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Infectious Hepatitis: British gammaglobulin proved very effective in preventing new cases in closed communities, where tendency of disease to spread is usually considerable (p. 451).

Haemodialysis and Infection: Suggestions made on how to diminish risks which are mainly associated with overcrowding of patients, faulty techniques, and inadequate disinfection of patients' skin and the equipment (p. 454).

Asthma in Children: Clinical signs are poor indication of degree of hypoxaemia and hypercapnia in acute attacks in childhood. Measuring arterial blood gas tensions is essential during oxygen therapy because of risk of increasing respiratory acidosis (p. 460).

Emergency Colon Resection: Performed in 25 patients with spreading peritonitis secondary to colonic diverticular disease, and 22 of these patients, who had purulent peritonitis, survived (p. 465).

Sticky Eye: *Mycoplasma hominis* was cause of eye infection in eight out of 250 newborn babies (p. 467).

Cancer and Smoking: In Rhodesia, where atmospheric pollution is negligible, 87.5% of patients with bronchial carcinoma were smokers, compared with 22% in a similar control group. Cigarette smoking is probably the most important factor causing bronchial carcinoma among Rhodesian Africans (p. 468).

Carpel Tunnel Syndrome: Delay in diagnosis and treatment prejudices satisfactory outcome, but in some patients pain persists after early successful surgery, possibly owing to recurrence of degenerative thickening (p. 470).

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Commonwealth Bureau: Twentieth Anniversary of B.M.A.'s advisory scheme for overseas doctors (*Supplement*, p. 101).

Area Health Boards

During the planning stage of the N.H.S. the medical profession put great store on getting the administrative structure right. By " right " it meant, among other things, that doctors should be well represented on all boards, committees, and councils, and that there should be at the centre a strong professional body to advise the Health Ministers. On the general practice side there was a ready-made base in the existing National Health Insurance scheme from which to develop the executive councils and local medical committees. New *ad hoc* bodies representative of lay, professional, and special interests were created to administer the hospitals in regions, and they in turn appointed committees of mixed lay and professional members to manage local groups of hospitals. Teaching hospitals were given their own boards of governors on which the universities and the medical profession were well represented. But no provision was made in the hospital service for medical advisory committees with statutory powers comparable to the local medical committees of the general-practitioner service. Nor could hospital doctors appoint their representatives on hospital boards and committees as general practitioners could their members of executive councils.

In the Minister of Health's scheme for England and Wales, set out in his Green Paper,[1] 40 to 50 area boards with about 15 members each would take over the functions of the existing 15 regional hospital boards, 36 boards of governors of teaching hospitals, 330 hospital management committees, 134 executive councils, and, to some extent, the health committees of 175 local authorities. This would mean a drastic reduction in the number of administrative committees. However necessary, and even welcome, that might be it is always easier to agree on the rightness of an end than on the means of accomplishing it.

A scheme for administering the health services locally through area health boards was first put forward by the Porritt Committee of 1962.[2] At first the medical profession was slow to take to the idea, but it has since moved much closer to accepting some such development as area health boards as being the most practicable way of integrating the N.H.S. by getting rid of its tripartite administrative structure. Thus in the forthcoming discussions on the Green Paper the main topic will probably be the nature of the proposed boards rather than their creation.

The medical members of the administrative bodies, along with their co-members from other spheres of interest, have done faithful service. It has been of undoubted benefit to have available the expert knowledge of doctors, and their presence has smoothed the relationship between authority and medical employee or private contractor. But events have not fulfilled the medical profession's pre-1948 expectation that its representatives on the administrative bodies could mould the development of the N.H.S. Since the scope of these bodies for individual action is strictly confined within statutory and financial limits it is not surprising

that the profession's thinking can now be seen to have been unrealistic.

That being so, the Minister's proposal that the few medical members of the new, small area health boards should not be nominated to represent special interests may not be seriously challenged. Much more likely to be opposed is his view that there should be no committees of the board to deal with particular services. Though elsewhere in the Green Paper is the seemingly contradictory statement that a change to a new area authority would not imply a material change in the existing statutory recognition of local medical and other local professional committees (reshaped to cover each new area), the Minister believes that any tendency for one element of the Service to "dominate or distort" a board's policy must be prevented. To promote integration there should be "a clean break from the existing divisions," and any standing committees of the board should be few and small and "cover all parts of the Service." The principle of promoting integration should also apply, in the Minister's opinion, in the constitution of any advisory bodies so that they could advise a board on "the whole range of services."

