medicine. In geriatrics, six of the seven senior registrars were women, and in psychiatry, 14 of the 21 were women. When United Kingdom figures for senior registrars are examined only child and adolescent psychiatry, microbiology and psychotherapy show a predominance of women.[5] The current trends within the west of Scotland at senior registrar level could soon be mirrored throughout the UK when statistics become available.

The preponderance of women trainees has implications for the delivery of care and for the development of general practice in the future.[4]

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Intrauterine contraceptive devices

Sir,

I would like to congratulate Liora Dafni and colleagues (October *Journal*, p.423) for the sustained observations made on intrauterine contraceptive device users in their practice over a 22-year period. The discussion section of their paper, however, contains several inaccuracies and their conclusion, that inert devices should be reintroduced, is misguided.

While it is true that larger devices have lower pregnancy rates and expulsion rates than smaller devices, the advent of medicated devices has obviated the need for large devices, with their associated high incidence of pain and bleeding problems.[1] The first copper devices had an efficacy approximately equal to the inert devices, the newer copper devices have better efficacy and the levonorgestrel device (already marketed in some countries) has the lowest failure rate of any device so far produced, with an efficacy approaching that of the combined oral contraceptive pill.[2] Dafni and colleagues do not refer to relative failure rates, a serious omission.

Periodic reinsertions seem a small price to pay for a marked decrease in pain and bleeding, particularly among low parity women. Of the Israeli women 63% complained of pain, bleeding or discharge; of these, over half requested removal. This seems an unacceptably high event rate when there is better technology available.

Regarding the duration of clinical effectiveness of copper devices, lifespans of up to eight years are now being achieved with the newer copper-bearing devices with no loss of safety or efficacy.[3] We need not wait another 20 years before deciding that inert devices have been superseded. Indefinite use of copper devices without reinsertion is not yet being advocated, except for devices inserted in those aged 40 years or over.[4]

The finding in the study by Dafni in 1983 that pelvic inflammatory disease is considerably less common in users of inert than copper devices is contrary to the findings in the literature. The literature shows no difference between devices. Two studies on infertility, rather than pelvic inflammatory disease, reported lower risks of tubal blockage with copper devices than with inert devices.[5] Recent work on pelvic inflammatory disease has shown that infection is related to the insertion process and to background risk of sexually transmissible disease rather than to any inherent property of the device. Indeed the levonorgestrel device protects against pelvic infection.[7] An editorial in the *Lancet* stated that with respect to pelvic inflammatory disease 'in all cases medicated devices releasing copper or levonorgestrel are preferable to the older non-medicated devices.'[8]

In my practice there are 2100 women aged 15–44 years; eight out of 98 current intrauterine contraceptive device users retain their inert devices. As long as they remain content and their haemoglobin levels do not fall, they may continue with their devices indefinitely. Any clinicians who still have supplies of inert devices, marketing of which has long since ceased, would be well advised to discard them and to use only medicated devices in future.

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Care of drug misusers

Sir,

Leaver and colleagues (November *Journal*, p.465) have produced an excellent analysis of their drug misusers' service workload and process, with important implications for future service delivery and funding. However, they do not address the issue of the relationship between doctor and patient that Robertson alludes to in his editorial (November *Journal*, p.451).

The relatively high temporary resident rate of 72% among drug misusers reported by Leaver and colleagues compares with a rate of 11% among my own patients (two out of 19 patients on a methadone programme, both awaiting residential rehabilitation). This suggests that Leaver and colleagues' patients attend for prescribing only and not for other aspects of care. However, the problems of drug abusers go beyond physical addiction and services for them must try to go beyond pharmacology.

A survey was conducted in my practice in October 1992 and consisted of a 30 minute semistructured interview with each of the nine patients then on a methadone programme. For five patients previous experiences of drug services revealed their unfulfilled desire to be treated as 'whole people', not just as 'drug problems', with an individualized non-judgemental approach.

My own approach, in close collaboration with the Newham drug advice project, is based on developing the doctor–patient relationship, the opportunity for which is underpinned by the prescribing programme. There is an initial stabilization phase encouraging mutual respect (to be respected is often a new experience for a drug misuser), in which the doctor is seen as a reliable and accessible source of help. There then follows a parenting-like process of gradual transfer of responsibility to the patient until he or she is able to