shown that the basic abnormality is reversed blood flow due to incompetence of valves in the internal spermatic vein, nearly always on the left side. This results in pooling of blood around the testicles and an increased scrotal temperature, the extent of which depends on the size of the varicocele.[15] Spermatogenesis is depressed on both sides,[16] probably as a direct result of the increased temperature rather than of reflux of adrenal metabolites.[7 17 18] Typically seminal analysis shows a depressed sperm count, with poor motility and an increased percentage of abnormal forms.[19]

Clinically the condition may be diagnosed by careful examination with the patient standing in good light. Small varicoceles are shown up by the Valsalva manoeuvre; they are important, since fertility may be improved just as much after ligation of a small as of a large one.[20 21] This finding has led to a search for varicoceles that are not detected on routine examination but suspected as a result of decreased left testicular firmness or increased venous pressure during a Valsalva manoeuvre. Comhaire *et al*[22] carried out scrotal thermography in 36 men suspected of having subclinical varicocele and the results were abnormal in 19; in 16 of these patients venography confirmed reflux in the spermatic vein. The simple non-invasive technique of thermography, widely available for early diagnosis of cancer of the breast, appears to offer a valuable screening test for minor or subclinical varicocele, and this test is also useful for postoperative assessment of cases with a few residual veins.

Varicocele may be corrected operatively by the supra-inguinal,[23] inguinal,[24] or scrotal approach,[6] and each route has its advocates. The inguinal approach is probably the simplest, since the enlarged veins unite at the internal ring, and both the internal spermatic vein and any secondary varicosity in the cremasteric venous system[25] can be dealt with simultaneously. The suprainguinal approach suffers from the disadvantage that the secondary cremasteric incompetence may be missed, and the scrotal approach is associated with a small but definite incidence of testicular atrophy.[26] Most varicoceles affect only the left side; bilateral varicoceles have been reported in 15% of cases, but the right side was affected alone in only 0·6% of cases.[27]

The results of surgery are good. In a recent analysis of 986 cases Dubin and Amelar[27] described improvement in the quality of the semen in 70%, and 53% of the patients' wives became pregnant. The results were better for patients who had had preoperative sperm counts of over 10 million/ml (85% semen quality improved, 70% pregnancy rate) than for patients who had preoperative counts of less than 10 million (35% improved, 27% pregnancy rate). The results in the latter group were improved by the empirical use of postoperative human chorionic gonadotrophin (55% improved, 45% pregnancy rate). These results are exceptionally good, and the high pregnancy rate implies that the operation on the varicocele was only one incident in the integrated management of both marital partners.

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Phased justice?

A trusting doctor might concede the Review Body's eighth report (p 1360) to be phased justice. But how many trusting doctors are there left? A decade or more of Government interference in the profession's independent machinery for pay review has made the average doctor suspicious. Since August 1975 suspicions have not been lessened by pay restrictions and taxation policies that have struck savagely, and often unfairly, at doctors' take-home incomes, seriously distorting pay relativities within the profession. The Review Body made its views quite clear in last year's report.[1] This year it has done so again: "It is the failure to take account of the need to correct these injustices that, in our view, is the principal cause for the decline in the morale of the medical and dental professions over the last three years. We have said before—and we repeat now, because the position has undoubtedly worsened—that, if this decline is not reversed, the consequences for the National Health Service and for the community as a whole will become increasingly serious."

The profession has previously urged the Review Body to publish recommendations on what size award NHS doctors should receive, disregarding government norms.[2] Until now the Review Body has eschewed the idea. This time it creates a welcome precedent by publishing two sets of recommendations: one giving "fully up-to-date" levels of pay at 1 April, restoring what it sees as the "proper relationship" of doctors' rewards with those of other occupations; and the other the amount to be paid on 1 April 1978, which is within the Government's 10% guidelines. The Review Body acknowledges the importance of the Government's pay policy and proposes that the £135m difference between the two sets of recommendations should be paid in two phases—April 1979 and April 1980.

Sir Ernest Woodroofe and his colleagues are not naive and presumably they view their work as of value to both doctors and patients or they would have resigned their thankless task long ago. In their eighth major review they confronted a delicate political dilemma, made no easier by their forthright support of the doctors' case last year.[1 3] Had they dutifully toed the Government line and proposed a simple 10%, the profession would have lost all faith in their independence. Had they recommended 30% now to bring doctors' pay up to date, the Government would have rejected it out of hand. But as the Cabinet had already issued promissory notes to the firemen, policemen, and the military it would have been extremely difficult for ministers to refuse a similar deal for NHS doctors. So the Review Body recommended accordingly.

