25 to 64 years inclusive. The project is interested in learning of any case of myocardial infarction occurring among residents of one of the two study areas, wherever the patient is at the time of his or her illness or death.

It would be most helpful if any general practitioner involved in the care of any patient from Edinburgh or Glasgow with a myocardial infarction could inform the appropriate project centre; either the Edinburgh MONICA Project Centre, Department of Community Medicine, Usher Institute, Warrender Park Road, Edinburgh EH9 1DW (Tel. 031-229 0714), or the Glasgow MONICA Project Centre, Royal Infirmary, 10 Alexandra Parade, Glasgow G31 2ER (Tel. 041-552 8944).

As speed of access to medical care may have an important bearing on the outcome of cases of myocardial infarction, may I make a specific plea that the following dates and times be recorded: that of onset, that of call to medical services, that of initial medical care, and that of first cardiopulmonary resuscitation, where this has been administered out of hospital.

W. StC. SYMMERS

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## Affiliation

Sir,

I seems that Council's proposals to explore the feasibility of affiliation to the College by members of other professions has caused an unwitting and unwelcome division with our colleagues in Scotland.

Having listened carefully to the arguments put forward by Scottish representatives at the Spring General Meeting it would appear that their expressed objections were mainly associated with the practical consequences of such affiliation. Concern was expressed that College-based facilities, both academic and social, might be less available to members as a result of affiliation. Furthermore, the argument was evinced that no other Royal College had similar affiliation and that hence it would be inappropriate for our College to differ.

The other Royal Colleges represent secondary care in contrast to our own primary role. Since much emphasis is placed on the role of the primary health care team by the College, affiliation to the College of other members of the team is entirely appropriate and in line with established policy.

Affiliation is supported by all other Faculties and, since Council is democratically elected, it has the power to impose this without unanimous consent. Every effort should be made to respond to the practical issues raised by the Scottish Faculties and to reassure them that affiliation can do nothing but enhance our relationship with other professionals and enrich the wider function and influence of our College, especially in a closer examination of the nature and function of the members of a primary health care team.

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## The general practitioner and the alcoholic

Sir,

In July 1983 Edwards and colleagues reported the preliminary findings of a follow-up study of 100 patients diagnosed as having alcoholism when they attended the Maudsley Hospital between March 1968 and November 1970.[1] Sixty-eight patients were interviewed, 54 (79 per cent) rated general practitioner intervention in their long term care as in 'no way helpful', 13 (19 per cent) saw such intervention as 'moderately helpful' and one saw such assistance as 'very helpful'.

These figures appeared contrary to our experience, so as part of a larger postal survey of patients treated for alcohol dependence in the Mersey Regional Drug and Alcohol Dependence Unit, in the period commencing 1 January 1978, we included questions about the help patients received from their general practitioners in the time since discharge from hospital.

We would like to present our preliminary findings. Three hundred and eighty three patients were sent postal questionnaires; 110 replies (29 per cent) were received, of which 67 (17 per cent) were available for analysis. There were 43 males and 24 females with an average age of 47.4 years in the range 21–71 years, all with varied but predominantly severe drinking problems.

Fifty patients (75 per cent of those analysed) reported that they have found their general practitioner to be sometimes helpful (17 patients) or very helpful (33 patients). Seventeen patients (25 per cent) saw their general practitioner as rarely helpful (11 patients) or never helpful (6 patients).

Despite the small sample size, these results are significantly different from those of Edwards and colleagues, and suggest that, in Mersey Region at the very least, some alcoholic patients are receiving a standard of care from their general practitioner that is more than satisfactory.

That general practitioners wish to be involved in the treatment of the patient with alcohol problems was demonstrated in 1967.[2] There has been criticism of the role of the general practitioner in the management of the alcohol-dependent patient particularly in terms of attitude towards alcoholics. Vocational training has given general practitioners a greater awareness of the problems associated with excessive drinking and a better knowledge of treatment facilities and options. The concerned and sympathetic general practitioner may already have a much greater role in long-term management that has been recognized.

The plan for the future should not be to continue to highlight the negative aspects of certain approaches but to emphasize the positive results of informed and well-timed intervention in order to support and encourage those already involved and to stimulate others to become involved in the difficult task of managing this chronic relapsing and debilitating disorder.

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**References**

1. Edwards G, Duckitt A, Oppenheimer E, *et al.* What happens to alcoholics? *Lancet* 1983; **2:** 269-271.
2. Rathod NH. An enquiry into general practitioners' opinions about alcoholism. *Br J Addict* 1976; **62:** 103-111.

## Doctors and nuclear war

Sir,

Dr Hodgson is right (Letters, February *Journal,* p.106). We have a duty to prepare our plans for dealing with the effects of a nuclear war and to publicize them.

By doing this, we can increase awareness of the fact that realistic effective planning for the results of such a catastrophe is impossible and that the only rational medical approach to the 'final epidemic' is one of prevention.

