

BRITISH MEDICAL JOURNAL

SATURDAY 12 MARCH 1983

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LONDON, SATURDAY 12 MARCH 1983

Doctors and the bomb

The publication this week of the report¹ on nuclear war by the BMA board of science and education sets a final, authoritative seal on the scientific consensus on the medical implications of nuclear conflict. Doctors and physicists in the United States, the Soviet Union, and Britain are agreed that the medical services would have no hope of coping with the casualties.^{2,3} The survivors of a nuclear attack could not expect any treatment for their burns, their injuries, their infections, or their radiation sickness; and they would probably have to face serious shortages or total lack of food, water, and electricity. In the words of Nikita Khrushchev, "the living would bury the dead."

The BMA board of science's report (which will be debated at this year's annual representative meeting) is based on the best evidence and is well referenced. Anyone wanting to challenge its main conclusions (see p 910) will need substantial grounds for doing so. On some issues, necessarily, the conclusions are based on opinions. Almost every expert agreed, however, that once nuclear weapons were used in Europe the scale of the conflict would rapidly grow to a massive exchange of virtually all available warheads.

Britain is the most vulnerable nuclear target in the world because of its combination of high population density and multiple military installations close to centres of population. Most experts put the weight of nuclear warheads likely to be loaded on and over Britain in a major conflict at around 1000 megatons. A one megaton bomb exploded over London any time would leave 650 000 casualties with major burns—more than the total of 136 000 acute beds in every NHS hospital in England and Wales. The conclusion is irrefutable: a single bomb of this type would overwhelm the medical services. The likely attack—200 or more such bombs exploded simultaneously over the whole country—would leave an unbridgeable gap between the millions of casualties (and tens of millions of dead) and the few surviving doctors with service-hospitals.

In realistic terms, therefore, no rational plans can be made for coping with the medical consequences of nuclear attack. What advice can doctors give to citizens who wish to maximise

their chances of survival? The report agrees with the government in ruling out mass evacuation—on the grounds that no part of the United Kingdom is that much safer than any other and that evacuation is, in any case, socially and economically disruptive. It has little faith, however, in the shelters advocated by the government. These might improve the survival chances for some people in the short term, but the overwhelming problems of infection, bacterial contamination of water, and the scarcity of food and fuel would still remain to be faced. "Most of the government's civil defence planning," says the report, "relates either to conventional warfare or to small isolated nuclear explosions . . . we doubt that the organisation and management implicit in the government's plans would prove to be effective."

The report makes few judgments outside the medical frame of reference, but it does reject the belief, found in some "survival" groups, that the aftermath of nuclear war would be a return to a rural civilisation of two centuries ago. We lack the skills, the technologies, and the resources for such a society; suddenly cut off from supplies of water, food, fossil fuels, and electric power, survivors would be exposed to the effects of cold, malnutrition, and infection with no medical services.

Doctors seem likely to respond to this bleak picture by denial (I am too busy to bother with all that and will go on with my daily work); by emigrating to the southern hemisphere (Nevil Shute's *On the Beach* may have got it wrong: little fallout crosses the equator); or by campaigning in the political arena. Each individual will make his or her own choice—but no one can now say they have been left in doubt of the consequences should our society mishandle the challenge. The rational medical response to the threat of nuclear war is to concentrate on prevention.

¹ British Medical Association. *Report of the Board of Science and Education inquiry into the medical effects of nuclear war*. London: British Medical Association, 1983.

² Anonymous. The final epidemic. *Br Med J* 1982;284:1140-1.

³ Clavian E, Chivian S, Lifton RJ, Mach JE, eds. *Last aid: the medical dimensions of nuclear war*. San Francisco: W H Freeman, 1983.

SUPPLEMENT

*The Week**Personal views of current medicopolitical events*

from nuclear warfare to the BMA's new logo, from police searches of patients' records to fees for the Lord Chancellor's medical visitors, from reform of the World Medical Association to renaming a BMA committee, from doctors' objections to part time fees, from toxic contamination to negotiating rights for Civil Service medical officers, council members performed some formidable intellectual leaps at their meeting on 2 March (p 907).

