RA - NHS

MR GRAY

MR WILSON, CABINET OFFICE

21 June 1988

I enclose a letter from Mr Michael Freeman, a Consultant Orthopaedic Surgeon at the London Hospital and a distinguished doctor. He is a strong supporter of the Government and of NHS reform, at least partly because he feels that British medicine is falling behind its international competitors.

He is largely free of the usual professional defence mechanisms as the second and third paragraphs of his letter suggest. I would urge very strongly that he be on our list of 'friendly' doctors to be consulted or called in aid when necessary. I have put him in touch with the CPS and the ASI.

John O'Sullivan

JOHN O'SULLIVAN

Incidentally, what was the upshot of your talk with Geoffrey Podger over the doctors' dinner?

The London Hospital Medical College

University of London

ARTHRITIS AND RHEUMATISM COUNCIL BUILDING

25-29 Ashfield Street, London E1 1AD **Telephone: 01-377 7000**

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Dr C Morris	*377 7114*

15 June 1988

J O'Sullivan Esq
The Policy Unit
10 Downing Street
London SW1

Dear Mr O'Sullivan

I write firstly to thank you for sparing me some of your time yesterday. I will contact the various gentlemen whose names you gave me.

I enquired a little amongst some doctor friends of mine à propos the question of changing general practitioners. I have nothing to add in connection with the difficulty or ease with which this can be done but a young doctor at the London drew my attention to a second problem of which I was unaware.

This doctor recently moved into an area of new houses with a growing population. He sought a general practitioner in the routine way through the appropriate local committee (I do not know its correct name). He was told that the lists of all the doctors save one were full and was therefore directed to the remaining doctor, Dr X. When my friend enquired about Dr X's competence he was told by a number of people on the estate that Dr X was notoriously incompetent. My friend therefore elected not to sign up with this doctor and found that there were a number of other people in the vicinity who had made the same decision as himself and who therefore were without a general practitioner. Apparently the administrative position then is that as far as the local general practitioner committee is concerned, all the population are satisfied since they have all been offered a general practitioner. The fact that one of them is so bad that no-one will sign up with him does not appear anywhere in the statistics.

I would venture the thought that there could be no possible justification for the medical profession running a closed shop in this way. Surely any doctor ought to be able to set up his plate wherever he chooses and then to treat both private and health service patients. This would provide competition for the doctors already in the area. Secondly as I think you felt yourself, patients ought to be able to change their general practitioner with no more difficulty than that with which they can change their lawyer or accountant.

A second point emerged in discussion. I do not know if this is correct but it sounds plausible and I pass it on for interest sake. This point is that under the present system it is much more profitable to a general practitioner to have a large number of patients on his list for each of whom he provides minimal care than it is to have a smaller number for each of whom he provides proper care. This situation flows from a payment system based on a head

count. If this situation in fact exists (and it sounds plausible) it would go some way towards explaining the tendency for practitioners to act as postmen sending patients to the hospital when anything significant is the matter with them. Of course if remuneration were to be based on a fee for an item of service, the doctors would overtreat unless the patients paid some or all of the fee.

Yours sincerely

M A R Freeman MD FRCS
Consultant Orthopaedic Surgeon

6R 1516186

Yes — PM meets at 11.00 we meeting in mid-June

M.A.R. FREEMAN, M.D., F.R.C.S.

01-935 4444

149 HARLEY STREET

LONDON W1N 2DE

John

23rd May, 1988

Tuesday 14 June 11.00am. @ No10. J.

J. O'Sullivan, Esq.,
The Policy Unit,
10 Downing Street,
London S.W.1

Dear Mr. O'Sullivan,

I write at the suggestion of Mr. Ray Whitney, M.P. to offer you whatever help I may be able to render in connection with your current discussions about the N.H.S.

By way of introduction, let me say that I am the senior of the orthopaedic surgeons at the London Hospital, and an immediate past President of the International Hip Society. I have in the past served on the Board of Governors at the London, an Area Health Authority, the Medical Research Council and one or two D.H.S.S. committees. All this, however, was some time ago and for the last 10 or 15 years I have concentrated entirely on my clinical practice which concerns hip and knee joint replacement. In that connection I lecture and operate abroad perhaps once a month and therefore have some slight knowledge of the situation overseas.

