are rarely of interest to a national, let alone international, readership. What worries me even more is that if this trend continues, the mere publication of papers, almost regardless of their quality, will assume the grossly inflated importance in the general practice career structure that it already has in hospital circles.

P. A. SACKIN

The Surgery
School Lane
Alconbury
Huntingdon
Cambridgeshire PE17 5EQ.

The above letter was shown to Dr Williams, who replies as follows:

Sir,
I feel that I must clear up some of Dr Sackin's misconceptions about my paper (January *Journal*, p. 33).

First, he talks of my 'ruling out' a link between oral contraceptives and chest pain, which I certainly did not do. I simply conducted a careful, statistically based investigation which, as I said, produced no evidence to implicate oral contraceptives with chest pain in women of childbearing age. I am sure Dr Sackin realizes that a retrospective study such as mine cannot rule out anything.

Secondly, he claims, without stating reasons, that my study is invalid because it covered only 500 women-years. In fact, had he read the paper more carefully, he would have noted that I studied chest pain in 489 Pill users and 289 controls for one year, which I make a total of 778 women-years.

I do not know whether Dr Sackin would object to this figure, but it is notable that the classic paper by Vessey and Doll (1968), which first established the link between oral contraceptives and thromboembolic disease, concerned itself with only 58 patients and 116 controls. Presumably Dr Sackin does not also doubt the results of that paper?

I could go on to answer the complaints expressed in Dr Sackin's last paragraph, but I shall resist the temptation, lest his letter, and my reply to it, attain the "grossly inflated importance" which he claims in his concluding sentence so much to despise.

K. WILLIAMS

192 Kirkstone Drive
Blackpool FY5 1QJ.

Reference

Vessey, M. P. & Doll, R. (1968). Investigation of relation between use of oral contraceptives and thromboembolic disease. *British Medical Journal*, **2**, 199-206.

TRAINING DISTRICT NURSES

Sir,
May I congratulate you on the thoughtful and constructive editorial in your February issue entitled 'Training district nurses'.

However, may I correct you on one point: the Queen's Institute of District Nursing did not close in 1967. What happened was that in order to stop the existing and expensive duplication between the National Certificate of District Nursing and the Queen's Certificate, the Institute decided to cease training and examining for the Queen's Certificate. The last Queen's Certificates were awarded in 1968. Thereafter the Institute concentrated on refresher and management courses, both of which continued to be in great demand for a number of years.

It is true that in 1973 the name of the Institute was changed to The Queen's Nursing Institute, but its concern and interest in district nurses continues unabated. In particular, we have lost no opportunity to press since 1948 for the extension of district training from four to six months, and for legislation to ensure that this training should become mandatory for employment as a district nurse. It was indeed gratifying when in 1978 these efforts at last met with success. Like you, however, we much regret that the Ministers have not accepted our strong recommendation that newly trained staff should follow a period of three months' supervised practice.

Finally, may I say how pleased the Institute is that its concern for the thorough training of district nurses—and through this the better care of the patient—is shared and supported by the medical profession, and at the same time assure you that the Institute is continuing to play an active part in this process.

MAUREEN ACLAND
Chairman of Council
The Queen's Nursing Institute
57 Lower Belgrave Street
London SW1W 0LR.

POSTGRADUATE COURSES

Sir,
I was interested to see the article by Dr Ronald Law (January *Journal*, p. 21). I had the opportunity of attending two of the five courses in his 'Ages of Man' series and I think I speak for all the participants when I say that the success of that series was in the main due to the enthusiasm and hard work of Dr Law and his colleagues.

I have since attended postgraduate courses, not many miles from Princes Gate, which still retain the elements that Dr Law opposes—too many consecutive lectures with little or no discussion.

The established general practitioner finds it very difficult to unearth worthwhile, stimulating postgraduate courses and I feel the College should be building on the foundations made by the 'Ages of Man'. The trainee and the overseas doctors appear to be well served by courses at the College. What about the rest?

T. B. G. LOWE

Well Close Square
Berwick-upon-Tweed.

A4 RECORDS

Sir,
As a general practitioner who uses A4 records I am concerned that my delight at using these records should cause problems to other doctors who may subsequently have my ex-patients registered with them and have to fold up A4 sheets to fit into the traditional medical record envelope.

One simple solution would be for the Central Registry to provide a photocopy reduction service for such records. If a Rank Xerox 7000 machine is used and switched to maximum reduction (size 5) the A4 sheets when trimmed down become almost exactly the same size as the FP7 continuation cards. They can then be stapled or tagged together and slipped into a standard medical record envelope. Although most doctors would not be able to write on the reduced sheets, they are easy to read.

Clearly this problem will affect an increasing number of doctors as more practices opt for the A4 system. A centrally administered service such as I have described would provide a solution until such time as all practices use either the A4 system or computer-held records.

MICHAEL HALL

Beech House
Shebbear
Devon EX21 5RU.

MIGRAINE AND CORONARY DISORDERS

Sir,
Migraine and coronary disorders are problems which face every general practitioner. Both are vascular disorders which appear to have several features in common.

