

towards their infant's welfare. This situation is not unique to Glasgow.

The group on which attention needs focusing are the unexpected deaths at home. Some of these are preventable, notably the deaths of children with gastroenteritis who have been given thickened feeds when they require an increase in fluids. Careful teaching might help to prevent these deaths. The same may not be true of some respiratory tract infections.

Surveys on the background to cot deaths, including two recent reports from Salford⁴ and Belfast,⁵ have produced a remarkably uniform pattern, and the Glasgow study shows the same again. In general there is an increase in those same factors which increase infant morbidity in general—illegitimacy, low birth weight, poor use of welfare services, poor living conditions, disharmony in the family, and poor work records.

Unexpected deaths at home have been largely cut off from the stream of research in paediatrics, because most of the infants have not been seen by paediatricians, and the mode of death is not usually ascertained by a paediatric pathologist even when one is available. In the Glasgow survey most of the necropsies were carried out by forensic pathologists; the excellent paediatric pathology department in that city is concerned only with children dying in hospital.

It is questionable how much the diagnosis of "sudden infant death syndrome" represents real ignorance or simply convenience. In a recent series (unpublished) of unexpected home deaths carried out by a paediatric pathology department the necropsy showed no evidence of long-standing disease in less than 5%, and a third of the deaths were related to diseases that were treatable with a fairly good prognosis. To suppose that these deaths can be prevented easily is wrong, but equally so is the supposition that they are due to obscure, unknown diseases. It is rare to have an unexpected child death when the relationship between parents and family doctor is good.

The emotional trauma of one of these deaths in a home can be very great, and steps are being taken by a charitable organization to help these people,⁶ but the first objective is to prevent the deaths. The mechanism of dealing with partially deprived homes and children needs reappraisal. Are health visitors now directing their activities to the right group of children? Is it only the converted that go to welfare clinics? Could clinic doctors and health visitors' time be better spent as staff members of the comprehensive schools teaching home and mothercraft?

What is most clearly indicated is that these unexpected deaths at home should be investigated by those persons best able to discover most from them and so prevent them. Necropsies on the babies should be done by paediatric pathologists. There is an urgent need for paediatricians to interest themselves in the early symptoms of relatively common diseases and in particular the contribution to them made by bad social conditions.

Learning to be a Drinker

Every citizen, whether drinker or non-drinker, learns a set of attitudes towards alcohol. He carries round as personal baggage a formed view of the social situations in which it is appropriate to drink, what substance it is pleasant to drink, how much it is proper to imbibe on any occasion, whether it is allowable to use drink to cure his tensions or aid his sleep or snuff out a snuffle, a view of whether intoxication means passing out cold or being a fighting drunk,¹ and much else besides. Does this attitudinal baggage affect the individual's immunity or susceptibility to the development of alcoholism? Sociological research rather convincingly suggests that it does.²

Study of the learning processes which transform the baby interested only in the next gulp of milk into the adult with his set of drinking attitudes is of importance to the prevention of abnormal drinking. With that belief in mind the Health Education Unit of the Scottish Home and Health Department some years ago gave support to the department of psychology of the University of Strathclyde. A study was carried out in conjunction with the Social Survey Division of the Office of Population Censuses and Surveys. The fruits of the research saw daylight last week in a two-volume report of much scientific interest.

The first volume³ might indeed be seen as reporting work which is in some degree pioneering. Studies of drinking attitudes have usually taken teenagers as the youngest group to be approached.^{4 5} Professor Gustav Jahoda and Dr. Joyce Cramond focused their attention on children aged 6-10 years. Rather than relying on questionnaires they designed a number of test "games" and with them examined the child's ability to recognize the smell of different types of beverage, his perception of what different dolls (child, man, woman) would think about alcohol, his ability to recognize a man's drunkenness portrayed in a film, and so on. The authors concluded that even by the age of 6 most children could recognize drunkenness and knew something about the relationship between different social rules and expected degrees of drinking, while by the age of 8 the abstract concept of "alcohol" had acquired considerable meaning.

