Minute 350 of the meeting of the representative body this year states:

"That this meeting is totally opposed to GP Budget Holding and:

a. Hopes that no GP will become a Budget Holder

b. Calls upon all GPs to cancel any expression of interest in budget holding."

Not only is there a conflict of interests for members of the BMA pursuing fundholding but it is essential that the constitutional problem is resolved before any further help or guidance is afforded to fundholders by the association.

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REPLY FROM THE CHAIRMAN OF THE GMSC,—Dr Tiarks is a member of the GMSC and at its meeting on 20 September 1990 he participated in the debate on this issue and the subsequent decision that the committee should continue to represent all general practitioners, whether fundholders or not. The GMSC reiterated its belief that fundholding in general practice will be detrimental to patients' interests and the NHS and resolved to place a priority on ensuring that all patients have equity of access to NHS services and to continue to represent the interests of all general practitioners. It is the latter objective that I wish to expand further.

A primary responsibility of the BMA's craft committees is to protect the interests of all doctors working in the NHS, irrespective of whether they themselves support the committees' policies. For example, those hospital doctors who will be working in the new NHS trusts will expect and receive the support of the Central Committee for Specialists and Consultants in their dealings with the management of the trusts. In the same way general practitioner fundholders rightly expect and will receive support from the GMSC in their dealings with family health services authorities, regional health authorities, and the health departments. This point can also be illustrated by a more mundane example. Traditionally, GMSC policy has been opposed to general practitioners working from health centres because owner occupied surgery premises provide a more secure basis for the independent contractors. The GMSC has, however, always given advice and assistance to general practitioners who have opted to work in health centres.

The conflict of interest to which Dr Tiarks refers simply does not apply. The BMA and its craft committees have always seen their duty to be that of protecting and representing the interests of all doctors and members, even if some of them pursue career decisions that are contrary to the association's policies.

I G BOGLE

General Medical Services Committee,
BMA

SIR,—All Fool's Day was aptly chosen for the government's new fundholding operation to begin. The health service administrators are still kidding themselves that the documentation will be ready, although there is an increasing body of evidence to show that the NHS is heading for a disaster. Even general practitioners who have been enthusiastically trying to make it work in the first wave practices are writing to the secretary of state to say that the scheme is fatally flawed. To quote from one particularly well informed general practitioner: "If somebody does not do something intelligent about this soon then it is political suicide."

Members should challenge the government statistics on the numbers of fundholding practices. The jargon has changed from the number of practices that have "expressed an interest" to the number who are "eligible to be" fundholders. This device allows the government to ignore the fact that more and more practices have pulled out of the mad charge towards fundholding in 1991-2, including my own partnership.

The editorial by Dr Michael Drummond and colleagues[1] was far too mild and academic. The BMA should be mounting an eleventh hour ambush on the fundholding concept and insisting on a well monitored pilot study in line with BMA policy. I suspect that the secretary of state would be only too relieved if it could be done in a way that is not too personal.

M G F CROWE

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BMA

1 Drummond M, Crump B, Hawkes R, Marchment M. General practice fundholding. *BMJ* 1990;**301**:1288-9. (8 December.)

Choosing a new partner in general practice

SIR,—Drs Jennifer King and Michael Whitefield concentrate on collegial perceptions of both the job and the candidates.[1] But what about the needs and perceptions of the patients?

The authors reported that the vacancy had arisen through the resignation of one of the two female partners in a practice of five partners: "It was assumed that the female partner would have liked another woman to join the practice, but during group discussions it became apparent that this was not so. . . . This shows how easily assumptions can be made and how they can be mistaken, even in a group of people who work closely together and know one another."

But how easily the authors assume that patients can be taken for granted. Did anyone think to consider if, for example, the gender balance in the practice mattered to the patients?

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1 King J, Whitefield M. How to choose a new partner in general practice. *BMJ* 1990;**301**:1258-60. (1 December.)

