NUCLEAR WAR

Sir,
Possibly the greatest environmental hazard threatening our patients is that of nuclear war. Implicit in the treatment this topic receives from the media is the notion that the effects of such a war on the populace and their environment can be contained by medical and public health measures. I do not think I am alone in believing that there is no effective medical response to a nuclear attack and that we have a duty to tell our patients so. If as a profession we remain silent, we foster the idea that realistic medical dispositions for such a disaster exist and we thus help to condition people to the view that nuclear conflict is acceptable, tolerable, survivable.

Is this not a topic which demands the attentions of this College, and one on which our views should be made public?

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Sir,
Public discussion of plans to increase the nuclear weapons based in this country and of civil defence preparations for nuclear war have been growing noticeably during the last 12 months.

It is argued by some that it is only the existence of balanced strategic nuclear weapons on both sides and the policy of deterrence by mutual assured destruction that has maintained peace in Europe for the last 35 years. Whatever the merits of that argument may be, it is no longer applicable. Official NATO policy now embraces the idea of 'theatre' nuclear war to be fought in Europe using 'tactical' nuclear weapons such as are carried by the Cruise missiles soon to be based in this country and the more recently resurrected neutron bomb. For the policy to appear credible to a potential enemy it is necessary that this country give the impression of being prepared to suffer and attempt to survive a nuclear attack. That is what the civil defence plans are all about.

In recent months many general practitioners have attended meetings organized by the Area Health Authorities to discuss the involvement of medical personnel in civil defence preparations. The general public is assured that the Casualty Collecting Centres will be established as soon as conditions permit after a nuclear attack and they will be run by local general practitioners and other available medical personnel. Whether we like it or not, we general practitioners are being assigned an active role in this nightmare. I cannot be alone in having been asked by patients for reassurance that the 'death pill' would be available in the event of a nuclear war.

We know probably better than anyone that the present high standard of medical care available to our patients depends upon an extremely complex organization of public health measures, sanitation, manufacture and distribution of vaccines, drugs and dressings, availability of transport and specialized hospital services dependent on highly developed technology. The NATO predictions of the degree of damage to be experienced in this country in the event of a nuclear war leave only 15 to 30 per cent of the population still alive, all services such as water, electricity and telephones unavailable and road communications impossible. The 30th Pugwash Conference (1980) recently came to the conclusion that "Effective civil defence against nuclear attack is impossible". It is unethical for us to join in this pretence that we can offer any form of medical care to the survivors of such an attack. The effects of nuclear war constitute an untreatable disease; the only logical approach is prevention.

Recently many doctors who have become aware of their responsibility to inform the profession and the public of the fallacies of the civil defence plans have come together from all parts of Britain to form The Medical Campaign Against Nuclear Weapons. The aims of the movement are to collect, review and disseminate information on the medical implications of nuclear weapons and to bring this to the attention of all concerned with public policy. Any colleagues who are interested may obtain further information from MCANW, 120 Edith Road, London W14.

As the Home Office presumes that general practitioners are prepared to play an active role in the charade of civil defence, perhaps it is time for the Royal College to consider the matter and to let the Minister know that, from a medical point of view, his plans are deceitful and unacceptable.

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Reference

30th Pugwash Conference, Netherlands (1980). Statement.

WHY NOT A STANDARD SUMMARY CARD?

Sir,
I was interested in Dr Sackin's "Why Not?" article (April *Journal*). His description of the use of summary cards seems to me somewhat complicated. We have modified the system using existing cards to give us problem-orientated records.

Our written records contain three sheets stapled together. The first sheet is a summary care FP9 which we label 'present'; in other words, these are present problems. The next sheet is again an FP9A or B summary card, which we label 'past', that is 'inactive' problems. This in effect is simply a case summary. The third card is an FP7A which is the immunization record card, and on the back of that card we put a drug summary. Because the three cards are stapled together, they form a unity which is very easy to spot.

The nice thing about this method is that it does not cost anything. It is very time consuming and has to be kept updated; nevertheless we find it of very great help.

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DECLINING STANDARDS IN GENERAL PRACTICE?

Sir,
There are two trends emerging in general practice which seem to me to be somewhat undesirable, not conducive to the best standards of general practice and which perhaps the College might like to consider.

The first is the tendency amongst general practitioners to request domiciliary visits by consultants without themselves attending. I am well aware, from personal experience, of the pressures that make such attendance difficult, but it seems to me that not to do so is regrettable for the following reasons: firstly, it is in my opinion somewhat discourteous on the part of a general practitioner to ask a consultant to visit a patient at home and not be present in order to introduce the consultant to the patient, and also to have available the patient's records in order to give him the full clinical picture. Secondly, I have always found that a domiciliary consultation helps to cement a relationship between the general practitioner and consultant and that it is commonly a very instructive and educational occasion.

