

did not, however, accept unquestioningly that all the features of orthodox antenatal care are of proved benefit and it has asked the DHSS and the Medical Research Council to fund, as a priority, research to determine how best antenatal care can reduce perinatal and neonatal mortality and morbidity.

One aspect of health during pregnancy on which there is no dispute is the danger to the fetus if the mother smokes. An earlier report² from this same committee had called for urgent Government action to discourage smoking. The current report repeats those strong recommendations "that every means, including the banning of advertisements and increasing levels of taxation" should be used: and it adds that a special warning about smoking in pregnancy should be put on all cigarette packets.

The committee's approach to antenatal care is repeated in later chapters; indeed, throughout the report three themes recur. More staff are needed: and among the specific recommendations are a 50% expansion of the consultant grade in obstetrics and gynaecology (with more consultants concentrating on obstetrics); an "urgent" increase in the number of consultant paediatricians to at least the 746 recommended by the Court Report³; and a national recruiting campaign to encourage nurses to train as midwives—whose pay should be improved above their basic nursing salaries. Better facilities are needed: the number of cots for neonatal intensive care should be increased from 176 to 400, and every region should have one or two specialist referral units and between three and five subregional centres providing facilities that cannot be available in every district hospital. Minimum requirements for both equipment and staff should be drawn up by the DHSS in consultation with professional bodies. And better monitoring is needed. The report suggests that each region should set up a perinatal working party with the duty of monitoring obstetric and neonatal work, rationalising services, and reviewing perinatal deaths, and recommends studies of the long-term outcome for infants at high risk of mental and physical handicap.

So this is a detailed, authoritative report which comes down unequivocally on the side of specialist skills and the setting of minimum standards. The committee recognises that there is an "unresolvable dilemma that the understandable preferences of mothers in regard to place of delivery may not be compatible with the requirements for the maximum lowering of perinatal and neonatal mortality." Much of the demand for delivery at home or in small units would disappear if the large units lost their reputation for impersonal lack of humanity. The improvements in facilities and in staffing recommended by the report would help achieve that change by relieving staff of unreasonable pressures on their time—and obstetricians are already responding to the climate of public opinion. Mrs Short's distinguished predecessors (Peel,⁴ Sheldon,⁵ and Court³) were consigned to the shelves of the DHSS with no action taken. Clearly the Government's economic policies will make it reluctant to increase public spending by expanding any section of the NHS. Anticipating this response, the committee has examined the financial implications of its recommendations in greater detail. Experience in Sweden has shown that perinatal morbidity (and so handicap) falls in parallel with perinatal and neonatal mortality. While the committee's detailed calculations may be challenged, the trend is unlikely to be wrong: and the potential saving of £150m in the next 10 years by preventing handicap should appeal to the Treasury. For once, humanitarian and economic considerations point in the same direction: by implementing the report's recommendations fully and quickly the Government would be investing in the future. And what else is our oil money for?

¹ Social Services Committee. *Perinatal and neonatal mortality*. Second report from the Social Services Committee 1979-80. London: HMSO, 1980.

² *First report from the Expenditure Committee 1976-7*. Recommendations 23-32. London: HMSO, 1977.

³ Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976. (Court Report.)

⁴ DHSS Welsh Office Standing Maternity and Midwifery Advisory Committee. *Report of the Subcommittee on Domiciliary Midwifery and Maternity Bed Needs*. London: HMSO, 1970. (Peel Report.)

⁵ DHSS. *Report of the Expert Group on Special Care for Babies*. London: HMSO, 1971. (Sheldon Report.)

Two jubilees in psychotherapy

The Tavistock Clinic and the Cassel Hospital, the two leading institutions in Britain in psychotherapy, are celebrating their diamond jubilees this month. They were founded independently in 1920 as pioneer organisations to provide systematic psychotherapy with a psychoanalytic orientation. Both came into the NHS at its formation.

The Tavistock Clinic in north-west London is an entirely outpatient clinic. From its inception it has concentrated on providing a multidisciplinary approach to psychotherapy and on teaching emerging skills in this discipline not only to future specialists but also to all those concerned with mental health and human relations.

After the second world war the Tavistock Clinic shifted the emphasis of its work from the simple provision of psychotherapy for two reasons. Firstly, the demand for psychotherapy was such that the clinic could clearly never provide more than a tiny fraction. Secondly, it had become apparent that most people in need of psychological help went to sources which were not part of the psychiatric services and, apart from family doctors, might not even be connected with the medical profession: social workers, health visitors, teachers, hostel wardens, or clergymen. For many years, therefore, one of the clinic's main efforts has been to develop and support the work of these primary caregivers.

The work of the clinic continues to be rooted in concepts derived from psychoanalysis and is carried out in multidisciplinary teams composed of members of five disciplines (psychiatry, clinical psychology, educational psychology, child psychotherapy, and social work) working in three departments (adult, adolescent, and children and parents).

The clinic provides a service for outpatients in individual and group therapy, and it also provides marital and family therapy. Training, however, has continued to expand and is now a big part of the clinic's work. Each year about 1000 students from all parts of Britain attend the training activities and some 50 others come from overseas. The training offered is of two kinds. Firstly, there is training for members of the five disciplines to provide specialists who will be able both to practise and to teach elsewhere the dynamic skills practised within the clinic. Secondly, the clinic runs part-time courses, many of which are for the primary caregivers to whom people turn in times of distress. In addition, the clinic provides a resource of skills that can be taken out into the community; and staff work in institutions such as schools, residential homes, and health centres to help the staff in dealing with the psychological problems they encounter in their work.

