Our Romanian colleagues will be particularly distressed to find that, despite their best efforts, a negative image of child care in Romanian institutions continues to prevail abroad. We can only hope that this incident will not compromise their readiness to cooperate with us in similar ventures in the future.

P A STEPHENSON
R MCCREERY

Centre for Public Health Research,
WHO Collaborating Centre on Health Systems Research,
651 82 Karlstad,
Sweden

1 Children's Health Care Collaborative Study Group, Romanian health and social care system for children and families: future directions in health care reform. *BMJ* 1992;304:556-9. (29 February.)

Report of the International Chernobyl Project

SIR,—I wish to respond to a few of the points in Ian Munro and Mary Brennan's letter about the overview document of the International Chernobyl Project.^{1,2} I believe that they are responding to inappropriate use of the overview documents by people who would like to suggest that there will be no health effects from the accident at Chernobyl. Such a view is clearly wrong. I suggest that anyone seriously interested in Chernobyl should read the technical report thoroughly.³

The primary purpose of our medical survey was to confirm or deny claims in the media that more than 30% of people suffered from anaemia and that over 70% of people in Byelorussia suffered measurable thyroid damage in the five years after the accident. The size of our sample was certainly adequate for this.

In addition to carrying out the medical survey, people from the project spent many weeks in the Soviet Union interviewing scientists and examining their raw data regarding both thyroid abnormalities in Byelorussia and hereditary malformations. Their studies were not "arbitrarily dismissed." The project undertook specific missions that brought in independent experts from other countries (including the United Kingdom) to peer review the raw data on thyroid function, fetal malformation, haematology, epidemiology, and radiation effects. These experts' opinion was that no effects related to radiation could be substantiated in the general population.

It is true that no attempt was made to study the people who had moved away from the villages. The original request from the Soviet government was specifically restricted to determining the health of the general population remaining in contaminated areas.

Munro and Brennan suggest that the location of the control villages was a problem and that the contamination in the external environment would have been higher than elsewhere. But contamination in the control villages was checked by the project's environmental and dosimetry teams and was lower than in many west European countries.

I agree with Munro and Brennan that prospective epidemiological studies should be conducted, and this, indeed, was one of the project's conclusions.

There are certainly limitations to investigations of the International Chernobyl Project, and these are detailed in the 600 or so pages of the technical report. It is unfair to criticise a study for limitations that its authors have already pointed out or for not having extended beyond the host government's mandate.

The technical report clearly points out that the risk of future neoplasms and genetic effects is increased for the population living in contaminated areas. At the time it was written no effects other than increased stress and anxiety were obvious in

the general population studied. Whether current claims of an increased incidence of thyroid cancer can be substantiated by careful peer review of data remains to be seen. Obviously, serious health effects have occurred in emergency workers and other groups that were not included in our mandate from the Soviet government.

FRED A METTLER JR

International Chernobyl Project,
Department of Radiology,
University of New Mexico School of Medicine,
Albuquerque,
NM 87131-5336,
USA

- 1 Munro I, Brennan M. Lessons of Chernobyl. *BMJ* 1992;304:254-5. (25 January.)
- 2 International Advisory Committee. *International Chernobyl project. An overview*. Vienna: International Atomic Energy Agency, 1991.
- 3 International Advisory Committee. *International Chernobyl project. Technical report*. Vienna: International Atomic Energy Agency, 1991.

Public opinion and purchasing

SIR,—Like Andrew Richardson and colleagues I welcomed the introduction of surveys of public opinion on health priorities because I thought that they would help health authorities in taking informed decisions on purchasing.¹ I rapidly discovered that, as in Oregon,² public preference is being used selectively to justify cuts in services—when it accords with the views of decision makers. (When it does not, as was the case with the 46% of respondents in Bath who found help with stopping smoking to be of little or no importance,¹ I suspect that it is being disregarded.) Such surveys require a healthy dose of scepticism. Separate from the questionable ethics of obliging an unaware public to collude in rationing is the equally disturbing way in which strategies borrowed from economics, such as "rationing for health gain," are being promoted as an appropriate basis for setting priorities. Grounded as such ideas are in the relativist notion of "capacity to benefit from health care" (which depends on what health care is currently available), these approaches have no necessary relation to health need (which depends on individuals' health status) and, indeed, are likely to increase existing inequalities in health. Informed and public discussion is urgently required so that these concepts can be examined,^{3,4} debated,^{5,6} and put in their proper context—whatever that may turn out to be.

