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Readers will note the absence from this issue of our usual features, 'Notes and News' and 'Communicable Disease Report'. We apologise for these omissions which resulted from the change in publisher and subsequent alteration in production schedule.

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War planning in the Health Service – a survey of community physicians

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Summary

A postal survey of community physicians and their views on war planning achieved a 70 per cent response. In only 15 per cent of authorities is there a war plan completed; in 45 per cent no planning has been undertaken. There is no evidence that personal conscience conflicts with public duty in the task of war planning.

In a postscript the authors review the respective contributions of the British Medical Association, the Faculty of Community Medicine and International Physicians for the Prevention of Nuclear War to health care planning in relation to nuclear war. They try to think beyond civil defence measures and call on the Faculty to take the lead in preparing and implementing a primary preventive strategy in order to avert the 'final epidemic'.

Introduction

Existing arrangements for Civil Defence in the United Kingdom date from the Second World War. The former Civil Defence Corps was run down in the late 1960s but public concern regarding the nation's state of readiness increased with the collapse of 'detente' and the deterioration in super-power relations following the Soviet invasion of Afghanistan in 1980.

Guidance from the NHS had been revised and consolidated in Home Defence Circular (77)1[1] which area health authorities were urged to implement by preparing detailed plans for incorporation into the overall Home Office arrangements for government of the UK in time of war. The training activities of the Home Defence College were stepped up and directors of health (designate) were encouraged to participate. This increased activity led to concern within the Faculty regarding the need of members for professional guidance[2]. The Board produced a Statement[3] which, whilst emphasising the prime need for prevention, urged community physicians to participate fully in civil defence planning for the care of possible survivors of a nuclear exchange, adopting a 'planning approach that does not compromise the clear need for prevention to remain the primary objective'. Publication of local plans was also to be encouraged for various ethical and practical

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reasons but particularly because 'the wider the appreciation of what a nuclear attack would involve the greater will be the general resolve to prevent it happening'.

It has fallen to the District Medical Officer to take responsibility for planning the Health Service role in the event of a nuclear or other form of attack. This task has had to be added to the many others crowding his desk and, depending upon his knowledge, attitudes and beliefs, has been given a variable degree of priority. This has also been influenced by the geographical situation of his work, i.e. rural or urban, and indeed, the political complexion of the Local Authority with which he has to liaise.

Community physicians in training have been concerned about the ethical problems of planning under the existing arrangements, which many think may mislead the public into believing that the measures proposed could mitigate the consequences of a nuclear war[4]. There has, however, been no attempt to ascertain the views of their established colleagues.

Donaldson and Hall[5] highlighted the administrative task of the community physician at the time and there has been little evidence to suggest that his role has changed. Their study also indicated that community physicians took very seriously the importance of providing information about their work. It was with this in mind that we thought it appropriate to use a postal survey to determine, if possible, present thinking in this sensitive area. During the course of the Survey the DHSS released a further and updated draft of their Health Service Circular for consultation (HN(85)16)[6] and the opportunity was taken to ask colleagues for their immediate views on this document prior to the end of the consultation period in August 1985.

Method

An initial questionnaire was prepared and modified in consultation with community physician colleagues. It was then circulated in April 1985 to all 234 regional, district and chief administrative medical officers in the United Kingdom, under cover of a joint letter from the presidents of the Faculty of Community Medicine and the Medical Campaign Against Nuclear Weapons (MCANW). This letter recalled the 1983 Faculty Statement, and indicated their joint interest in ascertaining whether the community physicians had found the Statement helpful and whether they had been able to follow its advice. Confidentiality was assured in relation to both individuals and to districts.

It was explained that MCANW is an organisation of doctors and other health professionals, unaffiliated to any political party, which is concerned to arrest and reverse the proliferation of nuclear weapons. A subsequent letter explained that MCANW had taken the initiative and was bearing the cost of work involved in the Survey. The literature pertaining to MCANW had been included with the original letter from the joint presidents to demonstrate the health promotional philosophy, with emphasis on prevention, which the Medical Campaign and the Faculty share. Following the publication of HN(85)16 in June 1985 a supplementary questionnaire was circulated to the 165 community physicians who had responded to the first enquiry, seeking their opinion on this new DHSS advice and on whether or not the Faculty Statement should be updated to take account of further developments, including the new Circular.