The Home Office did not fare well during the day's debates. The board of science's working party on the medical effects of nuclear war (p 910) had little faith in that department's rushed calculations on likely casualties in a nuclear war or in its plans for protecting civilians. The council also expressed its lack of faith in two clauses of the Home Office's Police and Criminal Evidence Bill: on police access to patients' records and doctors' participation in intimate body searches. Both subjects have serious consequences for the public profession, though personal confidentiality may seem irrelevant against the awful backdrop of a nuclear war. I recall my National Service days seeing a "classified" film on the devastating effects of a nuclear explosion, but the prospect was unthinkable that I stuffed it into my deepest memory bank. In such an assumption, I suppose, that no sane men could contemplate such a war. This report from the BMA's board of science not only revived the memory but also multiplied it because the weapons now available are so much bigger and more powerful than when I saw the film.

I found the report well written, comprehensive, informative, enlightening, and council members were clearly impressed. Its contents: the profession owes a great deal to the working party, particularly to Sir John Stallworthy, the chairman, skilfully steering himself and his colleagues through a tactical minefield and emerging with a report that is all the more telling for its dispassionate objectivity. From what I know, however, absorbing the extensive evidence presented to them and compiling the report profoundly affected its members, and at the press conference Sir John spoke with a feeling about the horrendous consequences of nuclear war. All doctors should read the report, which is to be discussed at the annual representative meeting. Arrangements are in hand for its publication, but meanwhile the summary of the report (p 910) and a leading article (p 823) will help us to think about the unthinkable.

* * *

Doctors who still believe that the BMA waxes passionately when the profession's pay is at stake should have visited the council's debate on the police Bill (p 907). It would have been an educative experience. Passions ran deep over the

threat to patient doctor confidentiality from clause 10 of this Bill. Members were also unhappy about the clause that might force doctors with being asked to do intimate body searches in the absence of free consent from the suspect. For some weeks now the BMA has been conducting a vigorous campaign against the two offending clauses, writing to members of parliament and achieving extensive publicity in the media. The Home Secretary has already conceded some amendments, that a circuit judge instead of a magistrate would decide whether the police should be allowed access to patients' records in connection with investigations into a "serious arrestable offence" that the request should be made by a senior policeman, that the doctor should be allowed to contest it, and that confidential medical information obtained by the police would be subsequently destroyed.

One or two speakers in council argued that the profession was unlikely to get the Bill amended any more and that the association should call it a day. That line of argument was less than politely received by other speakers, who rightly saw the matter as an important principle for patients and doctors. I agree. The government may be tempted to dismiss the BMA's protests as just another ritual defence of doctor-patient relations that are in any case changing rapidly as society's attitudes alter. But it should resist such a temptation. If clause 10 goes through unchanged it will seriously undermine the frankness between doctor and patient that is essential for satisfactory medical care.

The council's decision, by an overwhelming majority, to step up the association's campaign to get medical records excluded from the Bill was the right one. Had council members backed off I lay a dollar to a dime that divisions would have been drafted some very briskly worded motions criticising the council's pusillanimity for the agenda of the annual representative meeting. I trust that the BMA's forthcoming meeting—the second—with Mr William Whitelaw, the Home Secretary, will persuade him that clause 10, even as amended, is a hazardous stride down the slope of state access to patients' confidential medical records. It is a prospect that should worry doctors. Council members certainly saw it that way, and they want medical records excluded from the legislation.

I don't usually throw other people's money around (even "promissory notes"), but last week I carelessly added an extra £1 billion to the Trade Union Congress's call (p 813) for an additional £2 billion to revive the flagging National Health Service over the next three years.

I apologise for this mistake.

SCRUTATOR

From the Council

Medical effects of nuclear war

Council authorises publication of report from board of science

There was wide praise from council members for the report from the board of science and education's working party on the medical effects of nuclear war. A summary of this report is at p 910 and a leading article at p 822.

The council urged that the BMA should continue to press for the exclusion of medical records from clause 10(3) of the Police and Criminal Evidence Bill. There was also a long discussion on the circumstances in which doctors would cooperate in intimate body searches.

The BMA's policy is that the intake of medical students should be frozen at the 1979 level. The council has now called for a positive reduction in the intake, provided that there is an adequate supply of doctors to implement the commitment of the General Medical Services Committee to reduce the average list size.

Mr A H Grabham was in the chair when the council met on 17 March and in his opening remarks he reported that oral evidence had been given to the review body on 19 and 21 January and that the hospital junior staff would be giving additional evidence on 17 March.

