a remission of her psychosis, which reappeared when the drug was stopped. From this followed a trial in 13 cases of acute psychoses of varying aetiology, from which he and his team concluded that the symptoms of psychoses are attributable to hyperactivity of the beta-adrenergic system in the brain. There have been attempts at treatment with beta-blockers by other research teams, which have produced spectacular results in some hands² and dubiety so far as schizophrenic illness is concerned in others.³ Here one cannot rule out, in using such high doses, the possibility of a membrane-stabilising effect; but the doses used by Steinhert and Pugh⁴ were much lower.

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¹ Atsmon, A, *et al*, *Psychiatry, Neurology, Neurochirurgia*, 1971, **74**, 251.

² Yorkston, N J, *et al*, *British Medical Journal*, 1974, **4**, 633.

³ Schwarz, D, and Martin, J, *Nervenarzt*, 1973, **44**, 648.

⁴ Ungerstedt, U, *Acta Physiologica Scandinavica*, 1971, suppl, p 367.

Back pain—what can we offer?

SIR,—Your leading article (17 March, p 706) rightly stresses the need to recognise the predominance of “non-specific” back pain in the day-to-day experience of most doctors who deal with patients complaining of backache.

May I take issue with your statement that the diagnosis of sacroiliac strain is pathologically unfounded? In a series of 116 patients suffering from chronic or recurrent backache 82 (71%) had so-called non-specific sacroiliac pain.¹ I assumed that the lesion in these cases was a strain of one of the sacroiliac ligaments or a lesion of a ligamentous attachment to the periosteum. The treatment was the same as is widely used for “tennis elbow”—that is, local injection of a mixture of triamcinolone acetonide and xylocaine. Good results were achieved in 42 patients (51%), fair results in 23 patients (28%), and bad results in 17 patients (21%).

The method is based on the principle stated in your leading article: “The way forward should come from greater accuracy in identifying the lesion causing pain in the individual patient.”

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¹ Bourne, I H J, *Practitioner*, May 1979.

Prevention and violence

SIR,—Your leading article (31 March, p 839) on prevention and violence indicated that prevention of child abuse, as suggested by Ounsted *et al*,¹ is impractical if it is to involve the families thought to be “at risk” in the possibility of individual or group therapy.

With help from the Park Hospital for Children, Oxford, a simple management plan for prevention of child abuse in general practice² was developed at Didcot Health Centre. Further work led to group therapy³ for mothers and children for families at risk. The work has emphasised the need for a routine psychosocial history to be taken at the antenatal clinic by the health visitor working in conjunction with the family doctor and community midwife. The benefit from this approach is appreciated by both patients and

primary care team and it is found to be very practical

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¹ Ounsted, C, Oppenheimer, R, and Lindsay, J, in *Concerning Child Abuse*, ed A White Franklin, p 30. Edinburgh, Churchill Livingstone, 1975.

² Beswick, K, Lynch, M, and Roberts, J, *British Medical Journal*, 1976, **2**, 800.

³ Roberts, J, *et al*, *Practitioner*, 1977, **219**, 111.

Laboratory management in Europe

SIR,—Dr A G Marshall, (17 March, p 735) was either misinformed or misinterpreted the information proffered. The interpretation put on the word “pathology” would have been different to that commonly applied in the English-speaking world.

Dr Marshall says, “The Clinical Laboratory Service of the NHS has traditionally been the responsibility of medically qualified consultant pathologists or in certain circumstances a scientific officer of equivalent standing,” and he quotes a DHSS circular¹ in support of this. That circular makes it clear that within what we loosely call pathology there are several distinct disciplines each requiring the support of a department and each department requiring a head, who may be a consultant or a non-medical scientist of equivalent standing (the wording of the circular is slightly but significantly different from Dr Marshall’s). One of those disciplines is called clinical chemistry (or chemical pathology in England).

