the Charities. Well, maybe; but if that view is adopted too enthusiastically, there is a danger that the highest quality research will retreat to institutes and university campuses, and that the links between clinical practice and fundamental research will be weakened. If we fail to have the one nourish and influence the other, then research will miss the important opportunities as they present themselves, and clinical standards will fall away.

The NHS must continue to nurture clinical research; not just research related to patients, but any high quality research by clinician-scientists, whether at the bedside or in the laboratory. It would be ironic indeed if the new NHS R&D policies led to the eclipse of the outstanding clinician-scientist, to be replaced by the clinician-manager, director of quality assurance or implementer of guidelines. I suspect that it will take vigilance and political skill to ensure that this doesn’t happen, and that a sensible balance is achieved amongst competing research interests.

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Textbook of diabetes. Edited by John C Pickup and Gareth Williams. Blackwell Science Ltd, Oxford, 1997. 1,232pp. £195.00. (H/B).

Textbooks like this one which weighs 5.5kg and has 110 contributors, have been compared pejoratively to the dinosaurs, with the implication that their extinction is imminent. Continuing the simile, it is worth pointing out that the dinosaurs were extraordinarily varied and successful and still pull a good crowd 65 million years later. I want to stick up for the ‘old-fashioned’ textbook which is basically a series of review articles corrected and harmonised by the editors. For someone like me who cannot use the Internet (or even do a Medline search) it is essential to have an authoritative textbook close at hand. Furthermore, when it comes to looking up an ordinary clinical point — frequency and treatment of frozen shoulders in diabetes cropped up in the clinic last week — a textbook is much quicker. I looked up frozen shoulder in the index to this book, was directed to Chapter 63 and had the answer in 3 minutes. One of my colleagues spent 10 minutes trying to access the Internet and the other eventually produced a mountain of abstracts from Medline. My vote still goes to the old-fashioned textbook as a general reference source. Of course, if you want to know the very latest about the genes causing MODY 1 and 3, this textbook is no good because the papers were published in Nature while it was being printed. Apart from dating relatively quickly, another disadvantage of the mega textbook is that it gives you things you didn’t want. For example, most clinicians will probably never read Chapters 6 and 7 on the ultrastructure of the islets of Langerhans or the structure and phylogeny of insulin, although both are fascinating.

What makes Pickup and Williams different from its equally heavy competitors is the beautiful layout with exceptionally clear figures and a generous use of colour photographs. The general standard of all the chapters is high and several are outstanding. Those which are either especially interesting or not found in similar books include ‘diabetes in developing countries’, ‘genetic counselling’, ‘sexual function and contraception in diabetic women’, ‘eating disorders’ and ‘a patient’s view of diabetes’. The last is by Teresa McLean, one time cricket correspondent of the Financial Times, and her account of what irks patients about diabetes care in the UK in 1996 should have been sent to all politicians before the recent election.

Problems? The title of virtually every chapter is ‘The X of diabetes mellitus’. Why can’t they simply call it diabetes? In any case, ‘Insulin dependent diabetes mellitus’ is a tautology because there isn’t an IDDI (Insulin dependent diabetes insipidus). Several of the figures have incorrect attributions – for example, 33.10, 33.11 and 33.12 all of which, to add insult to careless editing, are from papers of which I am an author! The problem seems to be more general than Chapter 33 – Figure 67.3 is incorrectly attributed. A final grouse is that I didn’t get any CME points for reading the book, which is a must for every library and diabetic department.

Conflict of interest: Professor Tattersall co-authored a small part of Chapter 22.

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Clinical Intensive Care. By Ken Hillman and Gillian Bishop. Cambridge University Press, Cambridge, 1996. 835pp. £35.00.

According to the preface, this book is intended for junior clinical staff who rotate through an intensive care unit (ICU), as well as for other physicians involved in the management of critically ill patients in an ICU, but not as their primary specialty. It is co-authored by intensive care physicians practising in a major teaching hospital on the outskirts of Sydney. The authors have set themselves a difficult task. On the one hand, a book such as this needs to be comprehensive enough to provide some kind of outline for the junior doctor working in a stressful and frequently alien environment that demands a high level of decision making, with clinical consequences that are often uncomfortably immediate. On the other hand, intensive care, by definition, demands a high level of consultant-
based input, and to provide treatment algorithms for inexperienced clinicians to follow slavishly is an ineffective means of tailoring therapy supportive to the critically ill patient with complex problems.

