that should be approached are the health service administrators. Undeservedly they get a bad press, and yet, with the Department of Health and Social Security's policy of devolving power to the districts, administrators will be crucially important if more emphasis is genuinely to be given to prevention. The HEC should participate in training all these groups, supplying them with information, aids, and support. It must also create closer links with groups outside the NHS—especially industry and the trade unions.

One group of the greatest importance are the politicians. As Sir George Young has said, many of the country's health problems can be better managed by decision at the cabinet table rather than by incision on the operating table. Trying to limit the consumption of tobacco and alcohol has a considerable political component, but the HEC's job will be more to work with the DHSS and the Government than to antagonise them too much. Putting in pins where they hurt may be left to Action on Smoking and Health, Action Against Alcohol Misuse (if it ever gets started, and we are sure that it must), the Coronary Prevention Group, and other pressure groups, but the HEC will have to make its voice heard on political action to improve health problems. It should also let members of Parliament know what it is up to, possibly by inviting them in small groups to informal briefings at regular intervals. All MPs should be interested in the health of their constituents even if they are consultants to tobacco companies.

Once the HEC has impressed the politicians with its energy and enthusiasm—not to mention the immensity and importance of its task—it might ask them for more money. At the moment it has £8½m a year, but, given that prime time television advertising costs about £80 000 a minute (the whole HEC budget would not make a two hour commercial), that the drug industry spends £120m a year promoting its products within the NHS, and that the HEC has such a wide range of problems to cover, that sum does not seem nearly enough. It needs at least £25m, and, furthermore, it should have no difficulty in producing economic arguments that effective campaigns might lead to savings in lost productivity and to the NHS of much more than this amount.

So what must the HEC do with its new friends, influence, and money? Smoking must be its priority. We have incontrovertible evidence on the dangers of smoking, and as many as 95 000 Britons a year may die prematurely because of their smoking. Yet Britons continue to smoke heavily and the Government refuses to take effective action. Indeed, it has just signed a very weak voluntary agreement with the tobacco industry on the promotion of tobacco products, and the wicked web of tobacco sponsorship of sport and the arts seems to extend a little further each day. If sponsorship is not effectively countered then many of the leisure pursuits of the British will depend irreversibly on tobacco money. The HEC must be imaginative and opportunistic in its campaigns to limit smoking, and it should sell the British people the joy of not smoking and living a healthier life style. We are confident, too, that it will not touch the £11m so cynically provided by the tobacco companies for research into any kind of health promotion that does not include studies of smoking—"blood money" as Dr Player himself has so aptly called it.

Next on the list must be alcohol problems. Hit by the recession the country is drinking less, but alcohol is still causing an immense amount of social and health damage. Britain needs to drink less, and the HEC must convince not only the British people but also the Government of this. After several false starts the campaign in the north east to change people's attitudes to alcohol seems to be showing signs of success. The time has surely come to extend that campaign to the rest of the country.

HEC campaigns to convince people of the benefits of not smoking should contribute to bringing down the mortality from coronary artery disease. But perhaps the time is also right to start campaigns on diet and exercise. The evidence on the link between the two and coronary artery disease is hardening all the time. But is it time to act and what advice should be given? The HEC needs expert advice on this problem, as it does on several others, and, we believe, it should appoint more expert advisers. The HEC should be a centre for definitive information on current health problems, and it might well consider putting out regular position papers on rapidly developing topics.

Contributions of expert and academic advice would also be useful for the vitally important HEC evaluation programmes. It must know that it is getting maximum value for its money, and, as well as evaluating the effectiveness of campaigns, it should make pilot studies before launching any campaign. Too often the HEC's slogans have been misunderstood. The corollary of piloting and evaluating is that it must scrap those activities that are not working. Dr Player has already shown himself willing to take decisions to abandon projects on this ground.

Finally, there are two other possible new directions. Firstly, the HEC should try to do something about the regional inequalities in British health. A good start might be to create a regional office with its own director in both Wales and Northern Ireland. Secondly, it should consider directing more of its campaigns specifically at women and their problems. Women are beginning to catch up men in their smoking and drinking habits, but are at the same time more concerned with the importance of health than men. As part of its drive to force better links with the media the HEC should not forget women's magazines, which are read by millions of British women every week.

So here are a few ideas for Christmas stockings and New Year resolutions for the new chairman and the new director. Excited by their appointments, we look forward to working with them to see Britain healthier at the beginning of 1984 than it is at the beginning of 1983.

Measles and Indians

One hundred years after Columbus discovered America in 1492 the population of indigenous Indians in the Caribbean, Mexico, and Central and South America had dropped from around 130 million to 1·6 million.[1] This catastrophic decline was due to disease introduced from the Old World, with smallpox and measles the main killers. The peaceful Arawaks and the warlike Caribs were virtually extinct and the Aztec and Inca civilisations had crumbled away while the Spaniards, immune to the infections since childhood, were able to claim divine protection.

Smallpox and measles have much in common: very infectious, they have a high mortality in populations not previously exposed while giving survivors lifelong immunity. Both are recent introductions to the burden of human disease. They were unknown to Hippocrates, who could not have failed to describe such distinctive, dramatic infections. Probably fevers

of this kind with no animal reservoir of infection can be maintained only in large human populations; these circumstances came only when the Roman Empire had grown to the point that it had cities with populations of around 500 000. Retrospective diagnosis suggests that smallpox hit the Romans in AD 150 and measles 100 years later—with consequences almost as devastating as their later effects in the Caribbean.

