# FUNGI CAN HIDE FROM

# Sporanox*

itraconazole 100 mg

One of the notorious problems with fungal infections of the skin or the vagina is that the organism may penetrate the deeper layers of the epithelium, out of reach of topical medication. And besides, when treating fungal skin lesions locally, the infection is often already subclinically present at other sites of the body, waiting for a chance to start the trouble all over again.

Because Sporanox works **orally**, i.e. "from the inside out", it will destroy even the best hidden fungal cells. All the more so, because Sporanox has a strong affinity for epidermal and mucosal tissues as well as for the fungal cell wall itself where it must exert its fungicidal activity.

## SHORT AND SIMPLE ORAL THERAPY

**Standard dose in Dermatology**: 1 capsule (100 mg) once daily for 15 days
(Sporanox will remain active in the stratum corneum for another 3-4 weeks)
**Standard dose in Gynaecology**: 2 x 2 capsules (400 mg) for 1 day only
(Sporanox will remain active in the vaginal epithelium for another 3 to 4 days)

**This product is not yet available in all countries.**

*** Trademarks: SPORANOX, SEMPERA, TRISPORAL, SPORAL.**

**Properties:** Sporanox (itraconazole), a triazole derivative, is orally active against infections with dermatophytes (*Trichophyton* spp., *Microsporum* spp., *Epidermophyton floccosum*), yeasts (*Candida* spp., *Pityrosporum* spp.), *Aspergillus* spp. and various other yeasts and fungi. **Indications:** Sporanox (itraconazole) is indicated for vulvovaginal candidosis, pityriasis versicolor, dermatophytoses, fungal keratitis and oral candidosis. **Dosage and administration:** Vulvovaginal candidosis: 2 capsules (200 mg) morning and evening for 1 day. Pityriasis versicolor: 2 capsules (200 mg) once daily for 7 days. - Tinea corporis, tinea cruris, tinea pedis, tinea manus: 1 capsule (100 mg) daily for 15 days; highly keratinized regions, as in plantar tinea pedis and palmar tinea manus, require 1 capsule (100 mg) daily for 30 days. - Oral candidosis: 1 capsule (100 mg) daily for 15 days. - Fungal keratitis: 2 capsules (200 mg) once daily for 21 days. **Contra-indications:** Sporanox (itraconazole) is contra-indicated during pregnancy. **Warnings and precautions:** Although clinically Sporanox (itraconazole) has not been associated with hepatic dysfunction, it is advisable not to give this drug to patients with a known history of liver disease. **Nursing mothers:** It is recommended not to breast feed whilst taking Sporanox (itraconazole). **Drug interactions:** Sporanox (itraconazole) should not be given concomitantly with rifampicin.

Full prescribing information is available on request.

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# BMA NOTICES

## Resolutions passed by the annual representative meeting 1992

**The BMA's 1991 annual representative meeting resolved that resolutions passed at the annual meeting should be published in the *BMJ*. Some resolutions are published here. The rest will be published in a future issue.**

(1) *That James Leatham Tennant Birley*, BM, BCh, FRCP, FRCPsych, be elected president of the association for 1993-4.

(2) *That this meeting* instructs council to continue its support to the Medical Education Trust with an annual grant of not less than £15 000 for the next three years.

(3) *That this meeting* regrets that BMA policy in respect of the health service reforms is not being pursued as vigorously and imaginatively by the BMA leadership as the generality of the membership would wish.

(4) *That this body* expresses confidence in the chairman of council in his approach to responding to legislation on the NHS.

(5) *That this meeting* believes that the association should take greater account of the views of the membership and considers that it should now concentrate on developing the NHS changes for the benefit of patients.

(6) *That this meeting*, recognising the government's electoral mandate to pursue the NHS "reforms," believes that the BMA should seek to work with government on developments of the reforms which will allay the profession's fears, including: (*a*) the rapid production of a public health white paper based on effective promotion of health as a social value by all agencies, and (*b*) linking NHS boundary changes with the local government reforms so that the end point of the process will be a situation where health authorities and local authorities have the same boundaries so that they can more effectively work together on *Health of the Nation* and *Caring for People*.

