this hospital and in other hospitals) performed significantly better ($p<0.05$) in the practical test than those who had had less than regular training. In addition, the house officers performed significantly better ($p<0.02$) than the senior house officers.

The Royal College of Physicians has recommended an improvement in training in cardiopulmonary resuscitation and assessment of skills at both undergraduate and postgraduate levels.[5] Only a third of this study group had been questioned on cardiopulmonary resuscitation in a formal examination; none had ever been asked to demonstrate their practical skills. The Royal College of General Practitioners is the only royal college that requires examination candidates to be competent in cardiopulmonary resuscitation; perhaps other colleges ought to change their requirements.

Surveys continue to highlight the inadequacies of training in cardiopulmonary resuscitation for junior doctors,[6] and it is reasonable to assume that these shortcomings will extend throughout the medical hierarchy as time goes by. There is a need for regular training in cardiopulmonary resuscitation and more formal testing of skills both in medical examinations and in the workplace. At present the situation falls far short of the ideal.

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Management of childhood diarrhoea by pharmacists and parents

SIR,—The article by Dr Elizabeth Goodburn and colleagues on managing diarrhoea in children[1] raises concern about the inconsistent advice that may be given by pharmacists and the inappropriate action that may be taken by parents of young children when dealing with this problem. Pharmacists in Australia have tackled similar difficulties through a structured approach known as pharmacy self care.

This programme is now operating in all Australian states and is supported by both the professional organisation for pharmacists (the Pharmaceutical Society of Australia) and the industrial organisation for pharmacy owners (the Pharmacy Guild of Australia). It has three objectives: to improve community access to quality health information; to increase consumers' health awareness and self reliance in achieving better health and preventing illness; and to equip and encourage pharmacists to give advice and information.

To achieve these aims the programme provides fact cards for the public on 60 health topics; these outline information, warning signs, do's and don'ts for treatment and prevention, and sources of further information. Common topics on which the public seek advice mentioned by Dr Goodburn and colleagues—diarrhoea, coughs and colds, skin problems, and colic—are among those covered. Six times a year health months draw extra attention to particular issues—the need to be wise in the use of medicines being the most recent one.

In addition, self care pharmacists and their staff receive additional training and education by means of audio and visual programmes, visits from an educator, newsletters, and seminars. These resources keep the pharmacists' knowledge up to date and provide the motivation and equipment necessary for them to perform their counselling role effectively.

Although the programme has received some government support, the participating pharmacists substantially finance the management, development, and production of the resources. Promotion of the programme is financially supported in the main by the pharmaceutical industry.

Community pharmacists have an important role in providing accurate health information and advice. In its pharmacy self care programme Australian pharmacy has taken up Professor Michael Rawlins's challenge[2] in working towards achieving pharmacists' potential as key components of the primary health care network.

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Community obstetric care

SIR,—Ms Patricia Street and colleagues audited community obstetric care in West Berkshire in 1987 and 1989, before and after a change in booking policy.[1] The perinatal mortality rates in 1989 were 8·2 per 1000 in the consultant unit, 5·0 per 1000 in the community unit, and 10·2 per 1000 for complicated obstetric transfers.

My practice has for 20 years operated a minimal selection policy for deliveries in our integrated general practitioner obstetric unit, excluding only women with pre-existing complications and a bad obstetric history. We have monitored the outcome over the past 15 years of our total of 2130 deliveries. We have achieved a perinatal mortality rate of 8·4 per 1000 with a caesarean section rate of 7·3% and a forceps delivery rate of 12·3%, the proportion of babies with a birth weight of less than 2000 g being 4·9%.

Although these figures seem to relate quite closely to what might have been achieved in West Berkshire, the timescale over which they were obtained makes them of questionable value as quality indicators of general practitioner obstetric practice as no comparable figures exist. But the dilemma presented to the general practitioner who chooses to undertake the full obstetric care of his patients is whether the advantages of personal continuity of care are balanced by safety for the mother and baby. The annual figures for individual general practitioners are too small to create statistics, and collectively the multiple variables of practices in terms of both demography and obstetric selection policies make general practice statistics meaningless in terms of personal audit.

This is a sensitive aspect of practice open to criticism from many quarters,[2] and so personal audit is vital to prevent the general practitioner obstetrician being destroyed by anecdotal evidence of cases that have gone wrong. It would seem important, therefore, that each general practitioner as a long term strategy should endeavour to accumulate totals as we have done to try to create some benchmarks of standards. They should then as the opportunity arises make comparison with figures such as those provided by the West Berkshire group.

The general practitioner obstetrician is becoming rare but is not yet extinct, and it is important for the availability of consumer choice that he or she does not become so.

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Home peak flow meters

SIR,—In their editorial Drs A S Vathenen and N J Cooke clearly outline the advantages for patients of using peak flow meters in their own homes.[1] They describe the use of self management plans and say that such plans could be outlined on the asthma cards provided by the National Asthma Campaign (which they refer to as the Asthma Society). Readers may be interested to know that suitable cards are available for both adults and children, and there is also a version for a child to take to school that gives advice to teachers and school assistants on managing that child's asthma. The children's card is also available in Punjabi, Urdu, and Bengali. These cards are available free from the National Asthma Campaign, 300 Upper Street, London N1 2XX, and are supplied with guidelines on their use.

Drs Vathenen and Cooke also refer to the Department of Health's form FP1010 for recording peak flows as being poorly designed. This booklet of charts is now being revised and does have the advantage that it will easily hold together up to one year's recordings rather than the patient having numerous sheets of paper or diary cards.

The National Asthma Campaign strongly supports the wider use of home peak flow meters. The campaign believes that education by verbal, written, and audiovisual means improves a patient's confidence and satisfaction with treatment. For many patients, however, such education will lead to a change in behaviour and a reduction in suffering only when it is coupled with personalised instruction. Such self management plans will nearly always entail objective monitoring with a home peak flow meter.

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Emergency contraception

SIR,—Dr F C Reader's editorial on emergency contraception[1] perpetuates the confusion about this subject. Contraception means precisely what it says—that is, prevention of conception. Postcoital contraception is a misnomer as it acts by preventing implantation, as does the intrauterine contraceptive device, which is similarly misnamed.

Can we stop these euphemisms? Interference with potential life which has started at fertilisation should be called by its correct name, abortion. We doctors should be honest with ourselves as well as our patients and be clear in our thinking and teaching. We should also remind ourselves that the Hippocratic Oath states: "I will give no deadly drug to any though it be asked of me, nor will I counsel such, and especially I will not aid a woman to procure abortion."

I do not support applications for abortion, fit intrauterine contraceptive devices, or prescribe postcoital abortive agents as I believe that I should not interfere with what happens after fertilisation. As I cannot force these views on my patients I recommend that they seek another opinion if they so wish. A patient complained to the family health