intervertebral disc, which can in no way affect the sacroiliac joint.

On the diagnostic side it is possible to make a model with three sticks fixed into a triangle with plaster as an adhesive. Experiment will prove the obvious geometric fact that it is impossible to strain one joint without cracking the plaster of one of the other joints. It would therefore appear impossible to have an isolated sacroiliac strain: it must involve either the other sacroiliac joint or the symphysis. Certainly I have only been able to reproduce so-called sacroiliac pain by movements of the spine or straight-leg raising and never by applying the greatest force I can possibly exert on the bones forming that joint with thrusts of my full weight of 85 kg. Dr H J Bourne (21 April, p 1085) uses as his diagnostic criterion the statement, "I assumed that the lesion in these cases was a strain of one of the sacroiliac ligaments," which contrasts strangely with his final statement that "the way forward should come from greater accuracy in identifying the lesion." An assumption can never be a diagnosis, although it may lead to one.

The only causes of true unilateral sacroiliac joint pain that I can think of are inflammatory or neoplastic such as ankylosing spondylitis, gout, or tuberculosis.

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¹ Cyriax, J, *Textbook of Orthopaedic Medicine*, vol 1, 2nd edn. London, Cassell & Co, 1954.

Overseas aid—urban hospitals or primary care?

SIR,—Surely there is one short answer to the above question posed over Dr J S Yudkin's letter (21 April, p 1087): both.

What sort of primary care service can there be without the back-up of a referral hospital to tackle some at least of the misery it uncovers, to train and support its medical and ancillary personnel, to supervise and update its practice and infuse new methods and ideas? Primary care, on its own, can sink to abysmal levels.

In East Africa (as Dr Yudkin must know) provincial hospitals are not necessarily "urban." A town that administers and serves a vast area can be itself quite small. As to hospital access, the population in its immediate area is, of course, specially favoured but it is not only they who benefit from it. Country people can and do travel quite surprising distances for hospital care, on their own. And if a primary care service is worth its name there will be referral between it and the hospital, in both directions and over great distances—difficult though this may be by reason of terrain, season, etc.

No one will disagree with Dr Yudkin about the prevention of malnutrition, measles, malaria—not to mention tuberculosis, hookworm, anaemia, and all the rest. But it ill becomes those of us who have full medical care close at hand to preach preventive to the exclusion of curative medicine to people who are in great need of both. What is very desirable is close integration of the two, with decentralisation of specialist and training resources—not just one splendid "ivory tower" in the capital city, but a number of provincial or district hospitals to bring good clinical and laboratory facilities nearer to the people. Each of them should be a central powerhouse supporting the primary care and the preventive and educative units throughout its district,

closely linked with these in a supervisory and training role and referring patients in both directions. If I am not mistaken, this is exactly what the "referral hospital to serve two million people" (which Dr Yudkin so deplores) will be doing. According to Minerva's information (31 March, p 897), this hospital is to be at Mbeya near the Rhodesia-Malawi border, 800 km from the teaching hospital at Dar-es-Salaam.

No, the promotion and maintenance of good health are not an "either/or" matter. Prevention and care have to go together. And the applications and practice of preventive medicine lie, after all, as much in the fields of education, agriculture, engineering, and housing as of medicine itself—though inspired by and deriving from experience in medical practice and research. Nor is prevention itself cheap. The fruits of its success are longer life and a higher level of expectation in material things (including medical care) as living standards improve. The child whose death from cerebral malaria is prevented lives to have his hernia or his vulvulus or her uterine fibroma.

Of course, Dr Yudkin is right that the real problem of cost is one of recurrent not capital expenditure. But to imply that spending on hospital care must be using resources "which could more appropriately be used elsewhere" begs a lot of questions. It is quite easy to think of highly sophisticated developments in medicine and surgery which might be given a low priority in developing countries (as indeed also in the United Kingdom). But who are we to suggest that improved surgical, obstetric, paediatric, or psychiatric care are inappropriate, even beside other urgent claims, in another country?

Finally, as an ex-Ugandan (and briefly Tanganyikan) I may be excused for feeling that Tanzania, a poor nation now pulling Uganda out of the fire at enormous expense single handed, deserves all the help the world can give in every way.

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Claims for emergency recall fees and confidentiality

SIR,—In their letter "Claims for emergency recall fees and confidentiality" (21 April, p 1088) Mr D E Bolt and Dr J G Thomas offer guidance in respect of the validation of claim forms, stating that clinical information relating to a patient may be inferred from the association of the name of a hospital or the specialty of a consultant with the name of that patient on the claim form.

Surely these circumstances apply in the case of forms of request for outpatient appointments, and I should be interested to know what guidance they wish to offer in these latter circumstances. Is it recommended that either the name of the patient or the name of the consultant be omitted from the request form, and, if so, how is an appropriate appointment to be made?

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Accident and emergency services

SIR,—A great deal of consideration has been given to improving the staffing of accident and emergency departments in the last two or three

years. Improvement in the career prospects and creation of accident and emergency consultants have been the main remedies offered.

The immediate problem, however, is to maintain a service of doctors first on call to the accident department. It is difficult to foresee many of the huge army of doctors, needed to man our accident departments around the clock, becoming consultants even if this is accepted. The new junior doctors' contract emphasises units of medical time, rather than stressing the load of work shouldered.

With less overseas graduates being allowed in, and the GMC insisting on higher standards for doctors in the accident and emergency department, the end of the road for the staffing of accident and emergency departments could be in sight.

North Tyneside Accident and Emergency Department, which has dealt with 47 000 patients a year, of whom 26 000 are new cases, has been obliged to close with effect from 30 April 1979 through lack of medical staff.

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Radiologists group—consideration of new consultant contract

SIR,—Several radiologists have written to the *BMJ*, and also to me, about the new consultant contract. Many have fears that some of its provisions will be detrimental to their interests. I do not myself believe that this is so, but I feel that there should be a debate on this point and also on what should be the "norm" for a session's work. This latter is particularly important, as the DHSS has recently dropped the radiologists' points system and is trying to evaluate radiologists' work load in relation to radiographic points.

In order to consider these matters in depth, I have called a meeting of the Radiologists Group (at which all consultants and senior registrars are welcome), to be held at BMA House at 2 pm on Friday, 15 June. The timing has been chosen to avoid conflict in the morning with the AGM of the Royal College of Radiologists and the Knox lecture in the late afternoon; it is also a day when many radiologists and radiotherapists will be in London. The Review Body Report should be published by this date. The chairman of the Negotiating Committee, Mr David Bolt, will also be present. Nuclear medicine consultants and senior registrars are also invited to attend.

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BMA-sponsored candidates for GMC election

SIR,—As an unsuccessful candidate for selection as a BMA-sponsored candidate for election to the GMC 1979 I have naturally scrutinised the qualifications of the 39 who were chosen for the England constituency with interest. While admitting to both scepticism and partiality I think that analysis of this election must cause some anxiety—and this despite the presence of the Electoral Reform Society. The sponsored candidate has not only the