Points

Immunisation before school entry

Dr GRAHAM MOON (School of Social and Historical Studies, Portsmouth Polytechnic, Portsmouth PO1 3AS) writes: Dr Norman D Noah (16 May, p 1270) rightly draws attention to the comparatively limited information available on compulsory childhood immunisation and its impact in eastern European countries. He specifically mentions Czechoslovakia, a country which I recently visited as a medical geographer with a specific interest in vaccination uptake and the epidemiology of infectious disease. In Czechoslovakia virtual eradication of measles seems to have been attained by a combination of compulsory childhood immunisation and the measures which Dr Noah commends: administrative methods, health education, and service delivery. Though immunisation against measles has been compulsory since 1969, the law has been supplemented by comprehensive certification and recall systems, health education material stating that parents have a social duty to ensure the immunisation of children, and an extensive network of paediatricians with a specific responsibility for the immunisation of children within defined geographical areas. Interestingly, Dr Noah alludes to the paper by Sejda,[1] noting the reduction of measles cases to 25 in 1982. Since 1982 there has been a slight perturbation in the downward trend of measles notification. In 1983 there were 31 cases (0·2/100 000 compared with 235/100 000 in Britain) and in 1985, 33 cases. By contrast, in 1984 there were 2968 cases (19·3/100 000), of which 1637 were in western Slovakia. Circumstantial evidence suggests that imported cases were an influence in this outbreak and older age groups figured more extensively than expected among those affected. Though the effect of this localised outbreak is absent from the figures in 1985, it does suggest that optimism about the eradication of measles in Czechoslovakia cannot yet be confirmed.

1 Sejda J. Control of measles in Czechoslovakia (CSR). *Rev Infect Dis* 1983;117:2-13.

Inner city care

Dr DAVID CURTIS (London N7 8UN) writes: I find Dr Robin Hull's comparison of the defiance of the Jewish victims of the Nazi concentration camps with the behaviour of teenage male prostitutes who deliberately expose their partners to the acquired immune deficiency syndrome grossly offensive (2 May, p 1139). I hope I am not the only one. I even find it offensive that Dr Hull refers to such defiance—physical, moral, and spiritual in the face of certain death—as "pathetically futile." The purpose of being alive is not only staying alive, and whatever courage and resistance these victims of hideous persecution displayed has awed and inspired many who never met them but know them only through their example of human resilience and dignity. To me, such action does not seem futile.

Medicine and politics

Mr M A R FREEMAN (The London Hospital Medical College, London E1 1AD) writes: In the general election medical care (or more strictly the hospitals administered by the National Health Service) was a major issue. This suggests that politicians believe that there are votes to be obtained from a discussion of medicine, although it does not strictly follow (and certainly does not accord with my experience) that the average citizen in the United Kingdom is particularly interested in the subject. In spite of the fact that medical care was made an issue the standard of the political debate was, as Dr Richard Smith (6 June, p 1438) commented, uninformed. As so often in the past, the issues took second place to ideologically based position statements suggesting irreconcilable differences between the parties. Even allowing for electoral hyperbole, this does not augur well for the future of medical care in the United Kingdom. That all is indeed not well with our present arrangements for medical care is suggested by the low morale within the National Health Service. Today, therefore, it would seem that the arrangements for the provision of medical care in the United Kingdom are thought to be imperfect by the health care professions; that British citizens may have an interest in the subject and are perhaps concerned that things are not right; but that the political parties are not pursuing a constructive debate. If this analysis is correct there seems to be a need for a forum transcending party politics, in which a well researched, serious, and constructive discussion could address the issue of how best to provide medical care in Britain for the next 25-50 years. There is only one such forum within the United Kingdom—namely, a royal commission. I therefore suggest that the health care professions should lobby the incoming government, urging it to set up a royal commission on medical care in the United Kingdom. The issue is important, the present situation is unsatisfactory, and there is no alternative forum.

