the UK; others include physiotherapy and routine investigations, the idea of a physician in charge, information systems and annual reporting to the Board of Health and the concept of the health centre as a functional unit incorporating outlying dispensaries. At the risk of overwhelming our Finnish friends with medical tourists I would encourage other general practitioners to follow Roger Jones' example and go and see for themselves.

I predict that as with large schools and high-rise flats the economies of scale of the large district general hospital will increasingly be seen to be irrelevant to the health needs of the population beyond the year 2000. The present demographic structure in the UK implies a reducing need for paediatrics, obstetrics, and acute general medicine, general surgery and orthopaedics at least for younger accident victims. Better prevention in relation to accidents and heart and lung disease will reinforce this pattern until the majority of hospital clinical work is concerned with the elderly. Much of this work can be dealt with in general practice and this trend will be reinforced by consumer preference. Such a move would be greatly assisted by the development of a new type of cottage hospital facility based on health centres, even in the cities and perhaps especially in the outer city estates.

The result is that social support will be enlisted in care and some work provided locally where it is most needed; the problems of travel and access, not to mention those of public alienation from large hospitals, will be avoided.

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Falklands war veterans in general practice

Sir,

The publication of Jones and Lovett's paper on delayed psychiatric sequelae of the Falklands war (January *Journal,* p.34) shatters the illusion of problem-free adjustment for all who took part in this military campaign.

My research with veterans of the South Atlantic campaign indicates that a large number of ex-servicemen are currently in the throws of personal crises which mirror those of US Service personnel who took part in the Vietnam war. Alarmingly, my subjects also report another aspect of the American experience; that they do not know where to turn to for a considered clinical stance towards their problems.

The physical and psychological sequelae of war experience are varied and often idiosyncratic, presenting the primary care physician with a challenge. Apart from being attentive to presenting symptoms the general practitioner should look for clues to the patient's hidden psychological state. For instance, reports of being upset by memories of the war, having troubled dreams and being overcome by feelings reminiscent of those experienced during war indicate a need for psychological help, particularly if these are compounded by difficulties in getting close to people and living an increasingly constrained and impoverished lifestyle. Those servicemen most affected say they are now more jumpy and hyped-up and sleep less well than before the war; they feel guilty, particularly about surviving or not having done enough for those who were killed. Falkland veterans are also upset by confrontation situations such as fights or arguments and some go to extreme length to avoid these altogether. 'Control problems' over drinking, eating and smoking co-exist with those of containing impulsive eruptions of fear and anger. Doctors should be alert to the paradox of patients repeatedly being involved in frightening situations such as accidents and fast dangerous driving.

While Jones and Lovett suggest their three cases may be 'the tip of an iceberg', my research indicates that it would be unwise to assume that this is an iceberg of psychiatric morbidity. It is only the tip of the iceberg where psychiatric cases are found. Those in the metaphorically 'submerged' section suffer psychological distress traceable to war events and need help from professionals in psychology rather than medicine, preferably dynamic psychotherapy.

Management at primary care level should therefore be guided by diagnostic restraint plus an appreciation of the importance of appropriate referral. But even so, general practitioners should not be surprised if they encounter considerable difficulties in guiding patients towards effective help. Scarred by prolonged exposure to life-threatening activity by 'enemy personnel' plus lack of understanding from their peers, ex-servicemen do not readily establish trust, however well intentioned the helper.

I should be interested to hear from anyone who has, or has had veterans of the Falklands war in their care.

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Parents' attitudes to measles immunization

Sir,

The paper by Morgan and colleagues on parents' attitudes to measles immunization (January *Journal,* p.25) raises interesting and important issues. General practitioners cannot expect improved parental attitudes until they increase their own motivation to achieve high immunization rates. This involves being fully conversant with practice immunization protocol, and actively educating parents from the time of the postnatal visit. It is essential to have an efficient recall system and to follow up defaulters.

In Fife, 54% of general practitioners left the initiative for immunization to the parents; only 29% actively recalled patients when aged 15 months and their measles immunization rate in 1984 was only 73%.[1] It has been shown that a motivated practice can achieve the 90% uptake rate required to achieve herd immunity.[2]

We established a 'Baby clinic' in January 1985 in our 10 doctor urban practice — the adult unemployment rate in the area is 27% and the patients are largely in social classes 4 and 5. Prior to this our measles vaccination rate was 30%. We now recall babies for vaccination when aged 15 months by sending a letter and an explanatory leaflet to their parents. Defaulters are sent a further letter and are visited by a health visitor if they default a second time. I visit persistent defaulters at home for counselling and vaccination. Only two parents have refused immunization for their child after counselling.

The measles immunization rate in our practice for 1985–86 was 98.5% while the rate for the primary course of immunizations was 97.8%.

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References

1. Carter H, Jones IG. Measles immunisation: results of a local programme to increase vaccine uptake. *Br Med J* 1985; **290:** 1717–1719.
2. Ross SK. Childhood immunoprophylaxis achievements in a Glasgow practice. *Health Bull (Edinb)* 1983; **41:** 253–257.