to pressure. So much hangs upon the award it will be making in the spring of next year that it must be enormously difficult to isolate the various factors involved, especially those summed up in the phrase the National Interest. The Review Body's previous statement that it could find no evidence that general practitioners were underpaid does not make matters any easier. But doctors were reassured by Mr. Kenneth Robinson's statement (*Supplement*, 2 October) that the figures for the N.H.S. in the National Economic Plan will not "affect the freedom of the Review Body to reach whatever conclusions seem right to it in its pending consideration of medical remuneration."

It is little short of disastrous that a dispute about pay in the Health Service, and the methods of payment, should have reached such a pitch that the Health Service may founder if the decisions of next year fall far short of the medical profession's expectations. For it is necessary to remember that others than general practitioners are concerned in the deliberations of the coming months. In particular the hospital junior staff are dissatisfied not only with their pay and conditions but to a certain extent with the way these have been handled by their seniors. The Review Body is on the eve of its triennial review of pay of *all* doctors working in the N.H.S. The claims made on behalf of hospital staff will undoubtedly loom large in its computation, and against this it will have to look at the general practitioners' case in relation to that of other sections of the profession, and also in the light of the special position general practitioners claim to have established for themselves. And the background to all this is a shortage of doctors in the hospital service as well as in general practice, and continued emigration for which exact official figures are still not available. It is not in the National Interest that this state of affairs should continue.

All doctors working in the N.H.S., and in particular general practitioners, should, we suggest, keep in the forefront of their minds during the coming months certain assumptions that are at least reasonable if not undeniable. The first of these is that the medical profession itself sought out and approved the conception of an independent body of men who would periodically adjust the payment of doctors in the Health Service. The idea behind this was that men of such eminence and distinction as to remove them from the influence of pressure groups would take this difficult question of payment out of the political and public arena. Their judgment, it was confidently expected, would have the weight and objectivity of the judgment of Solomon. The medical profession was content with the observation in the Royal Commission's report that no Government would lightly turn aside the recommendations of such men. It was perhaps too readily assumed that possible governmental objection would be the only obstacle to acceptance of the Review Body's verdict. Things have turned out differently. Government has behaved with great correctness in being willing to accept the Review Body's recommendations. It is the medical profession, or at least a section of it, which has taken even violent exception to recent decisions. It appeared to us, and to others, that at least one of the legitimate grounds for this was the Review Body's attempt to decide on the distribution of the award of £5½m. in February this year. It was certainly in line with everyone's expectations that the Review Body's job was to decide the amount and that the distribution was to be a matter between the profession and the Ministry of Health.

But above all else the medical profession must hold firmly in mind the fact that whatever they may think of its decisions the Review Body is so constituted as to be above reproach. Men of such eminence and integrity may indeed make mistakes, but their intentions and their fairness cannot be called in question. And at the end of it all doctors working in the National Health Service must face the uncomfortable fact that they cannot dictate their own terms, that they cannot themselves decide what their value to the community is. And the other side of the coin is this, that the society in which we live will have to have in its midst a contented medical profession if it is to get the medical care it needs. It is in the balance of these two forces that the judgmatic skill of the Review Body will receive its severest test.

The Health Service is really still in an experimental stage, and everyone connected with it will have to exercise a good deal of patience and still more skill in devising different ways and means of bringing the experiment to a successful conclusion. And the success of the conclusion will depend upon the interpretation the Review Body and Government—and the medical profession—make of the term the National Interest.

As the evidence to be submitted to the Review Body from both sides is to be made public doctors themselves will have a good chance of judging how the Government is spelling this out on matters which at the moment are very important to them.

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Heart Failure in Old Age

Heart failure is a very common cause of ill-health in old age, and one in seven of the patients admitted to geriatric units has congestive heart failure.[1,2] Careful clinical examination[3] will often show the cause of it. Rheumatic heart disease, disease of the aortic valve,[4] and cor pulmonale account between them for perhaps one-quarter of cases of congestive failure, and syphilitic heart disease, thyrotoxicosis, and severe anaemia for a few more. But in about two-thirds of patients none of these conditions will be found, and usually ischaemic or hypertensive heart disease is then diagnosed. In an important and detailed study of the pathology of the heart in old age Ariela Pomerance[5] has greatly clarified these problems. She examined 368 hearts from patients dying over the age of 75 in a large general hospital; 162 of the patients had been in heart failure. Recent myocardial infarction was the apparent cause of heart failure in nearly one-quarter. The clinical diagnosis of this may be difficult, not least because, as Dr.