When I first realized that there was some rethinking going on in connection with the Health Service, I approached a friend of mine (Robin Maxwell-Hyslop, M.P.) asking him to pass my name to anyone who might perhaps be interested in a volunteer. I believe Robin forwarded by full C.V. to Mr. Moore and I think that this thought was reinforced by Michael Fairy at the D.H.S.S. who is a long-time friend of mine. I have however heard nothing.

My connection with Mr. Whitney simply flows from the fact that I read his book recently and wrote to congratulate him.

If there is anything useful you think I might be able to do, please let me know.

Yours sincerely,

M Freeman

M.A.R. FREEMAN
Consultant Orthopaedic Surgeon

cc. Mr. John Moore, M.P.

A new deal

A proposal for new contractual arrangements for employment of medical staff in the hospital service

M. A. R. FREEMAN, THE LONDON HOSPITAL

THE Central Committee for Hospital Services of the BMA having rejected *The Responsibilities of the Consultant Grade* (Working Party, 1969), as a basis for discussion with the Department of Health, on the medical staffing in hospitals, has accepted the Joint Consultants' Committee's *Progress Report* on discussions with the Department of Health—subject to certain assurances (Health Departments and Joint Consultants' Committee, 1969). Since the propositions on which the *Progress Report* is based are identical with three of the Godber Working Party's four fundamental principles, and since the implications of the propositions and of the principles are precisely the same, the British Medical Association's position is now difficult to interpret. Even if the Central Committee for Hospital Services were to have accepted the Working Party's proposals as a basis for discussion, it is obvious from letters to the *British Medical Journal* that the proposals were not acceptable to the majority of non-teaching hospital consultants. Since it would have been utterly wrong to have forced these proposals through in the face of opposition from many of those upon whom the running of the hospital service depends, the proposals would anyhow have had to have been rethought regardless of the formal position of the Central Committee for Hospital Services. It is important that any compromise which may be achieved carries the wholehearted support of the profession and of the Health Department and is not merely a compromise on paper.

What follows is a personal proposal originating neither from the Department of Health nor from any group within the profession, which aims at providing such a compromise.

THE PROBLEM

Principle C of the Godber Working Party and proposition C of the Joint Consultants' Committee imply that the junior grades will have vacancies *only* for doctors in training. The object of this suggestion was to overcome the uncertainties which at present surround a career in the hospital service, to provide a staffing structure in line with the proposals of the Royal Commission on Medical Education, and to overcome the profession's objections to the medical assistant grade. There are two disadvantages to this proposal:

1. Rigidity of career structure (a disadvantage which applies particularly to junior staff).
2. Redistribution of "sub-consultant work" (a disadvantage which applies particularly to consultants).

Rigidity of career structure

In the extreme situation generated by limitation of junior-grade posts only to those in training, a doctor would have to be successful in obtaining a post in a programme of general professional training as soon as he was registered: if he did not do so he would be unemployed. What if he were to be unsuccessful in interview? What if the programmes with vacancies did not attract him? In particular, suppose he especially wanted to work in a hospital where the next vacancy was one year away? What if he wished to change from one programme to another? In effect, consultants would then be chosen on registration. What of the late developer, the eccentric, the house officer who ventures to disagree with his chief? Many excellent consultants would not be consultants today if this system had operated when they were juniors.

These objections do not arise now because there are more SHO and registrar posts than training requirements demand and this excess provides employment for those doctors who are in effect, although not overtly, off the training ladder. Now, however, jobs which are in reality non-training posts are not clearly distinguished from jobs that really are training posts, so that all SHO and registrar posts tend to be open to the criticism (if they are viewed as training posts) that the occupant is being inadequately trained and is being "over-used" in the service sense.

Redistribution of "sub-consultant" work

It has been suggested that if the junior posts are limited to those with a training future, the number of junior posts will fall unless the consultant grade is rapidly expanded and that either way there will be a dilution of interesting work for existing consultants without any compensating increase in pay. (The latter point is crucial: the concept of "consultant" versus "sub-consultant" work does not exist in private practice.) In general, it would be pointless markedly to improve the lot of junior staff if in the process the consultants' job were to become so unattractive that junior staff (and consultants) no longer saw a consultant's job as being desirable.