The second aspect that I find rather disturbing is the tendency for general practitioners to live in an area well away from that in which they practise. This, of course, is very understandable in the inner city areas where the general living conditions are not particularly desirable and where one would not particularly wish to bring up one's children; but I notice that, even where these conditions do not apply, the tendency to divorce one's private life from the work of the practice is gathering momentum. I suppose it is a matter for a difference of opinion as to how much general practitioners should be involved in the general life of the area in which they work, whether they should join local organizations and societies and whether they are averse to meeting their patients in a social, as opposed to a professional, environment. My own opinion is that it is right for general practitioners to take some interest in the activities of the environment in which they practise and become part of that community and not just transient visitors when they happen to be working. I wonder what other members of the College feel about this?

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MONOSYMPTOMATIC HYPOCHONDRIACAL PSYCHOSIS

Sir,
For some time now I have been interested in studying patients who present with a false conviction of disease, abnormality or alteration in a single part of the body or a single organ system, when this solitary delusional belief is unaccompanied by other features of psychotic disturbance, does not occur in the context of significant cerebral pathology and does not represent the most prominent manifestation of a clear-cut primary pathological disorder of mood (severe depression or anxiety). For perhaps understandable reasons these patients tend to seek referral to general physicians or surgeons, dermatologists, venereologists, plastic surgeons, parasitologists, dental surgeons and so on rather than to psychiatrists.

I am currently collecting data with reference to such patients. This exercise involves the responsible physician/surgeon in completing a fairly straightforward questionnaire containing items related to the personal and family history of such patients, the specific nature of their complaint and its evolution and their therapeutic history. I wish to invite any of your readers who believe they may have encountered such an individual in the relatively recent past, and who might wish to assist me in this exercise, to contact me so that I can give them further information about the project. I would, of course, guarantee that the patients would remain anonymous and that the information acquired would be used for my own personal research purposes.

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MEMBERSHIP OF THE COLLEGE

Sir,
I felt less in the wilderness on reading Dr Griffiths' letter (April *Journal,* p. 250); at least there are some other voices crying out against the MRCGP exam in its present form.

I voted against the introduction of the exam and still think that the following, amongst others, are important criteria of membership: efforts to keep up to date—by attending courses, postgraduate meetings, group discussions and seminars; a willingness to support College activities, for example by teaching, doing research, attending meetings and serving on committees; overt demonstration of good practice administration and good clinical note keeping; and encouraging others to join the College.

Perhaps all who wish to join should be 'associates' for 12 or 18 months. During that time they could be assessed by members along the above lines; possibly some form of examination could be available for young doctors, but I am not sure about this, nor of the form that it should take. At the end of the 'probation period' the doctor would automatically become a member if he or she fulfilled the standards required.

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TRENDS IN GENERAL PRACTICE

Sir,
I wonder how many others have written to complain about the misleading title which you have advertised as *Trends in General Practice, 2nd edn., 1979.* Normally a 'Trends' series means that new editions contain substantially new material, if not actually new articles. Already possessing Trends 1977 I was looking forward to some new ideas in 1979—not just a slightly updated edition. Unfortunately, if in the future a really new 'Trends' is produced, I for one will miss it, presuming it is simply another edition of the original 1977 issue. Someone needs to give some thought to future titles!

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SPRING MEETING

Sir,
The Spring Meeting of the College in Glasgow, shrouded in a soft Scottish mist, was memorable for its conviviality if not for its academic content.

Discussing its purpose with a colleague afterwards, he dismissed it as nothing more than an opportunity for Members and Fellows to socialize, but I think otherwise. Why could it not be a forum for stimulating debate? It was disappointing that the three papers entitled "Profiles of Practice" produced little or no discussion, although they raised two of the most important problems facing general practice today: how are doctors to be encouraged to work in areas of gross social deprivation and is the move away from single-handed practice towards group practice a move towards improving the quality of care offered to patients or not? I believe the reason for the paucity of comment was the size of the audience—if the meeting had been given the opportunity to split up into small groups (there must be few doctors who have not had some experience of interacting in such an environment), discussion would probably have been lively. In particular, the authors of these papers could have participated and would have been questioned more closely and personally complimented on their presentations.

This leads me to another point. I find it a disturbing feature of the Spring Meeting that indiscriminate praise of each paper presented is an injustice to those that richly deserve it.

Finally, I think the Chairman of Council was deceived by the 'docility' of his audience. The silence which greeted his report was probably due to those present reflecting that, whilst we have our Easterhouses and our Brixtons, the leaders of our College might expend their energies more profitably at home than abroad.

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