the time they have finished their preregistration year they have had enough of 'structured' education culminating in their medical training, and wish to make up their own minds as to what the profession offers in this country.

Clearly, resident posts in paediatrics, obstetrics, and perhaps casualty are advisable; but many prefer to choose their job and hospital locality themselves, and possibly do a few general practitioner locums in between, before scanning the medical press for advertisements of trainee vacancies.

Each of my four trainees have done it this way. The three who have completed their year are settled as principals in other parts of the country, the first being now senior partner of his firm.

I personally feel that the store the College sets on the vocational training schemes is misplaced, and we should encourage the young to do it for themselves. General practitioners as a tribe are independently minded and self-reliant, and we should encourage these traits in those who will be joining our ranks.

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MATERNITY GRANTS—ROOM FOR REFORM?

Sir,

I was interested in your editorial on maternity grants (February *Journal*).

I recently tried to find out from official statistics how many women had been refused claims for maternity grant. The published figures seem to be too incomplete to allow this, but I did find out figures which enable an educated guess to be made.

The following figures refer to the year ending 31 March 1972 and show that of all women 822,000 received awards and 829,000 grants (the number of grants exceeds the number of awards because multiple births give rise to more than one grant). Maternity allowance was received by 247,000 women.

Among married women there were 783,000 awards and 790,000 grants, with 217,000 women receiving the maternity allowance. Among other women there were 39,000 awards, 39,000 grants and 29,000 received the maternity allowance.

Concerning the appeals to local tribunals and to the National Insurance Commissioner the following figures (actual numbers) are reported:

Total appeals to tribunals	490	
Decisions in claimant's favour	49	(10%)
Total appeals to the Commissioner	34	
Decisions in claimant's favour	7	(21%)

From general experience of the administration of state benefits it is known that only a small fraction of claimants who are refused benefit, or are paid at a reduced rate, take advantage of their right to appeal. It is therefore likely that the 490 appeals in 1971/72 are only the tip of a very large iceberg. The size of the iceberg obviously depends on the size of the fraction mentioned above.

For claims for supplementary benefit, it appears that the fraction of claimants with claims disallowed who actually appeal is somewhere between one in 25 and one in 30. I would be surprised if the fraction were greater for maternity benefits, since the incentive to appeal is greater for people who are refused supplementary benefit.

My educated guess therefore is that the 490 who appealed probably represent a minimum of 12,000 women whose claims were disallowed or who withdrew their applications after being advised that they were ineligible.

Unfortunately the figures about appeals do not differentiate between those referring to maternity grants and those referring to maternity allowances. However, since there are more than three times as many grants paid as there are allowances my guess would be that there are at least 9,000 claims for maternity *grants* refused annually.

If my estimates are anywhere near correct, it certainly supports your editorial that the claim of the Department of Health and Social Security that, " almost all mothers can get the maternity grant " is highly misleading.

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VASECTOMY

Sir,

Dr Henry Meadows' letter (March *Journal*) is important in that it highlights some of the erroneous conclusions that can be drawn from studies in this subject and the need for further investigations.

That over 50 per cent of couples in my survey reported an improvement in their physical and emotional relationship is a fact. To conclude, as Dr Meadows has, that their statements are necessarily accepted by me or anyone else as facts is wrong. They do, however, show that what was discovered by the Simon Population Trust survey after one year is still holding out, with all its limitations, after two years.

He is right, of course, to point out the potential fallibility of questionnaires. All of us who use them understand this, just as we recognise the weaknesses of interviewing techniques. They are just one tool to be used in the quest for truth. In fact the whole point of my article was to show that even careful preoperative interview probably did not expose all the reasons why people sought vasectomy and that many couples who before operation had denied psychosexual problems declared, two years after operation, that it had been a reason.

Vasectomy is an emotional issue. On this subject

many people tend to take up positions of extreme polarity. Dr Meadows' statement that " It is now widely agreed amongst psychiatrists that the removal of a man's fertility by a mutilating operation causes profound and serious disturbances to a man's body-image, evoking fears of castration " falls into this group. Not only is it unscientific but as Lear (1962) points out " Psychiatric literature is describing the three per cent of applicants who should not have been vasectomised."

Ziegler (1969) stated that increased coital frequency is neurotic response to vasectomy. If Dr Meadows believes this to be true, and yet as he states " fortunately most vasectomised men easily make the required psychological readjustment " why did 60 per cent of couples in my survey report an increase two years later? With my tongue in my cheek I am tempted to enquire whether diminution in sexual frequency indicates a quieter adjustment until total abstention is the most satisfactory response of all!

With his last paragraph I will agree. Here research is needed. In my view one way of doing this is to mount a prospective study of vasectomised males and their families. Perhaps this can best be done by matching them in the same way that the oral contraceptive survey has done. A follow-up of this nature, lasting five years, might give an answer to the question we want to solve. How to identify in practice the few couples who are unsuitable for vasectomy?

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Sir,

Though now an old man I find it hard to keep my temper with some of the points raised in Dr Henry Meadows' letter (March *Journal*). He quotes with some doubt Dr Drury's report of " an improvement in the physical and emotional relationships of over 50 per cent." I would—and can—put this figure considerably higher than Dr Drury's.

It is widely agreed " among psychiatrists ", but by very few others, that a number of adverse effects follow vasectomy e.g. " fears of castration, impotence and demasculinisation ". Any man considering this operation will have had all these fears discussed beforehand. Should a man still harbour such doubts after discussion he is strongly advised against having the operation by his doctor and certainly by the surgeon.

Appropriately vasectomised men do not seek reassurance about loss of sexuality because these things do not occur.

Vasectomy is not a *mutilating* operation because the subject is not deprived of any limb or organ—unlike hysterectomy.

" The vasectomised man is very likely to be driven by anxiety to dwell on sexual matters. . . ." Why? This is not borne out by facts. Ziegler and others reported sexual problems after vasectomy. How many? Why should post-vasectomy increased coital frequency be *neurotic*? Why not a result of relaxation, of relief of tension, and of the fear of pregnancy?

The Wolfers' have " probed " a very small number of vasectomised men. They criticise the postal method of questionnaire. What is the alternative? A long interview with a psychiatrist asking loaded questions (" are you sure that you feel all right etc.? ") in an effort to stir up doubts?

With reference to the penultimate paragraph psychiatric investigation is not needed because appropriately vasectomised men are not psychologically disturbed by the operation.

Dr Meadows' " latter group " will be identified and excluded from operation by the good family doctor or the surgeon. The vast majority of men who have vasectomies do so because conventional methods of birth control have proved unsatisfactory or unreliable. These men and their wives are entirely content with, and enthusiastic about, the results of the operation.

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USE OF COMPUTERS IN GENERAL PRACTICE

Sir,

While it may be gratifying to see that my recent paper stimulated correspondence in your pages, I naturally take great exception to Dr Sowerby playing games with my research method (March *Journal*). Others have similarly treated the matter lightly: perhaps you will allow me space to justify my position.

The approach I adopt is based on a careful study of the philosophy of science, especially that by Immanuel Kant. It is the most rigorous available in general practice, and in five or ten years, all other research methods will be obsolete.

Those who doubt this claim should consider the following. In my earlier paper (1972), the analysis of one year's data required 250,000 counting operations. If each of these took two