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Correspondents are urged to write briefly so that readers may be offered as wide a selection of letters as possible. So many are being received that the omission of some is inevitable. Letters must be signed personally by all their authors.

Raw or pasteurised human milk?

SIR,—We would like to comment on the important paper by Dr S Williamson and others (18 February, p 393). As they indicate, there are no established criteria for the safe bacterial content of human milk to be fed to term and preterm infants and it must be stated that the criteria they offer for the safety of raw milk are empirical. Indeed, their recommended upper limit for *Staphylococcus aureus* of 10^6 colony-forming units per litre of raw milk is contentious, and other authors have stressed the dangers of pyogenic staphylococci fed to babies.¹ In addition, because of the reliance on careful individual sample bacteriology needed, the use of raw milk would be impracticable in many units.

We have taken an alternative approach to bacteriological quality control in our human milk bank. Since pasteurisation preserves much of the desirable immunological properties of milk while probably destroying foreign (?undesirable) cellular components, we have elected to pool and pasteurise all our milk. We have shown that some organisms of potential pathogenicity are present after pasteurisation if their initial count is high² and have therefore chosen post-pasteurisation as our time for routine bacteriological screening. We believe this is particularly important because few hospitals will be able to ensure

that the milk donated is kept at the standards of cleanliness reported by Dr Williamson and his colleagues.

We would also like to draw attention to the precision that is required in pasteurisation if one is to rely upon it as a method for reducing or removing bacteria but not excessively damaging the protective components. The heat treatment to which each milk sample is exposed will depend on the exact details of design of the water bath and heating and cooling systems, the size and materials of the bottles used, and the number of bottles treated in each batch. For these reasons we have designed and built a compact automated pasteurisation unit³ which we use for our experimental studies and nursery routine. In this way we feel that we can confidently maintain the bacteriological quality control of our bank of human milk.

Finally, may we say that, although untreated raw milk has some theoretical advantages (which the authors discuss), we would be unhappy to recommend its general use in special care baby units at present? Because of the important bacteriological and immunological issues raised the use of "foreign" raw milk should be conducted as a formal study, and we do not think the authors' observation that they had "not encountered any unex-

pected gastrointestinal problems in neonate fed this milk" is sufficiently reassuring.

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¹ Soltan, D H K, and Hatcher, G W, *British Medical Journal*, 1960, **1**, 1603.

² Gibbs, J, et al, *Early Human Development*, 1977, **1**, 227.

Scope for family doctors

SIR,—The review by Dr Andrew Smith of *Trends in General Practice*¹ (18 February, p 431) is most interesting in reference to the scope offered to general practice by the Court Report at one end and geriatrics at the other. At the lower end, would it not be advisable to define what is meant by the "child"? Paediatrics has so far dealt primarily with the 0-5-year range. Some years ago a new concept appeared, "developmental paediatrics," and the great idea was to follow the developing individual to the end of growth. There was a large gathering on this subject at the Royal Society of Medicine, but by the end of the evening no one had mentioned a child over the age of 5. We follow the child into school, but at school the concept of school supervision still requires to be clarified, and after school there is the stress of adolescence in the uncertainty of starting work. The raising of the school leaving age in total disregard for adolescent

problems is to some extent a reflection of medical neglect; a failure to appreciate psychological and developmental problems is evident in the number who took to the streets.

Should we not clarify our philosophy? What do we mean by "child" and "health"? What do we want to achieve? Lastly, how should it be done? Only the universities, by their attempt to provide academic stimulus and stability in association with a student health service and consultation centre, have initiated a framework for a common cause, a source of reference for the developing individual moving towards maturity. Many years ago in a succession of papers I was rash enough to suggest that the school health service should be a *corps d'élite* of doctors working as specialists within the field of general practice and that the health of young people in industry should be similarly surveyed by successors to the appointed factory doctor. For over 20 years I pleaded in vain for experiment. On the educational side there should be a similar situation with the careers service extending into the early years at work on a tutorial basis. The concept received the approbation of the Seeborn Committee, which observed that there was no reason why the services for young people who did not have the advantage of college or university should be any less ample than the services, tutorial and medical, for those who did. In both spheres the positions should be filled by medical staff specialising within the field of general practice.

Schools and firms in industry are organisms with an "atmosphere," a life of their own stimulating towards health or sickness of mind and body. The specialist within the field of general practice is needed equally in the school and within the industrial sphere. Knowing the atmosphere of school or industry, working closely with teachers and management, he can report to colleagues in general practice and they can refer to him for information or assistance with young people in their care.

If every family doctor tried to follow his patients in school or factory there would be a great waste of resources and of efficiency. Partly for this reason schools and firms which can afford the cost appoint their own doctor to work within the school or firm. The doctor is, in many cases, a general practitioner and is working, in effect, as a specialist within the sphere of general practice to the advantage of school, of industry, and of general practice. A scheme of this sort could provide a continuity of care and stimulus, educational and medical, instead of the clang of the school gates. It would help to make learning a life-long process in a situation of dynamic change. We then have to decide how to train doctors for this work. There would be advantage in support from full-time specialist colleagues.

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¹ *Trends in General Practice 1977: A Collection of Essays by Members of the Royal College of General Practitioners*, London, ed J Fry. *BMJ* for the RCGP, 1977.