On 3 February the chairman had met representatives of the medical associations of Iceland, Norway, Sweden, Denmark, Finland, and the Netherlands in Copenhagen. The aim, he told the council, had been to try to reach a common policy on the World Medical Association. At present three out of the 40 members dictated the policy of the World Medical Association in its general assembly because of the voting pattern. In 1981 the BMA council had decided that unless the World Medical Association's constitution was reformed by 1985 it would recommend to the representative body that the BMA should withdraw. To achieve a change an amendment would have to be put to the World Medical Association in the autumn of 1983. A more equitable sliding scale of voting had been proposed by the northern European countries and the council endorsed it:

"For the first 40 000 declared members, one vote per 10 000 members or part thereof. Thereafter, from 40 001 to 100 000 declared members, one vote per 20 000 members or part thereof. Thereafter, above 100 000 declared members, one vote per 30 000 members or part thereof."

Police Bill opposed

Clause 10 of the Police and Criminal Evidence Bill would allow a police officer, where it is believed that "a serious arrestable offence" has been committed, to request an order from a circuit judge for disclosure of information before a person is charged with an offence. This would mean disclosure at a much earlier stage in proceedings than now. Previously, a doctor could be ordered to produce information under a subpoena only if a suspect had been charged with an offence.

The chairman of council reported that he had led a delegation to meet the Home Secretary on 26 January to discuss the Bill. The Home Secretary had been asked to exempt medical records because of the special relationship between a doctor and his patient and the importance of retaining the trust of patients that any information given to their doctors was on a confidential basis. Communications between a professional legal adviser and his client were exempted. Mr Liam Whitelaw had subsequently written to the BMA to say that he intended to table amendments to provide for an inter partes procedure on application to a circuit judge for the destruction of medical evidence as soon as it was no longer required. The trial ethical committee, which has been opposing the Bill, did not believe that these amendments were sufficient.

Mr Grabham said that the association did not want to make problems for the police if the Bill threatened to make cooperation

difficult. Support for the BMA's stand had been received from other health professions, he said.

Dr W J Appleyard supported the central ethical committee's plea that medical records should be excluded. The legal profession had protection of information disclosed by their

clients and patients should enjoy the same protection. If rules became so strict people would be discouraged from seeking help and confiding in their doctors if they thought that the information could be divulged.

continued at page 908

Medical effects of nuclear war

The council congratulated the working party of the board of science and education that had produced the report of the inquiry into the medical effects of nuclear war.

The working party had been set up as a result of a resolution of the 1981 annual representative meeting: "The board of science and education should review the medical effects of nuclear war and the value of civil defence in order that the British Medical Association should form a policy."

The working party had been chaired by Sir John Stallworthy and considered written evidence from over 60 organisations, including the Home Office, the Ministry of Defence, and the DHSS. The board of science adopted the report at its meeting in February.

The 1982 annual representative meeting passed (as a reference to the council) a proposal that the report should be published and made available to the public.

The report represents the views of the board of science and is not yet BMA policy. It will be sent to representatives attending the BMA's annual representative meeting in June and will be debated there. Chapter seven gives an outline of the report and this forms an appendix to the annual report of council (p 910). A leading article is at p 822.

The council agreed that the report should be published for sale, and discussions are taking place as to the best way to do this.

Annual report of council 1982-3

Appendix II: Medical effects of nuclear war: Report by board of science and education

The 1981 annual representative meeting resolved that:

"The board of science and education should review the medical effects of nuclear war and the value of civil defence in order that the British Medical Association should form a policy."

A small working party was set up to receive written and oral evidence; the membership is set out at p 911. A press statement set out the areas to be covered by the working party as follows:

(1) The blast, thermal, and immediate ionising radiation effects of nuclear weapons.

(2) The clinical problems, both immediate and delayed, likely to be caused by the detonation of nuclear weapons.

(3) Mortality and morbidity consequent upon varying nuclear attack patterns.

(4) Immediate and long term psychiatric effects on survivors of a nuclear attack.

(5) The probable effects of a nuclear attack on the work, organisation, structure, and management of the Health Service.

(6) Relations between the National Health Service and organisations involved in civil defence.

The working party decided that the medical effects of nuclear war should be examined sufficiently widely for the report to serve as a "stand alone" source of reference for doctors. Written evidence was studied carefully and several organisations and individuals were invited to meet the members of the working party to give supplementary information.

This is a summary of a report of the board of science and education. The report, which does not necessarily represent the policy of the British Medical Association, will be debated by the annual representative meeting in June.

The annual report of council will be published in the *BMJ* on 26 March.

BMA members are asked to keep this issue until the matters it contains have been discussed by their divisions.

