primary site disease in the sigmoid (skip lesions); disease in an unsually long segment of bowel; and linear confluent intramural ulceration due to a fistulous track running parallel to the bowel lumen.[15]

In practice it is important to distinguish between the two conditions. Routine segmental resection of the sigmoid leads to a high incidence of postoperative complications in Crohn's disease. The most common are delay in wound healing, disruption of the anastomosis with fistula formation and discharging abdominal sinuses, recto-vaginal fistula, and chronic anal fissure or fistula. There is also a high incidence of recurrent disease in the remaining colon or rectum, with consequent symptomatic relapse. Correct diagnosis will prevent the complications of inadequate surgical treatment and encourage a more determined course of medical treatment, including the use of corticosteroids.

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Kidney Donor Cards

Wide publicity was given last week to the case[1] of a Birmingham surgeon who was criticized by the family for removing the kidneys from the body of one of his patients after he had failed in his attempts to contact the parents for permission. This unfortunate episode illustrates the dilemma facing doctors who realize the need for more kidneys to be made available for transplantation. Delay of more than an hour after death before removing the kidneys makes them useless, yet this is the time at which inquiries about the relatives' attitude to the donation of organs can aggravate their distress.

Last year the Department of Health began a campaign[2] for more kidney donors and issued a "kidney transplant donor card" which could be carried by any member of the public who was willing that his kidneys should be used after death. The card, signed by the bearer with the agreement of his next of skin, gives a doctor all the legal permission he needs to remove the organs after death has occurred. So far about 2,000,000 cards have been issued; but many doctors still seem unaware of their existence, though they are available free of charge from the Department of Health. If every doctor's waiting room and every hospital outpatients department had a stock of cards on display surgeons would be spared the unpleasant task of having to discuss permission for operation from relatives at the moment of their bereavement.

[1] *Daily Telegraph*, 17 July 1973.
[2] *British Medical Journal*, 1972, **4**, 500.

Uncertain Metamorphosis

In the late 1950s public health doctors failed to persuade the Government to include them in the terms of reference of the Royal Commission on N.H.S. doctors' and dentists' pay.[1] Thus they were shut out at the start from the N.H.S. doctors' pay review machinery. The impending reorganization of the Health Service has ended their exclusion. Whether the outcome of the Review Body's first assessment of their worth[2] (*Supplement*, p. 11) will be to the liking of the 1,000 or so senior medical staff transferring from local government to the N.H.S. next April is doubtful. Many will be frankly disappointed, for in assessing the top posts of medical officers in regional and area authorities the Review Body has proposed salaries some way below the B.M.A.'s demands. The report recommended £10,248 against nearly £13,000 for top-of-the-scale regional medical officers and £9,354 against over £10,000 for similarly placed area medical officers. On the credit side the Review Body has accepted that the career grade for the specialty of community medicine should be "broadly equivalent to that of consultant and carry a similar salary scale." Furthermore, the report's proposals should enhance the financial prospects for many hospital medical administrators—there are nearly 200 of them altogether—who will also be joining the new specialty.

Lord Halsbury and his colleagues had no easy task, despite the B.M.A. and the Health Departments submitting much of the evidence jointly. Firstly, recommendations had to be made against the background of an incomes policy. This meant a careful comparison between what doctors in a new specialty will be doing in an unfamiliar situation in 1974 and the work their antecedents were doing in 1973—and public health was largely unknown territory to the Review Body's members. Secondly, the Review Body had to make its recommendations in haste, since the new posts had to be advertised quickly; and yet the start of the review was delayed by the profession's difficulties in deciding how community medicine should fit into the existing N.H.S. medical pay structure.[3] So it is hardly surprising that the Review Body admits to proceeding "with caution" and describes its recommendations as provisional.

In their two joint statements of evidence the profession and the Departments explained the present structure and functions of public health as well as what they envisaged would be the "job specification" of specialists in community medicine. Inevitably some of the work will be as before. Local health authorities will still need advice on environmental health, which will be obtained through the medium of "seconded" area health authority doctors[4]—presumably they will be community medicine specialists. Epidemiology will continue to be an important function, and the work of planning district, area, and regional health services will be an extension of existing activities. The School Health Service will be transferred to the N.H.S. and the work of its medical staff will presumably be broadly as at present. As a result of the Seebohm legislation most public health doctors have been relieved already of their social work responsibilities, a point the Review Body makes in explaining why it has not matched the top local authority medical salaries.

Summarizing the differences between the present and future posts the B.M.A. and Health Departments see the regional medical officer carrying out most of the functions of the S.A.M.O. "but over a wider field." This will be so

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