(7) *That this meeting* recognises the potential for interprofessional conflict arising from the NHS contracting process between purchasers and providers and urges council to provide guidance to GPs and hospital consultants which would help minimise such conflict and maximise the benefit to patients.

(8) *That this meeting* considers that the association should continue to monitor closely the progress of NHS trusts to provide early recognition of any problems and deficiencies.

(9) *That this meeting* deplores the cost, complexity, and lack of patient confidentiality inherent in the extra contractual referral system and calls for a no cost "knock for knock" basis for emergency ECRs and a simplified system for non-emergency ECRs.

(10) *That this meeting* considers that decisions relating to the clinical management of patients, including priority for admission, should rest solely with responsible medical staff and not with lay managers.

(11) (As a reference): *That the DHAs and FHSAs* should be combined to reduce administrative costs and to provide a single health authority for each population.

(12) (As a reference): *That this meeting* recommends that the system in Northern Ireland whereby health and social services are combined should be extended to the whole of the UK.

(13) *That this meeting* reaffirms its belief that in our society poor health and inequalities in health are largely related to poverty and deprivation and insists that government gives resources and high priority to combating these and related economic problems.

(14) *That this meeting* believes that in any model for the delivery of health care the public health approach to population based planning, and coordination of services must be maintained.

(15) *That this meeting* believes that access to NHS care must be determined on the grounds of clinical need.

(16) *That this meeting* believes that rationing of health services is an unfortunate fact of life and resolves: (*a*) that it should be done openly; (*b*) that agreement should be reached between the Department of Health and active members of the profession concerning its scope and the priorities within the service; (*c*) that while doctors should be involved in deciding priorities they cannot be held responsible for the consequences of political decisions about such rationing; (*d*) that rationing decisions should involve full consultation among health care professionals, the government, and the public; (*e*) that the BMA should give publicity to this fact; (*f*) that no patient should be denied medical diagnosis and treatment just because of advanced chronological years; (*g*) to request the board of science to review and report on priorities and rationing in health care.

(17) *That this meeting* urges the government to address the problem of underfunding within the NHS because: (*a*) the development of services will otherwise be impeded; (*b*) cash limits are proving an unsatisfactory method of distributing inadequate resources; (*c*) the cost of disease prevention cannot be sustained without additional resources; (*d*) it is a major cause of poor morale and frustration; (*e*) health service funding is much less than the average proportion of gross domestic product spent on health by other countries in the European Community; (*f*) services to the underprivileged and disabled may suffer unless the profession is vigilant.

(18) *That this meeting* calls for increased levels of regional BMA staffing as an inevitable consequence of the increasing local role of the BMA in local negotiations.

(19) *That this meeting* considers that the number of BMA industrial relations officers is too low to deal adequately with the increasing contractual problems encountered by doctors in the NHS at present, and calls on the association to employ substantially more IROs.

(20) *That in recognition* of the extensive work and achievements of the association on their behalf all practising UK doctors are encouraged to join.

(21) *That this meeting* calls upon council to consider: (*a*) establishing a mechanism whereby an SRM can be cancelled at short notice; (*b*) arranging amendment of the articles of the association such that council may reconsider its decision to call an SRM after a period of not less than eight days; (*c*) (as a reference) the use of a postal questionnaire to ascertain the views of the entire membership; (*d*) (as a reference) requiring a two thirds majority of those eligible to vote at the council to call a special representative meeting.

