ABORTION

Sir,

In your Editorial concerning the need for more data on the sequelae of abortion (April *Journal*) you point out that your two leading quotations are not based on sound evidence. This is certainly true: *Babies for Burning* hardly deserves reference at all following the analysis published in the *Sunday Times*, and it is not possible on reading Kotasek's paper to assess the validity of the statements made.

You have also misquoted him. Kotasek does not say that 20 to 30 per cent of women become sterile after abortion, but " permanent complications such as chronic inflammatory conditions of the genital organs, sterility and ectopic pregnancies are registered in about 20 to 30 per cent of all women who had pregnancy interruption ". You might have provided your readers with a more objective justification in calling for research into the sequelae of abortion had you referred to *Induced Abortion as a Public Health Problem.*

It has always distressed me that the data collected on a national basis from the notification of abortions to the Chief Medical Officer of Health have not been put to greater use. If the data are unreliable as might be suggested in the absence of definitions for the complications to be notified and because of variability in the quality of follow-up after abortion, why are the questions still asked?

Hopefully, the Manchester Research Unit and the Royal College of Obstetricians and Gynaecologists in setting up their welcome and necessary study will not make their objectives unattainable before they start by attempting to answer too many questions at once.

We still do not know on a national basis the incidence of immediate complications of abortion by age, parity, duration of pregnancy, technique and in relation to coincident sterilisation.

P. J. HUNTINGFORD
Professor of Obstetrics and Gynaecology

London Hospital Medical College,
Turner Street,
London, E1.

REFERENCES

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World Health Organisation (1972). Report of a Working Group. *Induced Abortion as a Public Health Problem.* Euro, 9601. W.H.O.

ABORTION AMENDMENT BILL

Sir,

It was a nasty jolt for me to read in *The Times* that my College had come out against the Abortion Law Amendment Bill. It occurs to me that perhaps the lack of one single letter in support of the bill is because members with my views have taken the rather more positive step of sending written evidence to the Select Committee (Abortion Amendment Bill) as I have done. I can see no alternative to the generally apathetic acceptance of abortion on demand but to support this Bill. I will not wallow in a sea of puritan condemnation, but would like to point out that the alternative would certainly be a strengthening of abortion on demand.

This, in its turn, would lead to a weakening of the principle of parental responsibility in our society by shifting responsibility for unplanned and unwanted pregnancy to the *State.*

J. A. A. NICHOLS

60 Manor Way,
Onslow Village,
Guildford,
Surrey.

REFERENCE

Royal College of General Practitioners (1975). *Journal of the Royal College of General Practitioners*, **25**, 774–76.

THE NUFFIELD EXPERIMENT

Sir,

Your Editorial on the *Nuffield Experiment* (August *Journal*) is illuminating and informative. It however omits one vital motivation for those of us who were instrumental in achieving it.

In 1972/73, vocational training for entry into general practice as a principal was accepted by the profession, with 1977 the target date for starting such training for everyone. This made it essential to increase substantially the number of general-practitioner trainers to meet the demand for training of an annual entry of over 1,000 young doctors.

To achievet his and ensure a high all-round standard of teaching, it seemed essential to organise general-practice teacher training centrally, so that each region or area would have an opportunity to second its keen and energetic innovators, who should be identifiable as the course organisers of training schemes. They, in turn, could then undertake the training of the general-practitioner teachers they needed in the schemes being developed in their own localities.

Your editorial does not record the farsighted planning done by Council and its Officers during 1973, as well as by Dr Ian Watson who, as Deputy President, was able to introduce this thinking to the Nuffield Provincial Hospitals Trust at their Conference at Pembroke College Oxford, in June 1973.

The Nuffield Provincial Hospitals Trust, as you say responded with vision and generosity to a need which was based on the clear recognition that special training for general practice had to be available by a certain date to all entering this field. This response may well prove as significant as their previous recognition of the need for postgraduate training centres.

