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.

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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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