Reference to the most recently published comprehensive work² on the staffing of clinical chemistry departments shows the following facts about countries among those visited by Dr Marshall. In The Netherlands there are 153 qualified clinical chemists registered by the Koninklijke Nederlandse Chemische Vereniging on the recommendation of the Commission of the NV voor Klinische Chemie. Their primary qualifications are in chemistry, biochemistry, or pharmacy. They usually possess in addition a PhD. Successful completion of specialist studies gives them the title of “doctorandus.” Qualified clinical chemists serve 95% of the hospital beds for their specialty and are in complete charge of their departments. In France the practitioners of clinical chemistry are graduates in medicine or pharmacy (apparently in about equal numbers) having postgraduate qualifications awarded by university faculties. In university hospitals the laboratory directors must be doctors of medicine or pharmacists and are generally professors of biochemistry in the faculty of medicine or pharmacy. In Poland the laboratory network is, apparently, managed by the “administering authorities.” Doctors are the specialists in diagnostics—trained consulting officers for the clinicians—while pharmacists are the clinical analysts. Full specialist training for both classes takes a minimum of five years of postgraduate study.

Clearly there is little on which to base comparisons of the individual specialties in Europe, let alone of pathology as a whole. We do not agree with Dr Marshall that “the management of pathology laboratories in the EEC countries and in Poland seems to be much as it was in Great Britain before the Zuckerman Report was published.” We do agree that claims by technical staff to take over management from doctors are not apparent on the Continent, and suggest that administrators have a hand in laboratory management only in

Poland. We wish to emphasise that an important part is played by non-medical graduates as directors in clinical chemistry laboratories both in the UK and the Republic of Ireland as well as in The Netherlands, Belgium, and France.

We believe that in clinical chemistry, as in medical physics, microbiology, and cytogenetics, the science graduate has as much to offer in his own way as has the medical graduate and that, where his postgraduate training is as protracted (evidenced, for instance, by the attainment of membership of the Royal College of Pathologists) as that of the medical graduate, he is on equal terms with him when applying for the post of head of department.

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¹ Department of Health and Social Security, *Health Service Circular (Interim Series)* 16. London, DHSS, April 1974.

² Rubin, M, and Lous, P, *Education and Training for Clinical Chemistry*. Lancaster, International Federation of Clinical Chemistry (MTP Press), 1977.

Difficulties in diagnosing meningococcal meningitis

SIR,—Dr L G Evans-Jones and Dr Anthony Bryceson (31 March, p 892) would be unwise to place too much faith on the usefulness of counterimmunoelectrophoresis in diagnosing difficult cases of meningococcal meningitis, particularly when antibiotics have already been given. No doubt this technique is valuable where the organisms concerned belong to group A or C, but unfortunately the capsular polysaccharide of group B meningococci is only weakly immunogenic. In countries such as Britain and France where group B strains predominate studies so far have failed to demonstrate any advantage of counterimmunoelectrophoresis over conventional bacteriology, either in partially treated cases¹ or in untreated ones.²

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¹ Mandal, B K, *Scandinavian Journal of Infectious Diseases*, 1976, **8**, 185.

² Ghanassia, J-P, *et al*, *Scandinavian Journal of Infectious Diseases*, 1977, **9**, 313.

Vetting and doctoring

SIR,—Your *medical expert* (31 March, p 885), answering a question about a child who persisted in pulling out his hair, advised that “he should be thoroughly *vetted* by a paediatrician.”

The verb “to vet,” meaning to submit an animal to examination, seems to date from 1891, and shortly after to have acquired a transferred application to man. The verb “to doctor,” meaning to tamper with or adulterate, seems to date from 1774. How has it come about that a word associated particularly with our noble profession, but also with the highest intellectual capacity—“one skilled in any branch of knowledge,” “learned divine,” “one who has attained to the highest degree” of a university—has entered ordinary speech as a verb solely in a pejorative sense?

I mean no disrespect for our sister profes-