Service problems rather than health problems. The Health Service administrative side of the work is very much "variations upon a theme by Aneurin Bevan." There are exciting possibilities for change, but trainees never glimpse them. The best education would be spent not in trailing round the Health Service but in leaving Britain to work abroad, living with completely different concepts of health and health services.

I believe that the education of community physicians should have a core of three months' statistics and epidemiology and that the placements should be in Europe, social service departments, housing departments, public health departments, and schools. The administration of the National Health Service could be left to general practitioners and consultants and epidemiology to the specialist epidemiologist.

Community medicine has a real part to play but not within the confines of the NHS, and rather than training being put into the brains of community physicians their minds should be educated out of the straitjacket of the NHS.

J A MUIR GRAY

Oxford

Thoracic discs are different

SIR,—Your leading article on thoracic discs (March 13, p 608) is a remarkable example of the differences between consultant and general practice which are now so great that it is becoming important, in any article which mentions any form of statistics, to state which department is concerned. For instance, I would not be surprised if a consultant were to tell me that he had not seen a case of pneumonia in a year, for I cannot remember when I last sent such a case into hospital, except to the geriatric department because the patient either lived alone or had a spouse too feeble to cope with the situation.

After 20 years of special interest in disorders of the spine I find that cervical disc lesions are most commonly of sudden onset, occurring on waking up or on a sudden movement. I have never seen a thoracic disc protrusion of the type described as usual, but I find as commonplace the type described as a case in a million. In fact, I saw two last week. Looking back over my records I find that I saw 35 such cases in a three-year period. Furthermore, they were commoner in the younger age groups. Not one of these cases was referred to a consultant. The reason why a consultant may not see such cases is that the majority recover spontaneously in 1-3 weeks. Manipulation sometimes results in immediate or rapid recovery. Obstinate cases, if they do not recover spontaneously while on the waiting list for a consultant appointment, are usually referred to the wrong department and are subjected to electrocardiograms, chest *x*-rays, or barium meals until they eventually recover undiagnosed.

The diagnosis can be difficult, as you rightly state. I must confess that I treated one of the above 35 patients for dyspepsia for 6 months before deciding to have a long discussion with him about his obstinate symptoms; he was as surprised as I was when I was forced to the conclusion that he was suffering from a thoracic disc lesion. He was fortunate to be one of the lucky ones who responded rapidly to manipulation.

I have never seen a case of paraplegia due to a disc lesion and hope I never do, but the consultants see many. Our experience is different because the consultants see the severely ill patients or those who fail to respond to treatment, while general practitioners keep to themselves those who are not in need of consultant treatment.

R T D FITZGERALD

Sheerness, Kent

Idiopathic acute pancreatitis – a myth?

SIR,—In a recent leading article entitled "Management of acute pancreatitis" (29 November, p 488) you stated that "the aetiology remains not clear in at least one-third of the patients in Britain." This is a substantial overestimate based on information derived from retrospective studies performed before 1970.

Our own initial prospective studies (cited in that article) revealed a much lower incidence of idiopathic cases.[1] The completed study included 191 patients with primary acute pancreatitis, and diagnostic criteria for the acceptance of biliary disease and alcohol as aetiological factors were carefully defined.[1 2] All patients were screened for hyperlipoproteinaemia, hyperparathyroidism, ampullary/pancreatic carcinoma, and drug history and in addition acute and convalescent viral titres to mumps and Coxsackie B infections were studied. This resulted in less than 6% of patients with no firmly established aetiology, and of this small number almost half had equivocal evidence of biliary disease but were not exhaustively investigated or subjected to surgery because of their age or poor medical condition. In view of this evidence it is suggested that the term "idiopathic acute pancreatitis" be used with circumspection.

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[1] Imrie, C W, and Whyte, A S, *British Journal of Surgery*, 1975, **62**, 490.
[2] Imrie, C W, and Blumgart, L H, *Proceedings of the 26th Congress of the International Society of Surgery*, 1976.

Consultants and junior hospital staff contract

SIR,—As a member of the Hospital Junior Staffs Committee for the past 12 months I feel that the statement by Mr D Kirk (3 April, p 840) that "once more, as with the 40-hour contract itself, policy has been decided by a small group" is unfair to say the least.

The 40-hour contract had a long enough period of gestation to allow all those who wished to examine it and pass an opinion to do so. The furore arising out of the October acceptance of the new contract was primarily over its pricing, and with grassroot opinion, support, and interest being so inconspicuous there was no alternative but to accept. I have yet to hear of a viable alternative method of maintaining junior doctors' salaries at an acceptable level—the day has long since passed when professional commitment was an argument for an adequately financed open-ended contract.

The lesson learnt in October by the HJSC was that never again would major decisions be taken without adequate regional consultation. If Mr Kirk and others could have seen the hours of paranoic indecision that dominated the multitudinous meetings between October and January precipitated by the right and proper desire to allow the grassroot opinion to be heard first he would not be so readily critical.

Finally, the HJSC motion was only to negotiate an *option* for those who wished to retain their present form of contract, as consultants already have contractually defined hours of work anyway.

CHARLES CLYNE

Waterlooville,
Hants

Campaign for Independence in Medicine

SIR,—As a junior hospital doctor I strongly object to having unsolicited expensive publicity material thrust on to me by the Campaign for Independence in Medicine and being expected to distribute it.

Although not a supporter of Mrs Castle's methods in the DHSS, I should like to see an end to the exploitation of those in the NHS who have to look after private patients but see the consultants receive the fees. Why should laboratory technicians, radiographers, nurses, and house officers give their duties free in this way? The end of pay-beds would also see the demise of the practice of placing private patients first on operating lists so that the consultant can then disappear, leaving his registrar to finish the NHS work.

Private patients, too, ought to know that in the majority of hospitals they are closeted out of the way in side wards with their primary care in the hands of newly qualified house officers who hesitate to bother their distant consultant if they have problems. They also miss out on the valuable team work and discussion of a whole "firm." In all, their medical care may often be inferior to that of NHS patients.

Let there be purpose-built hospitals and specially trained staff so that private patients can truly receive the care they pay extra for, and let the BMA stop wasting the subscriptions of those who work willingly in the NHS.

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Points from Letters

Computers in industrial medicine

Dr P P FARIDIAN (Computer Medicine Society, London SW5) writes: . . . Undoubtedly the best way of preventing catastrophes similar to that at the Hebden Bridge asbestos mill is by providing an early warning system that would alert doctors, officials, and, most important, a significant number of the workers themselves to any dangers many years earlier than is currently possible. Fortunately recent advances in computer design make the introduction of such a system very much easier and vastly less costly. Central to the system would be a national computer unit able to process most of the material already written down by NHS personnel as a matter of routine so that there would be no interference with the work of doctors, nurses, etc, after the NHS forms