Section 7 of the report gives a summary of the medical consequences that would follow the explosion of nuclear weapons over the United Kingdom. The working party has emphasised that it has formed its judgments about the effects of nuclear war on the basis of the information and evidence presented to it. The report's summary follows.

Summary

The United Kingdom contains a large number of targets likely to be attacked in war and has densely populated conurbations. Potential targets and population centres are intermixed across the United Kingdom so that it is not possible to discern areas, apart from remote tracts in Scotland, and perhaps in north Wales, that do not place potential targets adjacent to communities of people.

The population density of the United Kingdom is 593 people per square mile. England has a higher density of 920 people per square mile. The population density coupled with the number and distribution of potential targets is unique to the United Kingdom. No other country has so many people and so many potential targets concentrated into so small a land mass.

In the 1960s aggregation of world nuclear weapons of an explosive power of 400 megatons was thought to ensure deter-

rence by mutually assured destruction of both the United States' and Russia's essential targets. Estimates of the total explosive power of world nuclear arsenals in 1980 varied between 25 and 50 times that quantity—namely, 10 000 to 20 000 megatons. Any realistic assessment of the medical effects



Sir John Stallworthy, who chaired the working party which inquired into the medical effects of nuclear war.

of nuclear war must take account of changes in technology and military strategy. The effects of an attack in 1950 would have been very different from the effects of an attack now or in the future.

None of the organisations or individuals who sent papers to the working party, or who gave oral presentations, were able to predict with certainty where an attack on the United Kingdom with nuclear weapons would occur or in what form such an attack would be made. The unreliability of

basic assumptions has been a constantly recurring problem in all areas of our investigation. Uncertainty in areas of our report is inevitable: nobody has direct experience of a nuclear attack of the magnitude envisaged in the future. Both the government and independent authorities have, however, suggested that an attack could well be of the order of 200 megatons or greater. Furthermore—with one exception, all the experts who contributed to the working party said that a nuclear war could not be contained, but would escalate to an unlimited, total exchange of nuclear weapons.

There are discrepancies between the projections for blast, heat, and radiation produced by the Home Office and Scientists Against Nuclear Arms. The latter rely on methods and figures derived for the most part from the United States Department of Defence and the Office of Technology Assessment. We have examined the methods for calculating the projections used by Scientists Against Nuclear Arms, and the working party believes, on the evidence it has received, that the projections

"An objective and scientific account"

● "The purpose of this report," declare the authors in their introduction, "is to give the reader an objective and scientific account of the medical consequences that would follow the explosion of nuclear weapons. Any statement made about the use of nuclear weapons is inevitably controversial and we have been acutely conscious of our responsibility to present objective findings."

● "On the basis of the information and evidence presented to us we have formed our judgments about the effects of nuclear war. Each reader must make personal decisions about matters connected with the nuclear weapons debate—including, for example, whether or not a home defence programme increases the likelihood of the event it is designed to mitigate. The desirability or otherwise of stockpiling a nuclear arsenal was not part of the terms of reference of this working party."

from Scientists Against Nuclear Arms give a more realistic estimate of the blast, heat, and radiation effects of nuclear weapons. We understand that the Home Office is currently revising its calculations.

Civil defence—evacuation

Evacuation policies have their problems. Sufficient warning is needed in order to evacuate successfully. The economic cost to the country is tremendous and for these reasons governments would be very unwilling in practice to put evacuation plans into effect. If, however, an attempt was made to evacuate the general population this would be seen by an enemy as part of preparations for war and might invite a pre-emptive strike.

Given the uncertainty about the pattern of an attack—that is the number and size of weapons, where they would be detonated, the period of time over which the explosions would occur—evacuation is impossible in the United Kingdom. The government's advice to stay where you are, at home, at work or at school, effectively acknowledges this fact. There is no point upon the surface of the United Kingdom mainland that could be guaranteed immune from the effects of nuclear attacks.

Civil defence—shelters

The makeshift home shelters advocated by the Home Office would offer the occupants only slight protection against the blast emitted by an exploding nuclear weapon. Burns and injuries caused by flying glass from shattered windows could be reduced but there would be little protection against radioactive fall out. Repeated explosions would diminish the protection against fall out.

Advice to site the shelter at the central core of a house or building carries the risk that a substantial proportion of domestic shelters are likely to be buried when the surrounding dwelling collapses. No heavy rescue services would be available to excavate trapped survivors. If the shelter is situated near an outside wall the occupants are more at risk from the fall out.