The questions included in the Survey are set out in Table 1 and copies of the original proformas are available from the authors. Each could be completed in about 10 minutes. The questions were structured but amplification was encouraged. Non-respondents for each questionnaire were sent up to two reminders.

Results

Of the 234 initial questionnaires circulated, 165 were returned completed, a response rate

Table 1. Summary of answers to structured questions posed

Initial questionnaire	Replies No.	Percentage	Response
1. Has/will your Authority be preparing a health service war plan?	25	15·2	a. Yes, plan completed
	66	40·0	b. Yes, plan in preparation
	27	16·4	c. Yes, but not yet started
	16	9·7	d. No
	31	18·8	e. Don't yet know
	165	100·0	Total
2. How far has/will this issue be discussed by your Authority?	13	7·9	a. Has been in private session
	7	4·2	b. Will be in private session
	18	10·9	c. Has been in public session
	15	9·1	d. Will be in public session
	27	16·4	e. Not intended for discussion
	75	45·5	f. Don't yet know
	10	6·1	g. Not answered
	165	100·0	Total
3. How far has/will this issue be discussed by your Community Health Council?	3	1·8	a. Has been in private session
	5	3·0	b. Will be in private session
	7	4·3	c. Has been in public session
	8	4·9	d. Will be in public session
	31	18·9	e. Not intended for discussion
	96	58·5	f. Don't yet know
	14	8·5	g. Not answered
	165	100·0	Total
4. How available is/will be the plan to health service field staff?	31	19·5	a. Copies are/will be circulated
	12	8·1	b. Copies are/will be available on request
	12	9·4	c. Plan is/will be available to read on request
	23	14·8	d. Plan will be restricted
	57	37·6	e. Don't yet know
	14	10·7	f. Not answered
	149	100·0	Total

Table 1. *(cont.)*

Initial questionnaire	Replies No.	Percentage	Response
5. How available is/will be the plan to members of the public?	9	6·0	a. Copies are/will be circulated
	14	9·4	b. Copies are/will be available on request
	10	6·7	c. Plan is/will be available to read on request
	24	16·8	d. Plan will be restricted
	81	54·4	e. Don't yet know
	11	6·7	f. Not answered
	149	100·0	Total
6. Are you/will you be prepared to make provision for non-participation, on grounds of conscience, of individual members of staff in planning?	19	12·8	a. Yes, provision for non-participation is/will be specifically offered
	28	18·8	b. Yes, provision for non-participation is/will be available on request
	25	16·8	c. No, provision for non-participation is/will not be available
	69	46·3	d. Don't yet know
	8	5·4	e. Not answered
	149	100·0	Total
7.1 If you are/will be preparing a plan, are you experiencing or anticipating difficulties due to one or more of the following:	36	16·7	a. Staff indifference?
	9	4·2	b. Staff resistance?
	2	0·9	c. Confidentiality of home addresses of nurses?
	38	17·7	d. Local Authority resistance? Nuclear Free Zone? Yes: 25 (66%) No: 1 (3%) Not Stated: 12 (32%)
	41	19·1	e. Inadequacy of existing guidance?
	53	24·7	f. Revised DHSS guidance not yet issued?
	16	7·4	g. Other problems?
	20	9·3	h. No problems reported
	215	100·0	Total

Table 1. (*cont.*)

Initial questionnaire	Replies No.	Percentage	Response
7.2 If you are not/not yet preparing a war plan, is this because of one or more of the following:	4	3·5	a. A clear Officer decision not to?
	2	1·8	b. A clear Authority decision not to?
	5	4·4	c. Combination Officer/ Authority decision?
	37	32·4	d. Other planning activities taking priority?
	16	14·0	e. Anticipation of difficulties such as those mentioned in 7·1?
	38	33·3	f. Revised DHSS guidance awaited?
	6	5·3	g. Other reasons?
	6	5·3	h. Not answered
	114	100·0	Total
7.3 If your answer to 7·2 is 'revised DHSS guidance awaited' do you anticipate:	18	47·4	a. Your Authority will comply with advice to prepare plans?
	4	10·6	b. Will refuse to comply?
	16	42·1	c. Don't know
	38	100·0	Total
7.4 If your answer to 7·3 is 'will refuse to comply' is this because of:	1	25·0	a. A clear Officer decision not to?
	1	25·0	b. A clear Authority decision not to?
	–	–	c. Combination Officer/ Authority decision?
	2	50·0	d. Other planning activities taking priority?
	–	–	e. Anticipation of difficulties such as those mentioned in 7·1?
	–	–	f. Other reasons
	4	100·0	Total

