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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