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.

GEORGE IRWIN
Head of Department of General Practice
The Queen's University of Belfast
1 Dunluce Avenue
Belfast BT9 7HR

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.

JOHN BUTTERFIELD
Regius Professor of Physic
Cambridge School of Clinical Medicine
Addenbrooke's Hospital
Cambridge CB2 2QQ.

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.

DOROTHY E. LOGIE
ALEXANDER FRAME
IAN W. FINGLAND
West House
Edinburgh Road
Greenlaw, Duns
Berwickshire TD10 6XF.

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.)

HARVEY MARCOVITCH
Consultant Paediatrician
Horton General Hospital
Oxford Road
Banbury
Oxon.

References

Kamin, P. B., Fein, B. T. & Britton, H. A. (1965). Use of live-attenuated measles virus vaccine in children allergic to egg protein. *Journal of the American Medical Association,* **193,** 1125-1126.

Brown, F. R. & Wolfe, H. I. (1967). Chick embryo grown measles vaccine in an egg-sensitive child. *Journal of Pediatrics,* **71,** 868-869.

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

was therefore quite salutory to read the correspondence in the *Journal,* containing as it does my letter bemoaning the scant attention paid by your editorial writer to the possibilities of *Mycoplasma pneumoniae* being a significant respiratory pathogen in general practice, and his handsome admission that there might be something in what I have said. I then turned to page 185 of the collected works of Dr G. I. Watson and found an excellent chapter entitled "*M. pneumoniae* in general practice". At the risk of boring your readers to tears, I would like to make some last comments and then leave the field so that they can decide for themselves the correct course of action.

I would draw your attention to Dr Watson's account of an epidemic of *M. pneumoniae* respiratory disease during 1963 and 1964. Of 56 ill patients, 66 per cent had clinical evidence of pneumonic infection. When adults were affected, slow convalescence characterized by troublesome and prolonged physical lethargy was a notable feature of the disease.

If your author of editorials were to read my original article (1981) and then Watson's account (1967) of an epidemic, I believe that his conversion might be complete. By the way, *M. pneumoniae* can cause lobar pneumonia (Cockcroft and Stillwell, 1981). It is not safe to assume that lobar consolidation is caused by the pneumococcus.

J. A. McSherry
Assistant Professor
Department of Family Medicine
Queen's University
Kingston
Canada K7L 3N6.

References

Watson, G. I. (1967). *Mycoplasma pneumoniae* in general practice. *Journal of the College of General Practitioners,* **13,** 174-196.

Cockcroft, D. W. & Stillwell, G. A. (1981). Lobar pneumonia caused by *Mycoplasma pneumoniae. Canadian Medical Association Journal,* **124,** 1463-1468.

McSherry, J. A. (1981). Why not prescribe antibiotics for 'heavy colds'? *Journal of the Royal College of General Practitioners,* **31,** 49.

Watson, G. I. (1982). Epidemiology and Research in General Practice. London: Royal College of General Practitioners.

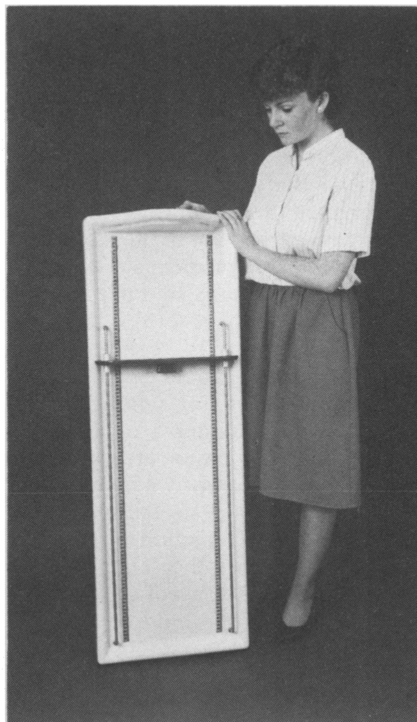
Stopping Medication

Sir,
I was very interested in your recent Editorial (December *Journal,* p. 723) as for the last eight months my partners and I have been involved in an exercise to separate patients from their medication. On taking over the list of a retiring principal we found 190 patients who were taking thyroxine with no evidence of its need. Our method for dealing with this was simple. We stopped prescribing forthwith, and on the advice of our local endocrinologist rechecked the patients' thyroid status after about two months. The advice was accepted by most people without too much difficulty, and most of the follow-up results have been normal. So far, we have had to restart six patients on thyroxine.

Although thryoxine is cheap and has few side effects, we should be concerned about any unnecessary medication. Lest anyone feel that my partners and I are being excessively critical of our predecessor, may I say that this is not intended.

R. M. Spokes
4 Copthall House
Station Square
Coventry.

The Halton Baby Measuring Table



Sir,
May I bring to your attention the new infant measuring table developed at Hallwood Health Centre by a local plastics firm and myself. The table is light, hygienic and easily portable. It can be used to measure from the smallest newborn baby up to an infant measuring 104 centimetres and is graduated in millimetres.

Many of us are taking on child developmental assessment in our own practices. This equipment has been tried out in our surgeries and clinics at Hallwood Health Centre and really is just what is needed for the tasks ahead.

The table is manufactured by A. N. Carlisle and Son, Widnes, Cheshire WA8 7HT. Tel: 051-424-3555.

B. W. McGuinness
16 Howey Rise
Frodsham
Cheshire WA6 6DN.

Primary Health Care in Industrialized Countries

Sir,
Hannu Vuori, Regional Officer (Europe) for Primary Health Care, perpetuates the myth concerning the organization of primary medical care in Sweden in his recent article (December *Journal,* p. 729). In 1978 it was estimated that just over 60 per cent of all primary care contact took place in hospital outpatient departments without any referral from a primary care physician (Stephen, 1979).

Although I have no up-to-date data, I understand that this has not changed significantly. To state that in the Scandinavian system (Finland and Sweden) the focal point of the provision of care is not the general practitioner but a health centre run by the local administrative unit is simply not true for Sweden. It is a serious matter when such inaccuracies are accepted as fact, particularly from an international authority such as the WHO.

The increased interest in primary health care on a worldwide scale and the growing awareness of its importance within the overall structure of any health service has resulted in numerous conferences and discussion groups within the WHO, as well as between international and national health institutions and colleges. Attempts have been and are being made to discover which country, or group of countries, has developed the most acceptable, efficient and rational service. But one of the most serious obstacles to any progress is the lack of basic information concerning the actual organization and structure of primary care in individual countries. Unless this is rectified there can be little hope of useful international co-operation or any chance of learning from each other.

W. J. Stephen
27 New Street
Wells
Somerset

Reference

Stephen, W. J. (1979). *An Analysis of Primary Medical Care: An International Study.* Cambridge University Press. p. 159.