In a large scale nuclear attack many areas of the country would be subjected to levels of blast damage sufficient to destroy these improvised shelters. The greater part of the country would experience blast pressures sufficient to break windows or remove doors or roof tiles from houses, which would in turn limit the protection provided against fall out. This factor is not allowed for in the current Home Office calculations.

Some of the commercially available prefabricated domestic nuclear shelters could offer a degree of protection against blast and heat and all would protect against fall out. None of the designs reported to the working party appear to have satisfactory mechanisms to eliminate dangerous combustion products of the air being drawn into the shelter. A large scale programme of public shelter building would be very costly. It could be effective in reducing short term casualties. Any survivors would face overwhelming problems in the world to which they emerged.

Long term effects of a nuclear attack

Water would be the first requirement of survivors of a nuclear attack on the country. Food, shelter, fuel, and electrical power would follow in that order of priority. The present water tanker capacity in the United Kingdom is wholly inadequate to supply survivors with water for even basic need. Government plans for the supply and distribution of emergency supplies of food do not aim to provide a balanced diet. This would have serious consequences for people requiring special diets—for example, diabetic patients. There may not be a sufficient quantity of food in store to tide survivors over until alternative sources could be found.

Working party

Sir John Stallworthy (chairman), emeritus professor of obstetrics and gynaecology, Oxford University

Dr J S Horner, district medical officer, Croydon Health Authority

Mr K S McKeown, consultant surgeon, Darlington

Professor J P Quilliam, professor of pharmacology, St Bartholomew's Hospital Medical College

Dr J D Dawson, under secretary, British Medical Association

Terms of reference

"The board of science and education should review the medical effects of nuclear war and the value of civil defence in order that the British Medical Association should form a policy."

Survivors would have to change their dietary patterns to include a much greater amount of diverse cereals and vegetables. Palatability of food that might be available would be a major problem. Water and fuel are necessary to render many cereals edible.

There is a probability that the atmosphere would be highly perturbed by a nuclear war. The large quantities of highly sunlight absorbing, dark particulate matter which would be produced and spread in the troposphere by the many fires would strongly restrict the penetration of sunlight to the earth's surface and would change the physical properties of the earth's atmosphere. It is likely that agricultural production in the northern hemisphere would be severely disrupted, so that food production for the survivors of the initial effects of the war would be very difficult.

Survival becomes even more difficult if stratospheric ozone depletions also take place. It is difficult to see how much more than a small fraction of the initial survivors of a nuclear war in the middle and high latitude regions of the northern hemisphere could escape famine and disease during the following years.

Other problems with implications for public health would be extensive radioactive contamination of the environment, failure of water and sewerage systems, and lack of basic drugs and medical supplies.

It is inaccurate and misleading to suggest that after a nuclear attack on the United Kingdom there would be a return to a rural civilisation of two centuries ago. The working party believes that there would be an increase in infant mortality, communicable diseases due to infections, and deficiency diseases caused by inadequate nutrition. The United Kingdom no longer possesses the skills or primitive technologies which allowed our predecessors an existence with some measure of comfort. The skills of the twentieth century do not permit a return to that style of life after a nuclear attack.

Effects on medical services

We cannot forecast what sizes of weapons might be exploded over the United Kingdom. Most current strategic and intermediate range or theatre weapons have explosive yields of between 100 kilotons and five megatons. The bomb dropped at Hiroshima was between 12 to 20 kilotons in size.

The extent of damage caused by a nuclear weapon does not

continued on page 912

Fees for "collaborative arrangements" to be linked to consultant and hospital practitioner grades

The council has endorsed a proposal from the private practice committee that the staff side claim for fees for work under the collaborative arrangements in community health services and for family planning work should be based on links with the consultant and hospital practitioner grades, as has been agreed in the case of work for government departments.

Before 1974 all local authority work was paid for by the local authorities and negotiated by the private practice committee through committee "C" of the Medical and Dental Whitley Council. With the 1974 reorganisation financial responsibility for certain services passed to health authorities, and the Department of Health and Social Security indicated that all part time fees should be negotiated in a single form. Those fees for local authority

work payable under what became known as the "collaborative arrangements" are negotiated along with fees for part time work in the community health service. It was resolved in 1979 that the forum for these should be the joint negotiating body for doctors in community medicine and community health, but that the private practice committee representatives should continue to attend for all discussions of part time fees and should lead such negotiations.