In paying this tribute to Dr Watson and the Nuffield Provincial Hospitals Trust, I should also like to reinforce the recognition given in

the Editorial to the immense efforts of Dr Paul Freeling in developing this Nuffield Project. His achievements, and those of the participants on the three annual courses, each of six weeks' duration in all, may well prove to be a significant landmark in the evolution of training for general practice and its recognition as a special discipline.

E. V. KUENSSBERG

191 Crewe Road North,
Edinburgh.

REFERENCE

Journal of the Royal College of General Practitioners (1975). Editorial, **25**, 547–48.

FLEXIBILITY IN VOCATIONAL TRAINING

Sir,

I would like to support Dr Mackie's point (June *Journal*) that many young doctors prefer to choose their own hospital postgraduate training; and only then, if they are attracted to general practice, will they seek a 'trainee' appointment. My six trainees have all been such doctors.

I would extend his plea for allowing variation in the content of the trainee year itself—each doctor's wishes are different. Only two of my trainees have done the day-release courses which are now considered to be of great importance. One devoted his spare time to studying to take again his anaesthetics diploma which he did successfully; he has now this established extra interest in his own practice. Two have chosen their own day-release subjects; all are now principals in general practice.

One trainee wished to have help and spend much time improving his skills of relationship with his patients in the consultation. He realised that he had difficulties in this—and this is really what it is all about. If a general practitioner has a poor rapport with his patients, then nothing else really matters very much.

This is not a letter to belittle the many splendid vocational schemes which are appearing all over the country. It is a plea for keeping open as many techniques of training as possible in this period of rapid evolution of training for general practice.

H. M. S. NOBLE

46 The Broadway,
Sheerness,
Kent.

REFERENCE

Mackie, L. (1975). *Journal of the Royal College of General Practitioners*, **25**, 440–41.

KEEPING CONTRACEPTIVE RECORDS

Sir,

A simple suggestion to aid record keeping in contraception in general practice—perhaps an extension to Dr J. O. Woods, theme. A continuation card FP8 could be issued in yellow, just as the summary cards have pink or blue backgrounds. All contraceptive information would then be readily to hand at a glance, the date of the last cervical smear could be seen, changes in blood pressure noted, and the signing of FP1001 or FP1002 recorded. This card could be speedily produced at minimum extra cost to the Department of Health and Social Security and would be well used until the advent of A4 folders, perhaps still ten years away.

If this idea is helpful, where should it be aired to obtain results?

G. D. TUCKWELL

Dullshot House,
12 The Parade,
Epsom KT1 5DW.

REFERENCE

Woods, J. O. (1974). *Journal of the Royal College of General Practitioners*, **24**, 865–74.

ACTIVITY SAMPLING

Sir,

The article by Dr Floyd and Mr Livesey, in the June *Journal* introduces an interesting technique in activity sampling in general practice. One of the pieces of information to emerge from the study, was that the doctors spent about one minute listening to the patients' problems, and I wonder if it could be that the patients did not wish to waste any of this valuable one minute's listening time in asking silly questions about a funny bleeping noise arising from various loud speakers in the consulting premises.

In a slightly more constructive vein, I wonder if it would not be better if the bleeps were on a random basis, but averaging every minute, as otherwise there is the possibility that the bleep might perchance coincide with the fixed pattern of the five minute appointment system, or alternatively the possibility that the doctor consciously or unconsciously will be able to predict when the bleep is going to occur and alter his behaviour accordingly.

K. A. HARDEN

Woodside Health Centre,
Barr Street,
Glasgow.

REFERENCE

Floyd, C. F. & Livesey, A. (1975). *Journal of the Royal College of General Practitioners*' **25**, 425–31.

HYPERTENSION IN GENERAL PRACTICE

Sir,

Dr John Fry's articles on hypertension in general practice in the July *Journal* contain interesting data, but he omits to mention the mean blood pressure of the practice population which he used to calculate the expected rates of stroke, dementia, primary artery disease, heart failure, and renal disease.

It is essential to know whether this group all had their blood pressures measured, since otherwise it may contain undiagnosed hypertensives, and this in turn might invalidate many of the