The prospect of a reduction in interesting and responsible

work has perhaps proved particularly unacceptable to consultants in non-teaching hospitals, since the progressive domination of professional training by the universities is seen by these consultants as likely to lead to a concentration of junior staff in teaching hospitals. This concentration might be expected to result in the NHS consultant staff as well as the university staff in teaching hospitals being cushioned from the service effects of a contraction in the number of juniors. Since the councils of the Royal Colleges are dominated by the university and part-time staff of teaching hospitals, the Royal Colleges and the universities are seen by consultants in non-teaching hospitals (in spite of repeated assurances from the Colleges to the contrary) as being unlikely to oppose a concentration of junior staff in teaching hospitals. Hence the current attempt to form a viable organisation outside the British Medical Association, the universities, or the Royal Colleges, to represent the views of non-teaching hospital consultants.

THE NEW PROPOSAL

It is now suggested that these objections might to some extent be met by the restructuring of all medical staff posts in the hospital service and the provision of two alternative basic forms of contract. Specifically it is suggested that:

1. There should be four grades (grades 1, 2, 3 and 4).
2. In grade 1 there should only be a training contract.
3. In grade 2 there should be a training or a service contract.
4. In grade 3 there should be a training or a service contract.
5. In grade 4 there should only be a service contract.

Grade 1

This would be the grade into which a doctor would enter upon provisional registration. He would be offered a full-time contract on a salaried basis tenable for six months. The contract would be renewable for a further six months to a maximum of one year.

These contracts would be training contracts—by which is meant that they would contain within them clearly described periods of off-duty for postgraduate training. The number of posts in this grade would be adjusted so that vacancies would be available for all British medical graduates obtaining provisional registration. The posts would be supervised by the universities so as to ensure that they would be suitable as pre-registration posts. Upon completion of one year in this grade the doctor would obtain full registration as at present.

The pay in this grade would be similar to the pay received by pre-registration house officers at the present time.

Grade 2

Full registration would be a prerequisite of entry into grade 2, either on a training or a service contract.

Training contract

This contract, like that in grade 1, would be a full-time contract in which the pay would be on a salaried basis and in which clearly described time-off would be set out for purposes of postgraduate training. The contract would be for a one-year period renewable on two occasions to a maximum total of three years. Doctors holding these contracts would not necessarily have to hold them on three consecutive years: if they chose, for example, they could hold a training contract on years 1, 3 and 5, and a grade 2 service contract on years 2 and 4 after registration. The level of clinical responsibility and the nature of the postgraduate training received while on this contract would be that appropriate to the Todd* concept of general professional training.

The pay would be similar to that obtained at present in the first three years after registration in the SHO and registrar grades.

The number of training contracts in grade 2 would be adjusted so as to be appropriate to the number of training contracts in grade 3 together with the number of vacancies elsewhere in the profession for doctors requiring general professional training.

Service contract

These contracts would be offered on a full-time or part-time basis. Throughout the period of time in which the doctor was under a contractual obligation to work for the hospital service his commitment would be entirely of a service nature and there would be no mention in the contract of time-off nor of facilities for postgraduate training. Part-time contracts would enable general practitioners and married women to work in the grade and, in principle, they would enable hospital doctors at this level to engage in private practice.

As with grade 2 training contracts, the contract would be on a yearly basis, but in contrast to the training contract it would be renewable indefinitely, and a doctor holding such a contract would be entitled to apply to the appropriate regional hospital board or board of governors to have his post established. Upon such application, the doctor would be interviewed by a committee composed of appropriate consultants and representatives from the regional hospital board or board of governors. If successful in the interview, he would be established in the post and would then be entitled to hold the post indefinitely. The decision to apply for establishment would be the doctor's voluntary personal prerogative and the initiative to apply for establishment would be his alone.

The pay under this contract would be somewhat greater than the comparable pay for the same year for a doctor employed on a training contract. There would be a considerably longer pay scale extending up to overlap the present general practitioners' scale. It would be possible for an employing authority to negotiate with a particular doctor the point on the pay scale at which the doctor entered the grade. Considerable flexibility should be allowed in this respect, in order to help, for example, the employing authorities responsible for unpopular casualty departments, to staff these departments by offering higher salaries than would be obtainable in more popular localities.

The number of grade 2 service contracts would in principle be unlimited. In practice limitations would be imposed on a basis to be described under grade 3 service contracts.