Legionnaires' disease in London

SIR,—Further to our recent letter (28 January, p 236) we have further information about our patient with suspected legionnaires' disease. Although the clinical criteria for this disease were basically fulfilled, review of the histology failed to confirm a definitive organism, the

initial identification being a "false-positive" associated with staining material. The antibody results showed no rise to the organism.

We feel that we should set the record straight with this case, in which a strong similarity to legionnaires' disease existed and which may have represented a contact case of that seen at St Stephens¹ but did not definitively have unequivocal evidence of the disease. It would be interesting to see whether any further cases of unusual pneumonitis have occurred during this time.

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¹ Ashford, R U, Edmonds, M E, and Shanson, D C, *Lancet*, 1977, 2, 1364.

Nutrition education

SIR,—A full-page advertisement has been appearing in the *Daily Mirror* and the *Radio Times* from the Health Education Council which asks 10 questions. Question 4 is about composition and balance of ordinary people's diets. It reads:

"(4) Do you think 'health foods' means things like nut cutlets?"

"A. You'd be wrong if you do. A health food is anything that does you much more good than harm. Everything from lean meats, fish, liver, low fat cheese and fresh vegetables to fresh fruit, bran, cereals and wholemeal bread. Plenty to get your teeth into."

It is difficult to work out what this message is trying to say. Senior nutritionists I have asked are either surprised or have not yet seen this advertisement. Provisionally I guess that the main part of the message is the 1968 Scandinavian dietary recommendations¹ that have been abbreviated, modified, and expressed only in positive form. People should eat less, presumably, of the foods that are not mentioned. These would include fats, sugar, confectionary, and eggs. But then what is wrong with low-fat yoghurt, fruit canned without sugar, frozen vegetables, baked beans and other legumes, polyunsaturated margarine, and potatoes? What is meant by "cereals"? What is the special value of low-fat cheese (it's low in calcium too)? Why is lean meat put first? If we all eat bran, who will eat the endosperm of our wheat? And what is wrong with nuts, even as "cutlets"? This advertisement would do nothing to prevent rickets.

Nutrition education for the whole public is very difficult.^{2,3} The "Dietary Goals for the USA"⁴ prepared by a Senate committee that took much evidence have come in for criticism from the experts.⁵ A properly designed nutrition—or other health-education—programme must surely meet three sets of conditions: (1) there must be a consensus of the experts in the country that the message is worth while and needed; (2) the advice must be intelligible, practicable (including its economic implications), and safe; and (3) the organisation should be set up to monitor and assess its effectiveness.

I cannot find any senior nutritionist—in the Department of Health and Social Security, the Ministry of Agriculture, Fisheries, and Food, the British Nutrition Foundation, the British Dietetic Association, or university departments of nutrition—who has played any part in designing the Health Education Council's new

nutritional advice. I wonder too about its economic implications and how the council is preparing to monitor its impact on people's habits. It seems sad that if the council has taken over the Scandinavian recommendations they did not use the whole package. The diet and exercise programme in Sweden and the food and nutrition policy in Norway were designed and are being pursued with the full consultation and support of those countries' scientific experts in nutrition in universities and in ministries.

Have the experts on exercise and "worry" been consulted by the Health Education Council about some of the other 10 points in their advertisement?

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¹ Quoted in Davidson, S, *et al*, *Human Nutrition and Dietetics*, 6th edn, p 652. Edinburgh, Churchill Livingstone, 1975.

² Truswell, A S, *Proceedings of the 7th International Congress of Dietetics*, Sydney, 1977. Abstracts pp 129 and 130.

³ Truswell, A S, *Proceedings of UNESCO First International Conference on Nutrition Education*, Oxford, 1977. Reprinted in *Housecraft*, 1977, 60, 277.

⁴ *Lancet*, 1977, 1, 887.

⁵ *Nutrition Today*, 1977, Nov/Dec, pp 11-27.

SIR,—In the supposedly authoritative *Health Education in Schools*, produced last year by the Department of Education and Science, nutrition as such appears to be allotted¹ a page and a third (in a chapter on "Biology and Health Education in Schools") compared with, for example, a seven-page chapter on "Pollution" and a five-page chapter on "Some Dangers Arising from the Use of Toxic Materials in Industry," the latter in particular being perhaps a topic dearer to the hearts of schoolchildren today than it was in my own school-days. Certainly, however, every schoolchild knows something about food and is interested in it; and of all the elements in our life style making for health or ill health and that are amenable to change, food is probably the chief, cigarette smoking not excepted.

The Department might plead that last year the Department of Health and Social Security published a booklet on *Nutrition Education*. To assist the working party that produced this slim document a one-day conference was held, attended by representatives from both the named government departments and from the Ministry of Agriculture, Fisheries and Food, the Health Education Council, the British Nutrition Foundation, and other bodies. The short shrift given to nutrition in *Health Education in Schools* may be explained by the fact that at this conference "the final discussion reached the conclusion that there was no need to initiate changes in the national diet in Britain" (italics in original).²

Leaving aside the question of how a discussion ever can reach a conclusion of substance, this clearly means that there need be no changes in our diet for if none is to be initiated none can occur. This is a remarkable conclusion. In view of the prevalence of, for instance, dental caries, obesity, diabetes, diverticular disease of the colon, coronary heart disease, and cancer of the breast and colon is it credible that 23 assembled experts should think there is no need to initiate *any* change in our consumption of sugar, white flour, fats, or cholesterol? Ought we not rather to take a leaf out of the American book? In particular, a report³ produced by the relevant United States Senate committee, after hearing expert