to work are ill served, because their doctors cannot have accurate details of the physical and mental demands of the patient's normal occupation and of the environment in which it is done. A patient can seldom give his doctor a valid description of his work because he fears that, if he minimizes the demands of his job, his doctor will recommend a return to normal work and thus do his condition further harm, while, if he exaggerates, his doctor will recommend a change of work with all it entails and confirm his worst fears about his prognosis.[7]

But perhaps there is a chink of light. In discussing the functions of the Employment Medical Advisory Service, now started (which is to have the equivalent of 110 full-time doctors), the Robens committee says that it should include "not only the provision to government and industry of medical advice on occupational health and hygiene but also advice on the medical aspects of training, rehabilitation and other employment matters . . . the health of young people at work . . . we think that medical aspects of training and the study of broad problems such as mental health in industry and sickness absence also fit naturally into this picture." The committee therefore thinks that, though many of the functions undertaken by existing occupational health services are not part of occupational health, these very functions should be carried out by Employment Medical Advisers. The committee does not explain how 110 E.M.A.s are to provide a service for two-thirds of the employed population, while 600 full-time and perhaps 1,500 part-time occupational physicians are at present providing occupational health services of some kind to the other one-third.

There is another anomaly in the committee's recommendations. The committee proposes more self-regulation within industry on safety matters while blessing the Employment Medical Advisory Service, which is to be imposed from outside industry and may duplicate those very occupational health services which industries have provided for self-help.[8] This help not only includes that part of occupational health dismissed by the Robens report, which is greatly valued, but also giving impartial advice on the toxicology, ergonomics, and effects on the general environment of new projects at the earliest stage of development—advice based on the implications for the industry and its employees as a whole—without the delay and formality of consulting outside bodies.

There are to be consultations between the Secretary of State for Employment and interested bodies before legislation is introduced to implement the recommendations of the Robens committee. The basic difficulty is that the Department of Employment is responsible for the prevention of industrial disease, and, though it does not want to know it, the Department of Health and Social Security has responsibilities for advising workers on their fitness to undertake particular types of work through the procedures for certification of incapacity to work. An exception, however, is the medical supervision of government training centres and industrial rehabilitation units, which is allocated to the Employment Medical Advisory Service even though the Tunbridge Committee[9] on rehabilitation recommends that formal rehabilitation should be the responsibility of the National Health Service. But a wider concept of occupational health and occupational medicine is needed, perhaps based on Lee's advice that the definitions should come from asking the question "Why is it done?" rather than "What is done?" or "Who does it?"

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[2] Department of Employment, *Safety and Health at Work, Report of the Committee* (1970-72), (Chairman: Lord Robens), *Volume 2, Selected Written Evidence*. London, H.M.S.O., 1972.
[3] Treasury, *Report of a Committee of Enquiry on Industrial Health Services*, (Chairman: Judge E. T. Dale), Cmnd. 8170. London, H.M.S.O., 1951.
[4] Medical Services Review Committee, *A Review of the Medical Services in Great Britain* (Chairman: Sir Arthur Porritt). London, Social Assay, 1962.
[5] Duncan, K. P., Occupational Medicine Following the Robens Report. Meeting of the Society of Occupational Medicine, 27 October 1972.
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New Cause of Tennis Elbow

Tennis elbow, or lateral epicondylitis, is a common affliction of middle age, characterized by pain over the outer aspect of the elbow, aggravated on radial extension of the wrist. Though it has been considered to be a self-limiting condition which seldom persists for longer than 12 months,[1] the inconvenience and sometimes the real disability that result from it cause the patient to seek treatment. Many types of treatment have been practised. They include splinting, deep massage, ultrasonic therapy, and local injections of hydrocortisone with or without local anaesthetic, and some measure of success has been claimed for all of them. Operative intervention has usually been reserved for lesions that have resisted conservative treatment.

Many operations for the treatment of tennis elbow have been described, including ablation of the common extensor origin,[2] resection of the orbicular ligament,[3] Z-lengthening of the extensor carpi radialis brevis tendon,[4] and denervation of the radio-humeral joint.[5] All have given a good proportion of success, which the sceptic may attribute to the combination of operative trauma and enforced rest that seems to be the only factor common to all procedures.

Though the disease is common the exact pathology remains obscure. Inflammatory tendonitis, strain of muscle or ligament, bursal irritation, nipping of synovial fringes, degenerative changes in the orbicular ligament, and a tear of the common extensor origin from the underlying periosteum have each been held responsible for the symptoms. The latest addition to the list is that described by N. C. Roles and R. H. Maudsley[6] as the radial tunnel syndrome. In its course from the lateral side of the lower third of the upper arm to its emergence as the superficial radial and posterior interosseous nerves in the forearm the radial nerve traverses a restricted space bounded by the structures forming the radio-humeral joint behind, the brachioradialis and extensor carpi radialis longus and brevis laterally, and the biceps and brachialis medially. Distally, the posterior interosseous nerve passes between the superficial and deep portions of the supinator. At various points along its route the nerve may be subject to entrapment—namely, over the anterior aspect of the capitulum of the humerus or the radial head,[7] by the fibrous edge of the superficial layer of the supinator,[8] or by a medial extension of the extensor carpi radialis brevis.

