11 Furth SE, Hocking J. Components of saliva inactivate human immuno-
deficiency virus. Lancet 1986; ii:1215.
12 Groopman JE, Salabuddin SZ, Sarnathgurum MG, et al. HTLV-III in saliva of patients with AIDS related complex and healthy homosexual men at risk for AIDS. Science 1984;228:
447-9.
16 Litten AR. Ansell RA, Brunet JR, Curran JW. The epidemiology of
AIDS worldwide. In: P
1984:441-63.

State of the public health

Sir,—The suspension of Dr David Josephs by South Bedfordshire Health Authority for his remarks about the action needed to contain the epidemic of the acquired immune deficiency syn-
drome contrasts sharply with the freedom of the
chief constable of Manchester to expand on the same subject. Taken together, these two examples
provide a dramatic insight into the state of public
health in Britain.

In the 1840s and 1850s there was widespread debate in Europe about the need for "medical police" to prevent health hazards. Some
an authoritarian style was never imposed, but in
Britain we developed a systematic approach to
the protection of public health based on technical
skill and scientific knowledge rather than popular
superstition about disease. This skill was housed in
the office of the medical officer of health in the
local authority. Starting with Duncan of Liverpool
in 1847, it came to be accepted that the medical
officer of health could not be sacked for speaking
out on contentious matters that might upset politicians or doctors but he could be sacked
only for professional incompetence. His powers
were reinforced by the Public Health Act 1848.

Since the 1974 NHS and local government
reorganisation this has changed, and the inde-
pendent advisory function of public health has been
all but lost. So far, this has occurred with the
apparent collusion of community physi-
cians, who have inherited the mantle of the medical
officer. In Britain today the public health function
is going by default; some should be making
their voices heard on behalf of the public health are
all too often keeping their heads down in self
imposed silence. Those few who are brave enough
to speak out find themselves reprimanded or, like
Dr John, with dyspepsia.

So while a self proclaimed prophet trained as a
policeman is free to offer public advice on public
health problems a doctor with technical skill in
public health who voices a legitimate opinion
into his livelihood threatened. David Player already
looks set to be sacrificed for speaking out across
the pedlars of ill health. We are certainly back
in Victorian Britain with a vengeance (pre-1848) and
increasingly seem similarly stuck in 1984; rationality,
sanity and professionalism seem to suggest that
suspension on the one hand and intolerance and
authoritarianism on the other. Surely it is
time to stand up and be counted.

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Points

An assessment of the preregistration year experience

Dr R F Gledhill (Department of Internal Medicine, Kala-
fong Hospital, Pretoria 0001, South Africa) writes: Drs J E Elizabeth and S Hughes (13 Decem-
ber, p 738) may have been too ready to accept the ver-
acity of the self assessments provided by their
Liverpool preregistration graduates. The known li-
imitations of the evaluation method1 were strikingly
illustrated in a report from the Mount Sinai School of
Medicine,2 in which 78% of subjects (third and fourth
year students and residents) felt confident in
their ability to perform cardiopulmonary resusci-
tation, but only 2-9% could execute this procedure
on examination. In contrast to the figure of more
than 95% at Liverpool, an average of only 37% to 75% of
Cambridge University graduates felt competent to
manage a seizure and acute presentations of left ven-
tricular failure, asthma, and gastrointestinal bleeding.3
Furthermore, whereas two thirds of the Liverpool
house officers considered themselves competent in
performing a lumbar puncture and abdominal para-
centesis, the figures for Cambridge were 50% and 12%
respectively.4 With respect to medical emergencies the
findings reported by Wakeford and Roberts5 accord
with those obtained in surveys of graduates from
McMaster University6 and interns from the University of
Stellenbosch.7 Liverpool University Medical School
may well conduct highly effective under-
graduate and postgraduate programmes but there
would also seem good reason to question whether the
results of the survey are especially impressive because
some of their respondents tended to overestimate their
abilities.

