Teaching Materials

A number of other current activities already support these developments. Publishing houses and journals are anxious to co-operate with the College in the production of what have been called "distance learning materials". These are not to be devised by remote groups of experts, but rather created by general practitioners in co-operation with their Faculty Boards or local departments of general practice. The MSD Foundation now wishes to target its new materials towards the continuing education of practitioners—for example by suggesting frameworks for the analysis of video-taped consultations. Discussions are far advanced with the Open University for setting up a Primary Medical Care Unit, which will be concerned with providing educational packages for co-operative learning by all those involved in primary medical care—doctors, nurses, social workers, administrators and receptionists and patient groups. The Stuart Fellow will promote small group work based on an exploration of the ideas contained in "What Sort of Doctor?", and will be visiting small groups in the Faculties in order to stimulate and co-ordinate this programme.

A Federal College

The title "What Sort of Doctor?" echoes that of a series of articles some two years ago under the title "What Sort of College?". It is my hope that the Education Division will give the following answers to the challenge of that title. This will be what Irvine called a federal College: the development of continuing medical education will be a matter for the whole membership, and responsibility will be devolved directly to Faculty Boards; the boundary between the academic and the practising doctor will disappear: continual redefinition of the content of general practice and of the monitoring of its quality will become an integral part of the doctor's professional work; lastly, the College will come to be seen not as a cosy club for its members, but as a College for all general practitioners, and for all of their patients. That is the task to which the Education Division will seek to make its contribution.

Marshall Marinker
Divisional Chairman

LETTERS

The College and Nuclear War

Sir,
We write to express our dismay at the way Council has handled the question of the President's attendance at the second Congress of International Physicians for the Prevention of Nuclear War. We are told (February *Journal* p. 123) that Dr Horder felt that:

> "... although he could support a congress concerned solely with the organizers' avowed aims of examining as objectively as possible the facts about nuclear war in Europe, he was worried that in the heat of the moment the Congress might abandon its other aim of not advocating any policy of nuclear disarmament and that it might adopt resolutions of a political nature which might be embarrassing to him as President."

This extraordinary statement, if accurately reported, must be seen at best as muddled thinking.

First, the very title of the Congress makes its purpose, the prevention of nuclear war, abundantly clear. Whilst declining to advocate any particular policy of nuclear disarmament it has never pretended to be an observer merely of the facts about nuclear war. It is disingenuous of College to suggest that it was unaware of this from the start.

The crucial issue is surely that any conceivable nuclear war in Europe would result in death, injury and disease on an enormous scale and that the threat of nuclear war represents the greatest challenge to the College's much vaunted policy of anticipatory care. The only meaningful medical response to nuclear war is to strive to prevent it. Even if we assume that the advocacy of nuclear disarmament is a political act, by its own declared standards the College stands condemned if it sidesteps this issue because of that. Council members should not need reminding of the concluding paragraphs of their report on "Health and Prevention in Primary Care":

> "two of the most powerful influences on the health of our patients are their behaviour and the environment in which they live. The latter is influenced by the decisions and policies of those in authority. Do these decision-makers take sufficiently into account the effect that their decisions will have on health? If not, is it because the medical profession fails to inform them sufficiently or to remind them often enough of the implications for health. . . .?
>
> If preventive care is to be taken seriously there are opportunities which the College should be more ready to seize in influencing political decisions than it has been hitherto".

We are told that Dr Paul Freeling felt that since College members had not mandated their representatives to speak on the issue of nuclear weapons, the President had no option but to withdraw. Has the College made any efforts to seek such a mandate from its members, or even to initiate debate on this overwhelmingly important challenge to preventive medicine? We feel in short that College has an urgent duty to its own ideals, its members and their patients. That duty is to inform and canvass its members on the issues, to present those issues to the public and to those in authority and, in the final analysis, to stand up and be counted in a debate that may determine the survival of us all.

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Donald Grant
Rachel Miller
Nicolas Rea
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Sir,
I think the reason for the confusion about the role of the medical profession in the nuclear debate (March *Journal*, p. 195) becomes clear when we separate the issues into aims and methods.

There seems to be a medical (indeed a general) consensus on aims: that war, particularly nuclear war, is likely to be so horrific (especially in its medical and social effects) that it must be prevented.

The disagreement is in the area of methods (of preventing war) and it is at this level that the only medical dimension to the debate is in the provision of medical services and shelters, and whether such provision would make war more or less likely. This can only be a political judgement. The debate is otherwise purely political, and the solutions offered are often diametrically opposed to each other. This, surely, is why it would be inappropriate for the College to become involved or even take sides in what is really a controversial (though important) *political* debate about methods.

