thereby providing the whole panoply of medical, psychological, social, and educational services for these children. When confronted with the choice between providing a children's ward within a regional (adult) centre organised on a specialty basis and "providing regional children's centres which bring together the various specialties and deal solely with children," the Court Committee¹ strongly favoured the latter, "because these children... need to have the overall paediatric oversight associated with a comprehensive children's department."

The officers of the North-west RHA and some adult oncologists feel quite differently and have planned to remove an excellent paediatric oncology unit from a children's hospital and place it in a large oncologically based hospital. It has been necessary for the Minister of State for Health to set up an inquiry team to advise independently on the situation. Obviously, such a team cannot be involved each time a controversial decision is taken by an RHA.

This issue therefore raises two important questions. (1) Do the DHSS and the RHAs accept the general direction of development of regional children's units within comprehensive children's departments? (2) Who should professionally advise an RHA on matters pertaining to child health? The views of the paediatric sub-committee (of the Regional Medical Committee) have been disregarded in this instance. Should we make an exception in the case of child health and have a travelling team of troubleshooters continually adjudicating for the DHSS? There must be a place for a regional health authority committee, a mixture of professional and informed lay members, to ensure that the officers of the authority accept honest and sound advice from the appropriate source. The lesson has been learnt at district level in the North-west Region at a tragic cost.² Do we have to repeat the lesson at regional level?

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¹ Committee on Child Health Services, *Fit for the Future*, 1978, vol I, p 193. London, HMSO, 1978. (Court Report.)

² Tribunal of Enquiry into the Death of Andrew Philip Brown at Rochdale Infirmary. Report of North-west Regional Health Authority and Rochdale Area Health Authority, 1975.

Choice of treatment in operable lung cancer

SIR,—We feel that your leading article on the choice of treatment in operable lung cancer (14 April, p 970) was misleading. The operative mortality for resection is now around 5%, the five-year survival rate is 27%, and the 10-year rate is almost 18%¹; postoperative morbidity is not a serious problem. No results which remotely compare with these can be offered by radiotherapy.

While it is true that radiotherapy carries no immediate mortality, your leading article made no reference to the late mortality, by no means negligible, from such causes as tracheo-oesophageal fistulas. Nor did it refer to the unpleasantness of the treatment itself, which has led many patients who have had both radiotherapy and surgery to say that they preferred the latter. To suggest that there is a "near

certainty" of an increase in the life span of two to three years after treatment with radiotherapy seems unduly optimistic.

The statement that "many of those hesitant or unwilling to take the risk may survive just as long without operation" is based on virtually no evidence, and is quite contrary to our experience of the fate of the patients who have not accepted our advice to have an operation. Surgery alone still offers the only real hope of prolonged survival. Radiotherapy, although invaluable in the palliation of symptoms, can offer no results which compare with it, and, on the available evidence, patients should not be told that they may do just as well if nothing is done.

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¹ Belcher, J R, and Rehahn, M, *British Journal of Diseases of the Chest*, 1979, 73, 18.

Hypnosis

SIR,—Dr H G Kinnell (17 March, p 751) argues that the case for the "specific usefulness of hypnosis" is not proved, and your leading article on hypnosis in the NHS (7 October, p 978) suggests that its hospital use is limited to psychiatrists and to a few specially trained psychologists working under the clinical responsibility of a consultant psychiatrist. I hope that these are not the last words because there are good reasons for supporting the cardiological uses of hypnosis.