8.1 Have you seen the 1984 Draft Guidance?	69	41·8	a. Yes
	86	52·1	b. No
	10	6·0	c. Not answered
	165	100·0	Total
8.2 If answer to 8·1 is 'yes' do you consider this an improvement on HDC(77)1?	40	58·0	a. Yes
	23	33·3	b. No
	6	8·7	c. Not answered
	69	100·0	Total
9.1 Have you seen the Faculty Statement 'Health Care Planning in Relation to Nuclear War 1983'?	127	77·0	a. Yes
	24	14·5	b. No
	14	8·5	c. Not answered
	165	100·0	Total
9.2 If answer to 9·1 is 'yes' did you find it helpful?	92	72·4	a. Yes
	23	18·1	b. No
	12	9·4	c. Not answered
	127	100·0	Total
10. Have you/will you be testing your plan?	11	7·4	a. Paper exercise
	6	4·0	b. Field exercise
	24	16·1	c. No
	94	63·1	d. Don't yet know
	14	9·4	e. Not answered
	149	100·0	Total
11. Have you or a member of your Department attended a course at the Home Defence College?	119	72·1	a. Yes, already have
	14	8·5	b. No, but plan to
	19	11·5	c. No, and don't plan to
	8	4·8	d. Don't yet know
	5	3·0	e. Not answered
	165	100·0	Total
12. What are your personal views on health service planning for nuclear war?	91	55·1	a. For
	28	17·0	b. Indifferent
	33	20·0	c. Against
	13	7·9	d. Not answered
	165	100·0	Total

Supplementary questionnaire				
1. Do you consider the Faculty's 1983 Statement should now be updated/improved?	41	a. Yes	31·8	
	38	b. No	29·5	
	50	c. Indifferent/Not read/ Not answered	38·8	
	129	Total	100·0	
2. Have you read HN(85)16 'Civil Defence Planning in the NHS' (May 1985)?	110	a. Yes	85·3	
	19	b. No	14·7	
	129	Total	100·0	
3. If your answer to 2 is 'yes' do you consider it an improvement on previous guidance?	77	a. Yes	70·0	
	27	b. No	24·5	
	6	c. Not answered	5·5	
	110	Total	100·0	

Table 2. Posts held by respondents to initial questionnaire

Post	No.	Percentage
Regional Medical Officer	6	3·6
District Medical Officer/Chief Administrative Medical Officer	121	73·3
Specialist in community medicine	14	8·5
Senior Registrar in community medicine	1	0·6
Administrator	2	1·2
Regional Civil Defence Organiser	2	1·2
Unstated	19	11·5
Total	165	100·0

of 70·5 per cent. Of the 165 supplementary questionnaires circulated 129 were returned completed, a response rate of 78·2 per cent. An analysis of the answers was undertaken and some of the cross-correlations are highlighted.

Table 2 shows the posts held by those who replied to the initial questionnaire and it can be seen that the majority were district medical officers or equivalent. The reasons given for non-response to the initial questionnnaire are shown in Table 3.

Overall, 15 per cent of authorities had completed a plan, and plans were being prepared in a further 40 per cent. However, the remaining 45 per cent, for various reasons, had undertaken no planning (Table 1).

Amongst the group which was already preparing or intended to prepare a plan, the most frequent difficulties experienced or anticipated were inadequacy of existing guidance and delay in issue of the revised DHSS Circular (together amounting to nearly half the total reported). Staff indifference and local authority resistance accounted for another third (Table 1).

Of the group which either had decided not to plan, or was not yet planning, the most common reasons given (about a third of the total in each case) were either that other planning activities were taking priority or that revised DHSS guidance was being awaited (Table 1). Just over half our respondents were in favour of planning with a fifth firmly against.

Overall the proportion of respondents answering 'don't know' to the individual

Table 3. Reasons given for non-response to initial questionnaire

Reason	No.	Percentage
No Officer competent to reply	4	5·8
Information considered 'confidential'	3	4·3
Objection to involvement of MCANW/ suspicion of political motives behind Survey	7	10·1
Letter received refusing to complete questionnaire but no reason given	5	7·2
No reply received	50	72·4
Total	69	100·0

questions detailed in Table I reflects the failure, so far, of most districts' plans to progress to the point where the respective issues require to be addressed.