Grade 3

Doctors would only be eligible to enter this grade if they had held a training contract in grade 2 for three years, that is to say if they had completed a period of three years of general professional training in the Todd sense. Assuming that the diplomas of the Royal Colleges remain as they are at present, the possession of a higher diploma such as MRCP or FRCS would also be a prerequisite of entry into this grade.

Training contract

The terms of this contract would be similar to the terms

* Report of the Royal Commission on Medical Education, HMSO, 1968.

training contract in grade 2, save that it could be held for a total of four years, not three years. The pay would be similar to that of present-day senior registrars. The number of contracts would be appropriate to fill the expected vacancies in grade 4 service contracts.

Service contract

The terms of this contract would be similar to those of a service contract in grade 2. Specifically, the arrangements with respect to tenure would be the same. The pay scale would also be similar but would start at a higher level. The number of doctors working on service contracts at any one time would, as in grade 2, be in principle infinite. There would, however, be certain preconditions which would have to be met before a service contract would be granted by the Department of Health. These preconditions would apply to service contracts in grade 2 and 3.

First, with respect to grade 3 contracts, the consultant establishment in the speciality in question would have to be expanding at an agreed rate. Agreement upon the rate of expansion should be reached annually by negotiation between the Department of Health and representatives of the relevant professional body. At this negotiation a 10-year projection for the rate of expansion of each specialty would be made and thus there would be a rolling 10-year projection for the expansion of the consultant grade which would be up-dated annually. Subsequent failure to achieve the projected rate of expansion of the consultant grade might be due to one of three factors.

First, the Department of Health might fail to produce the finances or for some other reason refuse to agree to a particular consultant appointment. In principle this possibility should be eliminated by the Department's undertaking, reached in its annual negotiations, to expand the appropriate consultant grade by an agreed amount.

Second, it might be due to a failure on the part of existing consultants in the specialty to apply for a sufficient number of new consultant posts. If consultants did fail to seek the creation of new appointments in this way, no grade 2 nor grade 3 service contracts would be granted by the Department of Health in the specialty in question. A difficulty would arise with respect to grade 2 contracts since it might well be difficult to distinguish at this level between one specialty and another. The numbers of grade 2 service contracts should therefore be related to the total expansion of the consultant grade rather than to the expansion of any particular specialty.

Third, suitable applicants might not be forthcoming even though consultant posts were sought and approved at the agreed rate. Failure to reach the agreed rate of expansion of the consultant grade for this reason would not debar the creation of additional service contracts in grade 3. The Department of Health would be required to keep a register of unfilled but approved consultant vacancies so that doctors holding grade 3 contracts could at any time contact the Department of Health to discover where a grade 4 (that is consultant) contract was unfilled.

Service contracts in grade 2 and grade 3 would lapse with the resignation of the individual holding the contract. There would therefore be no fixed establishment of contracts and the number would fluctuate in reponse to the laws of supply and demand. When a doctor informed his employing authority that he wished to resign a service contract, the employing authority could apply to the Department to have a new contract allocated in the place of the one which was about to fall vacant. It would be imperative that the machinery for approving the new contract acted speedily so that if a contract were to be approved (on the above grounds) an advertisement could be made for a replacement doctor in good time, or alternative arrangements could be made to cover or reduce the work load of the hospital in question.

It is important to be clear that service contracts in grades 2 and 3 would not constitute a separate "grade" analagous to the medical assistant grade. Tenure of such contracts could occur at any stage in the career of any doctor; periods of tenure would normally be short; permanent tenure could only be obtained at the specific request of the doctor concerned; and the number of such contracts available at any one time would be carefully controlled and variable—every contract would lapse with the resignation of its holder and new contracts would only be granted subject to certain safeguards.

Grade 4

These would be service contracts only and would be identical in all respects, save for the method of payment, to existing consultant contracts. Their numbers would be annually negotiated between the profession and the Department of Health as outlined above. They would be part-time or full-time and would thus be similar to service contracts in grades 2 and 3.

Payment under this contract would be by a basic salary rising to a maximum of £5000 a year payable on a sessional basis as at present. In addition to this there would be a supplement which would reflect the size of the service load discharged by the individual consultant. The size of this supplement would be adjusted so that although there would be no theoretical ceiling to a consultant's earnings on this basis, in practice it would be difficult for a consultant to earn more than an additional £5000 a year. The merit awards' system would cease to operate or, if it did operate, would do so on a very much reduced scale. It might well be that the inducement of a service-related supplement would lead to an increase in the amount of work carried out in the consultant grade and hence to a reduction in the number of service contracts sought by consultants in grades 2 and 3. Thus this element in consultant payment might affect a saving of salaries in the lower grades.