The second volume of the report⁶ is more conventionally concerned with the drinking of teenagers. A questionnaire technique was used, and the findings suggest that, by the age of 14, 92% of boys and 85% of girls will have tasted alcohol. The first drink is usually with parents, but a substantial minority learn to drink from other teenagers. Pub drinking for boys really starts at 17. As for correlates, the greater the spending power, the greater the amount of alcohol consumed. Many young people seem motivated towards drinking so as to avoid the "weak—unsociable" image which goes with non-drinking. A belief that being a drinker confers "maturity," and high scores on a "trouble/precocity" scale, are also predictive of heavier drinking.

Beyond the scientific interest, what is the practical relevance of these findings to preventive medicine? The authors are sensibly modest in their conclusions. To know something about attitudes and their formation does not necessarily give the educator power to build healthy attitudes; there is a large gap between understanding them and being able to change them. Nor can it be assumed that the data establish a causal connexion between observed attitude and later (let alone present) behaviour.

The most important message that comes from these two

¹ Department of Health and Social Security, *Confidential Enquiry into Post Neonatal Deaths 1964-66*, Reports on Public Health and Medical Subjects No. 125. London, H.M.S.O., 1970.

² Richards, I. D. G., and McIntosh, H. T., *Archives of Disease in Childhood*, 1972, 47, 697.

³ Taitz, L. S., and Byers, H. D., *Archives of Disease in Childhood*, 1972, 47, 257.

⁴ Vaughan, D. H., *Journal of the Royal College of General Practitioners*, 1968, 16, 359.

⁵ Froggatt, P., Lynas, M. A., and MacKenzie, G., *British Journal of Preventive and Social Medicine*, 1971, 25, 119.

⁶ Foundation for the Study of Infant Deaths (Welfare Office), 23 St. Peter's Square, London W6 9NW.

studies is that the social and psychological roots of alcoholism are to be seen as susceptible to scientific study rather than as for ever shrouded in mystery. To suppose that the present rather alarming rate of alcoholism in Britain⁷ is something we have to go on accepting with a weary shrug is no more permissible than passively accepting any other serious health problem. Professor Jahoda and his colleagues have made a timely contribution. Debate on possible revision of the liquor licensing laws bears exactly on this same health issue.⁸

¹ MacAndrew, C., and Edgerton, R. B., in *Drunken Comportment. A Social Explanation*. London, Nelson, 1970.

² Cahalan, D., *Problem Drinkers*. San Francisco, Jossey-Bass, 1970.

³ Jahoda, G., and Cramond, J., in *Children and Alcohol—A Developmental Study in Glasgow*, Vol. 1. Glasgow, H.M.S.O., 1972.

⁴ Jessor, R., Graves, R., Hanson, R., and Jessor, S., *Society, Personality and Deviant Behaviour*. New York, Holt, Rinehart and Winston, 1968.

⁵ Stacey, B., and Davies, J., *British Journal of Addiction*, 1970, 65, 203.

⁶ Davies, J., and Stacey, B., in *Teenagers and Alcohol—A Developmental Study in Glasgow*, Vol. 2. Glasgow, H.M.S.O., 1972.

⁷ Zacume, J., and Hensman, C., *Drugs, Alcohol and Tobacco in Britain*. London, Heineman, 1971.

⁸ *British Medical Journal*, 1972, 4, 625.

Integration or Disintegration

Doctors have so far played a big part in modifying the Government's plans to reorganize the N.H.S. But they are in danger of seriously reducing their influence because of internecine clashes over the future shape of their own representative organization. If working integration cannot be achieved in the profession's own advisory and negotiating machinery how then will the Health Service fare? April 1974 could see "paper integration" only, for as a correspondent, writing on p. 352 about an integrated child health service, points out, "Administrative changes alone, however, will not be sufficient. Attitudes must change."

It could be that the different branches of the profession are more willing to work, advise, and negotiate together than events at Tavistock Square suggest. For one of the big imponderables in the continuing arguments about reorganizing both the B.M.A.¹ and the N.H.S.² is the real opinion of doctors at large. Are they for or against change; do they praise or abhor Chambers, welcome integration or oppose it?

