must be regarded as a diagnostic challenge. If this attitude is adopted, medical work with the elderly becomes a fascinating, exacting, and rewarding discipline. Only by proper diagnosis can the elderly be helped to the full. If their symptoms are dismissed and "old age," "senility," "rheumatism," or some other conveniently vague label is applied, many opportunities for effective treatment of old patients will be missed, at the cost of much unnecessary suffering and disability.

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Contemporary Themes

Non-Accidental Injury to Children

On 9 October a report was published by the Tunbridge Wells Study Group entitled *Non-Accidental Injuries to Children*. This was an ad hoc group set up by Dr. A. White Franklin and Dr. Christine Cooper, arising out of an initial meeting of a working party at Tunbridge Wells in May this year. Its invited members represented most of the professional bodies concerned with the problem—namely medical men, social workers, lawyers, and members of the police. Each prepared a paper for circulation before the meeting, which was held at the Hospital for Sick Children, London, on 22 June, 1973. The document points out that "not every participant agrees with every detail and no participant could commit the body which he represented or of which he was a member. Nevertheless the greatest care has been taken to achieve wording most of which satisfies most of those who took part."

The report was sent to the Department of Health and Social Security, which has decided to send a copy to every doctor. The following is a summary of the resolutions that were passed, which the report says, with the exceptions of resolutions N and O, are "concerned with techniques for ensuring the maximum of support for families caught up in the problems of non-accidental injury to their children, so as to limit the harm done both physically and emotionally. They are concerned with prevention only in relation to repetition of the injury and to countering the effects of deprivation. This does not mean that the Study Group fails to recognize the supreme importance of prevention, which it is hoped will form the subject of a further meeting (see Resolution 2)."

Resolutions

(A) "That for children damaged by non-accidental injury or when this is suspected, immediate hospital admission of the child is the essential first step."

(B) "That close links should always be established between the hospital children's department and the accident and emergency department."

(C) "That health visitors should be informed directly of all young children involved in accidents, including poisoning (particularly those under the age of 2 years), so that they may visit the home. The general practitioner should always be informed."

(D) "That the social service department should be informed immediately whenever there is suspicion of non-accidental injury."

(E) That when non-accidental injury is suspected or known to have occurred, the N.S.P.C.C. or other voluntary society, when already concerned, should continue to be involved in management and included in all professional discussions.

(F) "That the police should be involved in the early discussion of these cases even when there is only a suspicion of non-accidental injury. The Study Group is aware that at present this involvement is often inhibited by fear of the effects on the family of some police investigations and therefore agrees that approaches be made to the Home Office, and Department of Health and Social Security and the Association of Chief Police Officers to explore the ways of promoting increasing mutual understanding between the police and the other professions concerned.

(G) "That representatives in the Study Group of each of the parties likely to be involved with a family, while reserving their professional rights, strongly deprecates unilateral action. When such action seems necessary, all the other parties involved expect to know what action is being taken and the reasons for it so that mutual trust and confidence can be preserved."

(H) "That the Study Group strongly supports the establishment throughout the United Kingdom of the case conferences and the area review committees as suggested by the D.H.S.S. (ref. Chief Medical Officer's letter with enclosure "analysis" of reports submitted by medical officers of health and children's officers) but recommends that the functions of these bodies be more clearly stated and that their composition be modified."

(I) "That review committees should be set up at area health authority and local authority level and should hold quarterly meetings. That case conferences should supervise the management of families involved and that review committees and case conferences should have the functions and the composition set out in detail in paragraphs 24 and 14 and 15 respectively."*

*The functions of the area committee recommended in paragraph 24 are: to act as a forum where the widest possible consultation can be held between all professions who play any part in managing the problem; to take responsibility for formulating policy and procedures; to review the work of the case conferences in its area; to ensure that long-term plans, whether with the child at home or placed either in a home or with foster parents, is being satisfactorily carried out; to promote the spread of knowledge; to encourage research; to co-operate in epidemiological studies; to be in touch with review committees in adjacent areas; and to submit an annual report to the D.H.S.S. and the Home Office.

The function of the case conference, the report says in paragraph 14, is "to bring together all those who can provide information about the family, those who make decisions and those who provide services. Responsibility for co-ordinating the details of treatment has to be delegated to one person, but it is necessary for the case conference to retain an overall responsibility for each step that is taken. This responsibility continues at least until after the child has returned to the care of his own family at home and therefore even if no actual meeting is convened, every member must be informed when the child leaves hospital wherever he is sent, and, very importantly, when the child returns home. No child under suspicion should leave hospital without the agreement of the social services."

Paragraph 15 deals with the suggested composition of the case conference, the named members providing, the report says, the minimum requirements: the senior paediatrician with members of his staff, the psychiatrist, the ward sister or the senior nurse concerned with the child, the senior member of the social service staff concerned with the child, the health visitor and the representative of any voluntary social agency such as the N.S.P.C.C. who may have been already involved. The family's general practitioner should be invited to attend. With regard to the police, a superintendent or chief superintendent, either of whom are able to make decisions, should be given the opportunity to attend. The police can then use their discretion about the need to attend and will no doubt be influenced by the seriousness of the situation and the degree of suspicion.

(J) "That specialized groups are also needed, such as those now being established by the N.S.P.C.C. to act as the focus for consultation, research, and training as well as to provide treatment facilities in their immediate area."