Clinic staff who have influenced its work substantially and who have contributed to its reputation include John Bowlby, who, with James and Joyce Robertson, studied patterns of maternal care and the effects on young children of temporary separation from their mothers; Henry Dicks, who made important advances in marital disorders; Michael Balint, who introduced new ideas into general practice—his particular approach to training seminars has been carried all over Europe; Wilfred Bion, who made a massive conceptual contribution to the theory of group dynamics and was one of the pioneers of group therapy; and David Malan, whose studies have had a major impact on the practice of brief psychotherapy throughout the world.

The Cassel Hospital in Richmond, Surrey, is predominantly an inpatient hospital but since it came into the NHS its staff have become increasingly concerned in outpatient, community, and liaison hospital work. T A Ross, who was medical director from its establishment until 1934, pioneered brief psychotherapy for the neuroses. After the last war T F Main introduced more direct psychoanalytic psychotherapy, developing a nurse-training programme that teaches psychosocial techniques embodying psychoanalytic findings, and creating a hospital structure to support and reinforce formal psychotherapy as one form of the "therapeutic community." Training for medical and other therapists and for nurses has gradually become more extensive and detailed, while at present efforts are being made to give the training programmes formal institutional shape and independent finance. The Cassel Hospital's experiments in structuring a therapeutic community have become widely known and copied in Britain and in other countries. Training now extends beyond the staff of the hospital in the form of seminars for various professional groups and as courses and placements for numerous visitors.

Before the war the hospital treated a wide range of neurotic and psychotic disturbance. Since the war it has increasingly treated more severely neurotic and borderline patients. It pioneered the inpatient treatment of puerperal mental illness and out of this grew the admission and treatment of whole families. Now there are units for "families and adolescents" and for "single adults." The presence of children and adolescents has led to the provision of a school as well as facilities for infant care.

Earlier concepts of treatment—individual psychotherapy carried out by doctors (usually psychoanalytically trained or in training), supported by a practical environment organised by nurses—have given way to concepts of combined individual, group, and community treatment, in which the hospital routine and structure integrate these different treatment aspects into a coherent whole. Evidence is accumulating that such a structure is a powerful therapeutic instrument which can effect substantial changes in severely disabled personalities relatively quickly.

A primary aim in treatment is to give patients responsibility for themselves and their illnesses. To the extent that the hospital has been able to do this may provide an encouraging model for other small specialised institutions faced with similar problems.

Though the work of the Tavistock Clinic and the Cassel Hospital is different, they share a common ideology and their endeavours complement each other. Over the past 60 years their efforts, while remaining rooted in the discoveries of the consulting room, have become increasingly concerned with the patient in his human environment. Psychiatry stands in their debt for their unwavering devotion to the psychosocial aspects of mental health and mental illness.

Evolution of colonic polyps

Both long-standing familial polyposis and chronic ulcerative colitis predispose to cancer of the large bowel, but most cases arise from one of the many different types of polyps found in the colon and rectum—the polyp-cancer sequence.¹ Surgeons need to be able to differentiate these varying types of polyps and to recognise and deal with those that are likely to be precancerous.

Juvenile polyps occur mainly in children and there is no evidence to suggest that they become malignant. Metaplastic or hyperplastic polyps are common, especially in the rectum, occurring with increasing frequency with age, being found in 95% of rectums removed for carcinoma; but, again, they are thought not to be precancerous. The colonic polyps found in patients with Peutz-Jeghers syndrome have little or no disposition to develop into carcinomas. All these polyps are either inflammatory, hamartomatous, or allergic, and are not truly neoplastic.

Adenomas of the colon are (after the metaplastic polyps of the rectum) the most common type of polyp encountered and are classified as tubular, villous, or tubulovillous. The tubular type is far more common (75%) than the typical villous tumour.² In gross appearance these polyps may be smooth and lobulated, shaggy, sessile, or pedunculated. Most villous adenomas occur in the rectum, and 85% cause symptoms—bleeding, passage of mucus, and watery diarrhoea—and often intussusception. Some villous tumours excrete large amounts of potassium and sodium chloride in the mucous discharge, leading to hypokalaemia, hypochloraemia, and peripheral circulatory failure.³ The incidence of invasive carcinoma is said to vary between 20% and 40% in the villous adenomas, especially in the larger tumours, but in a recent unpublished series from the General Hospital, Birmingham, the incidence was as low as 11%. Treatment of villous adenomas should be by local excision with later treatment planned after conventional histological examination—not by frozen section.

About one-third of all colons resected for carcinoma will have one or more adenomas in addition. These adenomas tend to be found more frequently near the carcinoma, and patients with adenomas are at an increased risk of developing more than one carcinoma—developing at different times.⁴ Patients found to have an adenoma with a focus of carcinoma are at a high risk, perhaps as high as 20%, of having an independent cancer either synchronously or later.⁵ Most adenomas containing focal carcinoma are seen in older patients, and most in the sigmoid colon and rectum. The risk of cancer varies with the size of the polyp, its histological type, and degree of dysplasia. The risk of cancer is low for tumours with diameter of 1 cm but rises to 50% when this is over 2 cm.²

Whenever adenomatous polyps can be seen through the sigmoidoscope they should be removed by diathermy excision. Use of the flexible colonoscope permits removal of polyps above the reach of the sigmoidoscope without subjecting the patient to laparotomy.⁶ Tumours under 5 mm in size, high in the colon, may be left with reasonable safety provided the patient is carefully followed up.

A recent report from New York⁷ presented experience with over 7000 endoscopically removed polyps from the colon and rectum. After analysis of the results with 5786 neoplastic or adenomatous polyps—the authors advocate the routine endoscopic excision of all colorectal polyps. The presence of over 100 adenomas in the colon is considered to be a case of multiple polyposis; this condition is inherited as a Mendelian