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

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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

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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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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.

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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