A problem might arise with respect to the effect of a service-related payment in the consultant grade for those consultants who had grade 2 trainees and grade 3 trainees working with them: there might be a tendency for these consultants to deprive their junior staff of work which would be valuable from the training standpoint in order to enhance their own incomes. A solution to this dilemma might be provided by offering consultants associated with training programmes a basic salary rising to £8000 instead of £5000, but to exempt them from the service supplement.

The location of staff holding contracts of grades 1, 2 and 3 Training contracts

The aim of these contracts should be to provide an adequate, controlled clinical training, rather than a post-graduate "education". The difference between a training and an education may perhaps be identified by saying that in the former the emphasis is on the acquisition of a professional skill while in the latter the emphasis is placed on the acquisition of knowledge. Although knowledge is a prerequisite of professional skill, it is not synonymous with it. Training implies that the trainee will be closely associated

a consultant, that the raw material of the craft (that is to say the patient) is in ample supply, and that the trainee acquires his skill by performing it, not merely by watching.

Programmes of postgraduate medical training must ensure, therefore, that the trainees are where the patients are, that is, in both teaching and non-teaching hospitals and also in general practice. As far as hospital trainees are concerned perhaps one half-day a week should be devoted to university-run but not necessarily university-staffed instructional courses. Staff should also have the opportunity of carrying out research, although it is arguable that this should not take place during a straightforward period of further professional training but rather that staff interested in research should have the opportunity of carrying it out either before or after their period of training. The strictly university role in the execution (as distinct from the supervision) of postgraduate training would therefore seem to be slight.

Service contracts

These would be available wherever a service demand existed.

Married women doctors

It is imperative that every facility be given to encourage married women to re-enter hospital or general practice. Service contracts in grades 2, 3 and 4 would provide permanent employment on a part- or full-time basis for them if they so desired. Married women might, however, reasonably aspire to continue their training after marriage and so for this group of doctors part-time training contracts might be offered (all other training contracts being full-time). For a married woman taking a part-time training contract, the total time spent in the training grade would be the same as for a doctor working in a full-time training contract (that is, if she took a half-time training contract she would spend twice as many years in the grade as would a doctor taking a full-time training contract).

General practitioners

These doctors could work part-time in the hospital service on service contracts of grade 2, 3 or 4. The contract given would depend upon their experience and qualifications.

The new contracts in practice

Some examples may be given to illustrate how these contractual arrangements would provide a career structure for different doctors.

For the man of first-rate ability and drive the opportunity would exist of working for eight consecutive years in organised training programmes which would take him from qualification to a grade 4 (that is, consultant) contract. All these eight years would be spent working under a contract with clearly specified training provisions. When he reached a grade 4 contract, at about the age of 32, he would have the prospect of earning a basic salary of perhaps £3000 plus a supplement based upon his work-load which would range up to £5000. Over the following years he would get annual increments to his basic salary taking him to a maximum of about £10 000.

For a doctor who was uncertain as to exactly what form of medicine he wished to practice after registration, the opportunity would exist to sample different specialties on service contracts in which, although not enjoying formal training, he would be able to earn slightly or substantially more than his colleagues on training contracts. When he had made up his mind as to what form of training he wanted to take up, he would be able to switch to a training contract in order to pursue the specialty of his choice.

Some doctors wish, or are forced by circumstances, to advance their training at a less than maximum speed. For example, they may wish to gain a little more clinical experience than would be provided for by eight years in training contracts, or they may prefer to "mark time" in the expectation of a particular training post, or they may fail to obtain a post of their choice or to pass a certain examination. Such doctors would be able to take advantage of a service contract to provide themselves with a reasonable standard of living while they were either obtaining the clinical experience that they required or "marking time". For doctors who were "marking time" because they had failed an examination, it would be perfectly possible to take the examination again from the service contract, and, if they passed it, to re-apply for a training contract in whichever grade was appropriate for them.

Some doctors might wish to make a small sum of money rapidly after qualification in order to have it behind them during their training years. An opportunity to do this would be provided by taking a grade 2 service contract in, for example, a casualty post where the employing authority might be offering high salaries to attract doctors.

