

Care and caring are by very nature personal. The entire concept of general practice, family medicine, primary care, call it what you will, in Britain is the continuing care of the patient as a whole. Once the patient is fragmented among a team of so-called experts personal responsibility and care lose their meaning.

The recent publication by the Office of Health Economics<sup>2</sup> must have either amused or exasperated general practitioners by its "academic" analysis of primary medical care with little reference to real life. Pray come down from the clouds and look at life as it is, not as it is assumed to be by whatever board or committee, however eminent the chairman be in his own field.—I am, etc.,

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<sup>1</sup> B.M.A. Board of Science and Education, *Primary Health Care Teams*. London, B.M.A., 1974.

<sup>2</sup> Office of Health Economics, *The Work of Primary Medical Care*. London, O.H.E., 1974.

### E.B. Virus and Treatment of Lymphomas

SIR,—Dr. R. Salm (25 May, p. 435) concludes that E.B. virus, as a passenger parasite of lymphomatous cells in Burkitt's tumours, is responsible for the sensitivity of the lymphoma cells to cytotoxic drugs. He then suggests the inoculation with E.B. virus of patients in temperate zones before chemotherapy to try to induce drug sensitivity. As we are conducting a comprehensive prospective seroepidemiological study on the relationship between E.B. virus and Burkitt's lymphoma we are prompted to comment on Dr. Salm's views.

To assume that E.B. virus is a passenger parasite in Burkitt's lymphoma in Africa is as presumptuous as it is to take for granted that this virus is the cause of the tumour. The evidence for an association between E.B. virus and Burkitt's lymphoma is both serological and virological. The serological response of African Burkitt lymphoma patients to E.B. virus antigens is not always found in lymphoma patients from temperate areas,<sup>1</sup> but when pathological evaluation and age are taken into account the serological picture is similar in Burkitt-type lymphomas in young children.<sup>2</sup> One cannot state that E.B. virus reactions do not correlate with the course of the disease, as studies have shown the opposite with regard to membrane-bound antigen reactions<sup>3</sup> and to complement-fixing reaction against the soluble antigen.<sup>4</sup> The second set of supporting data refers to the presence of E.B. virus fingerprints in the tumour cells. E.B. virus genomes and E.B. virus specific nuclear antigen (E.B.-N.A.) are found in African Burkitt lymphoma tumour cells<sup>5,6</sup> and search in American Burkitt-type lymphomas is in progress. Arguments for and against the aetiological role of E.B. virus in Burkitt's lymphoma have been reviewed by Klein.<sup>7</sup> Dr. Salm seems to have read only part of the literature on the subject, as 20 out of his 28 references are to one journal.

The E.B. virus has oncogenic properties, contrary to Dr. Salm's statement. E.B. virus infection in vitro of human and of some primates' lymphocytes results in the establishment of lymphoblastoid lines having characteristics of malignant transformed cells (infinite life, ability to heterograph, and tumour production).<sup>8-11</sup> E.B. virus infection in vivo of some primate species such as marmosets results in the development of lymphomas.<sup>11,12</sup> On the other hand, animal herpesviruses are oncogenic in frogs, fowl, and primates, and to dismiss the potential oncogenic activity of E.B. virus could lead to dramatic consequences.

The International Agency for Research on Cancer has based its study of the aetiological role of E.B. virus in Burkitt's lymphoma on the role of E.B. virus primary infection as a cause of infectious mononucleosis.<sup>13</sup> A prospective seroepidemiological study of 40,000 children aged 2-7 was begun 30 months ago in the West Nile district of Uganda.<sup>14</sup> Their sera are being kept in liquid nitrogen until Burkitt lymphoma cases arise among

them, which is already happening. The results will be analysed in the context of seroepidemiological data being obtained simultaneously in the general population of the West Nile district of Uganda and in other populations in Hong Kong, Singapore, and Europe, where Burkitt's lymphoma is less common.<sup>15</sup> Dr. Salm dismisses the hypothesis that malaria may be a causative factor in Burkitt's lymphoma because "typical cases of Burkitt tumour have been observed outside the endemic regions of Africa." Cofactors contributing to lymphoma causation differ from one area to another. The most striking feature about Burkitt's lymphoma in non-tropical countries is its great rarity compared with its incidence in malarial countries. Thus tropical Burkitt's lymphoma is possibly different from what is called Burkitt's lymphoma in temperate zones, and the high incidence in Africa may well be due to the impact of malaria on the immunological system. The International Agency for Research on Cancer's recent finding of a seasonal variation in the onset of Burkitt's lymphoma in the West Nile<sup>16</sup> also suggests hyperendemic malaria as a causative factor. Impairment of cell-mediated immunity and of the reticuloendothelial system may lead to massive E.B. virus infection, reinfection, or internal reinduction. Since E.B. virus is potentially oncogenic perhaps massive infection or reinfection of a depressed organism may lead to clonal transformation and further development of a tumour.

