(including peak flow monitoring at home) and there has been only one admission with a severe attack over about five years in this group and there have been no deaths.

W T BERRILL

West Cumberland Hospital,
Whitehaven, Cumbria CA28 8JG

Unrecognised femoral fractures in patients with paraplegia due to multiple sclerosis

SIR,—Having had two cases of unrecognised femoral neck fractures in patients with paraplegia due to multiple sclerosis in the last two years we agree wholeheartedly with Dr Simon Cocksedge and others' suggestion that this problem occurs more often than is generally recognised (4 August, p 309). Moreover, the fracture may be asymptomatic and an incidental finding.

Case 1—A 57 year old widow with multiple sclerosis for the past 18 years was admitted to hospital for reassessment. Both legs were spastic with impaired sensation. In view of unexplained fever, recurrent urinary tract infections, and recent urinary incontinence, an intravenous urogram was performed that showed (quite coincidentally) an ununited fracture of the left femoral neck through osteoporotic bone. There was no history of trauma or pain. The age of the fracture could not be determined from the radiograph, but alkaline phosphatase activity was raised at 386 IU/l with normal calcium and phosphate concentrations, suggesting it was recent. She was treated conservatively and discharged home and has remained symptom free from her fracture for two years.

Case 2—A 70 year old ex-nurse with multiple sclerosis since the age of 20 was admitted with a two week history of pain and deformity in the left thigh that prevented her from transferring from her bed to her wheelchair. There was no history of trauma. For many years she had been on betamethasone 0·5 mg daily. On examination there was severe spasticity and weakness of both legs and tenderness and deformity of the left upper thigh. A radiograph showed a transverse fracture through the upper third of the left femur. Calcium and phosphate concentrations were normal, but alkaline phosphatase activity was raised at 988 IU/l. She was treated conservatively with analgesics and discharged home after five weeks in hospital. One week later she died from a chest infection.

These two cases from the same hospital in two years suggest that this is a common problem. It is likely that raising the standards of care for severely disabled patients will contribute to longevity and therefore the extent of osteoporosis and consequent unrecognised fracture of the lower limbs. Also, the manhandling of such patients by their attendants or hoisting (essential during transfers from bed to chair, bath, or toilet) however gentle and careful may well contribute. A high index of suspicion is necessary for these fractures not to be overlooked.

PETER WILLIAMS
ANDREW FRANK

Rehabilitation Department,
Northwick Park Hospital,
Harrow, Middx HA1 3UJ

SIR,—A patient in our practice, a 34 year old woman with longstanding multiple sclerosis, sustained a painless femoral fracture. She is in the habit of leaning over and compressing her anterior abdominal wall against her thighs in order to empty her neurogenic bladder. On one occasion while doing this she heard a crack. It transpired that she had sustained a short oblique fracture of her right femur, which was subsequently fixed with a Kuntscher nail. The fracture was completely painless as in the other reported cases, and the patient was asymptomatic.

CHRISTINE M CRAWFORD
T ALCORN

Medical Centre,
Alexandria

The GMC asks the DHSS to hurry up

SIR,—Doctors appealing against any punishment inflicted on them by the National Health Service disciplinary tribunals are likely to wait for up to two years for a decision to be handed down by the Department of Health and Social Security. The General Medical Council will not deal with doctors accused of gross professional misconduct until such appeals have been decided, and it is intolerable that doctors should have the sword of damocles hanging over them for up to three years. Under these circumstances justice becomes injustice.

The GMC is asking the DHSS to remedy this problem, and I call on all other medical organisations to join in righting this wrong.

H W ASHWORTH

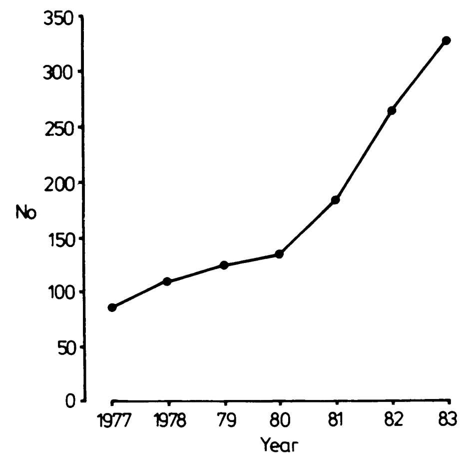
Rusholme Health Centre,
Manchester M14 5NP

GMC annual report

SIR,—When I achieved full registration in 1957 I paid a fee to the General Medical Council which gave me a licence to practise medicine for life. Subsequently that contract was broken unilaterally, and I have under duress paid steadily increasing annual fees to support this expanding quango. I see that the council now has an annual income of £2 740 623, from which it has managed to appropriate a "general reserve" of £1 658 462 and investments worth £3 356 201.

From its income the council disburses £611 512 in "costs which it would be difficult or unrealistic to apportion to particular activities." These include the production and distribution of a glossy covered *Annual Report* at a cost of £203 713. This is an extraordinary document. It devotes 15 pages to the pious platitudes of selected members of the council, nine pages to professional conduct and discipline, and four pages to its own finances.