(22) *That the standard rate* of subscription be increased by 3·9% (according to the subscription ranges stated below) with effect from 1 October 1992:

| | Recommended rate (£) | Reduction (%) |
|---|---|---|
| Standard rate | £222.72 (Current rate £214.32) | Nil |
| 1st year after qualification | £55.68 (Current rate £53.64) | 75 |
| 2nd, 3rd, and 4th years after qualification | £111.36 (Current rate £107.16) | 50 |
| 5th, 6th, and 7th years after qualification | £167.04 (Current rate £160.80) | 25 |
| Members in the armed forces, except those within seven years of qualification | £194.88 (Current rate £187.56) | 12·5 |
| Channel Isles and Isle of Man, except those within seven years of qualification | £194.88 (Current rate £187.56) | 12·5 |
| Overseas | £139.20 (Current rate £133.92) | 37·5 |
| Dental surgeons, except those within four years of qualification | £139.20 (Current rate £133.92) | 37½ |
| Preclinical teachers and non-clinical research workers | £111.36 (Current rate £107.16) | 50 |
| Retired from practice before 1 October 1992 | £83.52 (Current rate £80.40) | 62·5 |
| Spouses of members | £83.52 (Current rate £80.40) | 62½ |
| Medical student members | £20.16 (Current rate £19.32) | 91 |

Notes
(1) A salary link can be claimed by any member whose annual salary or professional income does not exceed the standard salary of a senior house officer at the second incremental point. This will be fixed at half of the standard rate of subscription.
(2) Members who are principals in general practice will pay the standard rate irrespective of the year of qualification.
(3) A member who claims the spouse reduction shall not receive as a benefit of membership a free copy of either the *BMJ* or *BMA News Review* unless he or she so requests in writing.

(23) (As a reference): *That this meeting* considers the great increase of membership subscription from £46.80 to £80.40 (an increase of 77%) an undue hardship for those retired members who are no longer in practice.

(24) *That this meeting* requests council to take urgent steps to create an accurate divisional and workplace mailing list of members.

(25) *That this meeting* strongly supports a no fault compensation scheme for the victims of medical accidents.

(26) *That this meeting* calls for the government to develop a mechanism whereby the review body increments are automatically applied to clinical academic staff.

(27) *That this meeting* applauds the CVCP's statement of intent to implement the change from UMTs to ADHs and joins with the committee in calling on the government to provide the necessary funding without delay.

(28) *That this meeting* condemns any plans to extend the preregistration year.

(29) *That the BMA* undertake a publicity campaign to inform the public about the past, present, and future importance of human and animal experimentation in the fight against disease and illness, and in the maintenance of good health in both humans and other animal species.

(30) (As a reference): *That this meeting* calls on BMA council to negotiate with local authorities in Scotland to ensure that practitioners are paid for reports for orange badges, etc.

(31) *That this meeting* insists that hospitals should discharge their responsibility for the change and removal of filled "sharps" boxes in accordance with BMA guidelines and Department of Health directives on the safe use and disposal of "sharps."

(32) *That this meeting* welcomes the board of science and education report on cycling and wishes to encourage safe participation in cycling by: (*a*) urging government to support cycling as a means of transport; (*b*) requesting government to enforce an improved standard of lighting on bicycles; (*c*) asking council to press British Rail to widen its provision for bicycles to be carried on passenger trains; (*d*) urging the urgent development of a network of cycle tracks.

(33) *That this meeting* believes that as the next stage of our campaign against boxing we should seek a ban on children below the age of consent from boxing.

(34) *That* (*a*) the forthcoming publication of the revised report on boxing be welcomed and, that (*b*) this meeting calls for a total ban on amateur and professional boxing in the UK.

(35) *That this meeting* calls for: (*a*) doctors to prescribe non-CFC drug inhalation systems wherever possible; (*b*) the small remaining requirement for propellant in medical inhalers to come from recycling existing stocks of CFCs; (*c*) urgent scientific research to produce environmentally safe alternative propellants to CFCs for widely used metered dose medication.

(36) *That this representative body* insists that, as the application of information technology to patient care will fundamentally alter the practice of medicine, doctors must play a leading role in these developments, and instructs the board of science to investigate the initiatives required to achieve this aim, and report back.

(37) *That the board of science and education* be requested to review the advantages and disadvantages of currently available methods of control and treatment of rabies; and to publicise its findings in order to inform the continuing debate on whether the present quarantine regulations should be maintained.

(38) *That this representative body* asks the board of science to consider investigating variations in the incidence of disease between different cultural groups within the United Kingdom.

