conflict between medically qualified and non-medically qualified staff in hospital clinical laboratories. The statement on future staffing in medical laboratories published by the Institute of Medical Laboratory Sciences obviously approaches an emotive issue, as illustrated by the comments of the pathologists of the Trent Region (12 February, p 441) and those of Professor Whitby and his colleagues from Edinburgh (26 March, p 833). These comments indicate an overreaction and may inflame a controversy which in many parts of the country at present does not exist. Medical and paramedical staff, whatever their professional designation, must co-operate to provide an effective service, and antagonism can do nothing but harm. Similar discontent seems to have been aroused in earlier *British Medical Journal* correspondence on "Nurse Consultants" (4 December 1976, p 1386; 25 December 1976, p 1558; 1 January, p 49; and 22 January, p 232), and as questioned in some of these letters maybe there is justification for thinking that some medical staff have an unrealistic attitude towards their role in an integrated hospital structure.

What has never been questioned and emphatically cannot be questioned is that medical staff have total clinical responsibility for patient welfare, but it must be equally true that in very many laboratories "technical" staff have important "scientific" and "managerial" functions. I would cite as an example the part played by technicians in the vocational education of "graduate scientists" entering the laboratory service in scientific officer grades. It would be interesting to observe the results if all technicians followed the advice of Whitby *et al* and performed only "purely repetitive technical functions related to day-to-day provision of the diagnostic service." This is a simple example, but I am sure that many more illustrations could be given showing the diverse nature of the role of technical staff in laboratories.

There are other anomalies in the letter from Professor Whitby and his colleagues. For example, repeated emphasis is placed on correct Whitley Council designations, but in obvious ignorance they use the term "probationer technician" to illustrate a grade in which graduates are being appointed. There is, of course, no such grade: the correct term being junior technician. Also, it is suggested that a correct function of graduate scientists would be the liaison between clinicians and the laboratory but numerous opinions from medical practitioners and indeed the leading article (2 April, p 866) stress that a medical training is essential for this important part of the laboratory service. Could it be that Professor Whitby is overemphasising an artificial difference between graduate scientists and technicians in an attempt to belittle the importance of the latter?

The *British Medical Journal* editorial, much of which appears to be taken directly from the evidence of the Association of Clinical Pathologists presented to the Royal Commission on the National Health Service, suggests that "the medical pathologist ran the laboratory in partnership with his chief technician." I feel that this view should be acceptable and encouraged by all. However, although it might seem desirable to add that the medical pathologist takes final responsibility for all that goes on in the laboratory, in some important areas of management this has already proved to be untrue. There are now a number of cases of litigation initiated against

technical staff without medical pathologist involvement, and there are vital aspects of laboratory safety which have been designated the responsibility of senior technical staff (see Health and Safety at Work Act, 1974). It thus seems that in these areas of law there is no overall "final" responsibility of the medical pathologist. The *British Medical Journal* editorial suggests that some of the problems relating to the apparent conflict between various groups of staff might be resolved by the establishment of a career structure for non-medical staff similar to that of the Scientific Civil Service. Surely it was on this basis that the Institute of Medical Laboratory Sciences policy statement on future staffing in medical laboratories was formulated. It is possible, therefore, that there may be significant common agreement as to what measures could be taken to improve the medical laboratory service. What needs to be debated, therefore, is the means of achieving this and not the conflicting antagonistic views of different groups of protagonists.

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SIR,—We cannot agree unreservedly with the views expressed in your leading article (2 April, p 866). The staffing of hospital laboratories requires graduate scientists who have undergone additional postgraduate training and gained extensive experience in the appropriate discipline to be in charge of each branch of the laboratory service. It is unrealistic to propound the thesis that there are sufficient medical graduates with the required degree of specialised knowledge to fill this role in every laboratory. It also shows a failure to appreciate the important contribution of science graduates, mostly biochemists but including some bacteriologists, who have for many years controlled significant numbers of hospital laboratories to the satisfaction of their clinical and laboratory colleagues.

It would be an anachronism to revert to arrangements that superimposed a consultant in another laboratory discipline upon, for instance, a top-grade biochemist simply because the former held a medical qualification. Ignorance is no substitute for specialised knowledge and merely invites the possibility of misinformed interference in the management and development of the branch of laboratory medicine that has been placed in the subordinate position.

We are not suggesting that medical graduates and science graduates are freely interchangeable in hospital biochemistry laboratories. We are, however, aware that clinical biochemistry is one of the shortage specialties, as is microbiology to a lesser extent. We believe that graduate staff in these laboratories, whether or not they hold medical qualifications, are all motivated to work for the benefit of patients. Both classes of graduate should continue to enjoy opportunities for getting to the top, by which time the differences in ethos of the two groups is not significant.

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Commitment to oncology

SIR,—Your leading article (2 April, p 864) is timely. Cytotoxic cancer chemotherapy is the fastest advancing sector in oncology, and some hard thinking must go into its organisation. One of your key sentences is, "Cancer chemotherapy is . . . too heavy a load to graft on to overworked radiotherapy departments." In practice this load is already shouldered by most radiotherapy departments (even willy-nilly) if only because no other department has the same overarching interest and experience in cancer management. The burden is often shared with haematology colleagues who may undertake, for example, the complete management of leukaemias and share in the management of, for example, lymphoreticular disorders like Hodgkin's.

The set-up will depend on local resources and interests (and personalities), and, though it may be true that it does not matter who gives the treatment as long as it is properly done, progress from now on will depend on adequate recognition, organisation, and research. The Royal College of Radiologists has advised that the word "oncology" should be included in the title of radiotherapists and radiotherapy departments—this with an eye to the increasing chemotherapy commitment, now included in the fellowship examination. Clearly there is the possibility of demarcation disputes (of which there have already been rumblings).

I believe it is true to say that at the moment, in most places, the radiotherapist is best qualified to do at least the major part of the job. But American experience plus developments in London and elsewhere show that the medical oncologist has, and will claim, a field of his own. Common sense tells us we must integrate them in the cancer team. There is more than one way of doing it and the pattern need not necessarily be the same everywhere. The Royal College of Radiologists might, for example, consider modifying their fellowship examination to cover non-radiotherapists by a special syllabus to exclude physics and increase pharmacology. Holders of such a qualification could work alongside the radiotherapists in major departments with more than enough work to justify their existence. If funds are short, a medical oncologist could well replace an existing radiotherapist with advantage. This is one possibility. There are going to be problems whatever we do (or don't do). Let us get down to them.

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Breakfast and Crohn's disease

SIR,—Dr A H James's article (9 April, p 943) has, with your leading article "Chasing the cause of Crohn's disease" (p 929), been taken by the lay press as a warning that cornflakes are dangerous to all.

Dr James mentions "inherited" susceptibility and the subject under discussion is not the "cause" but the provoking factor. Both articles assume that Crohn's disease is solely intestinal, though personal observation shows that it can affect any part of the alimentary canal from mouth to anus and, in addition, skin, joints, and perhaps other sites. The search for a dietary factor is some 20 years old. Maybe there is one, but as the non-alimentary