C. H. MAYCOCK

The Court
Neopardy
Crediton
Devon.

Sir,
We note that the Council of the RCGP has advised its President, Dr John Horder, not to attend the April meeting of the International Physicians for the Prevention of Nuclear War, because the meeting could become 'political'.

This is the second meeting of the IPPNW and will concentrate on the medical effects of nuclear war in Europe. It will be attended by some 200 eminent physicians and Presidents of Medical Colleges and Associations from most European countries, the USA and USSR.

In the event of a nuclear war, general practitioners would be called upon to provide medical services to their patients and the public. As such, it is essential that practitioners are well informed about the medical consequences of nuclear war and are able to inform their patients of the level of care that they can expect to give.

We are appalled by the Council's decision in preventing Dr Horder attending the Congress and can only assume that the College does not regard the medical consequences of nuclear war as of any importance. The College has been promoting prevention and health education in general practice in recent months and we regard it as irresponsible that the College is not prepared to make a significant contribution to either preventing or educating its patients about what has been described as the Final Epidemic.

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James Mackenzie and Myocardial Infarction

Sir,
I worked in the Edinburgh Royal Infirmary, first as a Clinical Assistant and then as House Physician to W. T. Ritchie, Professor of Medicine, for a year (1930 to 1931) and my memory of this time leads me to support strongly the view of Dr Yellowlees (February *Journal,* pp. 109-111) that myocardial infarction was almost unknown in Sir James Mackenzie's day, and that the present prevailing epidemic began about 1931-32 and has been with us ever since.

Yellowlees quotes Gilchrist, another Edinburgh cardiologist, as having seen 12 cases only in the two years 1928-1930 in the Royal Infirmary. My memory of the following year, 1931, is that there were practically none at all in Professor Ritchie's wards, although he was a world renowned heart specialist who coined the phrase 'auricular flutter' for that disease. Certainly there were no acutely ill 40 to 60 year olds who are so frequent today.

The main ECG indicators of infarction had been known since 1912, and the clinical signs of most attacks were obvious enough: the physicians of the time were not missing the diagnosis. I cannot believe that from Mackenzie's time till about 1932 there were more than the smallest number of 'coronaries'.

Dr (later Sir Ian) I. G. W. Hill worked on an occasional research case in Professor Ritchie's wards and he saw his first case in 1928.

Doing locums for 4–5 months in 1930-31 I do not remember seeing a single case.

I spent from October 1932 to March 1933 working in the Wenckebach Klinik in Vienna and found that small numbers of infarcts were being admitted regularly. This new development was ascribed partly to the increasingly stressful political situation in central Europe.

I began general practice in Yorkshire in the summer of 1933 and in the two years 1934 and 1935 I certified three deaths as due primarily to 'coronary thrombosis'. The deaths occurred at the ages of 68, 65 and 72.

I feel that we must concur in the general view that the modern increase in myocardial infarction began in the early 1930s and especially marked out victims in the 40 to 60 age groups. This is the significant point about the present epidemic—the younger age incidence. On one issue I agree with Professor McCormick, namely that infarction has always been present in the human race but with the proviso that up to about 1930 it was nearly always a terminal event in old persons.

There are fashions in filling up death certificates and these deaths in former times were often filled up as 'myocardial degeneration', 'heart failure', 'angina pectoris', 'old age', and so on, whereas many of them must have been due to myocardial infarction.

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Perinatal Mortality: Surveillance and Audit

Sir,
The suggestion in your editorial (November *Journal,* p. 643) that the above be looked into is reasonable but, before proceeding too far, up-to-date figures should be used. The Court Report used 1974 figures, and your editorial takes 1975 for perinatal deaths. In Scotland perinatal mortality has improved from 21/1,000 live births in 1975 to 13/1,000 in 1980, and of these totals slightly more than half were stillbirths and a significant proportion of the totals was due to congenital abnormalities.

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Acute Labyrinthitis

Sir.
Dr Brill's hypothesis of an association between acute labyrinthitis and influenza (January *Journal,* p 47) reminds me of a patient I was recently called to see. This 40-year-old mother of three complained of intense vertigo of sudden onset, with tinnitus and nausea. She was afebrile and the vertigo was reproduced by passive rotation of the head to the left with the neck in extension. My initial diagnosis was acute labyrinthitis. Jaundice appeared on the third day. She was the last of four consecutive cases of infectious hepatitis in her family and she had received an injection of gamma-globulin two days prior to presentation. All the other patients in her family had classic prodomal symptoms of hepatitis, with nausea and anorexia but no vertigo. She recovered fully but slowly over the next six weeks. The vertigo lasted about a week.

By Occam's Razor, her acute labyrinthitis was the prodrome of her viral hepatitis.

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