The arguments about the merits or dangers of the Chambers Report have been vigorously rehearsed among the profession's political cognoscenti as well as in print.³⁻⁵ It is perhaps ironic that the ambiguity of doctors' representative procedures, exposed and condemned by Sir Paul Chambers, should have been so clearly demonstrated by the General Medical Services Committee's own defence of them. For a major standing committee of the Association to despatch a document contrary to B.M.A. policy on Chambers to over 20,000 doctors⁶—about 70% of them B.M.A. members—is an event to bring wry smiles of admiration from exponents of Westminster infighting. However, the G.M.S. Committee's unashamedly partisan approach in its report has done a service to all doctors by provoking further thoughts before any irrevocable constitutional changes are made.

The Representative Body's appreciation of the Chambers Report's worth was tempered by a recognition of its weaknesses—hence the Special Representatives Meeting's overwhelming support for Chambers "in principle"⁷ rather than for the report "in toto." Furthermore this decision, as a letter on p. 350 reminds us, was not the same as a vote for the principles of Chambers. "In principle" allows far more

accommodation than some critics, inside and outside the B.M.A., have acknowledged—or even looked for. Of the two issues highlighted by the Chairman of Council after the S.R.M.'s historic vote (see *Supplement*, p. 35) autonomy is really a misleading description of the existing negotiating arrangements, while the non-member hurdle should not prove an insuperable barrier to progress. The discussion on Chambers reported in the *Supplement* (p. 33) points to ways in which Chambers in principle might be successfully introduced without the dire consequences foreseen by some. One participant observes that a single pyramid of representation is sensible in terms of communication and cost. But he emphasizes that mutual confidence between the profession's various branches is a prerequisite for its acceptance, a process which may take time. So he asks whether reform might be effected by stages.

A former Chairman of Council, Dr. Ronald Gibson, asks (p. 350) why with so much at stake time is being made so short, and pleads for yet more effort to resolve intraprofessional differences. Both these are constructive propositions, but only if everyone shows flexibility and goodwill and any extended timetable has a definite limit set to it. With reorganization of the N.H.S. almost on us it would be unfair to members and damaging to the profession's interests to have too long a period of uncertainty about the B.M.A.'s future shape.

It is quite understandable that some doctors—especially those in general practice—should look askance at any changes in the present system for it has functioned for many years to their satisfaction. Nevertheless, in a post-1974 context the logic of Chambers is persuasive and the Representative Body's lead in wanting the B.M.A. matched to the reorganized and administratively strengthened Health Service was right. Arguments about which professional negotiating or advisory bodies the Government will or will not recognize in future should not disturb doctors unduly. If the Association's members have the courage of the R.B.'s convictions then a new situation could quickly develop in which Whitehall would find it hard to avoid acknowledging the new B.M.A. as the major force in presenting the profession's views.

Certainly no one else can compete with the Association's large representative membership, financial resources, country-wide organization, powerful central administration, or experience. Since Sir Charles Hastings founded the Association in 1832 to represent the interests of the then neglected provincial doctor its often tempestuous history has seen some notable social, medical, and political successes. But to advocate that this or that group within the B.M.A. has been responsible for this success or the other is to start a sterile, introspective debate. The wide spectrum of doctors the B.M.A. speaks for—and the hearing it is given in the country—has been the source of its strength, and the Chambers objective of drawing the constituent parts much closer together should produce an even more formidable professional voice. For the past decade, since the Porritt Report⁸ doctors have made the running towards an integrated Health Service, with the goal of better care for patients. It would be a tragedy if in the home straight the profession's leadership was seen to be riding a pantomime horse instead of a winner.

¹ *British Medical Journal Supplement*, 1972, 2, 45.

² National Health Service Reorganization Bill, London, H.M.S.O., 1972.

³ *British Medical Journal*, 1972, 3, 655.

⁴ *British Medical Journal Supplement*, 1972, 4, 74.

⁵ *British Medical Journal Supplement*, 1973, 1, 15.

⁶ *British Medical Journal Supplement*, 1972, 4, 106.

⁷ *British Medical Journal Supplement*, 1972, 4, 55.

⁸ Medical Services Review Committee: *A Review of Medical Services in Great Britain*, London, Social Assay, 1962.