In 1977 the exercise known as restructuring of fees had begun, the purpose of which had been to bring some uniformity in the level of fees paid by different public departments. In 1980 an agreement was concluded with the then Civil Service Department covering all fees paid by central government departments. Under this agreement consultants' fees were to be linked to the rates of pay of consultants as determined by the review body, but modified to take account of the part time nature of the work. Other work that was mainly undertaken by general practitioners was to be linked to the hospital practitioner grade scale.

Discussions along similar lines followed with the local authorities over those fees for which they still have financial responsibility. The staff side representatives (Central Committee for Community Medicine) of the joint negotiating body have raised objections to the policy that the private practice committee representatives wish to pursue in negotiations for part time fees.

The Central Committee for Community Medicine was concerned, its chairman, Dr J S Horner, told the council, that an agreement based on the policy set out above would distort relationships between full time and part time doctors in the community health service.

Dr E B Lewis, however, argued that the private practice committee believed that if it was successful in increasing part time fees that would strengthen the position of the Central Committee for Community Medicine renegotiating the whole time salary structure.

BMA subscription for 1984

The council has agreed to recommend to the representative body:

"(1) That, with effect from 1 January 1984, the standard rate of subscription be increased to a sum not exceeding £132 (10%) and not less than £126 (5%), as the council may decide, in the light of inflation and the recommendations of the review body.

"(2) That, in the event of recommendation (1) being unacceptable the standard rate of subscription be increased, with effect from 1 January 1984, to £132."

Asking for the adoption of this recommendation, the treasurer, Dr R A Keable-Elliott, reported that the standard rate had been increased to £120 with effect from 1 January 1983. The finance and general purposes committee had been considering an appropriate rate to recommend for 1984. The difficulty was that the rate had to be decided by the council in March for inclusion in the annual report. In between March 1983 and January 1984 the rate of inflation was unknown and by March the review body had not reported. Another uncertainty was the possibility of a general election before January 1984. So the committee had decided to propose to the representative body that the council should be given authority to fix the subscription for 1984 later in the year within upper and lower limits. The BMA's lawyers had advised that this flexible proposal was constitutionally proper, the treasurer added.

Police Bill opposed—continued

from page 909

view the doctor would have a duty to society to carry out a search if the police asked him to do so. But there was a grey area when junior policemen and inexperienced police surgeons might be in difficulty.

Dr Simon Jenkins said that he was vehemently opposed to a search without consent in any circumstances. It was contrary to the basic ethical code.

But doctors had a duty to help preserve law and order, Mr R K Greenwood said. If a senior police officer, for example, believed that an explosive device was concealed on a suspect it would be better for a search to be made by a doctor than by a layman.

The council accepted that only on the rarest occasion—for example, terrorist activities—would a doctor be justified in carrying out a search where consent had not been given, but that legislation on this issue was entirely unacceptable.

GMSC symposium

The General Medical Services Committee is holding a half day symposium on the Association of British Pharmaceutical Industry and pharmaceutical matters at BMA House on Wednesday 16 March at 2 pm. The symposium is open to all general practitioners and has been approved under Section 63 with zero rating.

Medical effects of nuclear war—continued from page 911

increase in direct proportion to the explosive yield. Thus, to double the distance at which a given level of damage is caused requires an eightfold increase in explosive power. It follows that if a given total weight of attack is divided into a larger number of smaller weapons greater damage will be caused. The argument sometimes advanced that more accurate lower yield weapons will result in fewer casualties is a false one, so long as the total explosive power used in an attack remains similar.

The explosion of a single nuclear bomb of the size used at Hiroshima over a major city in the United Kingdom is likely to produce so many cases of trauma and burns requiring hospital treatment that the remaining medical services in the United Kingdom would be completely overwhelmed. An attack with, for example, 200 megatons represents an explosive power some 15 000 times greater than the Hiroshima bomb; or the equivalent of 40 times all the conventional explosive used in the whole of the second world war.

The National Health Service could not deal with the casualties

that might be expected following the detonation of a single one megaton weapon over the United Kingdom. It follows that multiple nuclear explosions over several, possibly many, cities would force a breakdown in medical services across the country as a whole.

There is no possibility of increasing the production of certain drugs in a short period of tension before a war, and if we wish to have large quantities of blood products available for transfusion purposes or the bulk of the present generation of medical practitioners in the country trained for certain eventualities, then all of these things would have to be done now and the country must exist on a more or less permanent emergency footing.

We believe that such a weight of nuclear attack would cause the medical services in the country to collapse. The provision of individual medical or nursing attention for victims of a nuclear attack would become remote. At some point it would disappear completely and only the most primitive first aid services might be available from a fellow survivor.