Sir,

As you rightly state in your Editorial (December *Journal,* p. 715) the Alma Ata Declaration placed its emphasis on primary health care. The WHO publication "Health Statistics" goes further than your Editorial in stating "Accordingly, the Alma-Ata Conference agreed that the translation of the principles of primary care into action would require the priority allocation of budgetary resources to primary health care, better distribution and use of existing resources and the improvement of managerial processes and capabilities at all levels of planning, implementing, budgeting, monitoring, supervising and evaluating, supported by a relevant information system. The fact that so little attention has been paid to primary health care generally, as compared with institutional care, is a matter of some concern."

It is true that Voluntary Service Overseas and the Bureau for Overseas Medical Service have developed "ways of getting doctors to the places where they are needed"—but have those doctors received the training that is required for the conditions they will encounter? Their skills are either in hospital medicine or in general practice, which are not the skills required for primary health care in the developing countries.

I would also disagree with Essex (1980) that plans made by foreigners "and geared to the appropriate level" can be made and can work. This is only true when the foreigner concerned has previously had a considerable field experience in one or more developing countries.

Primary health care in the developing countries, not infrequently the only type of health care available to the mass of the rural population which forms some 80 per cent of the total population, must be orientated to the needs of the population, its culture and the available manpower and facilities. It must rely on the team concept in its widest context, including agricultural extension workers, schoolteachers and social development workers. Nor is it provided by doctors, whose role is that of acting as a back-up in the district hospitals and in teaching nonprofessionals. Health planning must be undertaken by the indigenous and it should be a prime target of any aid programme to secure appropriate training for the indigenous at all levels.

Your Editorial's concluding remark, "We are doing very little. Don't we care?" rather negates the Liverpool School of Tropical Medicine and in particular the Department of International Community Health. This offers a Certificate in Tropical Community Medicine and Health to 50 students a year, and a Master in Community Health to 25 students a year. Both are specifically orientated to community medicine and primary health care in disadvantaged countries. The former course is for nonphysicians and the latter is fully interdisciplinary and able to accept suitable students who do not have a basic university qualification. The Department's third course is Teacher Training in Primary Health Care for the teachers of nonprofessionals. It is also fully interdisciplinary with students ranging from medical assistants from Africa to professors of preventive and social medicine.

These courses are grossly oversubscribed despite iniquitous fees. For example, the Masters course cost £1,500 in 1975 whereas the expected cost for 1983 is £8,000. It would appear to me that the people who "don't care" are those whose economic policies result in frozen appointments and fees so high that overseas students now seek their further education in America and elsewhere.

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References

Essex, B. (1980). Mental illness in developing countries. *Journal of the Royal College of General Practitioners,* **30,** 648-655.

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Sir,

May I congratulate you on your forthright editorial about the Alma Ata Declaration (December *Journal,* p.715).

What *can* the College do? I would like it to investigate the possibility of recognizing posts in the Third World as part of vocational training to encourage entrants to general practice to spend some of their training in a developing country. Also the College—a very rich organization by Third World standards—could develop academic and personal links with one particular primary health care project in a developing country.

What can we as individual doctors do? We can covenant money to one of the agencies involved in development. We can learn of the broader aspects of development issues, for example by reading the Brandt Report (Lorraine 1981). We can join or form a local branch of the World Development Movement which campaigns and educates on these issues in the local community. We can arrange sabbaticals or retire early to work in the Third World. We can send our unwanted drugs to agencies that will send them abroad.

I would be pleased to hear from those who are sympathetic to these ideas and who would like to explore the value of concerted action.

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Reference

Lorraine, J. A. (1981). Doctors and the Brandt Report. *Lancet,* **1,** 1356–1358.

Clinical and Population Medicine

Sir,

I welcome the opportunity to reply to the letter from Drs Wright and Stanley (January *Journal,* p. 58) and to clarify my remarks about teaching general practice and community medicine. The subjects are of course complementary and a medical student has to have a foundation of knowledge in both. The inherent conflict between the subjects to which I refer in the William Pickles Lecture (October *Journal,* p. 593) does not alter these assumptions. My belief stems from a long experience of teaching with social medicine academics, who constitute the academic core of community medicine.

In the sixties and early seventies I gained considerable teaching experience in both subjects, working with Professor John Pemberton and his academic colleagues in the then Department of Social and Preventive Medicine, the Queen's University, Belfast. We developed amicably an integrated course to teach both disciplines.

In more recent years I have developed an equally close and happy relationship with his successor, Professor J. H. Elwood, now Professor of Community Medicine. To achieve a close understanding we have had to acknowledge our differences in outlook, interests and attitudes to medicine. Herein lies the inherent conflict between these two branches of medicine. General practice learning is mainly about acquiring appropriate skills and attitudes to facilitate and improve individual patient care. There is little didactic teaching. By contrast community medicine teaching stresses facts and figures and a numerical approach to population medicine, including statistics and the science of

epidemiology. These differences lead inevitably to a different emphasis and frequently to a different methodology of teaching.

