Notice

Thoracic medicine in the regions

As long ago as 1960 the Standing Tuberculosis Advisory Committee, considering the future of the chest services, recommended that chest physicians and chest units should be part of the general hospital complex, and this advice was reinforced by the publication of the document *The Future of the Chest Services* by the Central Health Services Council (Ministry of Health) in 1968. This publication and in 1978 the Joint Committee on Higher Medical Training, Respiratory Medicine, both emphasised the fact that there was also a place for specialised thoracic units that would be responsible for special diagnostic problems, specialised investigations, research, and training of senior registrars. Generally, these units would be centred in major teaching centres and at least one would be required in each region.

Recently the British Thoracic Society and the Royal College of Physicians approved a document, *Requirements for Thoracic Medicine*, that provides guidance for staffing and for inpatient and outpatient facilities for thoracic medicine in district general hospitals.

In response to evident widespread lack of awareness about the more specialised aspects of thoracic medicine, the Council of the British Thoracic Society asked the Regional Representatives' Subcommittee to draw up an outline of the functions of a regional thoracic centre.

The resulting document was considered by the Council and adopted as official policy of the British Thoracic Society. It is reproduced below in the hope that it may be a helpful source of reference for administrators, clinicians, and others who have responsibility for the provision of thoracic medical services in each region, and that it may be of interest to others with similar responsibilities abroad.

SPECIAL FUNCTIONS OF THORACIC MEDICINE (NON-DISTRICT BASED)

Regional
Thoracic surgery
Unit for the care of cystic fibrosis
Bronchial challenge testing
Special aspects of occupational lung disease
Chronic ventilatory support

Supraregional
Participation in lung and heart/lung transplantation programmes
Bronchoscopic laser therapy

Subregional
More specialised respiratory physiology
  Body plethysmography
  Exercise testing
Specialised bronchoscopy
  Bronchial lavage
  Screening for biopsy of mass lesions, transbronchial biopsy
Needle biopsy
High speed drill biopsy
Open lung biopsy
Oncology
  Assessment for treatment
  Liaison with thoracic surgery and radiotherapy
  Cytotoxic chemotherapy
Lung pathology: specialised interpretation of small biopsy specimens
Specialised imaging (computed tomography, magnetic resonance imaging, digital subtraction angiography)

At all levels there should be *research* and the *teaching* of undergraduates and postgraduates. Senior registrar training should rotate through regional units.

[1] British Thoracic Society. Requirements for Thoracic Medicine. *Thorax* 1984;**39**:400.

Correction

Industrial benefits and respiratory diseases

In the editorial by Dr FG Ward (April 1986;**41**:257) there is an error in the definition of pneumoconiosis quoted from Dr Raymond Parkes. The word mineral should appear instead of "material." The definition of pneumoconiosis should read: "the non-neoplastic reaction of the lungs to inhaled mineral or organic dust and the resultant alteration in their structure excluding asthma, bronchitis and emphysema."

Correspondence

Industrial benefits and respiratory diseases

SIR—I read with interest Dr FG Ward's recent editorial (April 1986;**41**:257–60). Two points concerning the adjudication of benefit claims do, however, require clarification.

Firstly, Dr Ward states (p259) that in cases of fatal disease appeals are made to a Social Security Appeal Tribunal (SSAT), which "consists of a lawyer, an employee's representative, and an employer's representative." This is not strictly correct. National insurance local tribunals, which used to hear such cases before the advent of SSATs, *were* constituted in this manner. Since 1984, however, the wing members of SSATs have been "persons appearing to the President to have knowledge or experience of conditions in the area and to be representative of persons living or working in the area" (Social Security Act 1975, Schedule 10, para 1 (2), as amended). It may be that in practice some SSATs are still made up in the same way as the former NILTs, although this is not what the legislation now says. This change was purportedly made in order to achieve a broader representation of society on such tribunals.

Secondly, Dr Ward states that "either the claimant or the Secretary of State can appeal to the Social Security Commissioner on a point of law" from the SSAT. In fact, in such cases it is the adjudication officer (albeit a civil servant in another guise) and not the Secretary of State who enjoys such a right of appeal, along with the claimant. Furthermore, appeals may be brought on a point of law or of fact, or both, although the DHSS is currently seeking (via the Social Security Bill 1986) to restrict this right of appeal to matters of law alone.

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**This letter was sent to Dr Ward, who replies below.

SIR—I accept both of Mr Wikeley's points and I am grateful for his comments.

My editorial was intended, of course, as something of a layman's guide to the Industrial Injuries Scheme and my general explanation undoubtedly skipped over many of the finer points of the adjudication system.

Firstly, the rules for Social Security Appeal Tribunal members did change in 1984 as described by Mr Wikeley. Secondly, on appeals to the Commissioners I overgeneralised. My original intention was to describe appeals from Medical Appeal Tribunal decisions but unfortunately the final draft did not reflect this.

For those interested in the subject I recommend the following further reading:

Social Security Appeal Tribunals—a guide to procedure. London: HMSO, 1985.

The annual report of the Chief Adjudication Officer for 1984/85 on adjudication standards. London: HMSO, 1985.

Ogus AI, Barendt EM. *The law of social security*. 2nd ed and supplement. London: Butterworths, 1982.

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Thoracic medicine in the regions: study of sleep and breathing disorders

SIR—I hope it was only accidental that the investigation and treatment of sleep and breathing disorders was omitted from the list of functions of subregional, regional and supraregional thoracic medicine units 1986;**41**(June):496. It is already effectively a supraregional service with at least ten centres to my knowledge actively involved in the care of patients with mainly obstructive sleep apnoea. This service requires expertise and specialist equipment rarely paid for by the NHS, but usually out of research monies.

Failure by even the BTS to recognise this growing speciality within respiratory medicine when preparing "authoritative documents" will only hamper the chances of acquiring proper funding for it in the future.

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**Inquiries resulting from Dr Stradling's letter revealed that the omission was indeed accidental. A correction appears below.—Ed.

Correction

Thoracic medicine in the regions: study of sleep and breathing disorders

In the list of special functions of thoracic medicine (non-district based) which was prepared by the Regional Representatives Subcommittee of the British Thoracic Society and published in the June issue of Thorax (p496), "the investigation of sleep and breathing disorders" should be included among the functions that should be provided at regional level. Its omission arose through an oversight in the course of preparation of the document.

Book notices

Surgery of the Oesophagus. TPJ Hennessy, A Cushieri. (Pp 363; figs; £35, hardback.) London: Baillière Tindall, 1986. (ISBN 0-7020-1095-2.)

This multiauthor book is intended for surgeons who want to develop an interest in oesophageal surgery. In writing such a book, there are two possible courses to follow: either to give dogmatic statements based on personal clinical experience or to cover all possible methods of treatment that have appeared in the literature. This book tends to follow the second course, and a trainee who lacks experience has a rather bewildering choice. There are 11 chapters, covering anatomy, physiology, diagnostic techniques, and specific