been seen as prophecy indeed. His inference must surely be that the computer is now adding a similar revolutionary dimension to our work.

We suggest that the College experiment with its computer appreciation courses at a regional venue, such as Newcastle, and then consider in what ways it might involve itself in other computer courses. We, and our colleagues of the Northern Regional Primary Care Computer Group, would be willing to act as the College's agent in this and are confident that we would have the full support of our regional adviser.

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Children's immunization records

Sir,

Pennington and Wilcox's review of the accuracy of children's immunization records (November *Journal,* p.515) has important implications for future record linkage. They maintain that, since district health authorities have a statutory responsibility to keep records, the master record should be held at district level rather than in the practice. They rightly point out that this record must be immediately available and correctable by the practice. However, they do not consider that this will not be attainable for some time yet.

Computer access to a common file is under trial in several districts. At Winchester, the use of the 'Healthnet' has been disappointingly under-used by most general practitioners. East Dyfed operate a 'community index' but have not yet publicized their use of shared records as regards child health. The Exeter family practitioner committee/general practitioner links include information on claims for vaccination fees but will not include those done in district health authority clinics. The Northampton OSI project will link only one trial practice in the next three years. So for the forseeable future, certainly until well into the 1990s, there will be no widespread electronic data sharing of this kind.

Meanwhile, child vaccination rates are in great need of improvement and this, in my view, is impossible without holding records in tandem in practices and in health authority clinics. Rates exceeding the 72% quoted by Dr Wilcox are often only attainable by opportunistic action in practices. We all look forward to online sharing of this information in the future but until that is possible, the practice computer should be the master record.

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Use of cotton buds in the ear

Sir,

I was interested to read the letter from Dr Fisher on the appearance of wax plugs in ears cleaned with cotton buds (August *Journal,* p.375). Ears which are regularly cleaned with cotton buds tend to have the following: a completely clear external auditory canal with shiny canal skin; a rim of polished wax at the junction of the bony and cartilaginous parts of the external auditory canal and an occlusive wax plug in the bony external auditory canal with a highly polished surface.

A recent study[1] has shown that the use of cotton buds for aural toilet does not result in increased incidence of visually occlusive wax plugs in children and adults. However, the use of cotton buds should be discouraged because it is recognized that their use can result in injury to the external auditory canal and tympanic membrane and impaction of pre-existing wax plugs into the bony external auditory canal or against the tympanic membrane can produce hearing impairment.[2,3]

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2. Barton RT. Q-tip otalgia. *JAMA* 1972; **220:** 619.
3. Anonymous. Wax in the ear. *Br Med J* 1972; **4:** 623-624.

AIDS and chastity

Sir,

'The most preventable war, but we did not prevent it' was Winston Churchill's comment on the second world war. A similar comment, in the present tense, could be said of our attempts at preventing the acquired immune deficiency syndrome (AIDS).

There is a 'no risk' option in preventing AIDS, but so far I have looked in vain in reputable medical journals to find mention of it. At a world AIDS day symposium in Nepal in December 1988 one of the speakers commended the traditional Hindu concept of *Ek nari brahmachari.* This refers to one wife who is chaste and implies a chaste husband also. It is a reflection of post-Christian western medicine that this 100% certain way to prevent the venereal spread of AIDS is noticeable only by its absence in contemporary literature. The doctor who is encouraged to advise lifestyle changes with respect to obesity and cigarette smoking then receives criticism if he suggests the lifestyle change involved in practising *Ek nari brahmachari.*

Our forefathers failed to prevent world war two and reaped the consequences. Our failure to act adequately to prevent AIDS with more than platitudes and condoms (with their high failure rate in the prevention of pregnancy) will result in a similar catastrophe.

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My husband is not a wife

Sir,

This morning I received my first regular College *Journal* after passing the MRCGP examination. I also received an invitation to the Brighton meeting. Just as I was considering if it would be possible to make the occasion into a break for my husband and me, my attention was drawn to the 'accompanying persons' itinery. Wonderful. Imagine my irritation therefore to read, 'The pressure and demands of general practice can be wearying for the family of the doctor as well. With this in mind, wives have arranged a meeting for themselves'. Under the social programme for 'Stress and the family' there will be a panel including wives of general practitioners and paediatric and family counsellors.

While I must applaud the efforts made to accommodate families, with creche facilities and baby listening, what about my husband? This is the first time I have been moved to write on this issue. I am not a 'rampant feminist', just a woman and a general practitioner. Surely the College should be more sensitive?

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