The Porritt Committee recommended that each area health board should have a number of subsidiary councils responsible for the administration of individual services, and that there should be a statutory professional advisory committee to each council together with a statutory area professional advisory committee to advise the board. A working party of the Council of the B.M.A. has been examining the administration of the N.H.S. in expectation of the Green Paper, and, like the Minister, it sees a danger that subsidiary councils for individual services might perpetuate the tripartite system which area boards are intended to abolish. The working party would overcome this difficulty by having small executive committees to administer each section of the professional services, and each subcommittee would have an executive officer and be advised by an advisory panel elected by the profession concerned. The Minister, on the other hand, thinks that an area board's organization might consist of four or five major departments "staffed by administrative and professional officers responsible to its directing head, who might be either a professional or an administrative officer." The directors of the departments would form an executive which would be responsible for "advising the board on its objectives and policies, for organizing the services . . . and for executing the board's policies. . . ." Only in local district areas does the Green Paper seem to envisage practising doctors actively participating in running the services. Here their day-to-day co-ordination "would fall upon the senior staff working within them—for example, the chairman of the hospital medical advisory committee . . . the hospital administrator, the community physician, and . . . the general practitioners."

The proposals in the Green Paper would certainly lead to greater administrative efficiency and provide a sound basis for achieving integration of the health services. But, since the streamlining of the machine would greatly reduce the number of bodies on which they have been accustomed to serve, doctors will have to consider where in the new set-up they can most usefully make their contribution and how they can make their collective influence most felt. There is no indication that area health boards would have any greater freedom than the existing authorities to act independently of central direction. Such freedom could come only from financial independence, and the Minister has given no sign that he contemplates reforming the financing of the N.H.S. as well as its administration. To have a number of medical advisory committees within the organization of area health boards would therefore seem to be a dissipation of valuable medical time and energy to little purpose. There will, however, be much work to be done in developing the services locally, and in giving practical effect to integration in devising a working relationship between district hospitals, health centres, general practitioners, and community physicians. Doctors would neglect to do this work at their peril.

But it is at the centre that the advice of the medical profession could most effectively be brought to bear. It is there, according to the Green Paper, that the broad strategy and policies necessary to give "direction and purpose" to the Service will be formulated. No Minister or Ministry, in framing policies, could afford to disregard the authentic voice of medicine. It seems therefore that one of the profession's major and urgent concerns should be to concentrate on shaping its own policies for the development of the N.H.S., and then to press them on the Government. Doctors might then find that their influence on affairs was greater when exerted from the outside than it was when exerted from within.

[1] *National Health Service: The Administrative Structure of the Medical and Related Services in England and Wales*, 1968. H.M.S.O., London.

[2] *A Review of the Medical Services in Great Britain*, 1962, London.

Joint A.M.A.–B.M.A. Meeting in Australia

The Joint Meeting of the Australian and British Medical Associations, held in Sydney from 10 to 16 August in conjunction with the Third Australian Medical Congress, marked a notable coming of age. When previously the B.M.A. met in Australia—in 1935 in Melbourne—doctors in Australia belonged to a Branch of the B.M.A.; this time the youthful and vigorous Australian Medical Association was the host to its parent Association.

Sydney University, where the Medical Congress was held, and Sydney itself, Australia's oldest city, provided an ideal setting. There is much there to entrance and interest the visitor: the harbour with its many moods and faces, its renowned bridge, and burgeoning opera house; Botany Bay, which the Prince Henry Hospital overlooks, in 1770 Cook's first landfall on New Holland, as the continent was then called; the elegant buildings of Macquarie Street, Sydney's Harley Street, and the cast-iron-lace balconies of the small terrace houses in the older suburbs; the Universities of Sydney and New South Wales, the former's majestic gothic halls contrasting with the modern design at the latter; the constant interaction of new and old Australians moulding a new society, unlike either's, for the generation to come. This and much else besides.

The Meeting combined the 136th annual meeting of the B.M.A. and the 7th of the A.M.A. Under their joint President, Dr. C. O. F. Rieger, and the President of the Third Australian Medical Congress, Dr. R. H. Macdonald, members of both Associations took part in an extensive scientific programme and a variety of social events. Altogether over 1,100 doctors attended. There was a strong contingent from Britain led by the retiring President of the Association, Mr. Robert Cooke, and the other chief officers of the Associa-