Many patients are disabled because the pulse rate rises excessively in response to physical and emotional changes and the blood pressure climbs too high for too long in response to common-or-garden stimuli. Relatively small amounts of exercise produce the symptoms and signs usually associated with severe effort, and the subjects commonly are "played-out by continuous work, disturbed sleep and continuous strain"¹ or "exhausted by constant strain day and night... affected by sleeplessness... unable to go away and leave their posts."² Today it is recognised that profound abnormalities of the blood lipids, sugar, uric acid, and coagulation can also occur when exhaustion follows high and prolonged arousal.³

It is not known how exhaustion and hyperarousal produce this condition of sympathoadrenal hyperactivity and instability, where homeostasis has such a weak grasp; but the processes must be reversed before good health can be recovered in the majority of cases of severe arrhythmia, angina pectoris, acute coronary insufficiency, myocardial infarction, and hypertension. If we fail to reverse them we may be tempted to adopt symptomatic remedies such as long-term beta-blockade or even open heart surgery if arteriography happens to show inviting coronary arterial narrowings.

The major obstacle to reversing the processes and the major problem of cardiac rehabilitation is to persuade the patients "who would rather die than submit to enforced quietude"⁴ to rest and be still for long enough to get well. In this department of cardiology many of these warriors are dealt with expertly, and greatly to the relief of the rest of us, by a general practitioner who teaches autohypnosis and employs group hypnosis to provide an adequate degree of control over behaviour, and the enjoyment of escape from tachycardia, cardiac pain, and excessive hypertensive responses to life events.

I have not proved whether this colleague has "specific usefulness" but I do know that the staff and patients would not like to be without his strong and beneficent influence.

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¹ Lewis, T, *The Soldier's Heart and the Effort Syndrome*. London, Shaw and Sons, 1918.

² Mackenzie, J, *Diseases of the Heart*. London, Oxford University Press, 1908.

³ Nixon, P G F, *Practitioner*, 1976, 217, 765 and 935.

⁴ Dunbar, F, *Psychosomatic Diagnosis*. London, Johnson Reprint Co Ltd, 1968.

SIR,—Having benefited from instruction in the theory and application of hypnosis, I feel that Dr H G Kinnell's letter (17 March, p 751) merits some comment. As a GP I cannot speak about any possible use for hypnosis in the field of psychiatric medicine but now, after some nine years of practical experience, I can hardly imagine my own work without this valuable aid in therapy.

In what may just be described as tension states, be they physical, mental, or emotional, many of the "difficult" problems of general practice can be greatly helped, if not cured—these same problems having failed to respond to more conventional measures. The list could go on and on but includes dysmenorrhoea, migraine, nocturnal enuresis, the smoking habit, phobias, persistent warts, and many aspects of pain, including that of terminal malignancy.

I would like to answer some specific points in Dr Kinnell's letter. Is hypnosis of scientific value? The patient who is helped knows he is better able to control his problem and the question becomes academic. Lack of awareness of doctors and dentists surely stems from the failure of so many medical and dental colleges to implement the recommendation of the BMA subcommittee appointed some 25 years ago, to inform undergraduates and arrange training for postgraduate students in hypnosis.¹ This function is certainly fulfilled by the courses arranged by the British Society of Medical and Dental Hypnosis, to the benefit of many practitioners.

There are dangers in hypnotherapy, which is why Waxman insists that doctors and dentists, with their specialised knowledge and ethical code, are the people best qualified to assume full clinical and legal responsibility.² Patients' co-operation most certainly develops but degeneration of this to dependence on the therapist is surely the fault of the therapist, who should act only as a teacher, enabling the patient to realise that his tension is controllable and encouraging what Hartland refers to as ego strengthening.³

Clinical anecdotal tales abound, of course, and are of great importance to those actually involved. Can one dare to suggest that even in the biggest double-blind crossover trials all patients are still individuals on some doctor's list and therefore "anecdotal," whether they benefit from the therapy or drop out because of some toxic side effect. Hypnotherapy in properly selected cases is free from toxic side effects. It is economical, except for the investment of a certain amount of time in the patient. Quick induction techniques allow virtually all such time to be treatment time and often much can be achieved within a few minutes. Techniques depend on the experience of the therapist and waking hypnosis or regression, phantom or not, can all be of value in helping the patient to acquire some control