often quick to ascribe to the phenomenon all their ails, from asthma to zoster. Although most general practitioners would support their patients' claims, if only on aesthetic grounds, scientifically based evidence on the adverse effects of damp housing on health is hard to come by.[1]

## 'Bad' smells

The dirty-smelling house, with odours from different sources such as sweat, stale cooking and decaying food, may be of medical significance in several ways. Some general practitioners include these malodours in an index of their patients' inability to cope—an important consideration for example in interpreting the urgency of a house call, and in making management decisions regarding the prescribing of drugs or continuing to look after an ill patient at home.

The presence of children of preschool ages may add a contribution, and with windows tightly closed against the night air the atmosphere soon becomes fetid. Its impact is unforgettable and to the doctor, making an out-of-hours call for a minor malady, has added significance.

The odour of incontinence of urine has a sweetish component which differs from the more offensive malodour of urinary tract infection. These smells, usually more directly related to individuals and their clothing, may permeate a house. Once a distressing feature of institutions for the care of the elderly; nowadays they have been rendered less obtrusive.

The truly impoverished household may be characterized by odours from other sources, including various infestations such as bed-bugs, fleas and lice.[2] Such a combination of smells is remarkable in two respects. Though the smell may be overpowering at first, one quickly becomes acclimatized: after initial contact, the smell may cling to one's clothes for several days.

The malodours described above may be of significance in themselves—and so may be a *change* in the household smell. Detecting malodour for the first time in a house previously known to be odour-free may provide the doctor with additional evidence to corroborate suspicions of incipient senile dementia or depressive illness.

Health hazards associated with urea formaldehyde insulation have recently been in the news. Under certain conditions the chemical may give off an unpleasant odour. Whether this may cause illness is still open to question.

Household pets may add their contribution and the sense of smell might prompt the doctor to consider the possibility of one of the zoonoses in appropriate circumstances. Such a smell may also indicate poverty or possibly diminished social responsibility, for example in the household with the peculiarly pungent smell of a tomcat which has not been taken to the vet to be neutered.

On the other hand, a spick-and-span household fragrant with furniture polish and perhaps with a hint of antiseptic may betoken more than just the houseproud: is there a possible obsessional neurosis in the offing?

## Conclusion

Cleanliness, it may be, is next to godliness. At the same time, perhaps our society's preoccupation with BO, HO and deodorants contains a denial of individuality. Life would be a lot duller without smells, good and bad, and as doctors we would be the poorer. An assault on the nostrils can open the eyes!

**References**

1. Gray JAM. Housing, health and illness. *Br Med J* 1978; **2,** 100-101.
2. Cotterill JA. (1983). Nose in diagnosis. *Lancet* 1983; **1,** 293.

# LETTERS

## Measles Vaccine

Sir,

I refer to Dr A. P. Bennett's letter on the efficacy of measles vaccine (December *Journal,* p. 781). No real comment can be made on the efficacy of the vaccine on the figures presented and certainly the conclusions drawn about 'patchy success rates' are just not possible unless a comparison of the attack *rates* in the immunized and non-immunized groups is made in those exposed to the infection. The comparison of numerators without their accompanying denominators is not helpful and all too common. Attack rates are best demonstrated within schools, or even streets, exposed and containing immunized and nonimmunized children.

The campaign for the elimination of *indigenous* measles in the United States demonstrates dramatically the efficacy of efficient measles immunization. Immunization rates are now 97 per cent for children entering kindergarten or first grade. The number of measles cases in the USA in the first 37 weeks of 1982 was 1,230 compared with 12,843 in 1980 and 53,023 in 1977. The number of US counties reporting measles in the same period in 1982 was 165; 714 in 1980 and 1,429 in 1977. Such a policy will, of course, necessitate the continuation of high immunization levels and effective surveillance systems and responses to the occurrence of suspected cases, since the importation of measles from outside the USA will continue unchanged.

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**Reference**

Centres for Disease Control. *Morbidity and Mortality Weekly Report* 1982; **31,** No. 38.

## Teams for the Year 2000

Sir,

David Brookes raises an extremely important point (February *Journal,* p. 67) when he says that the primary health care team needs to encompass those people who used to work for and from the hospitals, and who have been considered to be ancillary workers in the past. These are nurses of various genres, technicians and the like, whom he strongly recommends to be drawn into the primary care team concept and management to the degree of total involvement. This is correct and praiseworthy, though probably impractical in the light of current medical politics.

However, his closing remarks worry me. He concurs with David Metcalfe's published opinion that 'hospital services are not geared to cope with the primary health care needs of the community and are bound to perform badly because they function best at finding and rectifying pathophysiologi-

cal conditions in a referred population'. Whilst it is always unhealthy and sometimes unfair to quote a man without quoting the context of his statements, I fear that this statement is an indicator of some of the failings of general practitioners and their concepts and particularly their teachers' concepts, as well as failings in the hospital service. Whilst one has to agree that the hospital will fail to manage all aspects of an individual's problems and the *menage* in which they occur, why is it a necessary corollary that the general practitioner will not, cannot and may not find and rectify a pathophysiological condition?

