original roughly estimated factors of increased risks[1 2] as though they were precise quantities and to ignore the wide limits of confidence within which the true factors would have been expected to lie. An equally important source of error is the failure to realize that Inman, Vessey, and Doll[1] based their calculations on data derived from a period during which about 53% of the oral contraceptives sold in the United Kingdom contained more than 50 μg of oestrogen.[3] The factor of risk was judged to be dose-related[4] and the Committee on Safety of Drugs predicted a drop of 50% in the mortality rate if only oral contraceptives containing 50 μg of oestrogen were used.[5] During the first six months of 1973 about 97% of combined oral contraceptives sold contained no more than 50 μg of oestrogen. Thus the conditions exist for the fulfilment of the C.S.D.'s prediction. Moreover, the appearance in the last few months of a combined pill containing only 30 μg of oestrogen, which formulation Sir Richard Doll has predicted will approximately halve the incidence of thromboembolism once again,[6] has further reduced the relevance of the original estimates of risk.

Another change that has taken place, almost unnoticed, but which on the basis of the original reports might be expected to have an effect of similar magnitude, is the substantial replacement of oral contraceptives containing mestranol by those containing ethinyl oestradiol. Inman reported (a direct comparison of equal dosage being impossible at the time) that at twice the dose mestranol appeared to carry three times the thromboembolic death risk of ethinyl oestradiol.[4] In 1965-9 53% of combined oral contraceptives sold in the United Kingdom contained mestranol, whereas in 1973 84% of pills sold have contained ethinyl oestradiol.

A reminder also seems needed of the impossibility of proving the attribution of any individual thrombosis to an oral contraceptive. This intrinsic limitation of epidemiological research often tends to be forgotten.

Doctors are at present obliged to attempt the reassurance of patients while armed only with estimates that are inprecise, obsolete, and much misunderstood. It would be of great benefit if the original workers were to review the data that have accumulated during the past four years and to produce a report that will not only revise the estimates of the various thromboembolic risks in terms of the oral contraceptives used at present, but also make clear the limitations of those estimates.—I am, etc.,

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1 Inman, W. H. W. and Vessey, M. P., *British Medical Journal*, 1968, **2**, 193.
2 Vessey, M. P. and Doll, R., *British Medical Journal*, 1968, **2**, 199.
3 Inman, W. H. W., Vessey, M. P., Westerholm, B. and Engelund, A., *British Medical Journal*, 1970, **2**, 203.
4 Inman, W. H. W., *Britisr Medical Bulletin*, 1970, **26**, 248.
5 Committee on Safety of Drugs, *British Medical Journal*, 1970, **2**, 231.
6 *General Practitioner*, 13th April, 1973. P. 4.

Psychiatric Aspects of Sterilization

SIR,—The "post-vasectomy syndrome" described by Drs. B. R. S. Nakra and R. Gaind (20 October, p. 168) is a stark reminder of the importance of proper selection of married couples before the man is subjected to vasectomy.

The ease with which this operation can be done after some practice and the subsequent low conception rate (providing other contraceptive measures are taken until two consecutive ejaculate specimens at least three months postoperatively are negative) make this an extremely attractive form of contraception. In addition, the Simon Population Trust report on vasectomy[1] showed that 99% of vasectomized men would recommend the operation to others, and many found that marital relationships were improved following the operation.

However, these good results in Britain will not be maintained if the rise in referrals for vasectomy to surgical outpatient clinics is continued. There is not time in these busy clinics to interview both husband and wife and fully explain the consequences of the operation. A minimum time of 15 minutes is required with each couple, and if there are two to four couples to see each session (as has been my experience during the past year) either they or other outpatients are going to suffer. Admittedly there is not the same pressure to have a vasectomy in this country as, for example, in India, but a man is not infrequently referred for vasectomy unwillingly, after pressure from his wife or a well-intentioned social worker. Should he then be seen in a busy outpatient clinic he may well be put on the waiting list without his reluctance being appreciated. Subsequent vasectomy would therefore have distressing effects on both him and his marriage.

It is essential that referrals for vasectomy should be to special clinics which have been established for the purpose, particularly by the Family Planning Association. There doctors experienced in the problem have more time to assess whether a vasectomy should be recommended. The clinics are also geared to performing the operation on an outpatient basis under local anaesthesia with minimal disturbance to the patient's personal life and a great saving in hospital beds, staffing, and finance.

Thus, to prevent a rise in the "post-vasectomy syndrome" in this country and to reduce the cost to the N.H.S., I would urge doctors to refer patients for vasectomy not to surgical outpatient clinics but to the special clinics already established throughout the country.—I am, etc.,

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1 Simon Population Trust, *Vasectomy, Follow-up of a Thousand Cases*. Cambridge, S.P.T., 1969.

Selection for Treatment in Spina Bifida Cystica

SIR,—The papers by Drs. G. K. and E. D. Smith (27 October, p. 189), Dr. Gillian Hunt and others (p. 197), and Dr. J. Lorber (p. 201) represent the genuine concern of the authors to find criteria for recognition of the child born with an open myelomeningocele who is bound to be severely handicapped however vigorously and successfully he may be treated; every surgeon who has been involved in the treatment of these children over the past 15 years has gone through his periods of heart-searching.

"Selection" means withholding active treatment from a certain percentage of children—striking some mean between complete rejection and complete acceptance for treatment. In the series of the brothers Smith this meant that 27% of the children received no active treatment, while in that of Dr. Lorber 67·5% received no active treatment. Comparison of results in these "selected" series with each other or with other results is of very doubtful value since reference to a unit may well depend on the published views of the consultant in charge. Dr. Lorber describes 37 newborn infants referred to the medical paediatric unit in the Sheffield Children's Hospital between May 1971 and 31 January 1973. Though *The Times* of 26 October assumed these to be the total myelomeningocele referrals to this hospital during that period, in fact 78 newborn children with myelomeningocele (excluding Dr. Lorber's cases) were referred to the paediatric surgical unit at the same hospital where "selection" is known to be less rigorous. This total of 115 myelomeningoceles referred to the Sheffield Children's Hospital in 21 months compares with approximately 180 cases referred in 21 months in 1969 and 1970 before the current change in the climate of opinion. It seems more than likely that in addition to "selection" we have pre-selection.—I am, etc.,

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Buying Added Years

SIR,—It has been already pointed out in several letters that the cost of buying back an added year of pension at £1,300 approximately is completely prohibitive and the Compensation and Superannuation Committee is aware of this fact. The question should first be raised as to why senior consultants should even have to consider buying any added years after working for a quarter of a century in the N.H.S. This situation has arisen because of the special conditions which were in operation up to the year 1960 approximately. During these years a free profession was compulsorily nationalized and its terms of operation and pay were changed gradually from dependence upon private fees to a system of state remuneration. In business terms this was a takeover by a monopoly employer. General practitioners received a token and somewhat mean recognition of payment for goodwill, but in hospital practice this was not so. The following special points pertaining to hospital consultants in the clinical specialties should be borne in mind by our negotiators, the conditions being quite unique:

Before the National Health Service Act routine hospital work was mainly carried on by juniors in the clinical firm for their seniors. In return, as in other long-established professions, they received training, advice, goodwill, and influence. Senior consultants had a private practice which in time their junior colleagues hoped to inherit. In the early, lean years, juniors survived as best they could upon payments from boards, insurance examinations, and a few private patients and by courtesy of their senior colleagues. Goodwill took years to build up but special circumstances per-