intracardiac and intrapulmonary shunt and cannot be used to localise a known intrapulmonary shunt.

Traditionally pulmonary arteriovenous malformations are excised and feeding and draining vessels tied, but occasionally a lobectomy is necessary for extensive lesions. Multiple malformations can be excised at a single thoracotomy, but this is not always practicable. In addition, further malformations may grow. Therapeutic embolisation offers an alternative to surgery. The ocluding device is usually a balloon, although steel coils may be used, which is lodged in the distal part of the feeding artery; careful angiographic assessment of the architecture of the malformation is mandatory. Successful occlusion results in a sustained rise in arterial oxygen pressure. The procedure requires considerable skill, and, as pulmonary arteriovenous malformations are rare, this should probably be undertaken in only a few centres. Paradoxical embolism of the detached balloon or coil is a possible complication, but no deaths have been reported.

C D R FLOWER

Consultant Radiologist, Addenbrooke's Hospital, Cambridge CB2 2QQ

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The BMA's priorities

What do members want from the BMA? Rather a lot, to judge from this year's annual representative meeting, which starts in Bristol next week. Just as with the National Health Service, demand on the BMA seems infinite, with each new service implying an increase in those demands. The BMA, like the NHS, will have to decide its priorities.

Fortunately, membership is healthy, especially among young doctors, and the BMA's resources are in good shape. This latter is due in large part to the retiring treasurer, Dr R A Keable-Elliott, who initiated a well defined financial strategy. With support from the craft trusts the subscription income (around £7-5m in 1986) is used to provide the wide range of national and local professional services; property income is spent on refurbishing and upgrading the buildings; the surpluses from publishing activities are held to start new ventures and as a cushion against the unpredictability of commercial publishing; and investment income is allocated to the reserves for a politically rainy day. So any debate about priorities is about how to spend the subscription income.

Three motions illustrate how choices will have to be made. The Hospital Junior Staff Committee wants to see more industrial relations officers, and a priority motion on the agenda contains a similar proposal. Another motion, from North and South Cambridge, emphasises the importance of the central negotiation of doctors' pay and conditions of service and calls for resources to ensure that standing committees charged with these responsibilities are adequately served.

Meanwhile, the Sheffield division calls on the council to ensure that the board of science can continue its excellent work. The question is thus how should the BMA divide up its resources among local services, national committees, and its scientific activities—now costing around £2·1 million, £2·4 million, and £600 000, respectively?

Local services, including the industrial relations officers and local committees, will be increasingly important as health authorities and their members assume greater autonomy and as political pressure increases for more efficiency in the health service. National committees will need to remain powerful to respond to government policy and to negotiate centrally agreed terms of service. Indeed, it may be necessary to fight for the continuation of national agreements on pay and terms of service. The BMA's board of science provides valuable information on health and social subjects to the public and adds a professional dimension to the association's activities, the public that it is more than just another organisation defending the territory and interests of a sectarian group.

A good case can be made for expanding each of these activities—and a working party is soon to examine the scope of regional services—but the dilemma is that the BMA's priorities are often arrived at haphazardly as a result of resolutions passed in separate debates at the annual representative meeting. Representatives will debate well each of the three motions I have highlighted and good decisions will be reached. But will the decisions fit well together and form a coherent strategy for the association? With the prospect of a full term government whose policies there is no great affection for the professions and whose policy on the NHS may be radical the BMA must have a good idea of where it wants to go and how it should get there. This year's annual representative meeting could start this process by initiating a review of the BMA's priorities. Next year's representatives could then have an
School dinners

When compulsory education began in Britain in 1880 school dinners were provided by volunteers. Later it became compulsory for local authorities to provide milk and dinners of specific nutritional standard for all schoolchildren who wanted them. But since 1984 much of the central control has been relinquished, and local authorities are now responsible for the cost and nutritional standard of school meals. The only statutory requirement is that they provide meals to children entitled to free ones, and this system is about to be replaced. In 1984 half of the school population of 6·6 million had school meals, and for 17% they were free (Department of Education and Science, unpublished census). Do school meals matter any more or are they an anachronism left from a time when absolute poverty was much more widespread?

