epidemic—as you yourself stress in your leading article.

In contrast, it now seems of nugatory advantage to attempt to control the situation by concentrating on antibiotic use. Highly communicable resistant bacterial populations have already been evolved under the hammer of selection pressure—a pressure which certainly existed long before the Swann Committee deliberated. And it is not only antibiotic use for veterinary purposes that has supplied that pressure: resistance genes existed in bacteria long before the antibiotic era began, and human use must have had an impact.¹¹ Intensive rearing, with all the environmental uniformity it implies, and the relative genetic homogeneity of many animal stocks will also have played a part. A further argument for no longer concentrating on antibiotics is the realisation that these agents do have an important role to play in the efficient rearing of animals and poultry for food.¹² Is it not time that we concentrated on the old-fashioned but nevertheless well-tried methods for controlling communicable disease—and really made them work?

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Inseminators as vectors of *Salmonella dublin*

SIR,—The spread of salmonellas via faeces or faecal contaminated instruments has been known to the Ministry of Agriculture for several decades, as has the potential risk from anyone, including inseminators, travelling from farm to farm. What D K Brooks (10 May, p 1189) has forgotten is that these same inseminators are aware of the problems of cross-infection, they are well trained, and they do take suitable precautions. Any connection between an insemination visit and an episode of salmonellosis would soon be detected by highly trained MAFF epidemiologists. Finally, to indicate that any possible danger from salmonellas transmitted by inseminators has been ignored is totally unwarranted. The Milk Marketing Board is very concerned about the spread of zoonotic disease and so too are MAFF, the inseminators, veterinary surgeons, and others whose work takes them into daily contact with farms and farm animals. I wonder whether Dr Brooks is aware of the Zoonoses Order and how outbreaks of salmonellosis are investigated. Does he know that *S dublin* is almost totally adapted to the bovine? I would suggest

a short visit to the nearest veterinary investigation centre or a telephone call to the Milk Marketing Board veterinary department.

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Careers for diabetic girls in nursing

SIR,—The letter from Eileen Bagshaw (17 May, p 1227) was most important and her survey of the attitudes of schools of nursing to the admission of young diabetics was invaluable. It was disappointing to learn that as many as 34 schools had strong reservations against the training of these young people. The British Diabetic Association wholeheartedly supports Miss Bagshaw's plea that suitably qualified diabetics should be allowed to train as nurses.

We consider that diabetic teenagers are particularly well suited to become nurses. Their own experience of having to live with a continuing disorder gives these young people an added insight to the problems of their patients and this is particularly true in counselling the chronically sick. A young diabetic nurse is likely to be especially understanding in her approach to sick children and she is peculiarly well equipped to comfort their parents in times of distress.

There is now evidence from industry to show that the sickness records of diabetics in general are superior to those of non-diabetics, probably because of the strict self-discipline that they have learnt to practise. From our own personal experiences we can state that this is particularly true for the nursing profession. Shift work and night duty present no difficulties that cannot be overcome and, as Miss Bagshaw says, should hypoglycaemia occur, they are assured of prompt medical attention.

The British Diabetic Association hopes that all schools of nursing will accept diabetics for training. By doing so they will add candidates to the nursing profession who are particularly well equipped to become nurses of the highest quality and dedication.

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SIR,—I was very interested to read the result of Eileen Bagshaw's survey (17 May, p 1227) showing as it does so well how inconsistent admission policies to nursing schools may be.

Having had many years' experience of medical screening of potential nurses in various teaching hospitals, I have come to the conclusion that there are very few medical conditions which should preclude the acceptance of the enthusiastic trainee. Diabetes is certainly not one of them. There may be a few diabetics who should not enter nurse training, but to exclude all automatically seems to be showing a lamentable ignorance both of the disease and of the potential of the sufferers. The same could equally be said of a number of other medical conditions which some schools also exclude. Such decisions should only be made on an individual basis after some type of health interview, if this is felt to be desirable. Surely the function of the

school is to assess the academic suitability of the applicant.

Thirty years ago I would have excluded a trainee with flat feet—I hope I am now wiser and less authoritarian. What is really needed is a good assessment of motivation as individuals with some disability are often much better motivated than their more "healthy" peers.

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Measles again

SIR,—The detailed criticisms of my paper on measles from two American sources require further comment.

Drs J A Frank and others (10 May, p 1185), writing from the Center for Disease Control, Atlanta, say that I have ignored the achievement of organised measles control programmes (as in the United States); on the contrary, I contrasted the scale of American success with relative British failure: "... immunisation policy there has resulted in a ten-fold decrease in measles mortality and morbidity."

The careful statistical analysis from Atlanta and similar comments from Drs J Desmyter and Saul Krugman (p 1185) merely support the view that measles is becoming a rare disease in the United States, and that there is an increasing proportion of cases in adults. These facts are not in doubt. Neither is there contention over the immunity induced by current measles vaccine, which has been most satisfactory for the period of observation. But valid as these points are they are almost irrelevant to the main question of my paper, which relates to immunisation policy in the United Kingdom and not the United States. The question to which my distinguished critics should address themselves is: in view of the overall low acceptance rates in the UK (approximately 50%, with wide regional variation), what should be our appropriate policy? In my paper I offered three choices—emulate American policy (that is, eradication), continue the present laissez-faire position, or adopt a selective policy in which vulnerable subjects would be protected. Given the present situation, a selective policy—incidentally, fully supported by Professor George Dick's letter (p 1186)—seems logical and economical.

What my critics really seem to be complaining about is the low acceptance rate for measles vaccine in the UK (the real reason for my original article) and the question must be asked, why the difference? Admittedly the reasons for these differences would be hard to substantiate but three points might be considered. Firstly, in general terms it may be true that vaccination programmes are received with greater scepticism by the general public in Britain than in America; perhaps the means and type of medical care in both countries has some influence on this attitude. Secondly, there has almost certainly been a reduction in the acceptance of vaccination procedures owing to the very wide publicity given to whooping-cough immunisation and its possible sequel. The third point is an important difference in policy in both countries in the United States. I believe that it is a requirement for schoolchildren to produce a certificate indicating that various vaccinations have been completed; there is no such compulsion at school entry in Britain.