(39) *That this meeting* supports the work of the Advisory Committee on Medical Training in establishing standards of both medical undergraduate and postgraduate training and competence in appropriate languages and: (*a*) welcomes the reference in para 9.3 of the annual report of council to discrepancies among EC countries in undergraduate medical training; (*b*) expresses particular concern about the lack of clinical experience driving EC students to seek compensatory experience in this country to the potential detriment of UK students; (*c*) calls upon the association to make representations on this matter to the Advisory Committee on Medical Training.

(40) *That this meeting* commends the council for working with the Overseas Doctors Association to find a satisfactory solution towards free movement of doctors who are citizens of EC member states with primary qualifications from outside the EC.

(41) *That this meeting* insists that: (*a*) medical students should be adequately funded; (*b*) their grants should be non-means tested; and (*c*) they should not be left with unacceptable debts at the end of their studies.

(42) *That all elective placements* in UK hospitals with undergraduate teaching responsibilities should be approved by the appropriate medical school dean so that the education and experience of home students is not compromised.

(43) *That medical training* requires adequate resources: (*a*) to ensure a priority for postgraduate clinical education over management training; (*b*) to recognise the training commitment of consultants and the consequent need for expansion of their numbers; (*c*) to "train the trainers"; (*d*) to allow protected time for study leave; (*e*) to guarantee adequate remuneration for GP tutors and course organisers; (*f*) to enable GPs to pursue continuing medical education.

(44) (As a reference): *That this meeting* believes that: (*a*) compulsory paid study leave for senior and junior medical staff should be an integral part of all NHS job contracts; (*b*) the enforcement of this should be the responsibility of the consultant in charge and reinforced by the regional postgraduate dean; (*c*) study leave should be adequately funded; (*d*) study leave funding should be ring fenced; (*e*) junior doctors should be represented at regional study leave committees.

(45) *That this meeting* approves the sentiments expressed in the patient's charter and believes that: (*a*) the goals as defined will require additional manpower and funding; (*b*) the application of these goals to outpatient department waiting times is unrealistic in the present climate; (*c*) investigation of patients' complaints should be comprehensive and establish the root causes of the event including faults in the system; (*d*) the patients' rights enshrined therein should be matched by patients' responsibility not to misuse the NHS.

(46) *That this meeting*: (*a*) believes that the waiting time between GP referral and consultant appointment is as important as the waiting time between the consultant outpatient appointment and admission to hospital; (*b*) calls on the department actively to discourage the artificial distortion of waiting lists; (*c*) insists that all waiting times must be measured from the day the GP refers a patient to secondary care, and not from the day a consultant places the patient on a waiting list.

(47) *That this meeting* welcomes the GMSC statement of 20 February 1992 stressing the fundamental importance of GPs being able to influence the commissioning of care for their patients, and believes that, to achieve this: (*a*) adequate remuneration and reimbursement should be available from DHA/FHSAs and health boards for all GPs involved in these activities; (*b*) participation in these activities should be regarded as protected time and should count towards a practitioner's hours of availability; (*c*) all practices should have equity of access to the necessary support staff and systems to allow them to carry out these activities; (*d*) LMCs should be helped and encouraged to provide the necessary framework through which these initiatives are advanced, taking into account the right of individual practices to formulate their own strategies in the interests of their patients and the communities they serve.

(48) *That this meeting* recognises that a substantial minority of GPs are now involved in fundholding, and that the GMSC should continue to represent all GPs in negotiations with the department.

(49) *That this meeting* insists on provider units giving equal priority, at the same costs, to patients whether from fundholding practices or from DHA purchasing departments.

(50) *That this meeting* reaffirms its opposition to GP fundholding as being detrimental to patients' interests and the NHS.

(51) *That fundholding* must be voluntary.

(52) *That the tendency* for trust managements to exert pressure on consultant staff to "fast track" patients from fundholding practices be deplored.

(53) *That this meeting* asks the GMSC to enter into discussions with the department on the out of hours responsibility of GPs in order to amend the terms of service so as to remove from GPs the contractual obligation to provide out of hours cover.