Until the oncogenic potential of E.B. virus has been more thoroughly explored it would be unwise to inoculate patients with it. In fact, such inoculation occurs when seronegative patients are transfused with E.B.-virus-infected blood, and we believe that soon blood donors will have to be screened for serological evidence of infection.—We are, etc.,

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### Distribution and Supervision of Oral Contraceptives

SIR,—We would agree with Dr. M. V. Smith and others (19 October, p. 161) "that it would be a responsible and constructive step forward in medical practice to widen the range of those empowered to dispense oral contraceptives." But we would take issue with their suggestion that persons empowered to "dispense" oral contraceptives

should include nurses, midwives, and health visitors who have had some additional training in contraceptive practice. It seems to be the consensus of opinion that in most cases the decision to embark on oral contraceptive therapy is one which can be made by any responsible woman on her own account, and the fact that the Royal College of General Practitioners suggested<sup>1</sup> that "the estimated risk at the present time of using the pill is one that a properly informed woman would be happy to take" bears out this view.

We would suggest that the person best qualified to undertake the supply of oral contraceptives for nearly all women wanting them should be the pharmacist, who has the necessary academic qualification and understanding of the medical consequences together with the degree of availability which is so well put in your correspondents' letter. We recognize that by preventing unplanned pregnancies and reducing the need for abortions a considerable contribution would be made toward further reducing maternal mortality, but unless the service is to be easily accessible to those at risk little will be gained by increasing the number of those able to prescribe the pill. It would seem highly desirable that any patient should consult her general practitioner before taking oral contraceptives as only he has access to the full medical history. But, with this safeguard, there seems to be no contraindication to registered pharmacists prescribing oral contraceptives, following guidelines drawn up in the light of clinical experience.—We are, etc.,

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<sup>1</sup> Oral Contraception Study of the Royal College of General Practitioners, *Oral Contraceptives and Health*. London, Pitman Medical, 1974.

SIR,—Most of the fears expressed by Dr. N. C. Chisholm (2 February, p. 287) follow from his statements in the third and fourth sentences: "Today delegation in family planning is no longer at the discretion of the individual doctor. It is a matter of clinic procedure." At all discussions on delegation in the Clinic Doctors' National Council of the Family Planning Association (of which I have been a member for five years) it has been emphasized (and minuted) over and over and over again that delegation must be only at the discretion of the individual doctor.

I must therefore ask Dr. Chisholm to provide a list of all clinics where delegation is "part of clinic procedure" and not at the discretion of the clinic doctor.—I am, etc.,

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### Erythema Infectiosum

SIR,—In 1952 I came across my first epidemic of erythema infectiosum. We had some seven cases in the practice, and Dr. George Gibson, who was the county medical officer of health, came over and saw four of the patients. He confirmed the diagnosis of

erythema infectiosum. A brief description of this minor epidemic was published in 1954.<sup>1</sup> From time to time I have seen the odd example of this exanthem, but I have never seen two cases in one house nor, until last month, have I been able to detect the infection of one child by another. On 9 September I saw a girl aged 8 with the typical red face, rubella-like arm rash, but no enlarged lymph nodes and no constitutional upset. On 27 September I saw her friend, aged 7, with the same clinical picture. The two girls are constant companions. It is just possible that there was a cross-infection here with an incubation period of some 18 days.—I am, etc.,

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<sup>1</sup> Watts, C. A. H., *Lancet*, 1954, 1, 573.

### Challenge to the Profession

SIR,—Dr. D. Morley's admirable paper (12 October, p. 85) introduces a challenge to the medical profession. Not only have doctors failed to solve the health problems of the less developed countries—in spite of their ever-increasing skills and technology—but, because of these very skills, they have actually hindered the application of appropriate solutions to these countries' health problems. When Ivan Illich said provocatively to a Scottish medical gathering recently that within the last decade the medical establishment had become a major threat to health<sup>1</sup> he was expressing what I believe to be a profound truth.

The medical profession dominates the field of health planning. Our professionalism and exclusiveness dictate that only doctors are able to make decisions on health priorities and it is assumed that the doctor is automatically the "leader" of the health team. This has led to expensive medical training programmes everywhere in the world and institutionalized medical care systems inappropriate to the health needs of most of the people. Doctors are increasingly expensive to train and thus more expensive to employ. Because they have been "elegantly" trained, as Fendall has so aptly described it,<sup>2</sup> with supportive and ancillary services they will naturally not want to work in an "inelegant situation" without these, hence the urban migrations and the world-wide brain drain. You cannot expect doctors, as we now recognize and train them, to work in rural health centres. It is naive to think that they will—if only we add more preventive medicine and community health to their training curricula. Even in Tanzania, recognized as having a particularly enlightened policy towards rural health development, the curriculum, with its continuing emphasis on basic sciences, bears little relationship to what is stated to be the job of a Tanzanian rural district medical officer. I think it is impossible to train doctors to do the work we now expect them to do without drastically revising our concept of what we are training doctors for.