The report does not tell us how many British doctors it registered in 1983. Perhaps the council is shy about this number as it records the full registration in 1983 to practise in Britain of no fewer than 1554 doctors who qualified overseas. The numbers of doctors from the European Economic Community the council has registered in recent years are shown in the figure. The floodgates are open. Dr B R Bewley (p 4) says that the GMC has a responsibility to ensure that doctors' educational standards do not fall below what would be considered acceptable. Is it not aware that in Italy, the principal contributor, where there are now about 300 000 doctors for a population rather less than that of Britain these requirements are minimal? There are very limited educational requirements for admission to a medical school, no regular courses of clinical instruction, and no requirement to attend lectures. The final examination can consist of short oral examinations with a right to re-admission in the event of failure. The numbers being examined in some medical schools are so great that more than a very few failures might result in the system breaking down.



Number of EEC doctors granted full registration by the GMC in successive years.

It seems amazing that the council, "composed of intelligent hardworking and sensible people with an overriding regard for the repute and best interests of the profession (p 2)" should not have tackled this matter in a forthright manner instead of concerning themselves with increasing their own numbers. Are they blind to the problem? Perhaps the health procedures detailed by the president (p 13) should be applied introspectively? I suppose the GMC will answer that consideration of EEC registrations is outside their statutory remit. Such a restriction has not before inhibited them from pressuring for and obtaining from parliament the authority to interfere—for example, in postgraduate qualifications, which are properly the concern of the royal colleges and universities.

D F HAWKINS

Institute of Obstetrics
and Gynaecology,
Hammersmith Hospital,
London W12 0HS

Appalled junior surgeons at St Thomas's Hospital

SIR,—The junior surgeons at St Thomas's Hospital may be appalled (11 August, p 382) at the blow to the short term career advancement of one of them occasioned by the removal of a senior registrar post, but the unlucky individual would doubtless be more appalled to spend a further 5·5 years in training only to find no consultant post available.

Unfortunately their attempt to generalise from this has not been properly thought through. Hard though it may be to believe, a reduction in senior registrar posts in surgery will have *no* effect on the prospects for the current registrars in the specialty. This apparently anomalous conclusion is due to the excessive average duration in the senior registrar grade. At 5·5 years for general surgery it comfortably exceeds that of any other specialty.[1] The only effect of reducing senior registrar posts is to reduce this average duration while processing the same number of doctors.

Consider a very simple model—an average demand of two consultant posts a year and 11 senior registrar posts. Over 11 years there will be 22 consultant vacancies and each of the senior registrar posts would empty and be refilled twice, and the average duration in post

Br Med J (Clin Res Ed): first published as 10.1136/bmj.289.6443.501-d on 25 August 1984. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.

of each senior registrar would be 5·5 years—as now. The relation is quite simple:

$$\text{Number of vacancies a year} = \frac{\text{Number of senior registrar posts}}{\text{Average duration in post}}$$

If senior registrar posts were reduced by one (a savage 9% cut) the 22 consultant vacancies would be filled by 22 senior registrars from the remaining ten posts, and senior registrars would spend an average of five years in the grade. No one loses, and everyone gains. If the loss of a senior registrar post induced the creation of another consultant vacancy there is a double benefit—the average duration goes down to below 4·8 years and the same number of surgeons are being employed.

Although extra consultant posts have the same effect on senior registrar duration, it would need the creation of more than two consultants (a splendid 10% expansion) in this model to achieve exactly the same career effect—but at vastly greater cost. The argument must therefore turn on whether surgical services need expanding or not. As consultant expansion is demand led from the periphery and there has been no demand for expansion for years one can only deduce that they do not. Perhaps cutting a few senior registrar posts will induce the necessary demand. There is plenty of senior registrar slack to take it up.

M D VICKERS
Chairman,
Manpower Advisory Panel
in Anaesthetics,
Faculty of Anaesthetists

Department of Anaesthetics,
University of Wales College
of Medicine
Cardiff CF4 4XW

[1] DHSS Medical Manpower Division. Medical and dental staffing prospects in the NHS in England and Wales, 1983. *Health Trends* 1984;**16**:25-9.

Conscience and nuclear war

SIR,—The annual representative meeting this year rejected a motion on civil defence planning which asked that doctors should be allowed to refuse on grounds of conscience to take part. Under the revised civil defence regulations agreed by parliament last November all authorities and persons concerned are required to participate in planning and related exercises ordered by the appropriate minister. The regulations cover civil disasters and hostile attack (unspecified). It is hard to imagine any doctor having a conscientious objection to planning for civil disasters or for hostile attacks of the kind experienced during the second world war. The issue of conscience arises in relation to planning for defence against a nuclear attack because of the implication that nuclear weapons are accepted as usable instruments of war and that civil defence against their effects is worthwhile and could be effective.

