Meeting patients' needs

Qualitative research among patients with chronic back pain shows that they have a great desire for an explanation, a diagnosis, instructions, referral to a specialist, and, above all, for their complaints to be taken seriously.[5] Sadly, we do not offer much to fulfil these expectations. In most cases there is no real diagnosis and no specialist who can simply stop the pain, and a new operation is often counterproductive. In one patient series, almost 80% of the patients who had repeat surgery reported dissatisfaction with the results in the long term, despite apparent initial success.[1 2]

Therefore, efforts have to be directed at restoring normal everyday life as far as possible. Contrary to the belief of many patients, conservative treatment or no treatment does not lead to more complications but to fewer. Our fear of paralysis and disability is usually based on an appealing but rather simplistic, mechanistic view of disc herniation: the disc has burst out of its packaging and the nerve root has become wedged between the disc fragment and the vertebra. However, many people have herniated discs without noticing any symptoms or signs.

Remaining active or doing physical exercises will not lead to a relapse or an increase in neurological symptoms. On the contrary, this can have significant beneficial effects.[6] A customised rehabilitation programme led by a physiotherapist can build up self confidence. Although there is some evidence that exercise is an effective therapy after an operation on a herniated disc, I would prefer rehabilitation to be organised in a multidisciplinary setting with a specialist in back pain, a psychologist, and a physiotherapist working as a team.[1] Granted, no evidence is available that this is more effective than other rehabilitation measures, but the combined approach has the advantage of dealing with physical and mental issues at the same time.

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Corrections and clarifications

Role of living liver donation in the United Kingdom
We mistyped a word in the summary points box of this Education and Debate article by James Neuberger and David Price (20 September, pp 676-9) and it slipped through our checking processes. In the third point, donors have a risk of morbidity [not mortality] of 40-60%. This should reassure potential donors.

Claim that smallpox vaccine protects against HIV is premature, say critics
In this news article by Jeanne Lenzer (27 September, p 699), we mistakenly said that the George Mason University had been criticised for announcing, before peer review, that the smallpox vaccine protected against HIV. We should have said that the university had been criticised for announcing, before peer review, that the vaccine might protect against HIV. We also incorrectly described the Soviet biowarfare programme, Biopreparat, as an "anti-Soviet" programme.

Quality improvement perspective and healthcare funding decisions
We inadvertently omitted to publish a figure in this Education and Debate article by Ashley Bloomfield and Robert Logan (23 August, pp 439-43). The figure (see bmj.com) shows the four distinct but interrelated levels of activity for quality improvement in the model developed by New Zealand's National Health Committee, and also the five dimensions of quality that are important in understanding, defining, and improving the quality of health care. The three principles of the Treaty of Waitangi underpin the model.

The reunion

Having qualified at the Welsh National School of Medicine in 1953, I am about to attend our 50th year reunion. I cannot say that I am looking forward to it. For a start, some of those of whom I have the fondest memories will not be there because of the Grim Reaper. Others with whom I was friendly have chosen not to come. No doubt we will hear of a few who are no longer oriented in time and space. For my own part, those long distant days were golden, but I have learnt that it is seldom possible to recapture a good time.

Of those that do attend, there will be those with whom I was never particularly friendly, nor they with me. Most will show ageing to a degree that will remind me just how much I have aged myself, and a few will look no older than they did 50 years ago, which is unforgivable. Others will boast of the incredible achievements of their children and grandchildren, and will be boring. Probably we will not find a great deal in common.

But then again, we were a heterogeneous year. Some of us were straight from school, whereas others had fought in the war. Also, the 1950s turmoil, when many sought posts abroad and others had to do their national service, meant very different subsequent lives and careers.

But I intend going to the reunion, if only to support the unquenchable enthusiasm of the person in our year who continues to believe that our six years of closely shared experiences so long ago are worthy of remembrance. He is probably right, particularly when one recalls that the year of 1953 first came together in 1948, the first year of the NHS. Come to think about it, we have more worth remembering than most.

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