this hospital have had excellent results and no significant side effects, and a report of this work is being prepared for publication. I understand that the question of manufacturing the drug for human use in Europe is under consideration by Hoechst Pharmaceuticals Ltd.—I am, etc.,

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- ¹ Chung, H.-L., *et al.*, *Chinese Medical Journal*, 1965, **84**, 232.
- ² Wang, S.-M., *et al.*, *Chinese Medical Journal*, 1965, **84**, 748.
- ³ Joplin, W. H., *Treatment of Tropical Diseases*. Bristol, Wright, 1968.

Local Renal Hypothermia

SIR,—With reference to Professor J. P. Blandy's letter (30 August, p. 542) concerning local renal hypothermia, having now used regional hypothermia in some 300 operations, mostly for the removal of cast calculi of the kidney, I really cannot agree that the need to use this technique occurs as infrequently as is suggested. We have found it particularly useful in providing good protection of renal function while permitting an unhurried operation on the kidney in a dry field.

Statistical analysis and pre- and post-operative clearance studies in our own series¹ and those of other workers² have shown excellent protection of renal function despite periods of ischaemia of up to 115 minutes. In contrast, reported studies on cases of calculi treated without hypothermic protection seldom detail the effect of the operation on renal function. A large proportion of the cases that we have dealt with have been second referrals following incomplete removal of stones by non-ischaemic techniques.

Methods of producing hypothermia such as those described by Marshall *et al.*³ have been used for some 20 years and are perhaps one of the reasons that regional hypothermia has not been more fully utilized. Precisely to improve on this situation we have developed our own method of achieving renal cooling over the past eight years.

I would encourage other surgeons to persevere with regional hypothermia using more recently developed techniques. Professor Blandy's 24 cases seems an insufficient number on which to make adequate judgement.—I am, etc.,

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- ¹ Wickham, J. E. A., Coe, N., and Ward, J. P., *Journal of Urology*, 1974, **112**, 702.
- ² Boyce, W. H., and Elkins, I. B., *Journal of Urology*, 1974, **111**, 307.
- ³ Marshall, V. R., and Blandy, J. P., *British Journal of Urology*, 1974, **46**, 253.

Private Practice in the N.H.S.

SIR,—If surgical private practice is to continue throughout Great Britain the private beds must remain in our hospitals as at present. Once they are "phased out" it would be only too easy to clamp down progressively on independent private facilities, as has been indicated in the recent consultative document (23 August, p. 497).

It is therefore our opinion that if we allow the pay-beds to go, then for ever after we shall have to fight a rearguard action, inevitably ending in retreat into full-time contracts with all that this implies (for ex-

ample, the recent freeze on pay increments due to anti-inflation action).

It has been shown^{1,2} that it is in the practical interests of the N.H.S. to keep the private sector geographically within the main hospitals where the consultants work. There is also considerable benefit from the extra money and incentive that private practice brings into the N.H.S. The only reason for removing pay-beds is political ideology, and we know where this will eventually lead.

We believe that in the interests of the N.H.S. we must keep the pay-beds as they are. When it comes to the crunch there may be no alternative to resignation or strike action, and in view of the nature of their work it could well be that the surgical specialties may have to take the lead.—We are, etc.,

J. J. SHIPMAN

ROGER H. ARMOUR

P. R. B. PEDLOW

Lister Hospital,
Stevenage, Herts

- ¹ *Fourth Report from the Expenditure Committee* (Employment and Social Services Subcommittee). London, H.M.S.O., 1972.
- ² *Private Practice in National Health Service Hospitals*. Cmd 5270. London, H.M.S.O., 1973.

SIR,—The present attack by the Department of Health and Social Security on private practice led me to perform a detailed analysis of my working time during the week 11-15 August 1975. My post is that of a general surgeon working away from the teaching centres in the south of England, and I suspect that comparable figures could be produced many times over by those in a similar position. None the less, I feel that statistics of this type need to be publicized simply to indicate the benefit at present obtained by the N.H.S. from its part-time consultants.

My working hours and minutes were recorded in detail by careful "clock-watching" from 0750 on the Monday until 1715 on the Friday. The week was probably above average in hours worked, by a small margin, but was by no means chosen as the busiest—indeed no choice was involved as I started the analysis on a typical Monday morning.

TABLE I—Hours Worked 11-15 August 1975

	N.H.S. h min	Private h min
Operating	16 40	3 05
Outpatient consultations ..	8 15	5 50
Ward rounds	7 30	5 50
Travelling	2 35	1 05
Administration and paperwork	1 35	4 30
Domiciliary calls	30	30
Clinical meeting	35	
Total	38 20	15 50

Grand Total = 54 hr 10 min.

Table I shows the hours and minutes worked under various headings. My total of about 38½ hours of N.H.S. work is seven hours more than my contracted time and this excess varies from 0 to 15 hours each week, mainly in relation to time spent on emergencies. The 16 hours spent on private work is much of it in the evenings and is probably an average figure.

Table II shows the item-of-service analysis. All the operations listed were performed personally and the classification into "major," "intermediate," and "minor" is that used by the British United Provident Asso-

TABLE II—Item-of-Service Analysis

	N.H.S.	Private
"Major" operations ..	9	1
"Intermediate" operations ..	4	3
"Minor" operations ..	3	1
New O.P. consultations ..	42	8
Old O.P. consultations ..	63	7
Ward consultations ..	57	9
House calls	1	1

ciation. (Table III illustrates this classification for those unfamiliar with it.) Table II indicates an N.H.S. work load which is five times that performed in private practice. This is borne out in operating terms by table III, which analyses the operations performed, and by reference to the time spent actually operating as shown in table I—more than five times longer spent in N.H.S. theatres than privately. The disparity in total working hours for the two systems (N.H.S.=2½ times private instead of 5) is attributable to the longer time per patient spent in private consultations and the somewhat longer time on paper work, telephoning, and administration, as shown in table I.

TABLE III—Operations Performed

Type	N.H.S.	Private
"Major"	Simple mastectomy Hemithyroidectomy Laparotomy; ileocolostomy Partial gastrectomy Retropubic prostatectomy Total gastrectomy Subtotal thyroidectomy Retropubic prostatectomy Right hemicolectomy	Cholecystectomy
"Intermediate"	Resuture burst abdomen Hernia repair Exploration of sinus "Cutback" for covered anus	Hernia repair Excision of hydrocele Hernia repair
"Minor"	Manual dilatation for haemorrhoids Cystoscopy Manual dilatation for fissure	Manual dilatation for haemorrhoids

I suppose that I would be considered indiscreet to indicate the exact sums involved in remuneration; suffice it to say that I am maximum part-time on the fourth incremental point (and apparently staying there!) and that my private income for the week in question was just in excess of three times my N.H.S. income. This figure, coupled with the five times greater work load for the N.H.S., gives a 15 times difference in remuneration. This seems to me like "good value for money" for the N.H.S., and the present attempt to destroy the system, if successful, can lead only to a sharp increase in emigration and a gross deterioration in the service.—I am, etc.,

JAMES GROGONO

Marlow, Bucks

SIR,—Mr. R. S. Murley (6 September, p. 596) writes with his usual rational lucidity on this very important subject. However, he misses the most important and dangerous portent. The profession is not only threatened by a separation between the N.H.S. and private sectors and a starvation of private beds. I see the day not very far away when it will become illegal to practise private medicine of any kind and by any practitioner within the United Kingdom.

Surely now is the time for the profession