Hospital doctors' responsibility for prescribing

Dr S E JOSSE (Brownlow Medical Centre, London N11 2BD) writes: In theory the letter by Dr J S Wright and colleagues (2 May, p 1162) seems fair, but in practice the issues are much more difficult. As scrutiny of hospital records will show, patients are followed up with monotonous regularity, indicating a degree of follow up and supervision well beyond that needed purely to provide an opinion. Immediately a hospital medical officer takes on this role he becomes just as responsible for treatment as the general practitioner, and he then has a responsibility to prescribe as is appropriate. There may well be shared care (in patients with diabetes, hypertension, pregnancy, epilepsy, etc) with the general practitioner, and under these circumstances the general practitioner will obviously prescribe. This, in fact, is not the problem, nor is there a problem concerning the prescribing of very toxic or new drugs through a hospital clinic. What is particularly irksome is for the general practitioner to be asked to prescribe a drug, usually expensive, on behalf of a hospital medical officer when the patient remains under the active treatment of that medical officer, is being supervised by him on a regular basis, and would otherwise have no reason to return to the general practitioner for the condition that led to his referral to hospital. Hospital doctors are just as capable of determining previous allergies and idiosyncrasies. For a hospital doctor to evade his responsibility and for a health authority to make policies concerning prescribing by hospital doctors and dispensing of drugs that effectively make it impossible for a particular patient to receive his drug treatment through a hospital, on the grounds of the general continuing responsibility of the general practitioner on the one hand and as a cost cutting exercise on the other, is really unacceptable.

Public not private property

Drs STAFFORD LIGHTMAN and BARRY EVERITT (Charing Cross and Westminster Medical School, London SW1P 2AP) write: We were surprised that, in his review of our book *Neuroendocrinology* (25 April, p 1091), Dr P E Belchetz suggested that our figure relating plasma osmolality to plasma arginine vasopressin concentration was "lifted" without acknowledgment from the work of Dr Peter Baylis. This is a strange accusation as all laboratories with a research interest in plasma vasopressin need to construct a normal range for their assay. Since a normal range varies with plasma osmolality the plasma vasopressin concentrations need to be measured at different plasma osmolalities, as originally shown by Dr Gary Robertson. The data in *Neuroendocrinology* represent the normal range in the laboratory of Dr Lightman at Westminster Hospital. Dr Baylis is a respected colleague, and his studies on the clinical control of vasopressin secretion (a summary of which is to be found in Dr Belchetz's own book) are interesting and important. The necessary efforts to limit the number of references quoted in the chapter unfortunately resulted in a lack of referral to these studies, which, we agree, was a pity. This, however, is a very different matter from the suggestion that we actually used his data without due acknowledgment.

Medical harmony

Mr N J S KEHOE (St James's University Hospital, Leeds LS9 7TF) writes: In response to a question posed by Minerva (11 April, p 976) regarding the musical capabilities of English teaching hospital medical staff, may I mention an orthopaedic quartet: Cobb and the Elevators, who recently performed on stage at the Queen's Hotel, Leeds. For half an hour or so the delegates of the 12th annual dinner of the British Scoliosis Society were treated to a varied programme of music played to a very high standard. Before a distinguished gathering of spinal surgeons the quartet of Professor Robert Dickson on piano, senior registrar James Robb on double bass, university tutor John Cruickshank on French horn, and consultant Kevin Sherman on percussion brought much pleasure and considerable harmony. Unfortunately, their varying clinical commitments prevent many public appearances, but the quartet continues to gather for private occasions.

Doctors and the death penalty: an international issue

Dr PETER DOHERTY (Guild of Catholic Doctors, London SW13 9QE) writes: Dr Anthony W Clare (9 May, p 1180) raises serious ethical issues regarding the direct participation of doctors in lethal injections. Though the article confined itself to the administration of capital punishment to convicted prisoners, the broader ethical issues of the death penalty raised by Dr Clare must include the taking of innocent human life. Abortion is now a widespread practice and is frequently accomplished by the administration of a lethal injection by a doctor.

Time for action on hepatitis B immunisation

Dr SHEILA POLAKOFF (Hepatitis Epidemiology Unit, Central Public Health Laboratory, London NW9 5HT) writes: Mr M P Shoolman implies (9 May, p 1232) that hepatitis B vaccine is supplied from the Central Public Health Laboratory in Colindale. This is a common misunderstanding. In fact, the material distributed from this and other public health laboratories is specific hepatitis B immunoglobulin, used for postexposure prophylaxis, which is in limited supply. Hepatitis B vaccine is obtained by prescription.[1]

1 British Medical Association and the Pharmaceutical Society of Great Britain. *British National Formulary No 13.* London: British Medical Association and Pharmaceutical Society of Great Britain, 1987:392.

Cervical smears: new terminology and new demands

Dr D M D EVANS (Llandough Hospital, Glamorgan CF6 1XX; British Society for Clinical Cytology) writes: The excellent leading article by Professor H Fox (23 May, p 1307) correctly reports that the working party of the British Society for Clinical Cytology considered recommendations for the further management of patients. These recommendations have now been published.[1]

1 Evans DMD, Hudson EA, Brown CL, Boddington MM, Hughes HE, Mackenzie EFD. Management of women with abnormal cervical smears: supplement to terminology in gynaecological cytopathology. *J Clin Pathol* 1987;40:530-1.

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