A pilot study has been launched with the aid of the Royal College of General Practitioners Research Unit in Birmingham to investigate this problem on a

statistical basis. We wish to widen the scope of this work and would be grateful to hear from any practitioner who would be willing to provide information on this topic. Funds are available to cover postage and similar costs. An information sheet is available which I shall be glad to send to any interested general practitioner.

K. M. HAY

2 Greswolde Park Road
Acocks Green
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OBESITY

Sir,
I have recently been awarded an Upjohn Travelling Fellowship by the Royal College of General Practitioners to spend some time this year studying obesity.

I would like very much to hear from anyone who has any useful experience in this field which I may not have heard about, especially those who have special clinics or groups in their practices who can tell me whether or not they have been successful.

JOHN COHEN

77 Templars Avenue
London NW11 0NR.

NANYUKI COTTAGE HOSPITAL

Sir,
Kenya may seem a long way away from home to many of your readers, and possibly the last place that they would expect to find a small cottage hospital.

Nanyuki is a town with a population of approximately 19,000 of all types, races, and creeds. There are a few cottage industries and other large-scale industries, but the surrounding area is mainly agricultural. The local community consists of people with widely varying standards of living: from farmers living at subsistence level, to millionaires! Her Majesty's Armed Forces also visit the area twice a year.

The Nanyuki Cottage Hospital which lies beneath Mount Kenya, with the Nanyuki River running past the front door, is an independent, non-profit making concern. It was purpose built in 1951, with its own operating theatre, x-ray room and facilities for outpatients and nine inpatients. It enjoys a good working relationship with the local government hospitals and laboratories. The Sister is an experienced British-trained state registered nurse with a full nursing staff in her charge. There is tremendous potential within the community for maternity, short-stay patients and outpatients, as well as long-stay and geriatric patients.

The Hospital Committee is very keen to make these facilities widely available to the community, and in fact it hopes to nearly double its size in the near future. However, we are finding this increasingly difficult without the services of a doctor! There is surely great scope here for an enthusastic and enterprising person to start his own practice, and gain vast experience in all types of medicine and surgery, while at the same time doing research among a tremendous cross-section of patients.

Nanyuki's climate is very congenial, with the Equator just south of the grounds and an altitude of approximately 6,000 feet. The cost of living is not very high, especially as we supply a small cottage in the hospital grounds. There is easy access to all sporting activities, and good primary education available nearby.

G. L. M. MURRAY
Chairman,
Nanyuki Cottage Hospital Committee
Nanyuki Cottage Hospital
PO Box 95
Nanyuki
Kenya.

TRAINEE GENERAL PRACTITIONER

Sir,
I have felt for some time that the term 'trainee' is rather derogatory. It suggests to patients that he or she is not a 'proper doctor'. How would one like to be operated upon by a 'trainee' surgeon?

In fact, some of my trainees have been very experienced, albeit mainly in hospital practice.

Can we think of a better name? For a start could I suggest 'registrar in general practice'? That has a certain ring about it.

H. M. S. NOBLE

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46 The Broadway
Sheerness
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POSTAL QUESTIONNAIRES AND THE CARE OF THE ELDERLY

Sir,
While visiting the very old is time-consuming, I have serious doubts about the use of postal screening questionnaires such as that described by Professor Barber (January *Journal,* p. 49).

More than one in four of his patients failed to co-operate fully in an exercise which was pursued for their own good and one wonders if this was because they undervalued the shortened and over-general questions. Many of my own patients are "without a relative whom they could call on for help" but have friends or neighbours who are more than sufficient for their needs. Clearly, a restricted view of community networks does not help us to identify those patients at risk of isolation. Similarly, simple questions like "Do you have difficulty with hearing?" are poor predictors of health problems because of the nature of people's obtuse expectations of ageing.

Surely, postal questionnaires are not really necessary? Most elderly patients visit their doctors in any one year and it is a simple matter to screen these at the surgery and then follow up non-attenders at home. If there are too many non-attenders for the practice team to cope with, why not mobilize local voluntary visiting services like those organized by Age Concern?

The major characteristic of our society is that we do not show old people that we care about them by talking to them. I see little point in professionalizing schemes to discover disease if the patients are so lonely or isolated that they could not care less whether they are healthy or not. Completing a postal questionnaire is hardly as therapeutic as a chat with another human being. Tools like those proposed by Professor Barber can be of tremendous use, but not in the way he suggests. As indicator questions to be used by lay volunteer visitors they can combine screening with social contact, surely a much more cost-effective exercise in the long term.

J. D. WILLIAMSON

Athena
24 Westville Road
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SELF-AUDIT OF PRESCRIBING HABITS

Sir,
I would like to comment on the article by Dr M. C. Sheldon (December *Journal,* p. 703). Examination of one's practice habits is useful, but the examples given seem to me to be more faults of diagnosis than faulty prescribing. Figure 1, which seems to be a photocopy of an actual prescription, bears this out—a prescription for birth control pills and varicose ulcer does not make good clinical sense.

I feel articles of this kind do nothing