Nutritionally the primary school years are quiet and interest focuses on children at secondary school, particularly as they pass through puberty and adolescence. Both sexes experience a growth spurt; in girls it is earlier, peaking at around the menarche, and substantial extra fat is deposited; while boys grow taller and develop bigger bones clothed more in muscle than fat. Faster growth requires more food, bones need more calcium, and the menarche and muscles need more iron—the nutritional implications are clear.

Food is much more, however, than just a purveyor of nutrients. In all societies eating together is a vehicle of social interaction, and this probably needs to be taught at school because just as with learning to cross the road and sex education we cannot assume that all parents will take it on. The school meal could also illustrate current concepts of healthy eating, although, just like ways of teaching mathematics, these concepts change as much in response to fashion as to objective evidence. Several schemes have combined the school meals service and other school or health departments, such as home economics, science, and health education.1

So it is possible to weave a plausible nutritional, social, and educational argument that school meals are beneficial—but is there any objective evidence of recent benefit in Britain? A 1983 survey showed that generally total nutrient intakes of British children were above the recommended dietary allowances, although in common with people of all ages energy intakes were lower.1 The children exceeded the height and weight standards for age, and the survey found no great differences in the nutrient intakes of children in different social circumstances. The quantity was thus reasonable, but the quality of the children’s diet might cause concern. Over one fifth had an intake of energy from fat of over 40%, when current thinking is that it should not exceed 35%.15 Many of the children ate many chips, crisps, cakes, and biscuits.

School dinners provided about a third of the children’s total energy intake and were generally satisfactory, although they gave two points for concern. Firstly, older schoolchildren, particularly girls who ate lunch at cafes and the like rather than at school, had low intakes of many nutrients both at lunchtime and in the day as a whole; their iron intakes were especially vulnerable. Secondly, the older children who qualified for free school meals got more of their total energy intake from school dinners than was the case for children who paid. The differences were not large but demanded caution—for example, among girls aged 14 and 15 those paying consumed 8·1 MJ (390 kcal) daily and got 3·1 MJ (740 kcal) (35%) from school dinners; those receiving free school dinner consumed 8·6 MJ (2050 kcal) daily and got 3·7 MJ (880 kcal) (43%) from school dinners. Does this mean that underprivileged older schoolgirls depend more on their school dinners than more fortunate children and that therefore school dinners are an essential part of educational medicine? Or does it mean that older schoolgirls who have free meals eat more at school and so their total intake is higher than that of more fortunate children? From the data provided by the survey we can accept neither interpretation.

The Nutrition Surveillance Committee of the Department of Health and Social Security has encouraged and supported assessments of the nutritional value of school milk.1 Children aged 7 or 8 from large families and attending schools where many pupils qualified for free school meals were studied over six terms. Those receiving free milk gained more height (a significant gain but only a 2·93 mm difference) and more weight (a 130 g difference, which was not significant) than the control group—hardly resounding evidence that free school milk is essential for underprivileged primary schoolchildren. Would it be possible to have similarly objective evidence on school dinners? I am sure that other measures of nutritional state apart from growth and dietary intake would require assessment—for example, if iron intakes in adolescent girls eating out of school are low we need to know their haemoglobin concentrations.

My own belief is that school dinners are important in the nutritional, educational, and social environment of schoolchildren—but I cannot marshal convincing evidence on health. Nevertheless, even if immediate nutritional benefit cannot be shown I regard the educational and social role of school meals as important. Mothers with reasonable ideas on their own nutritional welfare are usually receptive to informed views on the nutritional welfare of their children; I believe that their own ideas can be moulded and modified by example at school.

Of course, the children need to consume the school dinner for it to be of any value. Fast food chains attract schoolchildren, and we may have something to learn from their marketing methods. Hamburgers are here to stay so let’s have lower fat, low salt ones at school with wholemeal buns and thick chips (they take up less fat). Many (not all) of the commercial weaning foods available in Britain are nutritionally sound and enjoyed by their consumers; could the manufacturers produce foods for older children? The food industry should be seen as a valuable resource to be used effectively in promoting school health, which is not to delegate our ideas on the nutritional adequacy of school meals. In my view it is unfortunate that nutritional guidelines are no longer specified by the Department of Education and Science, but some education authorities—for example, Birmingham—have set up their own. When evidence is lacking we should be wary of dismantling an institution that may be valuable, but better evidence is needed.