All countries stress the need for more doctors, but nowhere has it been shown on what criteria this need is based. Many less developed countries started medical auxiliary training schools which have been or are to be "upgraded" to medical schools because international pressure from "the profession" and its exclusive professional bodies require

that recognition can be given only when certain "standards" are met. So, increasingly, all countries aspire to train more highly-skilled personnel less able to meet the basic health needs of the ordinary people. Even the British Health Service is crumbling because we are overtraining primary medical care personnel to such an extent that we cannot afford enough of them. The U.S.S.R. has twice as many doctors per head of population (trained differently and for a shorter period). China has one "barefoot doctor" to every 200 people. For any health service system to have an impact on health there must surely be a high ratio of primary care personnel to population. The more skilled and expensive the doctors are the fewer there will be and the more inappropriate they will be for the job of caring for people at the primary care level. What all countries need is large numbers of people able to recognize and manage the common community diseases, to know the families under their care, to screen for and prevent disease, and, above all, to counsel. It does not take six to eight years to train people to do this.

Do we as a profession have the courage and the vision to recognize that we are right out of step with the health needs of the world?—I am, etc.,

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<sup>1</sup> *Guardian*, 1974, 28 September.

<sup>2</sup> Fendall, N. R. E., *Auxiliaries in Health Care: Programs in Developing Countries*. Baltimore, Johns Hopkins Press, 1972.

SIR,—Paul Ehrlich pointed out that to face honestly the need for population control may "expose one to the painful criticism of being both anti-people and anti-poor"—prophetic words indeed! They are quoted in Ivan Illich's deeply stimulating book *Tools for Conviviality*,<sup>1</sup> which every doctor should read. If they did I think we would see that the Health Service crisis is one partly at least of our own making. He argues that we have taken away the burdens of birth and death from the home and the family and transferred them to the increasingly expensive hospital ward. Instead, he says, we should be teaching people to care for each other and that doctors cannot work miracles. Unfortunately it is easier to give £50 worth of vincristine than to explain what people are unwilling to accept.—I am, etc.,

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<sup>1</sup> Illich, I., *Tools for Conviviality*. New York, Harper, 1973.

### Calf Haematoma

SIR,—I was interested to read the paper by Dr. D. A. Tibbutt and Mr. A. J. Gunning entitled "Calf Haematoma: A New Sign in Differential Diagnosis from Deep Vein Thrombosis" (26 October, p. 204).

In my experience and that of other general practitioners and indeed of our practice nurse, this sign is exceedingly common. Naturally, very few of these cases find their way to hospital, being treated in general practice by masterly inactivity.

The publication of this paper illustrates the limited clinical experience of hospital doctors and is further evidence that those considering a specialty should spend some time in general practice in order to gain experience of the 90-95% of illnesses treated at home.—I am, etc.,

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### Full View of the Road

SIR,—Professor R. A. Weale (19 October, p. 149) has quite rightly suggested that all optical devices should be clear if used for night driving.

While the scientific logic of such a statement must be recognized, the public ought to know that many of the light tints they have on contact lenses, spectacles, and wind-screens fall within the 85% transmission level. There is therefore no need for them to panic and change their appliances but only to seek advice from their practitioner on the next suitable occasion.

Professor Weale's interpretation of section 22 of the Motor Vehicles (Construction and Use) Regulations 1973 requires further discussion. Full view, I agree, should be interpreted as full field as well as minimal interference with acuity, but the practicality of making a perfectly transparent, distortion-free, toughened or splinterproof windscreen of large size and curved must not be ignored. I am sure Professor Weale's message would have been more forceful if he had insisted that on no account must "sunglasses," including polaroid, be worn at night, and this includes all windscreens and side windows tinted to a similar density.

The only other point to which I am sure Professor Weale has the answer is the use of antiglare yellow glasses. I had understood that the use of monochromatic light within the yellow-green range, coupled with good illumination, was helpful to decrease the diffraction of light caused by mists and fogs. The problem was not solely that of illumination. Ideally, if we could afford the cost, all our roads should be illuminated.—I am, etc.,

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### Agoraphobia

SIR,—I would like to comment on your leading article on agoraphobia (26 October, p. 177), particularly your brief review of treatment. It seems to me misleading to equate the benefits of modified leucotomy,<sup>1</sup> suitable for fewer than 2% of patients presenting with agoraphobia, with desensitization, which is available to all but which is dismissed in your article as producing poor results—the evidence for this assertion being based on a prospective survey of 20 patients treated by graded retraining together with systematic desensitization.<sup>2</sup> According to the authors most patients in this survey "were left with considerable residual disability." It was noted, however, that about three-quarters of their patients suffered from sexual difficulties, mainly frigidity, and they concluded that one of the reasons for the