If the computer return shows that a child has defaulted—that is, no reason for non-attendance is given—the computer will recall the child only once and then drop him or her, and thus the child at most risk is excluded from the scheme. If, however, the doctor dreams up a reason for such children's non-attendance and states on the return that a reason was given the computer will recall them repeatedly until they are immunised. We have found this simple manipulation invaluable and as a result get a monthly list from the computer of all the children due or overdue for vaccination. Formerly, children who did not complete their triple course were not offered measles vaccination under the scheme; this deficiency has now been rectified in the Greater Glasgow Health Board computer system. I agree about the benefit of highlighting on a child's record that vaccination is overdue but have found marking it in the mother's notes more valuable, as if she visits the surgery she may well have the child with her, who is probably healthy at this time. It is at her attendance that inquiry as to how the child is progressing can pay dividends, as if the parent tells you that the child is due for vaccination you can offer to do it there and then. No matter how busy that surgery is someone must find time to give the injection. This opportunistic treatment results in a satisfied parent and a satisfied doctor.

Reception staff should know who the defaulters are so that they can facilitate the making of appointments, even manufacturing immediate appointments if a poor attender's parent is inquiring about measles vaccination. Additional, non-computer sessions are helpful for those who prefer to make appointments at their convenience. Success depends on an open approach, which requires a team effort by the receptionist, the nurse, and the health visitor as well as the doctors.

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SIR,—I heartily concur with the hope expressed by Professor J E Banatvala (4 July, p 2), and would like to report on the experience of my practice in trying to achieve this aim.

Four months ago we drew up a register of all children born after 1980. By inspecting their records (90% are vaccinated in our practice) and by using our health visitor to inspect clinic records we drew up a list of all the missed vaccinations. As a result of an aggressive policy of opportunistic vaccination—performing vaccinations during any surgery, telephoning and writing to parents, and even dropping in unexpectedly on problem families—we are now near our goal of 100%. All the years from 1980 onwards show a ≥95% immunisation rate for polio and diphtheria, pertussis, and tetanus or diphtheria and tetanus and a ≥90% rate for measles. Our 1985-6 rate for measles was 95%, two parents refusing the vaccination for their children. No families have yet fallen by the wayside in 1986-7.

Measles antibody given simultaneously with the vaccine has been helpful in a few children. This is readily available from the Blood Transfusion Service and has allowed us to vaccinate children who had been told by previous doctors that they were unsuitable for vaccination owing to a history of febrile convulsions. Only six doses of the measles antibody were used from May 1986 to May 1987 in the whole of the west of Scotland (M A Peterkin, personal communication), and our practice received three of these. This raises the question of why more was not used, in view of the fact that the infantile febrile convulsion rate is 3-4%.

Though our practice is small—slightly fewer than 4000 patients between two full time partners—now that the register is running it is easily maintained. As we see nearly all of the children in the surgery ourselves, it is also possible to keep a check on such non-existent contraindications as eczema or a cousin's single febrile fit, which can prevent a child from receiving full protection against the life threatening infections that may be prevented by vaccination.

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Surrogacy

SIR,—Mr Patrick Steptoe (27 June, p 1686) seeks to challenge the motion sent by Ayrshire and Arran Local Medical Committee for debate in the BMA's annual round of conferences this summer.

The purpose of the motion was to allow debate on the BMA publication *Surrogate Motherhood*,[1] which was in draft form and confidential at the time motions had to be submitted. It has now been published, and copies were provided for all members of the annual representative meeting before the debate.

I persuaded my local medical committee to accept the premise that the booklet, which they had not seen, clearly established that the rights of the child must take precedence over the needs of the other parties to surrogacy arrangements and that these rights cannot be guaranteed. If this premise is accepted no amount of study of surveys and other evidence relating to the efficacy of surrogacy in the treatment of infertility has any relevance.

I am certain that every member of my committee has the greatest sympathy with the plight of the infertile and that they share my admiration for the innovative techniques and virtuoso skills that Mr Steptoe has developed, but I remain convinced that he should not use them with surrogate mothers.

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Secretary

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1 British Medical Association. *Surrogate motherhood*. London: BMA, 1987.

Minimising bruising in the antecubital fossa after venepuncture

SIR,—The paper by Drs A Dyson and D Bogod (27 June, p 1659) was timely indeed.

I believe that the original recommendation that the arm should be flexed after venepuncture was made by Haldane, who I suspect should have known better. Consideration of the anatomy makes it clear that if the arm is flexed over a cotton wool ball or swab in the antecubital fossa substantial bleeding is almost inevitable. Flexing the arm draws the tissues superficial to the vein away from it, and the swab may compress the vein both proximally and distally to the site of the puncture. If the compression is substantially proximal the vein is distended and will inevitably leak.

The practice of direct compression over the puncture site, as recommended for arterial puncture, has been my practice for 20 years, and I regret that I regularly have to demonstrate this technique to staff performing venepuncture. When I was a student the dark age of science was attributed to the practice of transcribing inaccurate myths from ancient to modern textbooks without considering their merit or attempting to establish the truth by experiment, and it was not until the Renaissance that this attitude changed. Or has it? I doubt if William Harvey would have flexed the elbow after venepuncture in the antecubital fossa.

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Screening for cervical cancer

SIR,—In her colposcopy study Dr Jane Chomet (23 May, p 1326) described 28 patients with inflammatory cervical smear changes, seven of whom had cervical premalignancy.

Inflammatory changes are a common finding among routine smears performed in sexually transmitted disease clinics, and in a recent study at this hospital 100 patients attending such a clinic who were found to have inflammatory changes on routine cytology were investigated for evidence of infection, with a repeat smear being evaluated about six months later. Follow up smears were normal in 39 of the women, with the remainder showing the following infections: 20 candida, 20 genital warts, 13 trichomonas, eight bacterial vaginosis, eight *Chlamydia trachomatis*, three gonorrhoea, and two herpes simplex. Three patients had evidence of mild dyskaryosis.

Rather than subjecting all patients with inflammatory changes to an already overloaded colposcopy service, I would suggest that a more cost effective approach would be to screen patients for infection in a sexually transmitted disease clinic and proceed to colposcopy in those who are found to have inflammatory changes on repeat smears or show evidence of wart infection.

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Taking money from the devil . . . and publishing the results

SIR,—In 1985 the *BMJ* published a leading article entitled "Taking money from the devil."[1] The devil was the Health Promotion Research Trust, an organisation set up by the tobacco industry, and powerful arguments were presented exhorting researchers not to take tainted money. It was therefore disappointing to see a short report (11 July, p 95) which stated "The study was supported by a grant from the Health Promotion Research Trust." Although it can be argued that it would be wrong to deprive readers of advances in knowledge, no matter how they are obtained, I feel that the publication of research supported by tainted money in respectable and respected journals is imparting undeserved respectability to the Health Promotion Research Trust and to the tobacco industry.

It is a shame that the *BMJ*, having taken such a commendable stand in 1985, should undo its good work in 1987.

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1 Anonymous. Taking money from the devil. *Br Med J* 1985; 291:1743-4.

*** To refuse publication of a scientific article because we disapprove of the source of its financial support would, we believe, be arrogant and intolerant and would conflict with the concept of freedom of speech in science. But we stand by our leading article.—ED, *BMJ*.

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