Those in favour of planning, not unexpectedly, were significantly more likely to make plans ($\chi^2, = 17{\cdot}093$, $p < 0{\cdot}001$). A plan already made or in preparation was significantly more likely to have been discussed by members of the Authority ($\chi^2, = 7{\cdot}465$, $0{\cdot}01 > p > 0{\cdot}001$). Most doctors had attended a Home Defence College course and this also was associated significantly with a greater degree of preparation ($\chi^2, = 9{\cdot}169$, $0{\cdot}01 > p > 0{\cdot}001$). Personal views on planning did not seem to influence the discussion of any plan with the Authority nor its availability to NHS staff or to the public. (Data tables available from the authors).

A wealth of unstructured comment was volunteered, additional information also being provided in covering letters and in personal and health authority comments on HN(85)16 which a number of colleagues kindly returned for perusal by the authors (more would be welcomed from readers). Space does not permit analysis of unstructured comment but, if there is a demand, we plan to collate this information in a non-attributable summary and make it available to colleagues on request. Much of this comment reflects community physicians' dissatisfaction with the guidance provided by the DHSS which is widely perceived to be vague and unrealistic in terms of scenarios and assumptions. HN(85)16 is generally considered to represent only a modest improvement.

Discussion

The initial questionnaire could be criticised for its failure to ask more open-ended questions. Possibly a shorter proforma would have been more attractive and the layout might have been improved. It would have been helpful to have validated the answers to this first questionnaire by personal interview with a sample of the respondents and, particularly, of the non-respondents. Clarification of some answers could then have been obtained as well as the reasons for lack of response even after reminders.

Promulgation of the 1985 DHSS Draft Circular, coinciding as it did with the period of the Survey, and also with summer holidays, was an unforeseen complication. The value of the supplementary questionnaire is uncertain since many respondents and their authorities had inadequate time for consideration of the Circular prior to the deadline set for completion of the Survey.

Several respondents criticised the initial questionnaire for concentrating on nuclear attack and for its failure always to distinguish clearly between conventional and nuclear war.

This Survey has revealed some of the difficulties which have faced community physicians endeavouring to discharge a duty which, until the recent reorganisation, has been their peculiar burden. It may be helpful to re-present and discuss the findings by depicting a 'typical' DMO in a 'typical' district, as revealed by the majority response to each structured question (Table I).

This DMO is personally in favour of planning and has a war plan in an early stage of preparation, but at present does not know whether the issue will be discussed by health authority or community health council. He is more likely to intend to circulate copies to health service field staff than to make the plan available to members of the public, but probably has not reached a decision about circulation and publicity, nor on whether provision will be made for non-participation on grounds of conscience.* He either has experienced or expects staff and local authority indifference or even resistance and has

* Where decisions *have* been made on these questions they are more likely to be *against* public discussion of and access to the plan but *for* provision for individual non-participation; such decisions being contrary to the advice of the Faculty and the BMA respectively.

found existing guidance inadequate. His efforts have been frustrated also by delay in the release of revised DHSS guidance. It is not surprising that, for our DMO, other more immediate peacetime problems of the NHS, for action on which colleagues and authority members are clamouring, have taken priority over war time disaster planning. For every DMO who can go ahead, there is another whose Authority either has decided not to plan or, more likely, remains undecided. Pressure of other priorities and delayed DHSS guidance are likely to explain this failure to plan, but compliance with the latter, when issued, is probable.

Our 'typical' DMO is more likely not to have seen the 1984 Draft Circular (whose distribution did not include health authorities and their officers) but if he *has* read it he considers it an improvement on HDC(77)1. However, he is aware that the basic planning assumptions of the DHSS have been rejected as unsound by the BMA[7]. He has read the 1985 Consultative Circular and considers it a modest improvement on previous guidance, but probably remains highly critical of its explicit and implicit assumptions. He has seen the Faculty Statement and has found it helpful but is unlikely to feel strongly that it should be updated. He has not yet decided how to test his plan, despite, almost certainly, having attended a Home Defence course.

Planning for war is a contentious issue which involves moral and ethical as well as logistic problems. Community physicians, and district medical officers in particular, are in a unique position within the Health Service, having both wide experience of planning and some special knowledge of the problems likely to follow a nuclear attack. They may be unwilling to put forward personal views when writing and speaking on behalf of their Health Authority. Conflict may easily occur when there is a mandatory obligation for a health authority to plan with a local authority but key individuals may, on grounds of conscience, have no wish to participate.

