occasion, 20 or so ticks off my skin, not giving them time to dig in. They are easy to remove if it is done promptly after a walk through their habitat.

Ticks can transmit a variety of arbovirus and rickettsial infections to man, but probably rarely do so in Britain. Some 33 cases a year of Q fever are reported in Scotland. Possibly some of these may have been transmitted by tick bites but probably most infections are acquired through milk, meat, or the handling of infected animals or their afterbirths.

DAVID STEVENSON

Department of Tropical Community
Health,
Liverpool School of Tropical Medicine,
Liverpool

SIR,—With reference to the inquiry from Dr J A Slater (29 October, p 1158) I acquired a tick on my wrist in September while bird-watching in the Breckland region of Norfolk. I disposed of my tick by the method I learnt to use in Central Africa—by lighting a match, blowing it out, and applying the hot end immediately to the tick. It was then possible to pull the tick out, head and all. I suffered no discomfort or induration.

M E R GRAY

London SW15

Red faces in Tavistock Square

SIR,—May I offer a postscript to "Anti-goats" (22 October, p 1079)?

The "herd instinct of trotters" was not
the right phrase
Which your erudite readers will note with
amaze.

In fact I intended a far different word,
Viz, the late Wilfred Trotter's "Instincts
of the Herd."

W E SNELL

Hambleden,
Henley-on-Thames, Oxon

Effect of calcium deposition on copper IUDs

SIR,—We were interested in Mr J Guillebaud's letter (10 September, p 705) and wish to enter the debate. The recent work of Dr Christine Gosden and others (22 January, p 202) and of Dr E Chantler and others from this department (30 July, p 288) indicates that there is a rapid fall in the rate of copper release after the intrauterine contraceptive device (IUD) has been in situ for a few months. Further studies from our group¹ indicate that there is a biochemical change in the endometrium associated with the use of copper IUDs and that this persists when the level of copper release has dropped considerably.

However, prolonged contraceptive efficacy can be determined only by long-term clinical data. Furthermore, we are concerned that advice with direct reference to its medico-legal implications should be given without confirmatory scientific fact. While we would concur with Mr Guillebaud's reservations about the selection of the two groups in the study reported from King's College Hospital (Mr J R Newton and others, 22 January, p 197), the performance of the copper IUD which has been in situ for two years does not appear to deteriorate after this time. In addition there are considerable and

far-reaching implications if copper IUDs are shown to be effective for more than two years. Indeed, there are data which would suggest that this might well be the case.

The accompanying table shows the cumulative event rates in a small series of women with Copper 7 IUDs which have been in situ for up to three years in Southampton. The device was fitted to 1752 women. The incidence of all three major IUD complications

Life table rates per 100 fittings ($\pm$ SE)

	Years after IUD insertion		
	1	2	3
Pregnancy . . .	2.5 (0.4)	3.8 (0.5)	4.8 (0.6)
Bleeding pain removal . . .	10.9 (0.9)	16.6 (1.1)	19.7 (1.3)
Expulsion . . .	12.9 (0.9)	14.0 (1.0)	14.4 (1.1)
No of patients remaining in study . . .	670	238	90

decreases with time and there is nothing to suggest that the fall in rate of copper release is associated with a rise in pregnancy rate. This is in keeping with the data presented by Edelman *et al.*,² who have presented figures for five years, and with those for the "continuation group" cited by Mr Newton and his colleagues.

On the basis of the evidence presented to date on the pregnancy rate of women wearing copper-carrying IUDs for longer than two years we would recommend that these IUDs can be safely left in situ for longer than two years. Indeed, a case could be made for them to be left in situ for up to five years if the lead of Zipper, who developed the concept of the copper IUD, is to be taken, since he is a coauthor of the report by Edelman *et al.*

J F MILLER

University Department of Human
Reproduction and Obstetrics,
Southampton General Hospital,
Southampton

MAX ELSTEIN

Department of Obstetrics and
Gynaecology,
University Hospital of South
Manchester
Manchester

¹ Buckingham, M S, in preparation.

² Edelmänn, D A, *et al.* *IPPF Medical Bulletin*, 1977, 11, No 4.

*.*This correspondence is now closed.—ED, *BMJ*.

Demand for patient care

SIR,—Dr H G Pledger's letter (22 October, p 1084) raises a number of important points which are covered in the official reports.¹ The number of beds available at the time of our survey in the Northern Area of Northern Ireland (24 September, p 799) was such that waiting for admission was the exception rather than the rule, so that it was reasonable to assume that there was virtually no unmet need for hospital admission in the community. As the population is geographically scattered, hospitals tend to be small and subsequently provide only mainstream specialties. Orthopaedics, ophthalmology, and paediatrics (which includes only medical paediatrics and not child patients of all specialties) are much more economically and effectively managed in the teaching hospitals in the capital city of Belfast, which has a population of half a million (a third of the Province) and is not more than 70 miles from the most extreme point of the

Northern Area. While the principle that a district should be self-contained for hospital services is administratively tidy, it seems more often than not to be unrealistic and impractical.

Our survey included patients living in social services residential accommodation. Unlike Great Britain, the health and social services have been integrated in Northern Ireland under one administrative structure so that regular contact with residential homes by district nurses is ensured. There are no private nursing homes in the area.

The catchment population of "about 300 000" was derived from analysis of admissions to hospitals in the Northern and adjacent Areas. As such it is open to the vagaries of the estimating procedure. The total is the sum of the effective catchment populations of all the hospitals, and local opinion supports the estimates for individual hospitals. Obviously 4 beds per 1000 is subject to greater variation. Not only does it incorporate any errors in the population estimate but it also mirrors the inherent weaknesses in the estimate of the beds required. Hence we felt it was, at best, only reasonable to suggest the magnitude of the demand in round figures: adjusting for occupancy creates a false sense of accuracy.

In writing the paper our main aim was to stimulate debate on the important issue of the provision of expensive acute beds and to suggest a simple method for a critical review of the use of present resources. Despite the limitations of the estimates we are convinced, and Professor C S B Galasko agrees (22 October, p 1083), that many inpatients in acute hospitals today could be equally well cared for in less highly staffed and equipped accommodation. If true, this has clear implications for the planning and financing of health services.

S N DONALDSON

Department of Health and
Social Services,
Belfast

A BARR

Oxford Regional Health Authority,
Oxford

¹ Northern Health and Social Services Board, *Development of Hospital Services* (2 volumes). Ballymena, NHSSB, 1976.

The drug bill

SIR,—Dr J F Lowe's suggestion that an "E" box be added to the EC 10 to enable dispensers to substitute a cheaper brand or *BP* equivalent seems to commend itself (15 October, p 1024). But the implications need to be fully assessed.

The dispensing pharmacists are already aware of the difficulties in helping patients to take their drugs according to the instructions on the prescription. To add to their difficulties may be unwise. There are many occasions when the instructions involve a modification of the previous dosage. The alert patient will generally reconsult the general practitioner to check that the change is in order. Others might not do so. But if the appearance of the tablets—their colour, size, or shape—is different considerable problems arise. Not least of these is the danger that the patient will take excessive dosage. The ready identification of branded drugs plays as important a role in their use as the memory-baffling "official" nomenclature, if not greater. It is perhaps unfair to the chemist to force him to become an arbitrator for the NHS in regard to the cost of individual