The general practitioner of today is a highly trained, clinically sensitive individual with, in most cases, direct access to specialized and sophisticated investigative procedures. At his fingertips he has the resource of consultant colleagues, who are paid to work in an advisory capacity in the domiciliary context, and I think it is an abrogation of the general practitioner's duty, if not an appalling waste of his education, not to admit that he is a clinician as well as a pastoral manager.

Dr Brookes makes the point that the hospital takeover in general practice has robbed us of much of our obstetric practice and this is true, an insidious act on the part of the Royal College of Obstetricians. We are being robbed of our paediatric practice but the General Medical Services Committee is conscious of it and trying to do something about it. We are not being robbed of our psychiatric practice in my view. Community psychiatric nurses have made domiciliary psychiatry much easier to practice. Attendance of the patient at hospital is vastly reduced and compliance in the management of psychiatric and behavioural problems is much greater.

Stoma care may appear to have been taken over by the hospital because general practitioners may not be interested, and therefore somebody has to do it. They are robbing us of diabetes and its management and that is our fault. The diabetitians have founded a domiciliary nursing service which supervises the dietary and therapeutic care of the diabetic and which reports to the consultant physician. That also is our fault. If we insisted that it reported to us, the coordination among the nursing service, the general practitioner and the consultant would be much better. The patient would be bound to benefit; the clinical standards of the general practitioner would be bound to be sustained to a higher degree.

The problem seems to be of the general practitioner allowing people to walk over him and then screaming that he is being badly treated. Therefore it is for us to approach the hospital services and for us to tell them what they will be allowed to practise, not the reverse, and this means that general practice may achieve the ascendancy it should hold in the community at large.

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*We showed Dr Million's letter to Dr Brooks, who replies as follows:*

I find myself agreeing with most of what Dr Million says. I would particularly wish to agree with his comments about the general practitioner's role as a clinician, as, I am sure, would David Metcalfe. Neither Professor Metcalfe's comments in his original paper nor mine in the editorial were designed to detract from the general practitioner's role in finding and rectifying pathophysiology in a *non*-referred population. It seems necessary (if somewhat tautological) to point this out.

We cannot serve our patients best by trying to tell hospitals what thay may or may not do. We can only influence our patients and the hospitals by providing a better service through the primary health care team. We need to find out what we mean by joint training for the team. What is possible? What does the word 'partnership' actually mean and how can it be developed in the interest of optimum team function? General practice will only survive if the community's needs for primary care are best met there, and this will only happen through effective team work.

## College Priorities

Sir,

I was interested to read in the January *Journal* that the College has over 10,000 members, but I wonder how many members are dismayed, as I am, by some of the initiatives the College is taking.

The first, which has received considerable publicity, is the setting up of the Patients' Liaison Group. Pendleton informs us that we must beware when 80 per cent of our patients express satisfaction with our services, but when these patients become members of the Liaison Group their views must command attention. Increased accessibility is requested, but this may be for a vocal minority while the less demanding or articulate may suffer. It is surely to be expected that people suffering from chronic conditions would be less satisfied than others—they would need to be saintly not to be dissatisfied on occasions. British medicine is overburdened by committees, and the establishment of new committees should usually be resisted.

Another curse of British medicine is the excess number of examinations. I am astonished to see the College cooperating in the establishment of a Diploma in Community Child Health. The benefits of paediatric screening are surely not so well established as to justify this step.

Even when we can recognize patients with problems such as smoking, obesity or an indifference to safety, our efforts to help frequently fail. Why we should do better with alcoholic patients who do not wish to bring their problems to our attention is not made clear in the editorial 'Alcohol—looking for problems' (January *Journal,* p. 8).

The overwhelming problem in general practice today is the inadequate facilities for the care of the elderly. The voice of the College should be raised to emphasize this, and when an improvement has been made here, then perhaps will be the time for some of these other ideas.

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## Alcohol—Looking for Problems

Sir,

Your editorial (January *Journal,* p.8) clearly exposed the writer's confused state on the subject of alcoholism—a state shared by many general practitioners.

Questionnaires are useful—essential—we all use them in the consultation by a different name to diagnose any disease. Angina is comparable. The diagnosis is historical and is principally achieved by a 'questionnaire'.

His shyness in using the terms 'alcoholic' and 'alcoholism' is commonplace because the words are also terms of abuse. Is he equally shy of using the word 'syphilitic' for the sufferer from syphilis? The acquisition of both diseases is probably due to bad behaviour (syphilis *can* be caught from lavatory seats and, I suppose, alcoholism from communion wine) but having acquired the disease the sufferer falls into the category of a sick patient needing and deserving treatment and not moral castigation.