establish that their patients did not have pancreatitis, further parameters such as the urinary amylase and the amylase creatinine clearance ratio could have been looked at. Nevertheless, their statement that routine serum amylase estimation is not justified in children is borne out by their study.

In the table of the diagnostic outcome of 50 children with recurrent abdominal pain, constipation was the diagnosis in 15. While constipation undoubtedly does cause abdominal pain occasionally, and the diagnosis is more likely to be made if a suppository or enema causes relief, it is an overworked diagnosis. It is doubtful that acute constipation of a few days' duration is as frequent a cause of pain as this. Pain is also not a feature of patients presenting with gross faecal hold-up and idiopathic megarectum. With regard to the 25 patients in whom no diagnosis was reached in the same table no doubt this is an honest assessment. However, there is a clear group of patients, who have an onset of recurrent central abdominal pain coming on around the age of 8 years, who have no demonstrable physical problems. This pain is explained as psychogenic in origin. The diagnosis is simply recurrent abdominal pain of childhood.

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Book review

Patterns of Hospital Medical Staffing—General Surgery by Robin Dowie. 52pp, paperback. HMSO, London. £6.45. ISBN 0 11 321379 4

Robin Dowie has published eight specialty reports examining clinical services and medical staffing arrangements of various specialties engaged in hospital practice in the National Health Service. This report concerning general surgery has been based on research carried out in five health districts. It is a valuable contribution to current thinking concerning the delivery of surgical care to the population of England and Wales. A major drawback of the study is that the fieldwork took place mainly in 1987 and since then significant changes to the organisation of the Health Service have come into being. In addition, much of the data examined was for the financial year 1987/1988, which was the first year of operation for the Körner information system and the author admits that there may have been some under-recording of workload activities.

Emerging from the review is the fact that the structure of surgical departments and the workload performed within them varies considerably. It comes through loud and clear that we have never had a structured system of provision of surgical care in this country and that currently surgical services are organised as a result of the quirks of history involving philanthropy, geography and traditional patterns of work.

The chapter concerning emergency admissions suggests that possibly the districts surveyed may not be representative of all districts as the emergency workload appears lighter than many hospitals' audited results. The report also seems to go along with the CEPOD breakdown of emergency operations into emergencies requiring emergency operations, urgent patients requiring operation within 24 hours and scheduled patients requiring an early operation within 1 to 3 weeks. I am not sure that all surgeons would agree that intestinal obstruction, arterial embolism and intestinal perforation should be considered non-emergency and could wait 24 hours before being operated upon. Attention is drawn to the fact that one-third of emergency admissions in general surgery do not receive an operation and there is a hint of criticism that perhaps this is an inappropriate use of surgical services. Undeniably some admissions do not need to come into hospital, but many conditions of abdominal pain do require inpatient non-operative treatment.

The chapter on junior doctors' hours clearly demonstrates the heavy physical demands made on all levels of junior doctors in general surgery. The different demands on pre-registration house surgeons in teaching and non-teaching hospitals is demonstrated. The interesting observation from a later survey of house officers in teaching and non-teaching hospitals in the four Thames Regions demonstrates that house surgeons in teaching hospitals started their days earlier and finished later, even though fewer patients were admitted as emergencies during the week, and there were fewer inpatients under the care of each doctor. Inadequate administrative help on the wards and poor arrangements for filing patients' medical notes seemed an area of genuine concern.

The minimal expansion in consultant numbers in general surgery between 1979 and 1986 is highlighted. The report concludes with various recommendations, most of which should be welcomed by the profession. Audit is encouraged; the provision of observation beds in the accident and emergency department is also encouraged, as is the setting up of routine pre-admission assessment clinics. A rationalisation of the use of different sized hospitals is also needed so that some small district hospitals may only receive elective surgical cases, possibly with a high involvement of staff grade doctors. The suggestion that acute hospitals of a larger population size be increased in number is in broad thinking with others, notably the South East Thames' Acute Services Strategy Group and their publication *Shaping the Future*.

The recommendations concerning manpower may not fully take account of the significant rationing of registrars since career registrars have been numbered in the last few years. That, coupled with stricter immigration laws, may well ration the number of doctors likely to be available for staff grade posts.

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