EPIDEMIC OBSERVATION UNIT

Sir,

The records kept by general practitioners in this, country contain a vast amount of extremely important information about the aetiology and natural history of disease. However, because each doctor usually sees only relatively few cases of any particular disease no total pattern can be seen from any one individual. The Epidemic Observation Unit is organising a network of practices which will provide useful data on the incidence of both infective and some non infective conditions. The morbidity patterns which appear will be correlated with several environmental influences, the importance of geological, geographical, climatic, and sociological factors will be assessed.

Each sentinel practice will be asked to keep a weekly record of 21 clearly defined common infective diseases, and to record on a monthly basis 21 non infective conditions. The table shows the diseases to be recorded. The number of diseases or syndromes which could be recorded profitably is almost infinite, but it was felt that at first simplicity should be the keynote of this project. To that effect a simple recording method has been devised and it is believed that the time required for recording is minimal. Generally, participating doctors will not be required to provide environmental data.

The information gathered will be used in several studies, the incidence of some infective conditions like measles, rubella and mumps will be used to check on the effectiveness of immunisation procedures, and correlations will be made between certain respiratory diseases and weather variables. A study of the non infective conditions will provide basic epidemic data and prevalence rates for many important diseases and when these are correlated with environmental factors. It is hoped that areas will be delineated which will be fruitful for more detailed prospective investigation into various causes of disease.

It is important to realise that often these morbidity studies can only come from general practice. Doctors engaged in teaching may find this research project a valuable way of illustrating to trainees basic practice research and data recording.

It is envisaged that this recording network should eventually be extended to our colleagues abroad, in this way comparable data from overseas may be used to check various environmental factors in any suggested disease aetiology. If your readers would like to find out more about this project they should write to me at the College.

PAUL R. GROB,
Honorary Secretary,
Epidemic Observation Unit.

Royal College of General Practitioners,
14 Princes Gate,
Hyde Park,
London, SW7 1PU.

TABLE

DISEASES TO BE RECORDED WEEKLY

(Numbers refer to the College classification)

Disease	
5	Acute gastroenteritis
6	Scarlet fever
8	Whooping cough
11	Measles
12	Rubella
13	Chicken pox
14	Herpes Zoster
15	Mumps
16	Infective hepatitis
17	Infective mononucleosis *
183	Otitis media, acute
240	Common cold
242	Sore throat including tonsillitis
243	Sinusitis
242	Sore throat including tonsillitis
244	Laryngitis and tracheitis
245	Epidemic influenza
246	Pneumonia and pneumonitis
247	Acute bronchitis
251	Pleurisy
86	Acute asthmatic (a) infective episodes: (b) non infective
22	Scabies
*	Additional information required

DISEASES TO BE RECORDED MONTHLY

Disease	
156	Multiple sclerosis
181	Retrobulbar neuritis
9	Meningitis/encephalitis
211	Myocardial infarction (acute)
213	Carditis
155	Acute cerebrovascular accidents
67	Acute leukaemia
91	Acute onset diabetes
88	Thyrotoxicosis
89	Myxoedema
277	Gastric ulcer
278	Duodenal ulcer
282	Acute appendicitis
66	Hodgkins disease
405	Rheumatoid arthritis
350	Spontaneous abortion
431	Birth: CNS abnormalities *
AS	Attempted suicide *
S	Suicide *
464	Cot death *
3/4	Venereal disease *
*	Additional information required.

REHABILITATION

Sir,

As National Organiser of Rehabilitation Engineering Movement Advisory Panels (REMAP) I was very pleased that during a public meeting in Torquay on 24 April it was decided to create a Panel to cover the area of Exeter and Torbay.

The major objective of a Panel is to provide equipment for the special requirements of handicapped individuals. It thus supplements the work of Departments of Social Services which, by and large, have to use standard equipment available from commercial suppliers. At the meeting in Torquay the Devon county authority gave full support and will co-operate in setting up the Panel.

The Panel will consist largely of engineers of various kinds but will have help from therapists and members of the medical profession. It would be all too easy for an engineer acting alone to provide a device which, though perhaps satisfactory in the short term, could do positive physical harm to a handicapped person in the longer term. As a minimum, our engineer handling a case will co-operate with the therapist and doctors concerned.

There is little formality in the organisation of a Panel. It consists largely of individual volunteers, often supported by the organisations with which they work—the support offered by technical colleges and industry at the meeting was truly impressive. A committee, largely formed at the meeting will set up a register of resources in the area and a network of communication which will find volunteers for individual cases. It will also look after its own finances.

All the effort and much of the raw material will be cost free. Sometimes, however, special components cannot be 'found' and have to be bought. The Committee will seek means for covering the costs involved, including recompense for travelling expenses of volunteers.

REMAP has been working on Teesside for ten years, and the local authority submits its unusual cases to the Panel there as a matter of routine. Since the drive to make the movement truly national started about two years ago, Panels have been formed in:

Buxton and District	Sheffield and District
Clwyd	SE Wales
Cheshire	Teesside
N London	Tyneside
SW London	W Cumberland

The meeting in Torquay was closely followed by agreement to form further Panels covering the counties of Cornwall and Ayrshire.

N. BREARLEY
National Organiser

British Council for the Rehabilitation
of the Disabled,
Room 277D,
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London SW1P 4QG.

ENVIRONMENTAL HEALTH SERVICE

Sir,

I have just been reading the excellent article on *The case for a national environmental health service* (February 1973). I found the article most interesting and I have certainly learned considerably from it.

One point however concerns me. I notice you make no mention of occupational health. As a considerable part of the community spend a large proportion of their waking life in the working environment where they are subject to 'environmental' conditions I would have thought that occupational health would be a significant and major part of any national environmental health service.

I realise that it is difficult when a report of a paper is presented in a journal to cover all the points mentioned in a lecture.

DAVID S. ROSS
Senior Medical Officer

Babcock & Wilcox (Operations) Limited,
Renfrew, PA 8DG,
Scotland.

REFERENCE

Grob, P. R. (1973). *Journal of the Royal College of General Practitioners*, **23**, 119–122.

JAMES MACKENZIE LECTURE

Sir,

I have read and reread Dr John Stevens' James Mackenzie Lecture, *Brief encounter*, published in your January *Journal*.

Thank you for the publication of what is undoubtedly the most brilliant and lucid exposition to date of personal physician responsibility in family-centered continuing medical care.

The humanity and intelligence of the author is reflected in each line. The requirement of the full measure of psycho-social and medical skills necessary for competence as a primary physician stands reaffirmed.

I believe this fervent and articulate work is an important milestone in the continuing development and definition of family practice.

IRWIN STREIFF,
Clinical Assistant Professor
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University of Miami,
Miami,
Florida 33152.

REFERENCE

Stevens, J. (1974). *Journal of the Royal College of General Practitioners*, **24**, 5–22.