Since successive governments have approved the basing of more and more NATO nuclear weapons in Britain and the equipping of British forces with these weapons it must be concluded that nuclear weapons are considered to be usable—even if the hope is that they will not be needed. Yet many persons, doctors among them, regard acceptance of nuclear weapons as morally wrong. As regards the effectiveness of civil defence against nuclear weapon attacks the BMA membership has expressed its scepticism by approving last year's report on *The Medical Effects of Nuclear War* and urging wider publicity for it. We do not yet know what will be the assumptions underlying the NATO exercise Lionheart due to take place in September nor those on which are based the revision of circular HDC(77)1 due to appear shortly. Should the planning include provision for nuclear attack, however, we are aware that the designated participants are likely to include some who do not only have a moral objection to nuclear weapons but also consider any feasible civil defence measures to be little better than a sham. There is surely a good case for exempting such concerned doctors without loss of status from participating in making plans in which they do not believe.

The ARM rightly recognised the harm which the arms race is doing both to developed and developing countries. We realise that it refused to request any blanket exemption of doctors from civil defence planning on grounds of conscience and that no absolute distinction can be drawn between planning for nuclear attack and other lesser disasters (including explosion at a nuclear power station). Nevertheless, there could be circumstances in which a conscience clause would be sensible and just, and we hope that in discussion with the Home Office the officers of the BMA will give consideration to this.

JOHN HUMPHREY
President

Medical Campaign Against
Nuclear Weapons,
Cambridge CB1 2DG

Should pharmacists be able to prescribe?

SIR,—The BMA has stated: "The idea that pharmacists should be able to prescribe separately from doctors would not be in the best interests of patients" (4 August, p 333). Although this was a more temperate response than other quotations from medical politicians, it needs to be considered dispassionately otherwise it will continue as a bone of contention between the two professions.

The views expressed in the Pharmaceutical Services Negotiating Committee document have been contained in the evidence that all pharmaceutical organisations have submitted to the inquiry into pharmacy practice by the Nuffield Foundation. They relate to an activity which pharmacists have been undertaking for as long as pharmacies have been open to the public—namely, giving advice with or without the sale of a medicine.

The BMA has previously agreed that this is an inevitable activity, and surveys have shown that the action taken by pharmacists is normally sound. Not only is this activity inevitable; it is also welcomed by most doctors because otherwise the general practitioner services would be overburdened or the public's advice on such matters would come from untrained sources.

The use of such terms as prescribing or discussions about whether the supply of certain products by pharmacists should be within the NHS should not obscure the precise nature of this traditional pharmaceutical activity. Whether or not the range of products which the pharmacists can supply should be extended is a matter for serious consideration, but whatever the range it is ill informed to suggest that the pharmacist's knowledge of drugs and medicines and of the treatment of symptoms is insufficient.

R DICKINSON
Deputy secretary

Pharmaceutical Society of
Great Britain,
London SE1 7JN

Possible crisis in radiology departments

SIR,—I want to let my hospital colleagues (and particularly consultant radiologists) know about a disturbing threat to emergency radiographic work. The College of Radiographers has recently issued a circular letter stating that after the end of August basic grade radiographers will not be allowed to do on call or emergency work (at night and weekends) unless they also have a more senior colleague on duty with them or they are paid at a more senior rate. If this goes ahead it will disrupt much of this work, which is often carried out by basic grade staff, some of whom are quite experienced.

The college bases its argument on the Whitley Council definitions of the radiographer grades and letters (not hospital circulars) from the DHSS to individual health authorities. The DHSS says it has some sympathy since about 40% of radiographers are on the basic grade, and it is offering to negotiate but can hardly be expected to come to an agreement on something started in the holiday period.

Consultant radiologists, with their superintendent radiographers, have every confidence in their radiographic staff and cooperate very well in hospitals. Thus we hope that rational discussion, particularly locally, will avert a crisis which would be detrimental to patients.

The College of Radiographers is also pursuing an odd course in another matter when it asserts in its newspaper that radiologists—that is, the consultants—should not be permitted to run their departments since medical degrees do not fit us for management.[1] Radiology departments are medical departments as the annual representative meeting recently reaffirmed.

F W WRIGHT
Radiologists Group Committee

BMA,
London WC1H 9JP

[1] Anonymous. Beware the office manager. *Radiography News* 1984;June:32.

Community health doctors need not "rage and despair"

SIR,—The report on the community medicine conference refers to the "rage and despair" of community health doctors (28 July, p 262). It also quotes extensively from Dr Kathleen Dalzell's account of events related to the working party which reported on a training programme for doctors working in this branch of practice.

The then chief medical officer (Sir Henry Yellowlees) originally asked the then president of the Royal College of Physicians (Sir Douglas Black) to advise on a training programme with the suggestion that the faculty of community medicine might establish a working party to draft the advice. This working party was established under the chairmanship of Professor John Knowelden and quickly produced a draft which I believe was acceptable to many doctors in the specialty.

Unfortunately it was not acceptable to the Royal College of Physicians or to the joint paediatric committee of the royal colleges of physicians, and the new president (Sir Raymond Hoffenberg) did not feel able to transmit the draft to the chief medical officer. Accordingly, he invited a small group to prepare a more generally acceptable report. I and Professor

Br Med J (Clin Res Ed): first published as 10.1136/bmj.289.6443.501-d on 25 August 1984. Downloaded from http://www.bmj.com/ on 19 April 2024 by guest. Protected by copyright.