Eastbourne 'new things' courses have demonstrated that a course for general practitioner principals can be devised and planned by general practitioners using only the resources available to a district postgraduate centre.

In a recent College publication[4] patterns of attendance at continuing medical education meetings were analysed. Lunchtime lectures and audit assessments still retain popularity but whether attendance at meetings made any difference to competence is debatable. Programmes should incorporate general practitioners who speak from their own experience and special expertise and the importance of small group teaching needs to be emphasized. Improved quality of care resulting from continuing medical education can only enhance and enrich practice.

ANIL KUBER

Group Practice
St Andrews Road
Tidworth, Hants SP9 7EP

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Incidence of mumps

Sir,

We were interested to read of the comparability of the weekly returns data and the Oxford regional sentinel practice scheme (October *Journal,* p.461) since we believe that such surveillance systems have an important place in communicable disease control. For example, evaluation of the success of the measles, mumps and rubella vaccine programme will require population data on the incidence of measles, mumps and rubella.[1] Mumps was made a statutorily notifiable disease in October 1988 but the main source of surveillance data is that collected by the Royal College of General Practitioners surveillance scheme and other similar schemes.[2] Since 1986 general practice surveillance of common infectious diseases including mumps, has been carried out in Wales, and we report data for mumps for the first year of the project.

From December 1985 to January 1988 practices throughout Wales, with a total patient population of about 200 000, have been recruited to report cases by age and sex each week. Fifteen practices with a patient population of over 100 000 reported throughout 1986 and their data for mumps are shown in Table 1. The age specific incidence rates for males and females were similar. For Wales as a whole there was a peak from June to August and a later peak in December. The peak incidence in the summer for 0–4 year olds was in June (3.8 per 1000 population) and for 5–14 year olds in July (1.9). The December rates for the two age groups were 4.7 and 1.5, respectively.

Table 1. Incidence of mumps in Wales in 1986 by age of patients.

Age (years)	Number of cases	Incidence per 1000 population
0–4	146	25.5
5–14	150	11.6
15–24	22	1.3
25–34	9	0.6
35–44	6	0.4
45–64	3	0.1
>64	2	0.1
Totals	338	3.3

The crude incidence of mumps in 1986 estimated from data reported by the College's Birmingham research unit,[3] which covered a population of about 200 000 people mainly in the Midlands, was approximately 3.2 per 1000 population, compared with 3.3 in Wales. Our data confirms the reliability of the College data published in the Office of Population Censuses and Surveys *Monitor* series as an accurate index of national trends. The incidence in 0–4 year olds in Wales in 1986 was similar to that calculated for the period 1974–81 from College data,[2] but the incidence in 5–14 year olds in Wales in 1986 was only 12 compared with 16 for the period 1974–81 from College data. Our data confirm that mumps is increasingly an infection of pre-school children. It has been suggested that the introduction of mumps vaccine may change the age incidence of mumps so that a greater proportion of cases occur in older age groups[2] when complications are more frequent. However, if there is a high uptake of vaccine the risk of disease in teenagers and adults should be less than at present.

Surveillance data from general practice will be an important means of monitoring the effectiveness of the measles, mumps and rubella programme and of assessing the completeness of notifications of mumps.

S.R. PALMER
ANNE BIFFIN

University Hospital of Wales
Heath Park
Cardiff CF4 4XW

GWYNETH HORNER
J.D. GRIFFITHS

Department of Mathematics
University of Wales Institute of Science and Technology
Cardiff

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Medicine in South Africa

Sir,

I am writing first to add my support to Dr Reissmann (Letters, June *Journal,* p.278) who suggested that the College should be breaking links with South Africa rather than encouraging them, and secondly, to draw readers' attention to avenues of positive action they can take to support the victims of apartheid.

The Star has reported that state medical expenditure for blacks in South Africa is less than one third that for whites. Medical services in the country are provided on a racially discriminatory basis and even the most progressive doctors cannot overcome the overwhelming effects of starvation, poor housing, harassment, torture and inhumanity. In effect, apartheid compromises medical ethics and by associating with bodies that work within the system, we compromise ourselves.

Norman Levy (Letters, September *Journal,* p.425) states that members of the South African Acadamy of Family Practice/Primary Care are practising independently and free of any constraints. The independence of the medical profession is limited by the acceptance of the stringent conditions of working under the apartheid regime's state of emergency. For instance, collation and publication of injuries inflicted by the South African police is prohibited (Proceedings of the National Medical and Dental Association Conference, 1987). Seventy doctors who signed a letter[1] outlining the appalling conditions at Baragwanath Hospital last year were forced by the authorities to sign an apology. Those who did not sign were not reappointed to their jobs and have had difficulty in furthering their careers.

We know that many South African doctors are assisting victims of apartheid and these doctors need our support. By failing to recognize official bodies that collude with apartheid, whether overtly or covertly, we support those doctors within the country who oppose apartheid. In addition, international academic boycott has