General practitioners, upon completing their training could retain or acquire, on a part-time basis, a service contract in grade 2, 3 or 4 (depending upon their professional qualifications and experience). They could of course re-enter hospital practice on such a contract after a period in full-time general practice.

Married women doctors could be employed in the hospital service in a similar way. Married women, general practitioners, and doctors working entirely in the hospital service could if they desired apply to have their full-time or part-time service contract of grade 2, 3 or 4 established: they would then be able to hold the contract uninterrupted for their professional lifetime. By special arrangement married women doctors might be enabled to re-enter hospital practice on part-time training contracts.

SUMMARY

A new set of contractual arrangements are proposed for the employment of medical staff in the hospital service. It is hoped that these would provide a well-defined yet flexible career structure for doctors in training and would make it simple for general practitioners and married women to re-enter the hospital service without their being contractually differentiated from other doctors working in the hospitals. It would make it possible for fully registered doctors to remain permanently in any grade in the hospital service, but only if the individual doctor voluntarily elected to do so. The result might be an increase in the number of doctors who would willingly work in hospitals, a result which, together with the proposed alterations in consultant remuneration, might help to meet the present objections of existing consultants to the staffing changes which are necessary if satisfactory career prospects for junior staff, and satisfactory working conditions for senior staff, are to be provided in this country. If these hopes materialise, medical emigration from this country might be slowed down.

Working Party (1969) Responsibilities of the Consultant Grade: Report of the Working Party appointed by the Minister of Health and the Secretary of State for Scotland. HMSO, London

Health Departments and Joint Consultants' Committee (1969) *Brit. med. J.* iv, Suppl. 53

BOOK REVIEWS

MEDICINE

Peripheral Arterial Disease
Robert L. Richards, MD, FRCPE, FRCPG

E. & S. Livingstone, 1970
Pp. 126. Price: £2.10.0

The contents of this short monograph, by a consultant physician with a longtime interest in peripheral vascular disease, are arranged in nine chapters. The first is a historical introduction to the subject, and this is followed by a chapter giving an elementary description of the normal peripheral circulation. Chapter three is of special value in clarifying the classification and nomenclature of arterial disease, and a great service will have been rendered if the suggestions made are universally adopted. Chapter four is concerned with clinical features and investigation from the practical standpoint, and is full of sound advice. Intermittent claudication is the subject of chapter five, though the place of reconstructive arterial surgery in therapy is discussed in only a few words. Chapters six and seven deal respectively with acute arterial occlusion and chronic limb ischaemia, while there is a practical account of Raynaud's disease in chapter eight. Chapter nine consists of brief descriptions of peripheral aneurysms, cervical rib syndrome and erythromelalgia. References are not given in the text, but there is a bibliography at the end of the volume, largely arranged with reference to the chapter headings.

In general, this monograph is brief, well written, and contains a wealth of practical clinical observation and advice. However, as the author says in his introduction "peripheral arterial disease is normally regarded as a surgical specialty" and the absence of a proper detailed discussion of the important role of reconstructive arterial surgery in lower limb ischaemia, which is by far the commonest presentation, must limit the appeal and value at this time of any book on peripheral arterial disease. Nonetheless, senior medical students and residents will find it to be a useful introduction to the topic.

J. A. GILLESPIE

Obesity
Edited by Nancy L. Wilson, BS

Blackwell, 1969
Pp. 254. Price: £5.0.0

The fact that this is the third book with the same title to be published within a year provides some indication of the interest now being taken in this subject. The present publication is an edited account of a symposium held in December 1967 in San Francisco and as such suffers from many of the drawbacks of such a collection. But for all the unevenness of style, overlapping of content and selectiveness of topics which this type of presentation almost of necessity entails, the present book is full of interesting and original ideas.

I particularly enjoyed the introductory chapter by the editor and her colleagues, the well-reasoned and critical appraisal of anthropometric measurements by Craig and the hard-headed account of energy metabolism and weight by Margen. In such a package there are bound to be some contributions which are less successful than the others: in my opinion these were the account of appetite control which was inaccurate in places; the otherwise sensible paper on psychiatry which was marred by what has come to be a typically American psychiatric over-emphasis on sexual anxiety as a causal factor in obesity; the chapter on starvation regimes which has a strangely redundant air in the light of recent findings that it is harmful and no more effective than standard regimes.