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A. K. Thould points out in his paper on page 1089 of this week's *B.M.J.*, myocardial infarction is often painless in old age. But the sudden development of heart failure in a patient with previously good exercise tolerance should always strongly suggest myocardial infarction if there is no disturbance of the rhythm of the heart[6] and no evidence of pulmonary embolism. The pathological diagnosis of ischaemic heart disease as the cause of heart failure may also be difficult if there is no large infarct, since there is no clear relation between the severity of coronary atheroma and the presence or absence of heart failure in old people.[7] The importance of small fibrotic myocardial lesions[8] is also not clear; Pomerance[5] believes that they contribute little to heart failure.

The certain diagnosis of heart failure due to hypertension is also difficult in the elderly. In "normal" old age there is a wide range of blood-pressure,[9 10] so that systolic pressures of up to 210 mm. Hg and diastolic pressures of up to 110 mm. Hg are acceptable as normal. Moreover, when the heart begins to fail the blood-pressure may either fall or, perhaps more commonly, rise. If a known previous sustained very high pressure is the diagnostic criterion, hypertension may contribute to heart failure in perhaps one-third of elderly patients.

Causes of heart failure other than those mentioned are rare, though recently attention has been given to massive calcification of the annulus of the mitral valve and to senile cardiac amyloidosis, both of which are virtually confined to old age. Calcification of the mitral annulus may produce mitral incompetence and occasionally obstruction,[11] and is recognized by the characteristic radiological appearances. Senile cardiac amyloidosis is found in as many as 10% of necropsies of patients over the age of 80,[12] the amyloid material being deposited in the endocardium, especially of the atria, and around the myocardial fibres. If severe, it may certainly result in heart failure,[13 14] but its clinical and electrocardiographic features are not yet sufficiently well defined to allow diagnosis in life. Its cause is quite unknown, but it may be a variant of primary amyloidosis.[12]

One of the basic features of geriatric medicine is that patients commonly have more than one pathological condition. Thus rheumatic and ischaemic heart disease may co-exist,[4 15] and thyrotoxicosis precipitates heart failure in patients with all forms of organic heart disease.[16] Pomerance[5] concludes that in as many as two-thirds of cases there is more than one cause for failure of the heart in elderly patients, and that there are very few, if any, patients in whom no cause can be found. This should sharpen our diagnostic acuity, and help to dispel the undoubtedly naive view[1] that cardiac ischaemia underlies all cases of heart failure in the elderly. It should also help to give decent burial to the unacceptable term "senile myocardial degeneration," which often appears on the death certificates of elderly patients.

Origins of Homosexuality

It is commonly estimated that about one in twenty of our male population is a practising homosexual.[1] His opportunities for establishing lasting relationships with homosexuals or with normal people are severely restricted by the current legal, moral, and social attitudes of our society.[2] Of all males who acquire venereal disease perhaps 30% do so by homosexual contact, and this promiscuity may derive from these attitudes. Male prostitutes, particularly the mincing effeminate type so frequently caricatured, are often bisexual or people with severely disordered personalities whose drift into homosexuality is part of a more serious failure in adaptation.[3 4] The effeminate homosexual is as often despised by other homosexual as by heterosexual individuals. Despite their vulnerability the majority of homosexuals live useful lives and are effective members of society.

Contrary to popular opinion the majority of practising homosexuals are not interested in prepubertal boys. The paedophiliac presents a distinct and largely unrelated problem showing more common ground with the exhibitionist than with the homosexual.[5 6] The role of boarding-schools and of childhood seduction in the genesis of homosexuality appears to have been exaggerated.[7] Nor indeed is there much evidence of emotional disturbance in the assaulted child, while there is increasing evidence to suggest that seduction in either sex is often a manifestation rather than a cause of disturbance in behaviour.[8-10] The crime of the homosexual is usually that which occurs between "consenting adults." Here the ratio of criminal acts to known offences is thought to be at least 2,500 to 1 and if Kinsey's estimates[11] are accepted may be as high as 30,000 to 1 in some age groups.[7]

Female homosexuality is less frequent and less subject to sanctions. Many regard the excess of male deviants as evidence of the operation of a biological factor, and E. Slater's observation[12] that affected persons are of late birth rank and commonly born to older mothers would appear to support this. Other workers point to the universal identification of the young child with its mother. In the female the mother model remains of prime importance, but the male child must turn towards his father as a model for later behaviour. Genetic studies have been inconclusive, for while F. J. Kallman[13] observed a 100% concordance rate for homosexuality between monozygotic twins others have cast doubts on his observations.[14-16] Chromosomal sex always corresponds to anatomical sex and in fact no abnormalities of the chromosomes have been detected in this condition.[17] At present no clear-cut genetic

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