On the other hand if 'the principal has previous experience of teaching or has completed a recognised course' (presumably a teachers' course) he scores four points. M.R.C.O.G. is equated with D.Obst.R.C.O.G. at three points, while M.R.C.P. scores only two and an M.D. whatever its narrow context—five.

These are perhaps nit picking points. The danger of this major contribution to a new look at teaching practices is that a potentially most valuable tool will become immediately regarded as a complete answer to a thorny problem.

Donald Irvine has given us the framework of a method of selection of teachers. It must surely be developed into a more meaningful instrument which assesses clinical and above all teaching capacity as well as organisational methods. There are many who welcome this paper, and as many who will be prepared to assist in the development of the method. It is still too early to rely too much on the scoring system used.

P. S. BYRNE
Professor of general practice

Department of General Practice,
University of Manchester,
Darbishire House,
Manchester, MI3 0FW.

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POPULATION AT RISK

Sir,

In the June *Journal*, neither the article on the *Analysis of Summarised Data* from the Research Unit of the College, nor Dr Dinwoodie's report on *Morbidity Recording*, stress the need for an accurate knowledge of the population at risk in calculating rates recorded during morbidity surveys. Indeed, Dr Dinwoodie states it is not possible to relate his data to practice populations, as only one partner from the practice was taking part.

Professor J. N. Morris (1970) illustrates how the actual membership of patients in a general practice was very different from that recorded by a survey of the National Health Service cards. I think it should be stressed that not only are age–sex registers needed for studies of morbidity rates, but that these can only be made when either or all the partners take place in the investigation, or if one out of several takes place, that he looks after a defined list of his own.

In addition, it is necessary to review the age–sex register with a critical eye at fairly frequent intervals, so that the inevitable errors of the list may be kept within reasonable bounds, which I suggest is about five per cent. Without this the figures are not really useful and the exercise is largely wasted.

E. J. C. KENDALL

52 High Street,
Epsom.

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NATIONAL TRAINEE CONFERENCE

Sir,

We welcome the opportunity to comment on the eloquently irrational letter of Dr S. L. Barley (June *Journal*)[1].

We think his attempt to belittle the intellectual capability of the trainees ill-founded. The trainees voiced conclusions in one week end that the intellect of Dr Horder took years to reach, and this surely highlights the value of the conference.

We completely agree (as did the conference) that discussion was severely limited, due in part to the excessive panache of the speakers[2].

A pioneer conference must inevitably retrace steps to find common ground, and the most fundamental principles of vocational training are not 'old hat' to some trainees, particularly those involved with the old scheme. Incidentally one of these (that the majority of trainees were *not* in favour of compulsory vocational training) seems to have found its way under a college carpet.

Isn't education largely learning from others' mistakes—at a national as well as regional and practice levels? On a practical note not only will regional conferences probably cost more; but under Section 63, financial assistance to trainees travelling outside their own region is restricted to courses not available locally.

We suspect the cross-fertilization Dr Barley envisages is likely to give rise to non-viable Mendelin recessives! However, regional solutions (aired nationally) can have wide reaching applications; Newcastle hasn't a hierarchy but will be pleased to share its organised anarchy,

Finally we would challenge the repeated assertion that a conference requires a hypothesis. A conference is 'a meeting for discussion and exchange of views'[3].

We thank Dr Barley for the velvet glove and the stimulus to think again, 'why a national trainees' conference? '—We still think its a good thing.

W. J. D. MCKINLAY
C. K. DRINKWATER
Vocational trainees
University of Newcastle scheme

Maternity Unit,
General Hospital,
Hexham.

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1. Barley, S. L. (1972). *Journal of the Royal College of General Practitioners*, **22**, 404.
2. *Journal of the Royal College of General Practitioners*, (1972). Report of national conference for trainees, **22**, 415.
3. *Pocket Oxford Dictionary*. Oxford: Clarendon Press.

ABORTION

Sir,

The method of self-induced abortion described by J. G. Lloyd in his annotation (May *Journal*) was widely known between the wars and in the 1950s.

I myself have recommended it to patients in the bad old days when Alec Bourne was so courageously trying to introduce a little sanity into the legal tangle surrounding abortion. However I always recommended a douch can rather than a Higginson syringe, on the grounds of safety. In those days, a douch can was commonly used in many bathrooms by fastidious females and so would not attract attention. More important the pressure of the injection could be accurately metered by the height of the can above the nozzle. There is no way of gauging accurately the pressure generated by a syringe. I always understood that the method worked because a little soapy water penetrated the cervix and irritated the uterus.

F. E. S. HATFIELD

Ongar House,
High Street,
Ongar,
Essex.

REFERENCE

Lloyd, J. G. (1972). *Journal of the Royal College of General Practitioners*, **22**, 354–5.

NATIONAL TRAINEE CONFERENCE

Sir,

In reply to the correspondence from Dr Barley, the primary objectives of the conference were:

(1) To confirm the principle of vocational training for general practice.
(2) To learn the consumers' view of current training programmes.
(3) To provide the College with information necessary to improve vocational training.

The Editorial and conference report (June *Journal*) demonstrate that to their authors at least these objectives were attained.

The conference steering committee decided that an introduction by a trainee on each main aspect of vocational training schemes was necessary to allow a balanced, researched view to be presented as a basis for discussion. A total of 2½ hours allotted to paper speakers in a conference lasting two days was not excessive considering the exceptional nature of the meeting.

Those present at the final training session will know that the principle of regular regional meetings was accepted but representatives of schemes geographically more widespread than East Anglia and Newcastle were quick to point out the practical difficulties of travelling and time.

The current generation of trainees has a duty to future generations and to themselves to ensure that the College sets and maintains standards of training schemes. The college representatives present were left in no doubt of the trainees' feelings on this point and I personally believe that message alone was sufficient justification for holding a National Trainee Conference.

SCOTT GREEN
Vocational trainee

100 Ringway,
Stakeford, Choppington,
Northumberland.

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CONTRACEPTIVE METHODS

Sir,

Dr Michael Altman, Chairman of the Vasectomy Society (June *Journal*) has done sterling service in popularizing vasectomy in this country and is obviously one of the many doctors who are seriously concerned about the need for control of population from the national standpoint, and also from that of individual couples seeking to limit their families.

May I suggest that the time has come to clear the air on the subject of methods of contraception? The Health Education Council recently took advertising space in national newspapers listing nine methods of contraception. For the normal couple, seven of these should be forgotten. There are only two reliable methods of contraception, the combined-hormone pill, and sterilization. These methods are virtually 100 per cent effective and other methods should be reserved for special circumstances only.

The 'pill' is ideal for the couple who are newly-married (or are unmarried) and wish to delay their first baby; it is ideal for the couple who wish to space their babies; but once the desired family-size is achieved, they want to be able to call a halt. At this stage, the wife may be only 25 or 30 (and sometimes considerably younger) and not many women, and by no means all doctors, are happy at the idea of the 'pill' being taken for perhaps 15 or 20 years. It is here that sterilization, usually by vasectomy, should be seriously considered as a routine procedure.