(54) *That this meeting* asks the GMSC to enter into discussions with the department to explore alternative methods of providing out of hours care to include: (*a*) requiring FHSAs and health boards to offer to individual practices, and groups of practices, the choice of whether to be responsible for providing out of hours cover for their own patients; (*b*) enabling FHSAs and health boards to contract with individual GPs, individual practices and group practices to provide out of hours cover for a specified list of patients in addition to their own patients; (*c*) requiring FHSAs and health boards to make alternative arrangements for out of hours care for those patients not covered by the arrangements outlined in (*a*) and (*b*) above; (*d*) no detriment to the position of those GPs who wish to provide this service.

(55) *That this meeting* confirms the right of GP principals to retain the independent contractor status.

(56) *That this meeting*: (*a*) supports the principle of centrally negotiated terms and conditions of service; (*b*) believes that, in the event of local pay bargaining becoming a reality, the GMSC must recommend mechanisms to protect practitioners providing services in deprived and remote areas.

(57) *That this meeting* is opposed to charging NHS patients: (*a*) for consultations; (*b*) for home visits; (*c*) for home visits "out of hours."

(58) (As a reference): *That the BMA* take urgent action to ensure that the out of hours supplement for trainees in general practice is increased substantially.

(59) *That this meeting* would like to congratulate the association on the extension of the successful Healthcall deputising services and urges them to extend the service even further.

(60) *That this meeting* reaffirms its commitment to a general professional contract and rejects moves whereby a doctor's commitment is limited to a fixed number of contracted treatment episodes.

(61) (As a reference): *That this meeting* expresses its concern that the secretary of state has refused to consider paragraph 190 appeals from trust hospital employees, except those who have retained their original terms and conditions of service and instructs council to: (*a*) renegotiate the paragraph 190 appeal procedure, or if this is not possible (*b*) test the situation in the courts.

(62) (As a reference): *That in the light of reports* of inappropriate employment practices the BMA should conduct an urgent survey of the use of the staff grade.

(63) *That this meeting* is seriously concerned about the very poor levels of pay endured by NHS medical secretaries and asks that a fundamental reassessment of secretarial pay be made by the government and the NHS Management Executive.

(64) *That this meeting* is appalled by the lack of uniform progress in implementing the new deal and calls upon the (new) health secretary to take urgent action to remedy this.

(65) *That the BMA* should continue to campaign for the reduction of working hours to a safe level and it should highlight the danger to patients when doctors work excessively long hours.

(66) *That the service* to patients will suffer if junior hospital doctors' hours are cut without proper support services being put in place.

(67) (As a reference): *That the aims* of *Achieving a Balance* should not be sacrificed to obtain the new deal on hours and conditions of work of junior hospital doctors.

(68) *That this meeting* is concerned at the quality of accommodation for junior doctors and medical students in hospital and calls on the BMA to campaign to: (*a*) accelerate implementation of the minimum standards of accommodation for junior doctors laid down in the new deal; and (*b*) ensure that these minimum standards of accommodation also apply to medical students.

(69) *That in the light* of the current concerns over the status of UK specialist accreditation, this meeting offers the following principles to guide those concerned with defining any new arrangements in specialist medicine which may become necessary: (*a*) all references will be open; (*b*) training schemes will be reassessed at fixed and regular intervals, with the trainees fully involved; (*c*) there should be structured and supervised training in all specialties, of fixed term.

(70) *That the BMA* should support junior doctors and medical students who refuse to perform procedures for which they are not adequately trained or adequately supervised.

(71) *That the contracts* of senior registrars and registrars should be held at regional level.

(72) *That this meeting* congratulates the BMA on the award of the WHO medal for its work on tobacco control.

(73) *That this meeting* congratulates the BMA on its continued contribution to public health in the UK by its tobacco prevention campaign, and urges it to continue its efforts for another year.

(74) *That this representative body* congratulates the public affairs division on its continued success, particularly its efforts in the struggle for the control of advertising of tobacco, which have brought great credit to this association.

(75) *That this representative body* believes that the advertising of tobacco should cease.