The point of this potted history is that smallpox and measles have one last, crucial feature in common: they can be eliminated by medical intervention. The combination of an effective vaccine with lack of an animal reservoir or a human carrier state means that vaccination can eradicate the disease. The World Health Organisation has already achieved this goal with smallpox[2]; measles could be the next human disease to become extinct.[3]

Indeed, in the United States there is every prospect that measles will be extinct by 1984; this year fewer than 2000 cases have been notified. The reason is very simple. American children have been vaccinated against measles as routine for 10 years; in all States in the United States children cannot enter school unless they have been vaccinated against all the common infections, and 97% of children entering kindergarten are now vaccinated.[4]

Here in Britain the Department of Health and Social Security still seems to live in the same state of ignorance as Hippocrates. Despite an average of 100 000 cases of measles a year and over 20 deaths (twice the average rate for whooping cough), the Department seems to have no campaign to persuade the public to accept measles vaccination, and fewer than half our children have been protected.[3] The vaccine is effective and safe. Why, as we ask elsewhere in our editorial columns this week (p 1764), is Britain so often among the last of the technically advanced countries to adopt effective programmes of preventive medicine?

[1] McNeill WH. *Plagues and peoples*. Oxford: Basil Blackwell, 1976.
[2] Anonymous. Smallpox and vaccination. *Br Med J* 1981;**282**:1880.
[3] Noah MD. Measles eradication policies. *Br Med J* 1982;**284**:997-8.
[4] Anonymous. Measles surveillance. *Weekly Epidemiological Record* 1982; **57**:367.

Need our streets be so filthy?

Asked anecdotally about what they dislike about Britain, visitors often cite the high prices of our hotels and the filthiness of our streets. Conversely, many tourists from this country will instance the cleanliness of others as being part of the pleasure they get from travelling there, only to mention the shock when they return of noticing anew our litter strewn pavements and gutters full of cans, bottles, and dog excrement, to say nothing of the similar defilement of our roads, railways, and countryside. Representatives at this year's Annual Meeting of the BMA in London showed their concern when they gave priority to debating a motion that Britain's lack of cleanliness in public spaces, buildings, and conveniences was a national disgrace and demanded remediable action.

This year's representatives had only, however, to look outside the Logan Hall, where the ARM was held, to see examples of what they were talking about. Possibly the streets of the London Borough of Camden (where the BMA is a major ratepayer) are no more or less dirty than those of many other boroughs. Possibly, also, as an inner city area, its resources are more stretched than those elsewhere, with its large stocks of old housing and a shifting, mainly poor population. Nevertheless, with its numerous central hotels and sightseeing attractions, Camden is also an important area for tourists, and, given that a neighbouring borough has energetically tackled its litter problems, it must be asked why Camden and other boroughs do not try the same.

Of three possible approaches to this problem, one—exhortation ("Keep Britain Tidy")—manifestly does not work, and another—enforcing the law which prescribes fines for litter offences—is rarely tried. A third—prevention—should be. The City of Westminster has persuaded local firms and organisations to sponsor brightly painted stout litter bins throughout the streets of the central area. Not surprisingly these are used and the Westminster streets seem distinctly cleaner than those elsewhere. In Camden litter bins are less conspicuous, smaller, and sparser; among the streets flanking six Bloomsbury squares near BMA House, for example, there are a total of only seven litter bins. With nowhere to put their rubbish, self evidently people copy others and throw it on to the ground. Moreover, the problem is compounded by the increasing practice of shops leaving their rubbish (including food and bottles) in the streets overnight either in unfastened bags or loose in fragile cardboard boxes—which the rain reduces to a pulp or the wind distributes around. Anybody who travels through, say, Kingsway in the early morning can see the result: filth all over the pavement and road.

London is by no means the only city in Britain with such problems, nor was it always so dirty. Our people surely have the right to the same standards of public cleanliness as in other civilised countries. Local authorities and others should ensure that these are provided, and maintained.

Do it yourself obituaries

The obituaries are one of the most read sections of the *BMJ*, yet they are not without their faults and could be much improved. Their main defect is obvious to anybody in our office who has to read a dozen obituary proofs all at once. All 12 seem to be the obituaries of saints. An assorted collection of general practitioners, orthopaedic surgeons, forensic psychiatrists, and ex-presidents of various colleges might normally be expected to include a few individuals who were overassertive, pompous, unhelpful to their juniors, talked too much, were mean, or were clumsy with their hands. Yet neither in the *BMJ* nor in the *Lancet* is there more than an occasional hint of imperfection. *The Times* may print considered judgments of leading statesmen, entertainers, and artists; the medical profession seems to prefer a postmortem coat of whitewash.

The tradition has long been that obituaries printed in the *BMJ* should be written in accordance with the maxim "speak only good of the dead." Dr John Rowan Wilson, who at one time was the *BMJ*'s obituarist, was one of the first to explain the code of understatement and platitudes, while Dr Richard Gordon, who also briefly oversaw *BMJ* obituaries, said that he learnt to write fiction while writing them. "Plainspoken" in a *BMJ* obituary is, all too often, a euphemism for offensive; "a perfectionist" may well have been an obsessional neurotic.

Yet to write an unswervingly honest obituary about a col-