importance of the functional approach to pathology for many years.[1]

Progress to clinical work should be partnered with the systematic teaching of pathology, in which an essential part should be practically based tutorials in small groups, mandatory attendance at postmortem examinations, and participation in regular clinicopathological conferences. The intercalated BSc years provide an opportunity not only to experience and understand the scientific method but also to gain deeper insight into pathology. Recruitment of trainees committed to pathology commonly occurs from those who have completed such courses. It became apparent at the Pathological Society meeting that those medical schools able to provide practically based teaching in small groups, and in particular intercalated BSc degree courses in pathology, were among those able to boast the highest number of recruits into pathology. Student elective periods are most commonly spent in the clinical subjects and are often used as an opportunity to travel. We believe that there should be adequate encouragement for senior medical students to use this time to gain a working knowledge of day-to-day pathology.

We make a plea for urgent reconsideration of the allocation of resources by medical schools to acknowledge that an increasingly sophisticated understanding of pathology is required in modern medical practice.

CHRISTOPHER S FOSTER
Honorary Secretary, Junior Members' Council
D G SPENCE
Chairman, Junior Members' Council
Association of Clinical Pathologists,
London SW1W 0LR

[1] Symington T. *J R Coll Surg Edin* 1964-5:**10**:262-81.

Better to be in the red than reduce standards of care

SIR,—Oxford Area Health Authority (Teaching) has suffered under the weight of two great burdens in recent years. Not only did the allocation of central funds to the area decrease greatly following the last RAWP recommendations, but it opened a new acute hospital 600 beds short of the original proposed capacity—the deficit resulting from the failure of the government of the day to guarantee funds to build the third phase of a three-phase hospital. The third phase would have enabled the AHA to close at least the other two main hospitals in Oxford and hence concentrate all on one site, instead of having the present distribution of resources between many different sites. The Oxford area is now broaching on bankruptcy, with an estimated loss in the current year of some £1·6m.

A recent working party, some recommendations of which have already reached the pages of this journal, has proposed a number of ways in which the area could "cut back" so as to keep the Oxford AHA(T) within its budget. This report has been the subject of some considerable controversy (17 January, p 245). Although the report aims to maintain the standard of patient care it admits that the standard is bound to fall if all the recommendations suggested in the report are instituted. Undoubtably many of the recommendations are going to be negotiated before they can be instituted in one form or another and this will mean that the Oxford AHA(T) will pass into the "red" whatever happens. What, however, will happen if the AHA(T) does declare itself bankrupt? Surely it is better to do this than to decrease the level of patient care below an acceptable standard.

By any definition, Oxford has maintained an excellent health service within its area—its perinatal mortality is well recognised as being one of the lowest in the country; its inpatient "turnover" rate (and by that I do not refer to two-hourly turnover) is one of the highest; it also maintains its level of academic excellence. With the institution of "nit-picking" savings this year the standard will fall, only to be further reduced the following year when the process will have to be repeated when the Government's cash limits are again reduced in real terms.

I propose that the time is ripe for the Oxford AHA(T) to take a stand and declare itself bankrupt. This may well mean a sacking of the AHA and the installation of an auditor, but the outcome will undoubtedly be one for the better with the increase in the amount of central funding to the NHS.

FINAL-YEAR MEDICAL STUDENT
Oxford

Using computerised lists of doctors

SIR,—Professor J Williamson's letter (3 January, p 77) highlights the thin end of what could be a very short wedge. Most doctors would agree that there is no reason why the BMA should not maintain a complete list of medical practitioners, hospital or otherwise. It is an entirely different matter however when one comes to consider the use to which such a register is put. The example referred to by Professor Williamson is an intrusion into the privacy of the doctors concerned. The use of a register in this way could easily lead on to its use for other less desirable purposes. I hope that most of my colleagues will agree that such practices should stop forthwith.

G K WILCOCK
Radcliffe Infirmary,
Oxford OX2 6HE

SIR,—On 3 January (p 77) you published a letter from Professor J Williamson pointing out that while it is perfectly proper for the British Medical Association to obtain a computerised list of hospital medical staff from health boards throughout Scotland, it is most improper that the same computerised list should be used to determine which doctors do not contribute to the Scottish Committee for Hospital Medical Services fund. The Secretary in a comment on the letter said that he could see no breach of confidence in these actions by the BMA.

This comment is completely unsatisfactory to me as a BMA member. It is axiomatic that a good end does not justify bad means and indeed bad means make the end bad. Modern life is bedevilled by the invasion of privacy associated with computers, and even the BMA cannot justify the investigation of doctors' disposal of their own incomes in this way. I would very much like to have an assurance from the Secretary of the BMA that this practice will forthwith cease. Professor Williamson has felt sufficiently strongly about the matter to resign from the Association. This letter is to show that he is not alone in his feelings of disquiet over this example of misuse of computer data.