Study of the unstructured comments suggests that individual doctors act as servants of their authorities and subjugate their private views to public duty. Once a plan had been drafted it was more likely that it would be discussed by the Authority and made available, if not to the public, then at least to NHS field staff.

Considering that the United Kingdom has been under a perceived threat of nuclear attack since the early 1950s it is perhaps surprising that little over half responding authorities have a plan either completed or in preparation, with only a sixth having a completed paper plan.

War planning is seen by community physicians as a task of secondary and tertiary prevention i.e. to minimize the damage, to cope with survivors and to regenerate society. It is our view that the primary prevention of nuclear war has yet to be addressed by community physicians.

Authors' postscript: the ultimate problem for prevention

Introduction

Here we express personal opinion which we believe may be shared already with other members of the Faculty.

Surprisingly little comment has been received from community physicians on how they perceive their role in primary prevention. How should we endeavour to forestall the ultimate disaster, bearing in mind the Faculty's emphasis on 'the clear need for prevention to remain the primary objective'? Although this receives no mention in DHSS guidance and leading questions were purposely omitted from our Survey questionnaires, it *was* stressed in the Faculty Statement which most respondents claimed to have read.

The British Medical Association made a substantial contribution to the debate through

a Board of Science and Education Working Party which reported in 1983. Their Report[7] concluded that 'the NHS could not deal with the casualties that might be expected following the detonation of a single one megaton bomb over the UK' and was also highly critical of the guidance provided in HDC(77)1. The Association has since called for improved guidance, and this resulted in the production of a Draft Circular in 1984[8] on which the Central Committee for Community Medicine and Community Health has commented critically[9]. The attention of readers of this Journal has been drawn to the perceived inadequacy and lack of realism of the Home Office approach[10]. The BMA has commented on the revised Draft Circular (HN (85)16) but details are not yet available (November 1985).

The BMA's assessment has been followed by several others, including the World Health Organisation's[11] and the Royal College of Nursing's[12]. Together with Scientists Against Nuclear Arms[13], they have all reached broadly similar conclusions, but these require updating to take account of the 'nuclear winter' predictions[14–17]. There is also increasing concern about the medical implications of chemical and biological warfare, which is to be the subject of a further BMA enquiry[18].

New Civil Defence Regulations[19], promulgated in 1984, require local authorities to collaborate with health authorities and boards in the production and testing of civil defence plans. These Regulations have, likewise, been criticised by many local authorities, particularly for the unrealistic and vague planning assumptions on which they are based. Resistance to the Regulations has been expressed by the spread of 'nuclear free zones' within which civil defence authorities are moving from 'non' to 'minimal' or 'creative compliance' approaches to their responsibilities, promoting public education through realism.

The Medical Campaign Against Nuclear Weapons, which includes some 3000 doctors, and is a UK affiliate of International Physicians for the Prevention of Nuclear War (IPPNW) has come out firmly against the possession and use of nuclear weapons and has emphasised the major problems which a nuclear attack on this country would entail for the long term care of its survivor population[20]. The Medical Campaign shares with the Faculty a 'creative' approach to civil defence planning, with the emphasis firmly on promoting primary prevention[21]. Even as this paper was going to press the contribution of IPPNW was recognised by the award of the 1985 Nobel Peace Prize[22].

Towards primary prevention

Community physicians are in a difficult position. They have a clear responsibility to plan, yet, because they have to speak on behalf of their Authority, may feel restricted in the open expression of their personal views on primary prevention. This inhibits the frank discussion of these difficult issues.

Perhaps what has been, and still is, lacking is guidance on how community physicians might contribute to primary preventive effort, although it was a minority of Survey respondents who considered the Statement should be updated/improved in this respect. Membership of an IPPNW affiliate is a matter for the individual as a *doctor*, but what primary preventive activity *does* fall appropriately within the sphere of the Faculty and its members as community physicians?

We live in an atmosphere of argument, frequently sterile, with one side or another seen as trying to 'trump' one fact with another. Unless community physicians are to opt out, we consider it is essential to take new initiatives and, in particular, to develop a primary preventive strategy. It is the task of community medicine to examine the size of the problem and the extent to which it can be measured, both in terms of the classical epidemiological indicators of time, place and person, and of today's more sophisticated

considerations, including option appraisal, cost *versus* risk benefit and the general determination of priorities within a Western community.

