of abuse. In the correct dose, pressurized bronchodilator aerosols are probably all as safe as effective drugs can be made. If toxic effects occur in these circumstances then idiosyncrasy is responsible.

I am quite certain, however, that the statement of Drs. D. Jack and D. Harris that "it would be a pity if . . . patients resumed the use of isoprenaline-containing aerosols instead of those containing drugs such as salbutamol which are likely to be safer even if they are abused" (11 March, p. 689) is an extremely dangerous one. I have on several occasions seen patients very ill as the result of abuse of salbutamol and will be reporting one such case in the near future.—I am, etc.,

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¹ Conolly, M. E., Davies, D. S., Dollery, C. T., and George, C. F., *British Journal of Pharmacology*, 1971, 43, 389.

Local Government Bill and Notification of Disease

SIR,—I wonder whether I am a lone voice crying in the wilderness, or whether other colleagues will have read your Parliamentary report about the Local Government Bill (1 April, p. 58).

I am sure we are all delighted to learn that the national health services are personal social services, and that public health services are related to materials, buildings, and substances, and that when the National Health Service Bill, not yet published, and the Local Government Bill are put side by side, it will be clear how the division was made. "Later," your report states, "Mr. Page moved an amendment to Schedule 14 (Amendment and Modification of Public Health Acts, etc.) to require that where an individual had to serve a notice on the medical officer of health—for example, where there was an outbreak of disease—the notice should be served on the local authority. The amendment was approved." This is obviously one of those matters where the distinction between personal social services, or should it be personal health services and public health services, is not quite so clear.

I wonder how many family doctors will wish to notify cases of infectious diseases directly to the local authority, as once again the question of confidentiality is being breached. I am not sure, if I should suffer from tuberculosis, that I would want details of my name, address, and illness exposed to any Tom, Dick, or Harry in the local town hall.

Of course, it is assumed that this work will be carried on by the chief public health inspector, but the appointment of chief public health inspector is not a statutory appointment in the new Local Government Bill, as is that of director of social services and director of education, and it can well be in the flexibility of management structure of the new local authorities it is decided that the chief public health inspector is a minor officer in the department of the planning officer or the borough engineer. In fact, it may even be decided that it is not worth having a chief public health inspector at all. The whole system can only be described as "woolly and imprecise," and one can only hope that the working party of the Department of Local Government and De-

velopment and of the Department of Health and Social Security makes sure that a copy of the notice at least goes to the community physician. If this is not done, the excellent control of infectious diseases which we have at present may shortly be a thing of the past. Personally, what I think is likely to happen is that family doctors, realizing that confidentiality once again is being broken, will face similar problems to those they have faced with the transfer of the mental health services to the director of social services, and, therefore, they will tend not to notify infectious diseases.

The result will be poor control of infectious diseases owing to imprecise notification to the local authority, and the resulting statistics will be useless.

I would appreciate comments from medical colleagues and their feelings regarding some of the "improvements" in the services which we are all accepting somewhat too readily.—I am, etc.,

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Community Medicine

SIR,—We are living in an age of semantics; new words are coined more often in response to fashionable trends than to portray a new conception. The name "community medicine" is of relatively recent origin but is synonymous with the functions of the early medical officers of health, who in fact practised communal medicine. His canvas was a large one. His functions as defined in some directives from the Ministry of Health were to make himself aware of all matters which might have an effect upon the health of the community that he served—a somewhat comprehensive assignment.

If we agree that the medical officer of health practised community medicine, we may logically review his activities one by one and consider whether such work fills the present day concept of community medicine. The whole environment came within his remit—namely, air, water, sanitation, food supply, and infectious diseases. His duty was to assess the relative health of his community using all available statistical data, and he had to be sufficiently adept in the use of such methods to give an intelligent appraisal of communal situations; in present day jargon we would say he practised epidemiology in his own geographical setting. His functions in connexion with communicable diseases are sufficiently well known to need no comment other than to hint that their effectiveness may well have been a contributory fact in his apparent decease.

With such comprehensive responsibilities it is not surprising that his trained technical and nursing support multiplied, and that he had to rely on other branches of medicine to support his work—for example, laboratory public health service, health inspectorate staff, analyst, and many others.

Professor Alwyn Smith referred to a possible definition of community medicine in the report of the Royal Commission on Medical Education para 133.¹ This paragraph, apart from defining the phrase as being what certain doctors, local authorities, central authorities and others do, says "It is concerned not with the treatment of individual patients but with broad questions of

health and disease in, for example, particular geographical and occupational sections of the community and in the community at large." Paragraph 134 is more forthcoming and is worth quoting.

"In community medicine, as we define it above, the doctor has no monopoly of responsibility or of contribution: many other people's skills are also required. Indeed in some fields, such as environmental control—the pioneering activity which first brought organized community health services into being—the day-to-day responsibility has largely passed out of medical hands. Nevertheless, medical leadership in community medicine is as important as ever."

The medical officer of health was burdened with many duties which are not relevant to a community physician—for example, the care of the physical and mentally handicapped. As a health educator and adviser to teachers the medical officer of health should continue his functions as a school medical officer.

I would suggest that the traditional duties of the medical officer of health where they are of a communal character are as important—if not more so—today than they were in the past.—I am, etc.,

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¹ Royal Commission on Medical Education. *Report 1965-68*, Cmnd. 3569, London, H.H.S.O. 1968.

Doctor-Patient Relationships

SIR,—We were glad to read the first part of Dr. D. Craddock's letter (11 March, p. 692), in which he claims that the doctor-patient relationship can only be improved by dispelling "the mumbo-jumbo and black magic on which the profession has relied in the past to maintain its authority." We would agree that no time which is spent in explaining illness to patients is ever wasted.

However, Dr. Craddock goes on to say that the doctor-patient relationship may be endangered by the modern trend towards group practice unless patients are trained "to attach themselves to one doctor only." We believe the opposite. We feel that doctors, rather than objecting to their pet patients consulting other partners within the group, should actively encourage this practice. If the group remains small (three or four doctors) the care is still personal, and ideally all patients know all doctors and vice versa. The advantages are as follows.

(1) Wider clinical observation. While no doctor can deny that it is flattering to be in continuous demand by faithful patients, it is easy to forget that this is not necessarily a yardstick of clinical judgement, and his insistence on keeping them to himself denies them the possibility of a different method of management which might be better for them. Everyone knows how frequently such insidious illnesses as myxedema or pernicious anaemia are overlooked, only to be finally diagnosed by a newcomer.

(2) "Personal" 24-hour cover. In a practice where 24-hour cover is provided by partners in rotation patients are rarely attended in an emergency by a doctor that they do not know. There is no occasion when a patient needs to feel more secure than this.

(3) Less "manipulation" (deliberate or accidental) by patients. With increasing familiarity, there is always a danger of less