(K) "That a direct approach be made to the Secretary of the Criminal Law Revision Committee about the law and about legal procedure in cases of non-accidental trauma to children."

(L) "That the Casualty Surgeons Association be asked to make, with the assistance of the D.H.S.S., a census by age groups and diagnosis of all children treated in accident and emergency departments."

(M) "That a small working party be set up to collect information on reporting, registering and notification in the United Kingdom and in other countries and to make a report on advantages, difficulties, and disadvantages."

(N) "That since child abuse is reported to be associated in a sizeable proportion with low birth-weight, representation be made to paediatricians, obstetricians, midwives, nurses, health visitors, and social workers about methods which can promote very early intimate mother-child interaction, and about the need for informed follow-up."

(O) "That the Study Group be kept in being; that a one-day meeting be called in about six months' time to review progress in the carrying out of the resolutions, and that consideration be given to a longer meeting at a later date to examine methods of harnessing to prevention the existing knowledge about vulnerable families and aetiological factors."

(P) "That in the meantime the original working party be asked to continue their discussions, and to supervise the appropriate carrying out of the resolutions."

Conference Reports

British Medical Association

Second Annual Postgraduate Meeting: Guernsey, 28-29 September

The second Annual Postgraduate Meeting on 28 and 29 September in St. Peter Port, Guernsey, was opened by Mr. WALPOLE LEWIN (Chairman of B.M.A. Council) introducing Mr. JOHN LOVERIDGE, the Bailiff of Guernsey, who welcomed the Association to the island. He reminded the meeting that Guernsey, once a part of the Duchy of Normandy, was one of the oldest adherents to the British Crown, and had an interesting history of government and institutions.

Mr. LEWIN paid tribute to Mr. Heber Langston, now visiting professor of orthopaedics in Baghdad, who had often mentioned Guernsey as a delightful venue for small meetings of this kind. He reminded the audience that not only had Guernsey been the only part of Britain to experience occupation during the second world war, but with meagre resources and no anaesthetic facilities, had maintained a high medical standard during that time including 1,400 deliveries with only one maternal death.

Dr. M. H. S. BOUND, chairman of Guernsey and Alderney Division of the B.M.A., set out to describe the unique and distinctive pattern of medical practice in Guernsey. At the last count in 1971 there were 51,000 residents in Guernsey, 2,500 residents in the other islands of the Bailiwick, and, during the summer, 15,000 visitors and 2,000 seasonal workers. There were 45 doctors to care for this population, whether in or out of hospital, including specialists in radiology, pathology, ophthalmology, psychiatry, geriatrics, plus the medical officer of health and his assistant. The service was otherwise provided by general-practitioner specialists, of whom six held the F.R.C.S., six the M.R.C.P., and three the M.R.C.O.G., with other diplomas thickly spread. These were grouped into six practices, giving a doctor patient ratio of 1:1,320, compared with 1:1,830 in the United Kingdom. Patients with unusual problems requiring expensive sophisticated equipment for their care were sent to the mainland; otherwise everything was done on the island by a doctor personally known to his patient.

The Princess Elizabeth Hospital was organized as a district general hospital with 145 beds (including 20 maternity), but an extension to provide 70 more beds for surgery and intensive care and more operating theatres was under construction. The St. Peter Port Hospital cared for geriatric patients.

Their medical service was based on private practice. Some patients belonged to provident associations, and pensioners were on social security benefits. A prescription scheme for medicines on U.K. lines had recently been introduced.

Dr. Bound emphasized that it was important to work alongside the government but not for the government, and he thanked the States Board of Health for its understanding that a State monopoly would be terrible in a small vigorous isolated community.

Mr. Walpole Lewin then invited Professor STANLEY ALSTEAD (Emertus Professor of Materia Medica, University of Glasgow) to give the opening address.

Opening Address: Faith Healing

The importance of his subject was as a meeting point between clinicians, ministers of religion, and philosophic laymen, Professor Alstead began. Before discussing faith healing he defined briefly the broader issue of healing, the process by which the body returns to health after having experienced disease. Faith healing he implied to any recovery directly attributable to an attitude of mind—in the patient or in others—produced by religious faith or experience.

In evaluating any kind of treatment, it had to be remembered that without spontaneous repair of tissues damaged by surgery or disease there was no return to health. Even specific therapy provided only one link in the chain of events leading to the patient's recovery.

Addressing himself more particularly to the non-medical members of the audience, Professor Alstead made four categorical statements:

Firstly, the acute illness with a sudden explosive onset usually tended to be of short duration and to yield rapidly to appropriate general management and therapy. On the other hand, diseases with an insidious onset and characterized by remissions tended to become chronic and intractable.

Secondly, a person might develop physical disease and be entirely unaware of it until it was discovered during routine examination.

Thirdly, although aware of the presence of disease a person might honestly declare the complete absence of disability.

Finally, a trivial illness might be accompanied by disability amounting to prostration because of the patient's inordinate fear. The patient's state of fear could thus become the physician's main therapeutic problem.

Many diseases were regarded as incurable and fatal. However, it was impossible to forecast with absolute certainty that any individual patient would die from such a disease, even when there was histological proof of its presence. It was important that the layman should share the doctor's appreciation of the extraordinary variability exhibited by some diseases in the course of their natural history.