Juniors' hours

SIR,—As chairman of the committee that recommended the regulations[1] that are rationalising the working conditions and the supervision of residents (junior doctors) in New York state, I would like to restate the intent and the rationale of the committee's recommendations.[2] The recommendations are concerned with improving the quality of patient care. Scheduling house staff to be sleep deprived and chronically fatigued leads to poor patient care and also is deleterious to the emotional and physical wellbeing of junior doctors.[3,4] Scheduled sleep deprivation and chronic fatigue are not good ways to teach young physicians medicine or humanism. This led to the recommendations restricting scheduled hours. Of greater importance than the restriction of hours are the supervisory regulations.[5] These regulations affirm that the responsibility for the care of the patient is that of the attending (consultant) physician. Patient care decisions are made only in the presence of the most mature and wise doctor, the attending physician.

The effect of the regulations on continuity of care and their cost have been discussed. The regulations concern schedules and do not change doctors' commitment to their patients. Physicians were expected to stay, as truly needed, with their patients when they were working more than 100 hours a week, and with a shorter working week the concept of commitment to patients (not to programme directors) will be better fulfilled. In the United States public policy makers decide on how much and where they wish to place their resources. In New York state the commissioner of health made over $250m available to implement the recommendations. The private hospitals have sued the commissioner. Their portion of the funds is in court. The public hospitals were able to improve supervision and train ancillary help[6] (clerks, phlebotomists, etc). The regulations are now law and implementation is proceeding. Few have raised the real issue, which is that in the United States training of doctors in hospitals is driven by service and not by educational needs.

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1 New York State Ad Hoc Advisory Committee on Emergency Services (Bell Committee). *Final report.* New York: New York State Department of Health, 1987.
2 Bell BM. Evolutionary imperatives, quiet revolutions: changing working conditions and supervision of house officers. *The Pharos of Alpha Omega Alpha* 1989;**52**:16-9.
3 Various authors. Juniors' hours: international overview. *BMJ* 1990;**301**:830-2. (13 October.)
4 Hoffman J, Anders F. Juniors' hours. *BMJ* 1990;**301**:1159. (17 November.)
5 Delamothe T. Juniors favour action over hours. *BMJ* 1990;**301**: 1235. (1 December.)
6 Turnbull NB, Miles NA, Gallen IW. Junior doctors' on call activities: differences in workload and work patterns among grades. *BMJ* 1990;**301**:1191-2. (24 November.)

Military secrecy and medical preparedness

SIR,—Messrs D A McGrouther and N Parkhouse rightly say that military secrecy must not leave those who are expected to treat casualties unprepared.[1] They go on to assert that in respect of chemical casualties the issue is shrouded in such secrecy.

This is not correct. The standard manual on the medical management of chemical casualties[2] is a completely unclassified document available through HMSO. It covers all anticipated chemical agents. In addition, all relevant information has been passed by the Ministry of Defence to the Department of Health. The Department of Health has circulated advice on the treatment of chemical casualties to all regional directors of public health and to the National Poisons Advisory Information Service.[3]

It should also be appreciated that all such casualties will have been decontaminated and will have received initial treatment before evacuation to the United Kingdom. Furthermore, specific advice is always available to individual practitioners through the close liaison that has been reinforced between military medicine and the NHS for this purpose.

N H MILLS

Ministry of Defence,
London

1 McGrouther DA, Parkhouse N. Military secrecy and medical preparedness. *BMJ* 1991;**302**:117. (12 January.)
2 *Medical manual of defence against chemical agents.* London: HMSO, 1987. (JSP 312.)
3 Department of Health. *Chemical warfare casualties.* London: DoH, 1990.

Correction

Screening for carriers of cystic fibrosis

An editorial error occurred in this letter by Dr John C S Dean and colleagues (5 January, p 53). The second sentence of the third paragraph should read: They calculated the risk that the partner is a carrier and is Δ F508 negative, given that she is a carrier (the joint probability), whereas we wish to know the risk that she is a carrier, given that she is Δ F508 negative (the posterior probability).

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