J S MILNE
Department of Geriatric Medicine,
East Fortune Hospital,
North Berwick,
E Lothian EH39 5JX

SIR,—Thank you for publishing my letter of complaint (3 January, p 77) about the misuse by the BMA of computerised lists of doctors in order to identify those who do not contribute to the Scottish Committee for Hospital Medical Services fund.

The Secretary does not deny that his Association actually does this but engages in obfuscation about knowing the names of doctors who subscribe to the BMA. It would be a remarkably inept secretary who did not have access to the names of his own members. By any reasonable standard it is a breach of confidence and unwarranted prying to seek deliberately to find out from employers how individuals are disposing of part of their income.

I remain disquieted—even more so than before in the face of what I regard as a deliberate attempt to divert readers' attention from the message in my letter.

J WILLIAMSON
Department of Geriatric Medicine,
City Hospital,
Edinburgh EH10 5SB

**The Secretary writes: "The criticism of the use of a list of persons for the benefit of a body other than the one specifically entitled to use it is accepted. Nevertheless, we must confirm that the exercise of comparing lists, whether computerised or not, by the legitimate user for his own purposes does not constitute a breach of confidentiality."—ED, *BMJ*.

Consequences of avoiding the use of locums

SIR,—I was disturbed to read the report of Dr Gerard Vaughan's written reply to Dr Roger Thomas, Labour MP for Carmarthen, on the use of medical locums (31 January, p 410). It must be pointed out that should this advice be taken up by employing authorities the following serious consequences would ensue.

Firstly, there would be an increase in the average hours worked by hospital junior doctors, especially those on one-in-three rotas. At present such a junior doctor contracts for a minimum of 84 hours a week. However, in practice most of them do not "clock off" at 5 pm on their nights off and "clock in" at 9 am the following day; and so a more realistic assessment of their working week would be 90 hours. If, in addition, those doctors had to cover prospectively for colleagues absent on annual and study leave, the work load would be increased by a further 10 hours a week. Dr Vaughan's advice means to indicate that 100 hours a week for junior hospital doctors is an appropriate work load. This conflicts with paragraph 120 of the terms and conditions of service, which states, "It is recommended that, in the assessment of contracts, a minimum of 88 hours per week of assured periods of off-duty, including freedom from on-call liability, should be made available to practitioners, always provided that the needs of patients permit."

Secondly, an immediate rise in medical unemployment would be created. Many doctors seeking a career in the hospital service are already finding difficulty in the smooth progression from one hospital post to another. They often have to fill in time between posts by undertaking locum medical work, thus alleviating the work load of their colleagues. If such locum work were no longer available, these doctors would have no option but to register as unemployed.

M R REES
Chairman, Hospital Junior Staff Committee

BMA House,
London WC1H 9JP

Doctors' pay review

SIR,—So that there may be no misunderstanding may I first say that I agree with Sir James Howie (10 January, p 140) and Dr P C Kennerley (31 January, p 404) that our increased remuneration, excluding expenses, must be kept down to around the 6% mark. I do not agree with the way that they suggest that this should be done.

When the Review Body was set up it was agreed by Government and the profession that the Review Body's findings should be binding on both parties unless, in the opinion of the Government, there were compelling reasons to set the award aside. These findings have been set aside in the past, thus establishing a precedent; but the Review Body has had its findings to take into account in after years—as witness 1980, when it did its best to make up a little of the shortfall of the years when its findings were set aside.

This year let us give evidence of our estimated needs for remuneration and expenses and let the Review Body award the correct amount, which the Government may then cut to x% for remuneration. Only in this way will we catch up when the days of the affluent society return—if they do.

JOHN V KILBY

Huntingdon, Cambs PE18 0HD

Concessions for widows?

SIR,—Membership of the BMA carries certain concessions. There are discounts on some hotels, car hire, BUPA and PPP subscription rates, and insurance advantages. These privileges are enjoyed by members and wives or husbands, but they do not continue to enjoy these advantages on the death of the member. This may well be a time when financial savings would be most important.

It should be possible to make some arrangement with the organisations concerned to apply the privileges to the widow or widower. A possible alternative would be the creation of some kind of associate membership of the BMA at a small annual subscription. This would carry concession arrangements but no other privilege of BMA membership. It might, indeed, provide a small financial gain to BMA funds.

R D ROWLANDS

Taunton, Somerset TA1 4HW

**The Secretary writes: "There are legal complications in transferring concessions that are tied with Association membership to deceased members' dependants. Nevertheless, we will investigate whether such an arrangement would be possible on, say, Provident subscriptions."—ED, *BMJ*.

