response to treatment may be misleading in an individual patient but this does not necessarily mean that it cannot be used as an assessment of response in a double-blind crossover study involving 20 patients.

With regard to their comments on the efficacy of intravenous aminophylline we would point out that our study was designed to assess the effects of salbutamol when given intravenously and by IPPB and therefore much comment about aminophylline would have been irrelevant. We cannot, however, support their claim that aminophylline is the bronchodilator of first choice in the treatment of severe acute asthma in hospital.

With regard to Dr Anderson's question, the dose of salbutamol administered by IPPB when a 0.5% solution is nebulised for three minutes via a Bennett ventilator cannot be precisely stated because of the several variables associated with this method of delivery.² However, it can be assumed that the maximum dose delivered does not exceed 10 mg.² Although we accept that we cannot state the precise dose of salbutamol administered by IPPB we cannot see how this "can make it difficult to assess our findings." These clearly show that 0.5% salbutamol administered by IPPB for three minutes (a nebulised dose not exceeding 10 mg) is more effective and less toxic than salbutamol 500 µg given by slow intravenous injection in the treatment of severe acute asthma. The dose of a bronchodilator drug given by IPPB does not have to be precise to achieve a maximum therapeutic effect.³

In a study involving treatment of severely ill patients there are advantages in being able to nebulise a drug for a constant period of time rather than administering a precise volume of solution. We would, however, agree that if our study had been designed to compare the effects of two drugs given by IPPB then it would have been desirable to make attempts to ensure that the same dose of drug was given to all patients.

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¹ Knowles, G K, and Clark, T J H, *Lancet*, 2, 1357.
² Choo-Kang, Y F J, Parker, S S, and Grant, I W B, *British Medical Journal*, 1970, 4, 465.
³ Paterson, I C, et al, *British Journal of Clinical Pharmacology*, 1977, 4, 605.

Mutual help service for doctors

SIR,—It is surprising that the letter from Mr K N Hambly, "Service for psychiatrically ill doctors?" (14 April, p 1020) has so far prompted little response, since it touches on a subject of extreme importance—and, of course, great sensitivity—to the profession.

Past experience suggests that if the medical profession does not solve its own problems others will sooner or later interfere to do this for it in ways it will not like. The problem Mr Hambly highlights can be expanded beyond that of the psychiatrically ill doctor. The profession needs to look into devising some form of confidential mutual help network and early warning system to assist and to defend doctors who are running into trouble in their working relationships, whether this is caused by psychiatric illness, physical disorder, or personality problems.

The first type of case is that of the doctor

who for some reason himself feels the need for help and advice, but is unsure of to whom he can turn for a fair, reliable, and confidential hearing. The second type arises when a doctor or doctors are so concerned about a colleague's health that they want advice about what they should do on his behalf. Thirdly, there is the doctor who is behaving in a manner which is apparently unreasonable and is causing distress to others on account of some idiosyncrasy of personality, a failure in the performance of his duties, or a change in his relationships with those about him.

In all these examples a doctor needs help for his own sake and to protect him and his patients before any of his action brings harm and discredit to him personally, his patients, and the profession.

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"Outwith my competence"

SIR,—The recent correspondence about "outwith" reminded me that 10 years or more ago I had to address the Conference of Local Medical Committees as a local representative, and the word had appeared in the GMSC report. I recall saying that only natural discretion prevented me from pressing a motion "Out with OUTWITH," since I felt that any attempt on my part to "have it out with" the redoubtable Dr James Cameron, the main author of the report, would probably result in his fellow Scot Dr Clark, who was chairman of the conference, crying "Out with him." I cannot remember now if I succeeded in persuading conference to support my main motion, but "outwith" provided a novice speaker with a laugh and I have liked the word ever since.

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SIR,—I am mystified at the correspondence this matter has provoked and the fact that no proper explanation of "outwith" and "with-out" has yet been offered.

The antonym is "within," which has a purely physical meaning. Its counterpart in a physical sense used to be "without," but this is now archaic because of its ambiguity; the word also means "not in possession of." Hence the present word "outwith." For example, "I am outwith my car" means something quite different from "I am without my car." And, incidentally, "outwith" is not a Scotticism. If you would like a current example of that consider the word "clerkess."

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Written information for patients

SIR,—I fully approve of the recommendations of Dr D A Ellis and others (17 February, p 456). In endocrinology this advice is particularly appropriate.

In this unit we have a number of printed or typed standard forms which we issue to patients (with copies going simultaneously to their general practitioners) to cover situations including the following: (a) thyrotoxic patients on carbimazole or propylthiouracil—warning of the significance of sore throat or

unexplained fever and appropriate action; (b) patients on vitamin D with or without calcium treatment—warning of the symptoms of hypercalcaemia, and appropriate action; (c) patients on corticosteroids either therapeutically or for replacement—with instructions on handling infections, operations, etc (in addition to information etched on a metal bracelet); (d) diabetics—a variety of forms to cover a number of topics.

In addition, in the majority of patients referred for an endocrine opinion or for long-term management copies of the letter to the referring doctor are usually sent to the patient as well (except where diagnosis or management is unusually controversial or where personal factors related to the patient's ill health are likely to cause distress if sent to the patient). In particular, whenever a patient with hypothyroidism is discharged from the clinic, the patient is given a detailed letter concerning presentation, physical signs, the laboratory tests which proved the diagnosis, usually the aetiology, and the recommended dosage of long-term thyroxine therapy. This should ideally prevent the common problem in endocrine clinics of the patient referred with a query about whether she needs her thyroxine. Patients seem to appreciate receiving the forms and especially the copies of letters to the referring doctor.

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Sacroiliac strain

SIR,—May I hasten to defend your claim (17 March, p 706) that there is no pathological basis for sacroiliac strain? There was a time when I used to make this diagnosis with gay abandon and absolute confidence in the correctness of both my examination and my diagnosis. Then I read James Cyriax on ailments related to the spinal column and intervertebral discs.¹ I thought that an interesting subject for research would be to try to refute Cyriax, which I have failed to do.

As part of this work I have been searching for the mythical sacroiliac strain for 25 years, during which time I have suffered the great disillusionment of finding only four cases which could possibly stand up to this diagnosis, and all of which were in pregnant women. I used the diagnostic criteria given by Cyriax together with an extra one of my own invention—applying my whole weight with a jerk on the sacrum of the prone patient, a test which cannot, of course, be carried out on the pregnant.

I discovered that my error had been one I have observed in everyone I have ever seen examine a patient with "sacroiliac" pain. The back is prodded till a tender spot is found on the posterior iliac border or the muscles just medial to it and up goes the shout of "sacroiliac strain." But the nearest point of the sacroiliac joint is behind the ilium two inches or more lateral to the part which has been prodded. The posterior iliac border is nowhere near the sacroiliac joint. Furthermore, this is a difficult joint to reach with an injection.

The natural history of the pain is that there are some cases of primary pain in this area, but the majority start with central back pain which moves to the posterior iliac border, thereafter frequently proceeding to the symptoms of sciatica. A large proportion of these cases respond to manipulation of the spine as for an

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