But the four weeks taken by the Government before announcing its acceptance of the eighth report suggests that there were political problems. Indeed, the Secretary of State admitted as much at his press conference. Presumably, the Cabinet's biggest worry was the effect it might have on other settlements in the public sector, particularly NHS workers, some of whom have been very restless over the 10% norm. Then there was the question of the consultants' new contract, which if it is to be of any use at all in reviving their spirits must attract extra money—and not at the expense of other doctors or of other parts of the NHS. Will the Treasury find new money or does the Government envisage paying for the contract out of the £135m and whatever additional "cost-of-living increases" the profession gets over the next two years? Or perhaps it has not looked too far ahead. After all, an election is not far away and, whichever party wins, Cabinet responsibilities will almost certainly have changed by the time these awkward questions have to be answered.

While the report does little more than record changes in manpower—a few more GPs, mainly women or overseas graduates; a rise of 122 consultants in England and Wales, but still gaps in the shortage specialties; a falling proportion of junior staff from overseas; and serious shortages, still, in community medicine—the Review Body has examined doctors' work load. GPs will be disappointed that despite some strongly argued BMA evidence about their case (p 1365) the referee's answer is "not proved." As a recent paper by Dr John Ball[4] pointed out, measuring work load in general practice is not easy. But most GPs are convinced that in terms of responsibility and complexity their job is becoming more difficult: measurement of mere hours worked or cases seen is too superficial a judgment. Perhaps the GMS Committee should persuade some members of the Review Body—or its staff—to spend some time with practices to get a real idea of the sharp end of medicine.

It is any easier to estimate the work load of consultants? The Office of Manpower Economics—the staff who service the three review bodies—has certainly had a good try and the results are published in an extensive appendix to the report. Despite the response being a disappointing 51%—10% of all consultants—the sample survey should provide a baseline because, in reviewing pay, trends are certainly as important as a single snapshot of work load. The July 1977 snapshot shows that whole-time consultants worked 48·7 hours a week, made up of about 39·3 on clinical or equivalent work (including travelling time between hospitals); four on NHS committee work; 4·3 on administrative work; and 1·1 on undergraduate teaching. Nine sessions and maximum part-time consultants worked about 43 hours a week, but in "whole-time equivalent terms" part timers worked longer hours than their whole-time colleagues. Quite possibly, however, by next year consultants will have their new work-sensitive contracts, which should give a clearer picture of what each consultant does and ensure that he is paid primarily for that. This brings us to the critical question: How will the Review Body price the new contract? For it will be of little help to the NHS unless new money is produced. While it would have been unreasonable to have expected firm five-figure promises, consultants will be uneasy that the Review Body has confined itself to a foggy description of the dilemma of the changeover. A positive statement could have done much for consultants' morale. What the report says might just prompt some consultants to wonder whether voting for a new contract is worthwhile. They should not be deterred from supporting it, but the CCHMS should ask for urgent clarification of this vital paragraph in the eighth report.

As promised last year,[3] the Review Body has made a start in sorting out the distorted internal differentials by awarding graduated percentages to hospital doctors within the overall 10% this year and proposing similar differential awards next year and in 1980. This will please the consultants, especially the younger ones, who will benefit—some by as much as 41·7%, according to the BMA. Junior staff will be less happy because their increases (approaching 8% overall, including UMTs, this year and for some well over 20% eventually) are the ones which will be affected. Presumably the Review Body feels that as the pay of most juniors has been less badly depressed than that of many consultants this was the fairest way of restoring appropriate differentials. Though many doctors may judge junior staff to have had a reasonable deal overall since 1975, juniors may well see themselves as having been penalised for the success of their own revised contract. It is doubtful whether junior doctors will be entirely mollified by the Review Body at last agreeing that their basic salary covers a 40-hour week or by again deploring their excessively long hours of work and urging action—in parallel with discussion on the consultants' contract. As a reduction in work load was one of the Hospital Junior Staff Committee's original objectives this is a fair point.

How doctors receive this pay award will rest on their judgment of national versus personal interest. As one of the hardest working groups in the community they will be annoyed that no productivity element has been included in the award, despite admitted phoney productivity deals in public sector industry.[5] Some economists and politicians fervently pursue a permanent incomes policy as if it were the economic holy grail. The average doctor can be only a bemused bystander to the esoteric arguments. But as a pragmatic scientist he will probably accept that there is some cause and effect in the fall in inflation after pay restraint. To this extent he will acknowledge the award and its promises to be as much as could be expected in 1978. Certainly the total of 30·4%, albeit phased, matches the BMA's target.

He will, however, be much less happy about the use of pay policies to level incomes as well as to restrain them. Government must think hard about the long-term consequences of this aspect. Incentives have a place in most cultures. Medicine requires a long training; it is a physically and mentally demanding occupation, as well as being emotionally and intellectually rewarding. The responsibilities and liabilities grow and the incentives must match these if medicine is to flourish. The Government's acceptance of the eighth report is a faltering step in the right direction. If, however, doctors find next year that the 1978 report was a mirage the consequences for the NHS will be disastrous.

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Correction

In the leading article on "Describing new syndromes" (14 January, p 64) the first sentence of the second paragraph should have read "Recently Garlinger *et al*[1] have used this approach to try to distinguish between a complete and partial trisomy 22 and so to identify a recognisable new clinical entity, partial trisomy 22."