The opening chapters deal with the organisation of a typical intensive care unit, routine care of the critically ill, and economics, outcome and ethics. The authors rightly state that intensive care nurses and non-clinical personnel frequently assume a range of responsibilities not normally attributed to non-medical staff. But the authors spend more time dealing with issues relating to quality assurance and audit, rather than giving some idea of the management and clinical structure of a typical unit within which such independent clinical decision making can be made. The chapter dealing with routine care of the critically ill starts promisingly enough, although the mnemonic to assist junior medical staff in day to day assessment may not be relevant across different medical cultures. Daily physical examination of patients is important, as is the need for regular biochemical and haematological examinations, and attention to indwelling tubes and cannulae. The section dealing with routine care of ventilated patients is less useful, and issues such as gastrointestinal tract haemorrhage, and nutritional requirement overlap considerably with other sections of the book.

The rationale for the organisation of the rest of the book is not always clear; Chapter 10 deals with cardiopulmonary resuscitation, Chapter 11 with temperature disorders and Chapter 12 with transport of the critically ill. Chapters on monitoring techniques and the assessment of acid-base balance are interspersed with others dealing with clinical management issues such as acute cardiovascular failure. A number contain useful ‘troubleshooting’ tables, highlighting questions and issues that may be particularly relevant to the clinical topic dealt with in the preceding pages. This is certainly an excellent idea, although not all chapters have such a summary, and not all tables necessarily deal with the most urgent or critical issues within each clinical topic. Further, the authors have been ill served by the publishers who frequently have split these tables between pages.

The clinical content of the book is sound and comprehensive and the authors are clearly masters of their topic. Since management styles and approaches differ not only between countries but even within hospitals, it is not surprising that any reviewer can highlight areas of controversy. Nevertheless, the emphasis for junior doctors must be towards safety rather than intellectual debate and to that end the book serves its purpose well. A number of chapters are particularly instructive, including those dealing with microbiology/ unidentified infections, and with fluid and electrolyte replacement which is well illustrated with tables and line drawings.

Would I purchase the volume for myself? The market for middle range ‘manuals’ in intensive care is already well served by books by Oh (Butterworths) and Hinds and Watson (Churchill Livingstone). However, the volume under review is certainly a worthy addition to a burgeoning literature.

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The Arts in Health Care: a palette of possibilities. Edited by Charles Kaye and Tony Blee. Jessica Kingsley, London, 1997. 290pp. £18.95.

In the last twenty years hundreds of articles have been written on art in hospitals, by architects, art critics and historians, artists and arts curators and committee persons. However, there have been few books, so Kaye and Blee’s is a most welcome and useful vademecum in this thriving field, especially as they are NHS administrators who ‘wanted to produce something that would interest all those who work in the NHS . . . and . . . gain the attention of chairmen and non-executive members of authorities and trust’.

John Kaye (who also wrote the overview) and Tony Blee (who covered primary health care) have an interesting and unusual approach to the editorial role: ‘We have allowed the contributors to say what they want, how they want’, which certainly ‘ends up in a good representation of all those who work in the NHS’ but gives a variable quality to the chapters. The range of disciplines is wide: administrators, architects, artists, arts coordinators, culinary, environmental, gardens, longterm care, music, psychiatric, and national organisations (Arts for Health, Health Care Arts in the UK; Society for Health Care Arts Administrators in the USA). However, the book is Anglo-American only, with no Ireland, Wales, Scotland or continental Europe.

I profoundly disagree with their cultural relativism ‘one thing we have learned is that there are no right or wrong answers. It is what appeals to the individual that is important’. Some of the 28 authors who do seem to have the right answers include Nigel Weaver (Charing Cross, Barnet) on purchasing and commissioning visual art, John Lynch (landscape architect), Guy Eades (hospital and community healthcare in the Isle of Wight), and artists-in-residence (two writers and the muralist Chris Barrett, who not only made major visual improvements in a year at Barrow-in-Furness, but also reminds us that 1 in 8 pathologists is likely to have impaired colour perception which may affect their histological interpretations). One of Gail Bolland’s projects for Leeds fostered a corporate identity through its sense of history. Malcolm Miles has two chapters, one entitled Does art heal? (unproven) and one on the (Hippocratic) Planetree patient-centred culture. From the USA