[1] Gold, P., and Freeman, S. O., *Journal of Experimental Medicine*, 1965, **121**, 439.
[2] Thomson, D. M. P., Krupey, J., Freedman, S. O., and Gold, P. *Proceedings of the National Academy of Sciences*, 1969, **64**, 161.
[3] Reynoso, G., *et al.*, *Journal of the American Medical Association*, 1972, **220**, 361.
[4] LoGerfo, P., LoGerfo, F., Herter, F., Barker, H. G., and Hansen, H. J., *Amercian Journal of Surgery*, 1972, **123**, 127.

Geriatric Plans

Since the end of the second world war geriatric medicine in the United Kingdom has developed from a specialty practised by a few enthusiasts to a well-recognized discipline employing more than 270 consultant physicians and reaching a standard higher than anywhere else in the world. In 1967 the Royal College of Physicians acknowledged this progress by setting up a committee to consider its standing and development as a special branch of general medicine. The report of this committee has now been released.

The report is brief, covering some twelve pages, and is easily read. It starts by defining geriatric medicine and suggesting aspects of the subject which are particularly important to the elderly sick. These include the part played by disability, mental capacity, and social background in the elderly patient and the importance of accurate diagnosis in making a full assessment of the patient's state. Consequently the report considers that most geriatric inpatient beds should be in the district general hospitals, though it agrees that some patients may be admitted to wards in smaller hospitals near their homes for continuing care.

In discussing the present position the report emphasizes that many geriatric departments are short of staff and facilities. Many of the buildings which at present house elderly patients are in a poor state, but the high work load and responsibility of physicians in geriatric medicine is only inferred. Nevertheless from the continuing tone of the report it is obvious that the committee was worried by the number of unfilled consultant posts and the problems of recruiting more people to the specialty. As an alternative to the fully committed physician in geriatric medicine they have suggested that some physicians might have defined commitments in both geriatric and general medicine. This type of appointment already exists, and the need for experiments of this nature has been suggested elsewhere.[1] The importance of co-operation between the physician in geriatric medicine and his colleagues is rightly stressed, for the problems of ageing involve many disciplines. The report emphasizes that the geriatrician has many parts to play and suggests that in large units individuals may elect to fill a specific role. The report has little to say about the lone consultant in a small unit, and indeed the problems of professional isolation experienced by some doctors are ignored.

In discussing future trends it is disappointing that the committee has not been more constructive, though few readers will quarrel with what it does say. It is the lack of new ideas which causes concern. There is for instance no mention of the importance of increasing turnover of beds within geriatric units. Instead it is suggested that increasing numbers of beds will be necessary during the next 30 years, yet R. W. Parnell[2] has suggested that if turnover is increased sufficient beds are available to cater for the expected increased number of elderly.

The report deals most adequately with the subject of further education and training posts and makes the important point that there is great satisfaction to be had in the specialty of geriatric medicine. If this can be demonstrated to undergraduate and postgraduate students, there is no doubt that the problems of recruitment into the specialty will be solved. Correctly, the report says that teaching should extend through every phase of the undergraduate curriculum, including the preclinical period.

Research is essential if the advance of geriatric medicine is to continue, and the report suggests that this be collaborative or individual. Collaborative ventures are difficult to organize, as is research on a longitudinal basis. To foster these it seems essential that an institute of gerontology and geriatrics similar to those in America and Russia is established soon. It seems a pity that the committee did not consider this possibility and pronounce upon it.

On the whole this is a fair report if at times pedestrian. There is a genuine problem of recruitment of hospital doctors to geriatric medicine. The importance of attractive buildings, efficient organization, and helpful co-operation with other specialties cannot be stressed too highly. The image of the job in question is all-important. If working conditions are bad, no amount of satisfaction in the job will compensate. Geriatric medicine has to overcome this problem. If the report's suggestions are adopted the position should improve. But immediately to replace the bad buildings and to increase the number of geriatric beds is unrealistic, since it will require too great an expenditure of capital and revenue. As the report recommends, more must be done to promote a healthy mental and physical environment for all people over 65. What should be done the report does not say: perhaps it was outside the committee's brief. Some other committee, perhaps from the B.M.A., will have to provide the answers.

[1] *Age and Ageing*, 1972, **1**, 129.
[2] Parnell, R., *Gerontologia clinica*, 1971, **13**, 136.

Medicine among the Managers

The professional life of most doctors doing clinical medicine in the N.H.S. usually touches the organization of the Service in only a limited way. The general practitioner conducts his surgery and visits his patients in a medical environment which is still largely fashioned by his own or his partners' wishes. Personal contacts with the executive council are infrequent, while the Elephant and Castle is a remote address. The consultant doing his ward round or the houseman examining a late night admission knows that his surroundings and equipment are provided by the hospital authority, but he is usually too busy to spare more than a thought—and then probably a critical one—for the complicated organization supporting the hospital service.