One mode of presentation is posterior interosseous paralysis. Roles and Maudsley suggest that another may be as a case of resistant tennis elbow. From a study of 38 elbows of 36 patients they describe a syndrome and signs

of acute tennis elbow but with no response or only temporary relief from local injections of steroid or other treatments and with alteration of the symptoms and signs. Pain radiated up and down the arms; the grip became weak; there were sometimes paraesthesiae in the distribution of the superficial radial nerve; and there was pain on resisted extension of the middle finger, a test that was positive in all cases. The object of operative treatment was to expose and relieve from pressure the radial nerve and its branches in the region of the elbow joint. Excellent or good results were recorded in 35 out of 38 elbows. While it is unlikely that radial nerve entrapment is usual in the common type of tennis elbow, it is a possible cause of tennis elbow that has resisted conservative management. Because of the strong capacity for spontaneous remission any decision about operative treatment should be deferred for at least a year from the beginning of symptoms. But, if operative treatment is required, exploration of the radial nerve and its terminal branches should receive strong consideration.

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[3] Bosworth, D. M., *Journal of Bone and Joint Surgery*, 1955, **37A**, 527.
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[7] Sharrard, W. J. W., *Journal of Bone and Joint Surgery*, 1966, **48B**, 777.
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Progress Report on N.H.S. Reorganization

Will April 1974 bring a rigid, impersonal, hierarchical N.H.S. or will the Government's aim be fulfilled of improved care for patients in an integrated, humane, and efficiently managed Service? Those doctors who have been closely watching events since the first green paper in 1968 will probably wish to reserve judgement. With the N.H.S. reorganization Bill grinding through its early stages at Westminster (p. 301) and the Service's structure at local level still being thrashed out who could blame them? Nevertheless, despite the rhetoric generated by the coming changes, many doctors are probably only distantly aware of the intense build up of activity, and a few, perhaps, have but the haziest notions of what all the rumpus is about. However, all doctors should have found helpful the progress report on the reorganization sent to them recently by the B.M.A. (*Supplement*, p. 29).

Until now the profession, having given its opinions on the general principles of Health Service reform,[1 2] has been largely content to let its central representatives get on with the tedious business of arguing with the Government about the new shape. But the action is no longer confined to Whitehall and its celtic counterparts and it should be drawing in many more doctors and N.H.S. staff during the run up to conversion day. The overall framework is now clear and it is up to the profession at local level to join in the planning. While the general administrative pattern for districts and area health authorities will depend largely on discussions in Whitehall—based on the grey book[3 4]—there should, nevertheless, be scope for local initiative.

The first local bodies to be set up to help with integrating the present tripartite structure are the joint liaison committees. Last summer the Government asked existing authorities that were to be merged to launch these committees, which were described by Sir Philip Rogers in his recent address to the G.M.S. Committee[5] as "essentially bodies which would do the office work of bringing together the various pieces of information—they would not plan . . . ." However, he also forecast that "as the time became short those committees might well have to do rather more of the preparatory work which would eventually fall to the shadow authorities." These shadow authorities, precursors of area and regional health authorities, cannot be set up until the N.H.S. Bill becomes law (probably in the summer). Hence though J.L.C.s have no executive power their influence on future patterns of medical care in their areas will be substantial, for instance, on such basic issues as the division of areas into districts. Thus it is important for the profession to play a full part in their activities, and B.M.A. divisions and local medical committees have been advised on how best this can be done.

In its circular on J.L.C.s the Department of Health wrote that they "will be expected to co-ordinate arrangements for consulting their staff and keeping them informed about future plans." In an organization that exceeds General Motors in size[6] staff relations require a knowledgeable and sympathetic handling that has not noticeably been the case in the present N.H.S. At a time of change this is specially important, and the Government with its N.H.S. Reorganization news sheets is trying to do this. In a comprehensive and practical commentary about preparations for change in the N.H.S. B. Edwards and P. R. Walker[7] devote a chapter to anxiety and change, stressing the uncertainty that will face staff throughout the Service, particularly those in the community services. This group, which includes public health medical staff, will be the most closely involved with the staff commission, the body responsible for ensuring the smooth transfer of staff. The Government, commission, existing authorities, J.L.C.s, and the shadow authorities will all need to make a special effort to keep staff in the picture and to provide advice and support. Otherwise, as Edwards and Walker point out, staff morale will drop and this could seriously hamper the changeover—and the patients will suffer.

The coming two years in the N.H.S. will plainly be hectic; indeed, Edwards and Walker forecast chaos. But they also suggest that from the chaos opportunities will arise. Doctors, locally as well as centrally, should seize these and use their considerable influence to shape the integrated N.H.S. so that it does not become a bureaucratic monster, as some fear,[8] but really provides a better service for patients.

[1] *British Medical Journal Supplement*, 1970, **2**, 111.
[2] *British Medical Journal Supplement*, 1971, **3**, **1**, 33, 98.
[3] *National Health Service Reorganization: England*. Cmnd. 5055. London, H.M.S.O., 1972.
[4] *British Medical Journal Supplement*, 1972, **4**, 21.
[5] *British Medical Journal Supplement*, 1972, **4**, 95.
[6] *British Medical Journal*, 1973, **1**, 160.
[7] Edwards, B., and Walker, P. R., *Si Vis Pacem . . .*, published for Nuffield Provincial Hospitals Trust by Oxford University Press, 1973.
[8] *The Times*, 1 January, 1973, 22.