In spite of these criticisms I think that this book presents one of the most informative and challenging accounts available of the clinical, epidemiological and physiological problems associated with obesity and should be read by all interested clinicians and nutritionists.

TREVOR SILVERSTONE

Tumours of the Thyroid Gland
Edited by Sir David Smithers, MD, FRCP, FRCS, FFR

E. & S. Livingstone, 1970
Pp. 334. Price: £5.10.0

This monograph on thyroid tumours is one of a series on tumours at various sites, edited by Sir David Smithers. Thyroid cancer is uncommon—there are less than 400 deaths in England and Wales each year from this disease—and the variation in natural history and response to treatment is greater than for many other sites. Since few clinicians not working in special centres are likely to see many cases it is particularly valuable to have an assessment of the disease by experts. But apart from its clinical interest, tumours of the thyroid illustrate many of the important general concepts of neoplasia and this has led to a considerable amount of work in many fields in experimental cancer research.

Like its predecessors in the series, the book covers a wide field. A brief historical introduction by Miss Jessica Thompson is followed by a section by R. A. M. Case on the mortality from thyroid cancer and non-cancerous thyroid diseases in England and Wales and some other selected countries. There is a substantial appendix which deals with some of the statistical methods used. The aetiology and experimental production of thyroid tumours is discussed by I. Doniach and the pathology of the more usual tumours is described by N. F. C. Gowing. E. D. Williams deals with medullary carcinomas which are thought to be derived from parafollicular cells, and may be associated with phaeochromocytoma, multiple neuromas and sometimes other genetic abnormalities. The editor reviews the published series of malignant lymphomas of thyroid and adds 19 cases seen at the Royal Marsden Hospital. The fourth section of the book is concerned with clinical diagnosis (W. P. Greening), X-ray diagnosis (J. S. MacDonald) and the use of radioisotopes (V. R. McCready). Greening also discusses surgical treatment and Howard and Smithers the indications for radiotherapy. Perhaps the most valuable section of the book is the analysis of results of treatment, mainly based on 267 cases seen at the Royal Marsden Hospital and a personal series of 222 cases from the Hammersmith and King's College Hospitals by Selwyn Taylor. The results of both series show the close relationship between the histological type of the tumour and prognosis, and the value of surgery in the treatment of differentiated tumours.

This is a useful survey of thyroid neoplasia.

L. M. FRANKS

Cardiac Arrest and Resuscitation (3rd edition)
Hugh E. Stephenson, Jr., AB, BS, MD, FACS

Henry Kimpton, 1969
Pp. 659. Price: £13.5.0

As may be inferred from the price tag and stable of origin, this is a finely-produced volume well calculated to please the eye and hand at first acquaintance. Dr Stephenson and his 18 contributors have filled it with facts some fallacies, hypotheses and anecdotes in their attempt to cover this ill-defined field. There are sections on mechanisms, recognition, prevention and treatment of cardiac arrest, postresuscitative care, medicolegal aspects, elective cardioplegia and a host of subtopics. The approach is essentially that of the surgeon and anaesthetist.

No work of this kind can be up-to-date by the time of its distribution but, even so, it is disappointing to read (page 120) that "the usual case of Stokes-Adams disease will not require the electrical cardiac pacemaker" and that ephedrine, epinephrine and atropine are the most commonly used drugs in the medical management of this syndrome. Such dubious statements are, regrettably, not atypical of much of the subject matter while labelling of the figures has also been careless here and there, for example, Fig. 10–2 where A is in reality but an enlarged portion of B.

Light relief is provided (page 403) by the story of the young man who nearly became a kidney "donor" but recovered just in time, though this finely told tale may not be appreciated by those enthusiasts who advocate changes in the (British) law to facilitate transplantation. Compilation of the index must have been an unenviable task by virtue of the fragmentation of related material throughout the several sections of the text. Hopes of using this manual for literature-search purposes are frustrated by the absence from its bibliography of practically all those references listed in the first and second editions, though allusions to them remain in the narrative. For any future revision the keynotes must surely be condensation and organisation of relevant material if this major work is to be worthy of a place as a standard text.

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NEUROLOGY AND NEUROSURGERY

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Contrary to the practice of most of the British specialist societies, the American Academy of Neurology not only encourages the active participation of specialists in training, but also presents at each of its annual meetings a short course in recent neurological advances for their special