across a carcinoma of the oesophagus so closely mimicking achalasia radiologically. The lesson, as Dr Bennett points out, is that "endoscopy is obligatory in any patient with dysphagia," even when radiologically there seems no doubt that the patient has achalasia.

K D BARDHAN
C C RIGBY

District General Hospital,
Moorgate Road,
Rotherham S60 2UD

Medical defence societies

SIR,—The letter from Dr Peter G T Ford (28 January, p 325) in his capacity as secretary of the Medical Protection Society contains all the reasons why I think that a new protection organisation is required.

I have thought for many years that the reasons for the increased number of claims and their cost of settlement should not be accepted as a "fact of life" but is due largely to the societies' incompetence in being unwilling to fight key cases.

We are told that as a profession we "manage" these societies. In 25 years' membership I have never been asked to propose or vote for a member of the management board of my society. A list of members of the board gives one the impression that they are separated from the hurly burly of clinical practice by age, medical politics, academic departments, or any combination of these factors.

As a practical example the Association of Anaesthetists through their "Linkman" conference has discussed the question of anaesthesia in patients taking oral contraceptives and the increased risks of thromboembolic incidents. Some academic gynaecologists recommend stopping medication six months before surgery, the pill manufacturers—no doubt litigation conscious—recommend six weeks. At the moment most anaesthetists probably ignore the risk. The medical defence societies advise against proceeding with routine surgery. Come the first claim will they fight it, or just pay up at my expense and change my clinical practice to the detriment of a large number of my patients?

The protection societies' annual reports used to consist of horror stories of medical incompetence; they now consist of horror stories of honest hardworking practitioners being let down by apparent legal conservatism, whose best excuse is that things are worse in the rest of the world. I suggest that this is not due to their diligence but to our good fortune in having a sensible judiciary.

FRANK BOSTOCK

St James's University Hospital,
Leeds

Effect of perforated appendicitis in girls on subsequent fertility

SIR,—Mr P Puri and his colleagues (7 January, p 25) conclude that perforated appendicitis in childhood is not an appreciable cause of subsequent tubal infertility. Similar findings were reported by Geerdsen and Hansen,¹ but Powley found a high incidence of infertility in women previously treated for appendicitis complicated by pelvic peritonitis or abscess.²

The striking difference in these three

reports is that Mr Puri's patients at the time of appendicectomy had a mean age of 9.1 years (oldest 13 years); Geerdsen and Hansen's patients averaged 11.6 years, but the youngest patient in Powley's series was 14 years. These figures confirm a clinical impression that I have had for many years that perforated appendicitis is far less damaging before puberty than after.

Barns, in his study of female genital tuberculosis, showed that the prepubertal girl is unlikely to develop pelvic tuberculosis, but the patient who acquires her primary complex at or after the menarche is greatly at risk of pelvic spread.³ Presumably the size, location, and limited vascular supply of the prepubertal appendages confer on them some safety from infection. The same may be true in the case of perforated appendicitis, even though the route of spread differs.

Gynaecologists with a special interest in tubal infertility pay great attention to a history of perforated appendicitis, and both hysterosalpingography and laparoscopy may be needed to diagnose the tubal occlusion or peritubal adhesions so often found in these patients.

The recognition that tubal infertility may be the result of perforated appendicitis, and not of ascending genital tract infection, is of practical importance: at operation, and particularly if salpingostomy is required, the fimbriae and endosalpinx are usually much healthier and the prognosis for pregnancy is correspondingly better.

HERBERT E REISS

London W1N 1PE

¹ Geerdsen J, Hansen JB. Incidence of sterility in women operated on in childhood for perforated appendicitis. *Acta Obstet Gynecol Scand* 1977;56:523.

² Powley PH. Infertility due to pelvic abscess and pelvic peritonitis in appendicitis. *Lancet* 1965;i:27-9.

³ Barns T. *Female genital tuberculosis*. London: Royal College of Obstetricians and Gynaecologists, 1953. DM Thesis.

Deputising services

SIR,—The present debate about out of hours care in general practice has once more polarised medical opinion. Differing statements about the amount of work generated out of hours make it difficult to take a balanced view of the complex issues involved. I have already made three contributions to this debate¹⁻³ and wish to make another.

I have compared the behaviour of our 5200 patients in requesting home visits during two separate years, 1977 and 1983. The practice size has remained virtually constant during this time.

In 1977 our patients requested a total of 2455 home visits. By 1983 this number had increased to 2706 (10% increase). Daytime requests (08 30-18 00 weekdays; 08 30-12 noon Saturday) decreased marginally during this time—from 1905 in 1977 to 1872 in 1983—whereas out of hours requests (18 00-08 30 weekdays; 12 noon Saturday-08 30 Monday) have increased from 550 in 1977 to 854 in 1983 (55% increase). Within these out of hours numbers there has been a similar increase in "out of bed" requests (23 00-07 00)—from 123 in 1977 to 189 in 1983 (54% increase). Thus the increase in the total number of home visits requested has been due entirely to the increase in out of hours calls.

These figures do not take into account the fact that each year about 300 of our patients elect to attend accident and emergency departments out of hours (in most cases quite appropriately) without attempting to contact the practice duty doctor, and about 75 of these do so between midnight and 9 am. Thus somewhere between a quarter and a third of the out of hours work generated by our patients is coped with completely outwith the practice.

In 1983 our 189 "out of bed" calls resulted in 137 visits being made; this is equivalent to a visiting rate of 26.3 per 1000 patients at risk per annum—the highest rate that has so far been reported. This means that the comparative chances of our duty doctor having a call between 11 pm and 7 am have risen from one in three nights in 1977 to one in two in 1983.

These are the kind of facts that suggest that patients are changing in the way they use out of hours services. They may also explain why some doctors, particularly those in their 50s and 60s, are becoming increasingly anxious about their ability to cope with their out of hours work. When compared with total workload out of hours work is numerically trivial but it is undoubtedly appreciable in the way that it saps the energy and emotions of those who have done it for 20 years or more.

J S K STEVENSON

Department of General Practice,
University of Edinburgh,
Edinburgh EH8 9DX

¹ Stevenson JSK. General practice in Scotland—why the difference? A comparative study of statistics from practices in the United Kingdom. *Br Med J* 1964;i:1370-3.

² Stevenson JSK. Self referral to hospital. *J R Coll Gen Pract* 1981;31:628.

³ Stevenson JSK. Advantages of deputising services: a personal view. *Br Med J* 1982;284:947-9.

SIR,—We write to express our deep concern over the failure of the General Medical Services Committee to resolve the debate on deputising services and to address the broader questions of standards of care in general practice.

We are appalled at the cynical posture adopted by the GMSC, which has quite unashamedly taken the part of the minority of doctors who fail to fulfil their contracts by the excessive use of commercial deputising services. The GMSC appears to have associated itself with those who wish to withdraw completely from out of hours commitments. Little foresight is needed to see that such a reduction in the provision of care is the basis of a salaried service. This is unacceptable to those of us who wish to retain independent contractor status.

The wider debate is about professional standards and values. These issues, which should have been addressed by the British Medical Association, have been left to the Royal College of General Practitioners to express in the recent, well considered, paper on the quality of out of hours care in general practice (4 February, p 421). We have looked to the association to express such professional views but have found it wanting. The BMA, through the GMSC, has failed to represent our views both as members of the association and as doctors interested in the future development of general practice. We believe that this is a view shared by a majority of the profession and that the BMA should have the