1 Keiner A, Koval GA, Lie RK, et al. Interns' evaluation of their
preparation for general practice: a comparison between the University of
2 Sciblasi SE, Wordell SK. Development of self assessment skills in

1 Nelson M. Evaluation of CPR performance among medical
students, residents, and attendings at Mount Sinai School of
2 Wakeford R, Roberts S. An evaluation of medical students' practical
3 Woodward CA, Ferrier BM. The content of the medical
curriculum at McMaster University: graduates' evaluation of
their preparation for postgraduate training. Med Educ 1983;
17:54-9.
4 Gledhill RF. Undergraduate clinical neurosciences programme

Man bites dog

Mr K HASHMEE (Accident and Emergency Service,
Mayday Hospital, Thornton Heath, Surrey CR4 7YE) writes:
"The dog which I find in the street has just bitten me.
"However, whereas two thirds of the Liverpool

head, and the hand is again raised in a high arm sling,
and these patients are reviewed daily. Those who do
not show evidence of spreading cellulitis are reviewed
at lengthened intervals. I have found the above
regimen extremely effective, and since its introduction
more than three years ago there has been no case of
serious complications or inpatient treatment.

Attitudes to prescribing iron supplements in general practice

Dr J J BANNISTER (Department of Surgery, Royal
Hallamshire Hospital, Sheffield S10 2JF) writes: In the
survey of Drs D G Waller and A G Smith most GPs
usually prescribed iron on the basis of the full blood
count, and in a blood film suggesting iron deficiency
(81%), apparently without further investigation. The
study does not delve into the reasons for the subjects
being iron deficient. It should be emphasised that iron
deficiency anaemia is not a disease in its own right,
to be treated with iron supplements, but merely a sign
of an imbalance between, on the one hand, the dietary
intake and absorption of iron and on the other hand,
the body's losses of iron. In all patients, with the
possible exception of women with heavy menstrual
loss or the loss of iron associated with pregnancy, the
finding of a microcytic and hypochromic anaemia
should alert the attending doctor to the possibility
of chronic bleeding from the gastrointestinal tract.
Testing the presence of occult gastrointestinal
bleeding may be useful in confirming bleeding, but a full
and prompt radiographic or endoscopic study of the upper
and lower gastrointestinal tract is recommended.
And, possibly remediable gastrointestinal lesions,
such as caecal carcinoma or colonic polyps, will be
detected.

Self help groups

Dr ELIZABETH BRYAN and Ms MARGARET HARRISON
(Home-Start Consultancy, Leicester LE1 7JL) write: Many
readers working with self help groups may have been
delighted to see Dr Stephen Lock's valuable article
about them (20-27 December, p 1596). But does it not
their role in preventive medicine deserve as
much emphasis as that of supporting patients (and
their families) suffering disease or disability? If an
overstressed mother can be prevented from abusing
her child or needing antidepressant treatment through
the committed support of another mother there can be
little doubt of the cost effectiveness, let alone human
benefit. In recent years this has been clearly demon-
strated by Home-Start, a voluntary scheme in which
volunteers offer practical support and friendship to
families with children under 5 in their own homes.
The role of the volunteer is, of course, complementary to
that of the professional worker, and the organiser of
each scheme always has close links with the statutory
services.

Depression after stroke

Dr DAVID AMES (Academic Department of Psychiatry, 
Royal Free Hospital, London NW3 2QG) writes: Dr
Alastair House's otherwise excellent review (10 January, p
76) contains a common but incorrect assumption about
the use of antidepressants to treat depression in the
general population so that the term "depression scale" may justifiably be put. Hamilton's depression
rating scale is intended not as a diagnostic instrument,
but is now used to help guide treatment of depression
as nurses in Home-Start schemes. The important question is the level of depression in patients already
diagnosed as depressed. Hamilton makes this point clear in his own lecture notes. For the only way in which to
improve the most standardised diagnostic interview is prob-
ably the geriatric mental state of Copeland et al. This
schedule is better suited to the diagnostic requirements of an elderly population than is the present state
examination.

1 Hamilton MA. A rating scale for depression. J Neurol Neurosurg
Psychiatry 1960;23:56-62.
2 Copeland JRM, Kelleher MJ, Kellett JM, et al. A semi-
structured clinical interview schedule for the diagnostic and mental state in the elderly: the geriatric mental state