Surely it is heartening that the motion complimenting the British Medical Association on its report on nuclear war was passed by a huge majority at the 1984 Annual General Meeting of the College. The ball is now very much in the court of those Members truly committed to the

principles of prevention. The 1984 AGM rejected the proposal (the second part of the motion) that an educational initiative be undertaken by the RCGP. Such members can take up the challenge thrown out by a speaker from the floor to bring to next year's AGM evidence that the educational initiative had, in the intervening year, been taken at local level. The AGM may then endorse it.

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Sir,

Dr Marion Birch, in her letter (February *Journal,* p.107) makes the interesting statement 'We must always speak the truth and we must find ways to make them listen.' In the context in which she writes this means that our truth must be impressed upon the countries of the Eastern bloc. I suspect that those very words might equally well have been spoken in the Pentagon, in the Kremlin or even in Downing Street. What we all have to try to keep in our minds in this very difficult debate is that what is true depends on where you are standing and that people do not like being told what they must believe. I can imagine Dr Birch's anger if her own sentence had been reported as emanating from Moscow.

For myself, the knowledge that both sides already have more than enough weapons to destroy us all several times over seems a very convincing argument for making an immediate start on bilateral reduction. To deplore the arms race while tacitly supporting it by the sort of arguments Dr Birch uses does not make sense.

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Sir,

Dr Birch's letter (February *Journal,* p.107) leaves me puzzled. What, in practical terms, does she want to do? Her suggestion of 'demanding' freedom and tolerance from a totalitarian regime, while continuing to point weapons of mass destruction at their people, seems unlikely to succeed. It would indeed be good to convince doctors (or, more probably, their rulers) behind the Iron Curtain that 'having differing political views from those of the ruling class does not constitute a mental illness', but her final paragraph claiming that we must 'identify and neutralize the enemy within' makes me wonder if some doctors in this country need convincing that dissidents are not only 'not mad' but also 'not bad'. (They may even be right!)

There are two moral arguments for nuclear disarmament (which is by no means the same thing as appeasement). The first is to say that any state which depends for its survival on the threat of annihilating life on earth is not worthy of the name of civilization, and can only ask itself 'Who started all this, anyway?' In the words of Kathleen Lonsdale, 'The real horror is not that we may be bombed, but that we should ever think of using the bomb on anyone else.' The second argument is that deterrence, if it is a valid long-term prospect, can be achieved by enough nuclear weapons to wipe out all cities and towns of over 150 000 population in the USA and USSR — that is about 200 warheads on each side. This represents about one per cent of the present stock of weapons; doctors in particular should ask themselves what the other 99 per cent is for, and whether we could not disarm by at least that much.

Alas, despite Dr Birch's statement, opponents of the arms race are not preaching to the converted in the West; the number and accuracy of our weapons mounts daily. Nor is it true that the Warsaw Pact has 'the most massive collection of atomic weapons'. Irrelevant though it is to deterrence, that distinction belongs to NATO.

LESLEY BACON

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Sir,

The letter by Dr Glanvill (March *Journal,* p.153) appealing to general practitioners to involve themselves in civil defence planning envisages the possibility of highly trained, well motivated medical teams springing into action after a nuclear attack. Such information as is generally available from government sources does not explain how this is to be achieved. More realistic estimates, for example the British Medical Association report, suggest a complete breakdown in medical services with experience gained in conventional warfare or peace time becoming irrelevant.

I am not a member of the Campaign for Nuclear Disarmament, but my answers to Dr Glanvill's questions would be:

1. There could be a war, especially since the increasing sophistication of nuclear weapons is deluding some strategists into thinking that a nuclear war could be won.
2. There could be some survivors, but those escaping trauma, haemorrhage and infection, living in a waste land of craters, cinders and radioactive fall out, cold, and without food or water would envy the dead.
3. Any doctor who attempted to help in the immediate aftermath would be killed by blast fire or radiation. If he could find effective shelter until radiation levels had fallen, how would he cope without basic resources or drugs, dressings, water, electricity and transport?

There is no effective response to nuclear war. The only hope is through disarmament or a freeze on nuclear weapons development. As with other threats to our patients' lives the role of general practitioners is in prevention.

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## Efficiency in general practice

Sir,

I retired from general practice at the age of 60 years some 11 years ago and since then have been able to read and study the many articles which have been published on patient attendances, doctors' workloads, use of drugs, efficiency and economy. However I have not found one investigation into the relationship between drug costs, X-rays, outpatient referrals and the length of certified incapacity of patients, the costs of sickness and the work output value of sickness. Nor have I found an investigation into the numbers of certificates issued by general practitioners. If we are to examine the efficiency of our profession, surely these factors must be considered worthy of investigation and of prime importance in assessing the value of the general practitioner to the country.

The savings of a few pounds on drugs is nonsense if by issuing a certificate a worker draws an extra week of sickness benefit and the nation loses a week's output.

A doctor who gives 'easy' certificates of incapacity can be a liability to the nation — unfortunately such doctors do exist, though rarely one hopes.

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