ALEX SCOTT-SAMUEL

Liverpool L18 6JN

- 1 Richardson A, Charny M, Hanmer-Lloyd S. Public opinion and purchasing. *BMJ* 1992;304:680-2. (14 March.)
- 2 Honigsbaum F. *Who shall live? Who shall die? Oregon's health financing proposals*. London: King's Fund College, 1991. (King's Fund College papers 4.)
- 3 Radical Statistics Health Group. Missing: a strategy for health of the nation. *BMJ* 1991;303:299-302.
- 4 Smith A. Setting a strategy for health. *BMJ* 1992;304:376-8. (8 February.)
- 5 Harris J. QALYing the value of life. *J Med Ethics* 1987;13:117-23.
- 6 Breen D, Chalmers J, MacLean I. Setting a strategy for health. *BMJ* 1992;304:641-2. (7 March.)

Raw deal for academics

SIR,—I congratulate D K Peters on his editorial in defence of academic medicine.¹ I particularly endorse his comments that the accreditation process should be rationalised so as not to demoralise clinical academics and delay their usefulness in senior supervisory posts.

The recent introduction of the (T) system is a retrograde step in this regard. This is the scheme whereby a practitioner's trained status will be indicated in the medical register by a (T) after his

or her entry. To be regarded by the Royal College of Psychiatrists as trained you need to do four years of approved higher clinical work; without this a (T) will not be granted. It has been mooted that without such accreditation academic consultants should not be allowed to train juniors on an approved rotation. I suggest that an (R) should be introduced to indicate proper research training, without which no clinician should be allowed to supervise any research student or research fellow.

ROBERT KERWIN

Institute of Psychiatry,
London SE5 8AF

- 1 Peters DK. Academic medicine. *BMJ* 1992;304:651-2. (14 March.)

SIR,—D K Peters points out many of the problems faced by clinical academics.¹ A further inequality has arisen with the recent replacement of units of medical time by additional duty hours as payment for extra duties. Currently in Leeds the university pays junior clinical academics for their extra duties and has no plans to change from the units of medical time system to additional duty hours. My NHS colleagues are paid 50% of the standard rate for on call work, whereas I and my junior clinical academic colleagues are paid 34% of the standard rate for on call work.

I think that many applicants for junior clinical academic posts are unaware of the extra demands that these posts carry and the uncertainty about parity of salaries. If these problems remain unresolved young doctors will soon not take up careers in academic medicine.

M G BRADBURY

Department of Paediatrics and Child Health,
St James's University Hospital,
Leeds LS9 7TF

- 1 Peters DK. Academic medicine. *BMJ* 1992;304:651-2. (14 March.)

Telephoning for an ambulance

SIR,—Minerva reports that general practitioners can save valuable minutes if they "tell the patient to phone for an ambulance" when the patient telephones and gives a history suggesting cardiac pain.¹ I think that this recommendation is misguided. Sudden death may occur before the patient can telephone, and lesser medical events such as vomiting could also delay the telephone call.

An even greater delay in the chain of events leading to admission to hospital with cardiac type chest pain occurs when the patient telephones and the general practitioner is not in the surgery. Sometimes the receptionists relay the call; at other times patients must telephone an independent doctors' answering service. On the receiving end, general practitioners may have to find a working telephone box to answer their bleep. These delays have been eliminated in our area by training receptionists and operators of answering services to call an emergency ambulance themselves if the story strongly suggests cardiac pain and then to notify the general practitioner.

In these circumstances, well trained operators can save minutes and lives. That is, if patients can get through to them. In this age of the patient's charter should there not be a maximum time for which patients should expect to ring when calling an emergency ambulance (in my experience, sometimes four minutes) and doctors' surgeries or answering services (which are often engaged)?

MARK ASHWORTH

London SE11 4HJ

- 1 Minerva. *BMJ* 1992;304:788. (21 March.)