(76) *That this meeting* asks the government to do everything in its power to reduce tobacco smoking by: (*a*) complying with EC directive on tobacco advertising; (*b*) removing tobacco from the cost of living index so that fiscal measures could be taken without detriment; (*c*) specifically targeting antismoking in primary schools; (*d*) reducing smoking in public places.

(77) *That this meeting* deplores the granting of subsidies to EC tobacco growers.

(78) *That this association* warns the government that unless the community care provisions are fully funded, the consequences for the chronic sick, their carers, the hospital service, and general practice will be disastrous.

(79) *That this meeting* believes that the secretary of state for health should be accountable for standards of all community care—including that contracted to groups and organisations outside the NHS.

(80) *That community care funding* should be ring fenced and sufficient to allow the most appropriate use of NHS resources.

(81) *That this meeting* urges council to draw the attention of the Department of Health to the substantial demands arising from the Children Act on a wide range of its members, particularly community health doctors, paediatricians, child psychiatrists, and GPs.

(82) *That this meeting* feels that patients should continue to have the choice of attending either a family planning clinic or general practitioner for contraceptive advice.

(83) *That in view* of the increasing numbers of teenage pregnancies, this meeting recommends that the BMA initiate talks with the Department for Education to include teaching on reproductive health and responsible relationships in the national curriculum.

(84) (As a reference): *That this meeting* believes that directors of public health should be encouraged to establish formal links with practices for the purpose of obtaining standardised morbidity data and that GPs be adequately funded for and assisted in the collection and transfer of such information.

(85) *That this meeting* believes that the delay in progress of the review of the law on infectious disease is detrimental to public health and urges the central committee to press the department to publish the conclusions from consultation.

(86) *That this meeting* congratulates and thanks the members of the Joint Working Party on Medical Services for Children and their predecessors for their sterling work in producing the interim report. It urges them to expedite the publication of the final report, so as to lead to the beginning of implementation of their recommendations by 31 March 1993.

(87) *That this meeting* strongly supports the development of combined child health and paediatric services and encourages purchasers to promote this through their contract quality standards.

(88) *That this meeting* considers that the provision of a consultant led occupational health service should be an essential requirement for the licensing of all trust and private hospitals in the United Kingdom.

(89) *That the chief executive* of the NHS Management Executive be asked: (*a*) to prepare and publish the priorities by which he intends to meet the statutory obligations placed on him on 1 January 1993 under health and safety legislation; (*b*) to seek from government the resources necessary to implement that legislation, without prejudice to patient care; (*c*) to agree with the Health and Safety Executive, in the interim, some means of protecting individuals or groups from prosecution if it can be shown that lack of resources was a significant factor in the criminal offence of which they are accused.

(90) *That this meeting* is concerned to ensure that: (*a*) hepatitis B vaccination should be offered to all NHS staff at risk by reason of their employment; (*b*) deans of medical schools are made aware of their legal responsibility to offer hepatitis B immunisation to medical students prior to clinical attachments; (*c*) acceptable arrangements are made for doctors who contract hepatitis B; (*d*) (as a reference) the anomalous pricing of the vaccine is addressed.

(91) *That this meeting* deplores the lack of career structure for part time medical practitioners in the NHS.

