216.7 (33.1) mmHg; $P=0.07$) in patients who presented in March.

Our findings are in keeping with a seasonal variation in arterial blood pressure as it is known that higher blood pressures are recorded in winter than in summer.^{3,4} There was, however, no seasonal pattern to the incidence of malignant phase hypertension.

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Histopathology and medical laboratory scientific officers

EDITOR,—Some of the reactions to my personal view on the future of histopathology^{1,2} were disappointing, although not entirely unexpected. A few months ago colleagues and I sent a questionnaire to all those, both consultants and registrars, who had worked for us over the last 17 years. All of the 15 replied (nine registrars, of whom five are now consultants, and six consultants). Although their opinions on our practice diverged, none expressed any concern for the quality of our service. When asked their opinion of the Royal College of Pathologists' code of practice—"all selection of tissue blocks for processing and examination must be carried out by a histopathologist"—five of the former registrars agreed with it, two disagreed, and two were unsure about its relevance while two of the consultants agreed and four disagreed. The diversity of opinion among the 15 respondents was perhaps highlighted by the near universal unsolicited view that medical laboratory scientific officers could be trained to undertake more responsible tasks (unspecified).

It has never been my view that every medical laboratory scientific officer should be given the opportunity of being trained to dissect surgical specimens, for I believe that a selection process should operate; neither did I say that medical laboratory scientific officers should be unsupervised. A day does not go by without one or more of us being called to decide on the appropriate approach to some unusual or difficult specimen. As one of our former consultant colleagues commented, however, "the vast majority of surgical specimens are of a highly standardised nature, the dissection of which is well within the capacity of a trained MLSO."

Dennis H Wright and T J Jones miss the point when they invoke the possibility of medicolegal litigation stopping us in our tracks.³ Like all consultants, we take responsibility for the work of our junior staff; in any event, most errors that give rise to liability to damages occur in the microscopist's domain.

Perhaps Wright has been away from the sharp end for too long to see the banal lesions I was referring to, such as fibroepithelial polyps, seborrhoeic keratoses, and intradermal naevi. Proper training can safely point to aspects of the microscopic picture that require more circumspect

examination by a consultant. I have no doubt that in the years ahead selected medical laboratory scientific officers (laboratory practitioners) will be entrusted with defined aspects of microscopic diagnosis.

J Denis Biggart and Derek C Allen of Belfast City Hospital state that ours is not the only establishment to use medical laboratory scientific officers in this more effective way.² Our practice is as theirs, and we follow an agreed protocol (standard operating procedure). It is a sad reflection on Clinical Pathology Accreditation (UK) Ltd that, for the same reason that their laboratory was accredited, ours was not (Richard I Harris's letter).² I look forward to a time when pathologists and medical scientific laboratory officers can work together without the intrusion of arbitrary and rigid lines of demarcation.

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Failure of consultant expansion

EDITOR,—Stephen Brearley is right to bemoan the lack of progress towards a consultant led service but is too pessimistic.¹ It is important to look not just at the years leading to an appointment as a consultant but also at the years after that appointment. Here, continuing medical education has a role.

In the past many people have seen the achievement of the consultant grade as having "made it." This is understandable in view of the numerous hurdles they have had to overcome. It has then been customary to stay in post until retirement. I believe that this is an outdated model. With a shorter period of more intense training, followed by a statutory requirement for continuing medical training, we may well have to change our view of the nature of the consultant grade itself. I realise that this is a heresy, but models exist to guide us.

In public health, consultants work alongside but ultimately under a director of public health without feeling demeaned. Similarly, doctors in Europe often have a system of senior and junior consultants. Is it too much to suggest that, having aped their system of training, we should follow their system of appointing consultants? Such a system would have spin off benefits. In this more mobile world, having a job for life has lost some appeal. Doctors often need to leave one area of Britain to follow their partners to another area. The creation of more grades might help to allow this fluidity, which might encourage more women into consultant positions. Secondly, with continuing training and development, consultants might wish to follow some new interest, and jobs for life would hinder this.

The real difficulty with appointing more consultants, however, is the cost. Perhaps we have to bite the bullet. Should young consultants in their early 30s start on salaries of £40 000, which shoot up quickly after that? We face a clear choice: either we stay as we are with long and frustrating training or we grasp the future of a well trained, developing workforce, whose pay develops as they do. I suggest that we must grasp that future, warts and all.

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Human rights in Iraq

EDITOR,—Human rights in Iraq have been violated for decades. The fact that doctors are forced to participate in violent atrocities adds another dimension to the suffering of the Iraqi people and, especially, our medical colleagues. Recent reports suggest that doctors have died for disobeying orders to perform amputations and other abominations, defending their conscience and integrity. In the past and during the Iraq-Iran war Iraqi doctors were subjected to terror to force them to carry out violations of human rights on innocent people. This resulted in an exodus of doctors from Iraq.

Doctors are also under pressure because they feel helpless towards their patients. The harsh, punitive sanctions imposed by the United Nations since August 1990, which include sanctions against the supply of the *BMJ*; the destructive war in January and February 1991; the suppression of the civilian uprising; and the continuation of the embargo have resulted in hundreds of thousands of unnecessary deaths, especially among children.^{3,4} Today's lack of medicine and food brings the Iraqi people nearer to a predicted "massive starvation and disease" in one of the rich countries in the world.⁵ The assertion that medicine and foodstuff are exempt from the sanctions is meaningless since Iraq has no funds to buy them.

The unprecedented punitive sanctions have affected the whole of the Iraqi people except the original target, Saddam Hussein. The technical condition for lifting the sanctions—that is, that Iraq will not again be able to make weapons of mass destruction—has been whipped away, as the United Nations Security Council was informed by Rolf Ekens, the head of monitoring of Iraqi weapons. The political condition—the removal of Saddam Hussein—still remains. As recent events in Haiti have shown, economic sanctions and blockades cannot be effective against oppressive and inhumane political regimes unless they are combined with other measures. So does the United Nations, and in particular the United States, want to use force against Saddam Hussein again? Or is it time to lift the punitive sanctions and relieve the suffering of the Iraqi people and their doctors?

We urge all medical professionals and bodies, especially the BMA, to put constant pressure on the British government and international bodies to lift the punitive sanctions on Iraqi people. Measures must be taken internationally to stop the export of any weapons to the regime (and other, similar regimes). The unnecessary death of more than 200 babies and children a day must be stopped and the Iraqi people allowed to regain self respect and a humane existence. This would ensure some alleviation of fear and the persecution of doctors in Iraq.

We have collected an extensive bibliography on the impact of the Gulf war and the sanctions on the people of Iraq; this is available on request.

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**We have now been allowed by the British government to send the *BMJ* to Iraq.—EDITOR