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.

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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.

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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

helped individuals within the apartheid system to bring about change within their organizations as well as raising the awareness of the inequities of the apartheid system overseas.

The National Medical and Dental Association was formed in 1982 by 1000 progressive doctors in South Africa and represents an alternative to the establishment Medical Association of South Africa. These progressive doctors affirm that you cannot divorce health in South Africa from the apartheid system and they deserve our full support.

I would like to draw readers' attention to the Health Workers Against Apartheid organization which was formed in London in September 1988. Membership is open to all health workers and at present comprises doctors, physiotherapists, psychologists, speech therapists, medical students, nurses, dieticians and health visitors. The organization aims to provide information, act as a pressure group on health related issues in South Africa, support people and groups who oppose the oppressive system, and to raise funds for the victims of apartheid.

The Health and Refugee Trust of South Africa is one of the charities supported by Health Workers Against Apartheid. The aims of the charity are 'to provide relief of poverty, homelessness and other forms of distress, the protection and preservation of mental and physical health and the advancement of education' among refugees and their families from South Africa. The charity is currently raising money to fund three major projects:

1. The children's project will help to rehabilitate refugee children who have been brutalized by detention and torture in South Africa by providing psychological support and treatment by appropriately qualified South African psychologists familiar with the cultural and social backgrounds of these children.

2. A workshop on the management of common diseases in refugees in southern Africa has the aim of developing a common approach to their prevention and treatment and compiling an essential drugs list and a rational policy for their use.

3. An on-going project provides education about the nature of the acquired immune deficiency syndrome and human immunodeficiency virus infection, its manner of spread and modes of prevention.

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For further information please write to: Health and Refugee Trust (HEART), 23 Bevenden Street, London N1 6BH; Health Workers Against Apartheid (HWAA), 13 Mandela Street, London NW1 0DW.

Breast self examination

Sir,

I was disturbed to see another call for general practitioners to teach the technique of breast self examination on an opportunistic basis (Letters, October *Journal,* p.470). The benefits of this technique are, despite an extensive literature, as yet unproven, and little has been said of its costs.

The most recent meta-analysis of the studies of breast self examination[1] relates to 12 trials, half of which purport to show some benefit from the technique. The endpoint taken was stage of disease at diagnosis. A small effect on the size of tumour (smaller) and presence of nodes (less likely) at diagnosis was reported in women who had ever practised breast self examination. Interestingly, there was no difference between stage of tumour diagnosed according to whether it was first detected by breast self examination or by accident. The authors conclude that breast self examination 'increased awareness' of changes in the breast, and therefore that the actual method of disclosure is irrelevant. This conclusion is not supported by evidence. The technique of meta-analysis suffers from the fact that 'positive' studies are more likely to be published than negative ones. All the studies analysed were retrospective, and recall bias is therefore a major confounding factor.

It is obvious that survival of women with breast cancer is longer if the diagnosis is earlier, but it does not necessarily follow that earlier diagnosis alters the course of the disease or decreases mortality. An equally plausible hypothesis is that earlier diagnosis simply makes the patient feel miserable for longer since the course of the illness may be little altered by treatment. The continuing uncertainty over the efficacy of mammography, which detects much smaller tumours than those found by breast self examination, highlights this point.[2,3]

What of other disadvantages of breast self examination? First, it takes time and causes some discomfort if correctly performed. Some women find it embarrassing.[4] For every case of breast cancer diagnosed and treated, a number of false positives are generated, with all the anxiety, pain and financial cost that this entails. Finally, what of the guilt of women who have breast cancer diagnosed and who have never practised breast self examination? The more this technique is promoted, the bigger this problem will become. We would do better, pending good research data, to work on persuading people to stop smoking, and to offer breast examination only to women requesting it, rather than trying to deal with our own anxieties by promoting a technique of dubious merit.

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Clinical psychologists in general practice

Sir,

The paper by Drs Milne and Souter (October *Journal,* p.457) does indeed paint a different picture of the role of the clinical psychologist in general practice from other recent papers and editorials on the subject.

It is hard to explain why the experience of clinical psychologists in health maintenance organizations in the USA is not mirrored here in the UK. A 50% reduction in subsequent consultations for any reason is not infrequently recorded in some American studies where outcome has important financial implications.[1,2] In addition, costs of prescriptions fall and patients as well as therapists report satisfaction with outcome. I suspect that the differences are due in part to the doctors' cultural expectations of the psychotherapists and the expectations of the patients who expect something to be done to them. Unless the referring doctors can accept the need for additional training to enable them to make appropriate referrals and to accept their responsibility for ensuring regular contact with therapists and counsellors little will change. Therapists too need additional expertise in managing what is often a new style of brief intervention work which needs to concentrate on limited goals, transference both negative and positive, and the planning of the therapeutic process to encompass beginning, middle and ending of the therapy.

We have a lot to learn in this country from the experience in the USA where the third party carriers (insurance companies) long ago put a stop to indefinite and