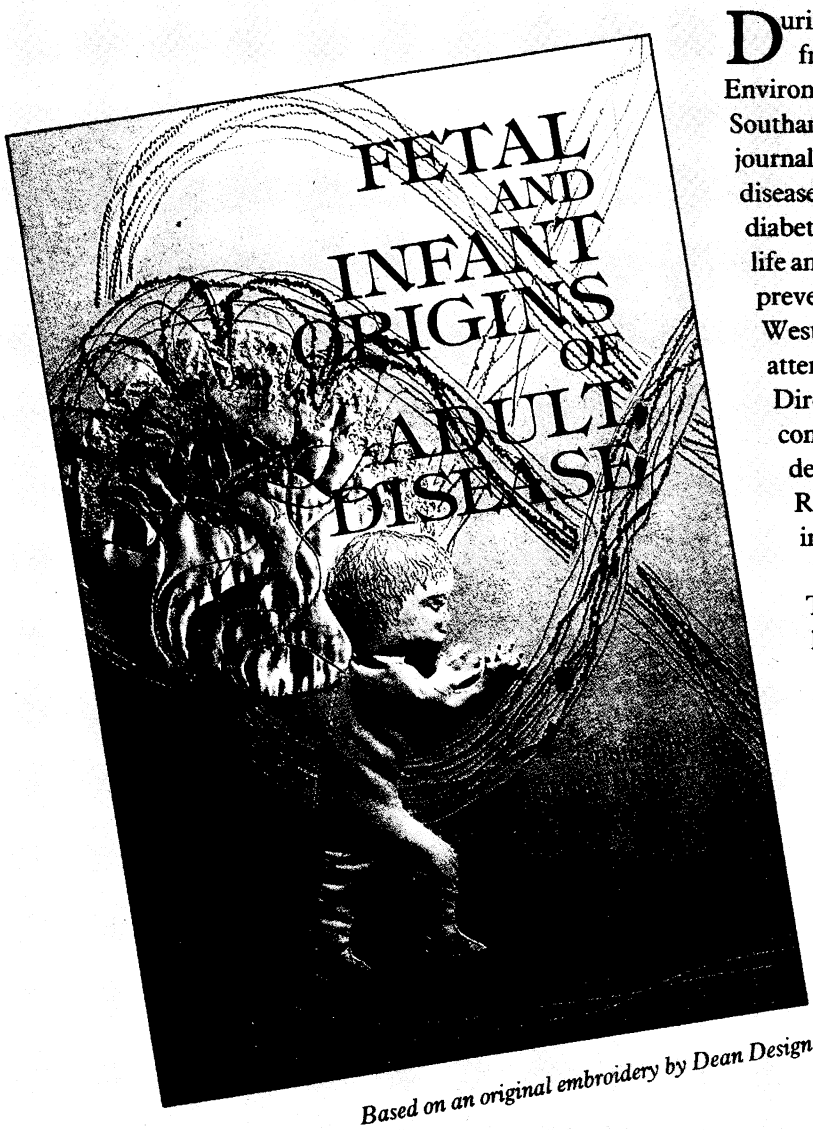
(92) *That this meeting* strongly supports the introduction of flexible or part time working opportunities at the SHO level, but believes that these schemes must be within the current manpower limits, and should be centrally aided.

(93) *That this meeting* regrets the privatisation of much of the general ophthalmic service work and the consequent underutilisation of those ophthalmologists working in it; it furthermore presses for negotiations at the highest level so that this medical manpower may be wholly utilised within the National Health Service once again.

(94) *That this ARM* opposes the existing charges for eye tests.

(95) *That this meeting*, while welcoming care in the community for the mentally ill, requests council to resist any move towards making the care of the chronic mentally ill unduly dependent on private charitable and voluntary organisations, leading to diminution of proper medical and nursing supervision.

# *Are the ills of middle and later life rooted in our early development?*




*Based on an original embroidery by Dean Design*

During the past few years a series of articles, mostly from the Medical Research Council's Environmental Epidemiology Unit at the University of Southampton, has been published in leading medical journals. They set out the evidence that certain adult diseases, including coronary heart disease, stroke and diabetes originate in impaired development during fetal life and infancy. Because of the obvious implications for prevention of some of the commonest diseases in Western society, they have attracted international attention. In this book, Professor David Barker, Director of the Unit, has selected 31 articles that he considers seminal and a comprehensive guide to the development of this important topic. Professor Roger Robinson's introduction summarises and interprets the evidence for non-epidemiologists.

The first chapters describe the origins of the hypothesis in geographical studies in England and Wales. These are followed by a series of studies of men and women in middle and late life whose early growth was recorded at the time. In those who have died, cause of death can be related to early growth. Examination of the living has allowed blood pressure, blood lipid and insulin concentrations, and other measurements to be related to different patterns of early growth. Together, the findings show that early development affects the risk of coronary heart disease, stroke, obstructive lung disease and diabetes at least as strongly as obesity, smoking and other aspects of adult life style.

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