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with no loss of safety or efficacy.[3] We need not wait another 20 years before deciding that inert devices have been superseded.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

deal appropriately with the vicissitudes of life without recourse to drugs.

I am not sure how this process can be adequately recorded or audited, but it is an important aspect of a drug misuser's rehabilitation and needs to be observed, and to be part of the research agenda.

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Sir,

Leaver and colleagues (November *Journal*, p.465) found that 14 of their 29 patients on a methadone programme missed at least one booked appointment over a 26 week period while none of the non-drug using controls missed any. This is at variance with a survey performed in my practice in which heroin addicts (those smoking and/or injecting heroin) were followed up for a 13 week period from November 1990. At the time of the survey, the practice had 4860 registered patients, with three partners and one trainee. The addicts were seen by only two of the partners. Over the period only three appointments were missed out of a possible total of 59 by the 11 addicts (5.1%). This compares with a 5.2% non-attendance rate among all patients not known to be heroin addicts who made appointments over the same period.

The addicts in my practice were well motivated to attend regularly in order to receive their methadone prescriptions. The guidelines issued prior to treatment state 'If you fail to attend, or are late for appointments, no further prescriptions will be issued.' It is surprising that in Lever and colleagues' study none of the control patients failed to attend but this may represent a different practice population compared with that of my practice. Prior to my survey it was thought that heroin addicts receiving methadone were less likely to attend booked appointments than other patients, but this was not confirmed. Attendance may depend on how flexible the treatment programme is: if addicts know that failure to attend will result in them being removed from the treatment programme, their incentive to attend may be greater despite their, at times, chaotic lifestyle.

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Medical certification

Sir,

Dr Toon presents an unjustifiably adversarial view of medical certification (November *Journal*, p.486). The value to an employer of a medical certificate is to confirm that the sick employee has sought medical care. It carries the assumption that adequate and appropriate treatment is being provided. The employer's primary concern is that the employee recovers and becomes fit to resume work as soon as possible. The production of a certificate is not an end in itself. A main objective of a national primary health care service is to maintain a fit and efficient working population.

As a National Health Service manager I demand and expect priority care for any sick members of my own department so that they can return to their caring roles with the minimum of delay. I am sure all doctors would intervene similarly on behalf of their own staff. However, this raises some pertinent questions.

Should the general practitioner and specialist services of the NHS afford priority care to all sick employees in order to ensure their rapid recovery and return to work? What criteria should a general practitioner use in determining the period of time for which the medical certificate is valid? What degree of liaison should exist between general practitioner and occupational health physician in deciding upon optimum care for those in the working population who become sick?

These are questions of concern to all who believe that the *Health of the nation* refers not just to the physical and mental wellbeing of the community but to the existence of a fit and economically productive workforce without which the NHS itself will founder.

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Sir,

Dr Toon's excellent discussion paper on the ethics of medical certification (November *Journal*, p.486) makes a timely contribution to the subject given the proliferation of third parties requesting information on patients.

The problem of role conflict needs to be addressed further. The present situation, where general practitioners allow themselves to act as patients' advocates at one point and as third party agents at another, makes a mockery of the issue of confidentiality. Although the patient's consent is sought before any information is disclosed, the service that a patient might require from a third party would not be obtainable without surrendering the rights to confidentiality between doctor and patient. The complacency of our profession in taking on two conflicting roles is somewhat surprising and is in contrast to the attitude of other institutions. The Catholic church, for example has made confidentiality in confessionals absolute. Similarly, journalists and the police go to great lengths to protect their informants.

Most medical certificates are only a bureaucratic exercise. One solution to the problem would be to place the onus on patients to provide their own certification and for third parties to contact doctors only if verification or clarification were required. This would then be similar to the Inland Revenue's attitude to tax assessment which places the onus on the individual to provide accurate information and an investigation is only conducted if fraud is suspected.

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Flourishing or floundering in the 1990s

Sir,

Marsh's article[1] and the correspondence from both Taylor and McCormick (letters, November *Journal*, p.492) reflect two of the more familiar arguments for the future face of general practice. But attention should be paid to, and debate directed at, the ethical conflict created by our apparent ready acceptance of our new role as businessmen within the new market-driven health care system.

This tacit acceptance by the profession is regrettable. There has been a wealth of published material from the longest running experiment in market force driven health care, the United States of America, that should make all doctors wary of mixing medicine with business. The editor of *The New England Journal of Medicine* initiated the discussion in 1980 by recognizing 'the new medical–industrial complex.'[2] Eleven years later Relman commented 'Today's market-orientated, profit-driven health care industry therefore sends signals to physicians that are frustrating and profoundly disturbing to the majority of us who believe our primary commitment is to patients. Most of us