has been done. Through the local medical committee and the medical advisory committees he now has ready channels of communication which provide a mechanism for the immediate expression of any criticism or dissatisfaction. This provides a means of control arising from the point of delivery of the service, which is much more effective and much more rapid than any powers which might be given to the Secretary of State for Social Services by legislation.—I am, etc.,

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Verapamil in Cardiac Arrhythmias

SIR,—I was interested to read Dr. L. Schamroth and colleagues' paper (11 March, p. 660) on the efficacy of verapamil in controlling supraventricular dysrhythmias. I noticed, however, there was no reference to its use in postinfarction dysrhythmias. Recently, I used this drug on two patients who were admitted to the coronary care unit at Edgware General Hospital.

A 63-year-old woman had a history of