properly carried out by reputable and competent operators, invariably confers permanent and absolute safety as regards further pregnancies. Very occasionally, as every experienced gynaecologist knows, a pregnancy can subsequently occur. There is then a growing tendency for litigation to follow, involving the defence societies and some of their members in a good deal of unwelcome harassment. This tendency must clearly be resisted, since recanalization of a tube does occur and such occurrences will obviously increase as more and more tubal ligations are requested, particularly in the postpartum or postabortive state, when the subsequent risk of failure is probably a little greater.

Professor Walker's letter raises one other aspect. There is a growing hostility from many quarters against those who are said to be attempting to coerce women requesting termination to submit also to coincident tubal ligation if the request for termination is to be met rather than refused. This is a disturbing criticism and, as Professor Walker intimates, the idea of coercion or a package deal is certainly, in the vast majority of cases, totally unacceptable.—I am, etc.,

H. VINCENT CORBETT

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Care of Casualties

SIR,—As a former Lord Chief Justice remarked when quashing a judgement of an eminent barrister but recently elevated to the Bench, "No one is infallible, not even the very young."

I am delighted to learn that Dr. R. C. Redman (1 September, p. 502) is an obviously keen doctor working, as our trainees do, with a foot in practice and one in hospital, to everyone's advantage, not least that of the patient. He appears to think, however, that it is praiseworthy to sew up a scalp laceration and then refer the patient for x-ray, because it saves the casualty officer trouble. I submit that to sew up what you believe may be a compound fracture without further investigation and x-ray (unless you happen to be in a desert or a jungle) is not good enough. If the other side of the fracture may communicate with the patient's brain, this practice is potentially lethal. No one, I hope, would do this with the femur. Why choose the skull?

What really matters is that the injury should communicate with the brain of the doctor, I am, etc.,

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Confidentiality

SIR,—I have read the recent letters on the subject of confidentiality with interest. That the protagonists of record linkage can say almost nothing reassuring about the main objections to such schemes should prove very worrying to doctors.

Professor M. R. Anderson (28 July, p. 232) confirms what we already know: that if the profession transmits a great many personal data about patients our statisticians and planners will be better informed. He believes that a more efficient medical service

will result. He does not ask whether the public or the medical profession wish to add to the ceaseless centripetal flow of information about the identified many to the often anonymous few. Nowhere does he suggest that society in general should have any voice in deciding whether efficiency is the only criterion by which the public good is measured or that a choice can be made between administrative inquisitiveness and personal privacy.

Dr. J. A. Baldwin and Sir Richard Doll (18 August, p. 405) assure us that personal information will remain confidential once it is within their computers. It is difficult to see how they can guarantee its security for all time and every political climate, and they beg the much larger question of whether they should possess this information at all.

Hitherto, identifiable information about patients has rarely passed beyond the treatment team without each inquiry being considered upon its merits, and commonly with patient consent. Doctors are now required to accept a new definition of confidentiality in which individual consideration is to be replaced by a blanket authority permitting bodies irrelevant to treatment automatic access to personal data. It is disturbing to see people of the eminence and authority of Dr. Baldwin and Sir Richard Doll promoting a scheme which so distorts the concept of the confidentiality which we are legally obliged to provide for our patients. They are clearly aware of the potential dangers of data banks, as evidenced by the precautions they list. In spite of this they suggest that all will be well, ignoring the questions of public knowledge and consent, which have barely been asked, let alone answered. They fail most notably by adopting such a system in the total absence of any framework of legal safeguards. As initiators, it was surely their responsibility to learn the views of the public, the medical profession, and Parliament before starting this expensive and dangerous machinery. While we have listened to bland assurances about confidentiality, we have watched the progressive intrusions into privacy of Hospital Activity Analysis, the Mental Health Inquiry, record linkage, and other schemes. If we accept these in their present form, doctors will have created legal precedents which will allow no defence of patient privacy in the future.

Urgent action is required by the profession as a whole. We should accept the invitation of Dr. Baldwin and Sir Richard Doll and cease to supply any identifiable information about patients to central organizations until a full professional inquiry into data storage and confidentiality has been made. I hope that those doctors and hospitals which have indicated their support for the attitude of the Aylesbury hospitals will do so publicly: the administration is unlikely to publicize dissent, and this matter should not pass by default. We do not have to await the promised White Paper on computer-stored information, as this is not a matter for political direction but for a look at our own ethical standards. Whether such an inquiry came from the B.M.A. or a reformed G.M.C., it should come from within the profession and should seek the views of the public. It should happen quickly, before it becomes a retrospective historical exercise.—I am, etc.,

RICHARD R. L. PRYER

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Femoral Artery Complications after Diagnostic Procedures

SIR,—The paper by Dr. John Bouhoutsos and Mr. Tom Morris (18 August, p. 396) gives a timely warning of what may happen if femoral artery puncture is performed without sufficient attention to the details of the technique.

I am increasingly disturbed to find younger colleagues (radiological and cardiological) embarking on the Seldinger procedure without adequate instruction in the details of the technique and sometimes without adequate supervision of their initial efforts. The level of the femoral artery puncture is one such detail not sufficiently appreciated, as the paper from Hammersmith points out. If the puncture is made where the femoral pulse is felt most strongly, this will, more often than not, be too high, possibly dangerously so. I have for many years followed the advice of a Swedish colleague not to make the skin puncture at a level higher than $1\frac{1}{2}$ in (3.8 cm) below the upper border of the symphysis pubis—a landmark easily determined by palpation, even through sterile drapes.

As regards tearing of the femoral artery during introduction of a catheter by the Seldinger method, I think this may be caused by disparity between the size of the puncture needle (and cannula, if used) and that of the catheter. There is a tendency to use the smaller (PE160) size of Seldinger needle in the majority of cases—possibly because it looks less traumatic than the larger (PE205) one, and possibly because most cardiac catheters of American manufacture have the tips attenuated to accept a 0.035 or 0.038 in (0.89 or 0.96 mm) diameter wire guide which fits the smaller cannula. Forcing too wide a catheter through too small an initial puncture in the artery wall strikes me as potentially dangerous, though I have no documentation to substantiate this belief. My experience over the years has, however, not shown any increased bleeding problem when the larger Seldinger needle and cannula have been used.—I am, etc.,

T. N. COWIE

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Social Workers in Hospitals

SIR,—Stimulated by Mrs. Carole R. Smith (25 August, p. 443) may I pay tribute to those many social workers who for years have been loyal, hard-working, and most valuable members of the clinical team in which I have been privileged to work. Patients have benefited from their skilled and sympathetic evaluation of distressing domestic or personal situations of which the clinician knew nothing.

While it is true that we do not need "a time-expired sociology student fresh from the barricades of the L.S.E. creeping around the wards," Dr. Cabot's words, as quoted by Mrs. Smith, are as true today as they were in 1909: "Unless he [the doctor] has already acquired the 'social point of view' . . . he will think that the social worker is trying to teach him how to do his work whenever she does what he didn't or couldn't do before. Naturally, he will resent this indignantly."

These two views are not as conflicting as at first they seem to be. The "creeping