Primary prevention brings us into the political arena but should community physicians become involved in the nuclear debate? Whilst some may support the correspondent[23] whose response to the Report of the Faculty Study Group was to urge community medicine to press for action aimed at 'complete and universal disarmament, not only of nuclear but also conventional weapons' and the achievement of a 'healthy world' with the 'fullest equality within and between every country', the majority of members would probably take a more restricted view of appropriate Faculty activity. The Study Group recognised that 'individual community physicians cannot, so to speak, disconnect the nuclear red buttons, acting today in a way which would echo John Snow's removal of the handle of the Broad Street pump' but emphasised their responsibility to 'inform and influence the course of public discussion in relation to defence, military expenditure and international relations'.

The way forward

1. *Education and information*

The continued education of doctors, other health professionals and the general public concerning the effects of nuclear war both upon themselves and upon the communities in which they live, the havoc that would be wreaked and the likely continuing chaos for generations to come, needs to be reiterated frequently and on a public platform. It is only in this way, with the subject being discussed openly and sensibly, that it can become an issue which will influence democratic voting patterns. Certainly, should nuclear attack occur, it is unlikely that 'the best-laid plans of mice and men', which, no doubt, will all be filed away, will be of much use, but the more information that is available to the men and women who may come forward as the natural leaders of their war-scarred communities the greater the chance of some possibility of survival. The prime purpose of an education exercise must be to encourage a political will towards disengagement, negotiation and disarmament but it may offer also an improved chance for any survivors of a nuclear exchange.

2. *Research into causes and effects of nuclear war*

There is considerable disagreement among scientists about fundamental matters relating to nuclear war which points to the need for an independent research unit, enjoying academic neutrality, high scientific status and international respect. Not only could basic work on burn, blast and irradiation be commissioned but also computer simulations and environmental experiments on climatic change following nuclear war could be studied. The contributions of individual and sectional interests, for example environmentalists, psychologists, military planners, farmers etc. could be collated and given proper weighting and significance. Links could be established with other academic units such as the Bradford School of Peace Studies and the Home Defence College at Easingwold.

Nuclear strategy is a complex and fast-changing field of knowledge. Few people are able to comprehend fully a subject which embraces particle physics, military planning, human psychology, ecology, economics and politics. There is a need to communicate this 'nuclear casebook' in a way which will be understood by the man in the street. One of us (DSJ) has urged the Faculty to make this its most urgent future task[24]. The Faculty could bring the various disciplines together and contribute the skills of community medicine, epidemiology, health care planning, environmental health and communication. This indeed would be a magnificent initiative for a Royal College and underline the aims of Alma Ata[25].

3. *Understanding the 'enemy'*

We all have different pictures of our adversary, whether that person be Russian or American, and these are reinforced by the daily stereotypes which we see on our television screens and in our newspapers. Sepping[26] has proposed 'twinning' of local authorities (and why not health authorities?), with exchange of officers, members and even ordinary citizens. Could similar international exchanges be arranged between departments of community medicine and their equivalents, within a framework negotiated by the Faculty?

The international climate is now more conducive to the development of these personal contacts which could promote the breakdown of social, cultural and economic barriers and the development of an understanding that the problems of the human race are more or less the same wherever they occur.

Planners and officers would obtain a realistic picture of the way in which different communities spend their money on health and welfare services and, indeed, on war planning! It would certainly be a salutary experience for any community physician in this country to exchange with a colleague, perhaps working in Moscow or Leningrad for a one year sabbatical. We see no reason why exchanges should not be arranged and suggest, indeed, that only by allowing East–West personal contact can we obtain a proper understanding of how we see others and how they see us.

It is by escaping from the concept of the enemy as someone who does not count, whose death is of complete unimportance, that the psychology of 'kill and overkill' and, indeed, 'launch on warning' and all the other smug and horrifying jargon of war planning can be seen in its proper perspective.

Conclusion

Sepping concludes 'a good doctor does not now treat insomnia with barbiturates. This leads to addiction and, eventually, further insomnia. He inquires into the causes of the disease and treats them. Likewise we must address the true causes of mutual armed suspicion between East and West, not prescribe the sleeping draught of civil defence and whistle in the nuclear dark'.

We agree. Sepping's analogy may not be entirely appropriate but, in our view, it sounds the alarm which must prevent, not precede, the Third World War. Prevention is too vital an issue to leave to scientists and soldiers, to politicians and peace activists!

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