I find it surprising that I have to write this for the benefit of Drs Wright and Stanley. In my experience students and staff alike at Queen's are fully aware of the differences and discuss them quite openly. My clinical academic colleagues in the Queen's Medical Faculty are continually striving to resolve the conflict, in order to integrate better the teaching of community medicine with clinical experience.

A glance at the general practice overall learning objectives of the Queen's University, Belfast (October *Journal,* p. 595) reveals a balance between clinical objectives and those related to population medicine (for example the uses of epidemiology in service, teaching and research in general practice). These objectives do not conflict because they reflect the work and interests of general practitioners in the NHS.

Finally I disagree with Drs Wright and Stanley that the issue of departmental status is a separate matter. The differences already defined, and the enormous scope and breadth of each discipline, make it preferable that each should enjoy independent status and work harmoniously in partnership, each developing its own philosophy of education and credibility.

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Eliminating Polio

Sir,

In 1979 Save the Children initiated a programme aimed at eliminating polio as a threat to children throughout the world. To date the STOP Polio Campaign, of which I am Chairman, has administered over six million doses of vaccine and has conducted or supported immunization campaigns in 11 Third World countries. This Campaign has the unqualified support of the World Health Organization, and Campaign staff have usually co-operated with local health authorities to combine polio vaccination with full Expanded Programme on Immunization. Even if eradication is a distant target it is impossible not to appreciate the benefits even of partial success.

If eradication is to be achieved, Save the Children must obtain more financial support to continue and expand this activity. This brings me to the reason for this letter. British parents are able, free of charge, to have their children protected under the NHS. It might be that if given the opportunity, they would be happy to make a small donation to enable us to afford a less fortunate child in the Third World similar protection.

What we have in mind is placing a collection box in general practitioners' waiting rooms accompanied by a suitable poster, and perhaps the doctors administering immunization could draw parents' attention to it. If any of your readers would be prepared to help in this way, either by accepting a collection box or by organizing collection of the boxes, perhaps they would write to me, c/o Save the Children Fund, Mary Datchelor House, 17 Grove Lane, London SE5 8RD.

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Nuclear Warfare

Sir,

We welcome the recent statement by the College (November *Journal,* p.708) in relation to nuclear warfare, and in particular the unequivocal warning to Government that following major attack involving the use of nuclear weapons no organized medical aid would be available to survivors, and that prevention of nuclear war offers the only security against its consequences. However doctors should consider most carefully the terrifying significance of the words in paragraph 1 of the statement—"that any major attack involving the use of nuclear weapons would prove catastrophic to the extent of threatening the extinction of all civilized life". If any other public health hazard could be so described, we in the medical profession would be shouting warnings from the housetops, heedless of the niceties of political boundaries.

We may have no mandate, as a College, "to support or oppose any particular strategy", but we have a continuing responsibility, as part of our commitment to preventive medicine, to warn and to keep warning the Government and the public of the extent of death, disease and injury resulting from nuclear explosions, and actively to support any policy which genuinely reduces this danger.

In the recent controversy over seat belt legislation, Government responded only to energetic and repeated representations by the Royal Colleges. Surely, even more, in a situation that "threatens the extinction of all civilized life", the College cannot simply make a statement and leave it at that. It is imperative that our voice be heard urgently and repeatedly in what must be the greatest public health challenge of our time.

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Measles Vaccine

Sir,

Dr M. J. Knightley and Dr R. T. Mayon-White (November *Journal,* p. 675) reiterate many of the invalid assumptions on which children are denied measles vaccine. In doing so, however, they give credence to another mythical contraindication. The fact is that egg allergy is not a reason for withholding vaccine (Kamin *et al.,* 1965) although caution is necessary in immunizing anybody with a known allergy to anything. Live-attenuated measles vaccine, prepared in chick fibroblast culture, has been safely used in numerous egg-allergic individuals. (Brown and Wolfe, 1967; Katz, 1978; Ford and Taylor, 1982.)

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Katz, S. L. (1978). Safety of measles vaccine in egg-sensitive individuals. *Journal of Pediatrics,* **92,** 859.

Ford, R. P. F. & Taylor, B. (1982). Natural history of egg hypersensitivity. *Archives of Diseases in Childhood,* **57,** 649-652.

Antibiotics in General Practice

Sir,

By sheer chance, October's *Journal* arrived by the same post as my copy of "Epidemiology and Research in a General Practice" by Dr G. I. Watson. It