Medical advisory machinery

SIR,—I was concerned to read the report of the working party on medical advisory machinery (17 January, p 239) and to note the support given in your leading article (p 174) to its recommendations.

In our anxiety to rid ourselves of the complexities of the present structure it is all too easy to overreact and to sweep away some of the more positive benefits of the 1974 reorganisation. With the elimination of the area tier much of the duplication and confusion in the local medical advisory machinery will disappear, and it seems quite unnecessary to propose the removal of the district medical committee as well. I am well aware that this committee has functioned badly in some districts, but I suspect that in most instances the fault lies within the profession, and the working party should be giving positive encouragement towards bringing our various disciplines together, rather than proposing that we all withdraw to our "craft committees." These are fine for medicopolitical matters, local domestic problems within a discipline, and for letting off steam generally but hardly encourage the broad and objective approach to the problems of the district as a whole that is necessary if medical advisory systems are to be taken seriously. The work of the district management team is facilitated and intramedical debates avoided by having both clinical district management team members elected by and individually accountable to the same body where such problems can be debated and resolved. Cross representation or informal meetings which in practice never take place are no substitute for a single medical advisory committee, which others in the Health Service will quite reasonably expect our profession to provide.

Having been chairman or vice-chairman of a district medical committee over a six-year period (now completed), I have no illusions about the problems of successfully operating such a body, but I have also become increasingly aware of the benefits and hope that those districts that wish to retain such an arrangement will not merely be permitted, but positively encouraged, to do so.

B E P WOOKEY

Boston, Lincs PE21 8UE

Points

Parkinson's disease more common in non-smokers

Dr J A SIMPSON (Department of Neurology, Institute of Neurological Sciences, Glasgow G51 4TF) writes: Recently Minerva (10 January, p 154) drew attention to an observation that Parkinson's disease is more common among non-smokers than among smokers. This observation has been made in several studies. In your own columns, Doll and Peto[1] have reported that death from Parkinsonism was negatively related to cigarette smoking. In the media only bad news is good news. . . .

[1] Doll R, Peto R. *Br Med J* 1976;ii:1525.

Gnawing pain in the hand

Dr JOHN A MATHEWS (St Thomas's Hospital Music Society, London SE1) writes: Dr David Pyke's explanation (17 January, p 229) of the authors' confusion (20-27 December, p 1683) in numbering the injured ring-finger metacarpal of a rugby footballer's hand carries conviction. Similar confusion occurs in musical circles—a pianist's fourth finger being a violinist's third. Perhaps the authors are string players.

Poisoning due to ingestion of fish gall bladder

Dr W L NG (Department of Pathology, University of Hong Kong, Queen Mary Hospital, Hong Kong) writes: I was most interested to read your leading article on fish poisoning (4 October, p 890) and would like to report a further mode of presentation. A Chinese patient had ingested a raw fish gall bladder from a grass carp (*Clenopharyngodon idellus*) and six hours later he developed abdominal pain, nausea, and vomiting. There was no diarrhoea. He was admitted into hospital because of anuria. The interval from the ingestion of the fish gall bladder to the onset of anuria was about 18 hours. . . . Apart from gastrointestinal and neurotoxic effects, renal tubular damage has also to be considered in fish poisoning.

Pillar of salt

Dr D A N FERGUSSON (Brook Lane Medical Mission, Bromley BR1 4PXO) writes: While comments in "Personal View" often need to be taken with a pinch of salt, rather more would be needed in the case of the last paragraph of Mr J C Griffith's article (3 January, p 65). *Genesis* (19: verse 26) makes it quite clear that not Lot himself but "Lot's wife looked back and was turned into a pillar of salt."

Who was Willendorf?

Dr R SCHEUER-KARPIN (Hope Hospital, Salford M6 8HD) writes: Your notice of *Discovering the Human Body* by Bernard Knight (29 November, p 1464) asks, "Who was Willendorf?" The answer is: Willendorf is a village in Austria; the figure was found there and named Venus of Willendorf.

Vaccination against smallpox

Dr K N WILKINSON (Aberdeen Children's Hospital, Aberdeen) writes: It would indeed be a good thing if smallpox vaccination could be discontinued (11 October, p 1004; 3 January, p 70); but I would like to add a word of caution in a troubled world. Smallpox could be developed as a means of biological warfare. Would it not be easy for a country to carry on with widespread vaccination and go undetected? I would hope that if this seems relevant at least military personnel will continue to be vaccinated. If it were done discreetly a biological war could start without the recipient's knowledge. He would assume that natural smallpox had not been completely eradicated.