Thus the Green Papers,[1 2] the consultative document,[3] the subsequent discussion, and the resultant White Paper on N.H.S. reorganization,[4] though not unnoticed by the average busy clinician, have probably been passed by with only a cursory glance and a thought that 1974 is a long way off. Now a Management Study Report has been published.[5] It deserves closer study than it is likely to get, for though its proposals are designed to affect the working lives of doctors they are set out in a jargon that will deter any but professional readers of such documents from penetrating its secrets.

The report has as an objective "a fully integrated health service." It also acknowledges the importance of links with local authorities, a matter looked at by another working party.[6] Its emphasis on local needs is welcome, but how much local autonomy will there really be, and how much integration can there be in the wake of the Seebohm legislation? Doubtless to reassure medical readers the report gives us such glimpses of the obvious as: "Health services are heavily dependent on the dedication of doctors and the other healing professions" and "The first duty of a clinician is to practise clinical medicine." It is at pains to affirm that without clinical autonomy neither consultants nor general practitioners can do their work properly. But the main aim of the new proposals is to get the profession into a "management process" which is summarized in the favourite phrase—"delegation downwards should be matched with accountability upwards."

One of the principal places where doctors will play a part under the new management is in the district medical committees. Each committee is intended to represent all general practitioners and hospital doctors. With about a dozen members, it should co-ordinate the medical aspects of health care throughout the district. Each member would represent a group of doctors with common interests. Among other things the committee will have to arrive at a "consensus view" of medical policies and priorities, and according to the report "it will use its authority as a self-regulating body to persuade individual clinicians to co-operate in the implementation of plans agreed by the consensus." Its functions will also include "using persuasion" to influence expenditure on drugs, surgical supplies, etc. (the report's "etc."). Clearly these district medical committees are intended to be powerful bodies, and it seems hardly necessary to add that if they come into being the medical profession will have to watch very carefully the influence they are expected to exert.

Another function of the district medical committees will be to make recommendations to the district management teams. These are to be composed of representatives of doctors, one or two of whom will be elected by the district medical committee, dentists, nurses, and other health workers, and they are charged with managing most of the operational services of the N.H.S. They must review the community's needs for health care and the provision of services within their district. From that they will identify opportunities for improvement or changes in priority and then submit plans to the area health authority. Thus the district management teams will be the units with chief local influence over the running of the Health Service and with communication through the management hierarchy to the Minister at its apex.

Doctors must have many reservations on whether the new proposals for the management of the Health Service will actually improve the care of patients. The effect of the changes is difficult to guess at because they depart so greatly from the existing arrangements, and this in itself must give grounds for doubt, because real improvement in a complex organism such as the Health Service, with a long history that goes back far beyond its initiation in 1948, does not commonly follow except by inching forward to fairly predictable goals.

The question that must be asked of the new scheme is whether it will lead—insidiously rather than blatantly—to interference in the doctor-patient relationship by people who are concerned with management rather than medicine. Doctors appear to be offered a responsible position in it, but the fact is that the great majority of them are busy men and women in the grip of an exacting profession. They have all too little time to bring their influence to bear in a State machine that provides the conditions in which they practise it. The immediate danger is the threat to clinical independence. The more remote one concerns the whole position of a profession in a tightly controlled State service. For the present the report goes out of its way to make placatory utterances and to encourage the medical profession to enter into the running of the reorganized Health Service. The extent to which its proposals seem capable of being fulfilled in reality needs the most careful scrutiny.

1 *The Administrative Structure of the Medical and Related Services in England and Wales.* London, H.M.S.O., 1968.
2 *The Future Structure of the National Health Service.* London, H.M.S.O., 1971.
3 *National Health Service Reorganization: Consultative Document.* London, H.M.S.O., 1971.
4 *National Health Service Reorganization: England,* Cmnd. 5055. London, H.M.S.O., 1972.
5 *Management Arrangements for the Reorganized National Health Service.* London, H.M.S.O., 1972.
6 *British Medical Journal,* 1971, **3**, 439.

Success of Adoption

In recent years adoption has been an increasingly popular means of providing substitute care for children. It has proved to be remarkably successful. This is the encouraging message of the latest report of the National Child Development Study.[1] The report describes the development at the age of 7 years of a representative sample of 200 adopted children born in 1958 and compares it to the development of children born in the same week who were not adopted. Of particular importance are comparisons made with the development of illegitimately born children who remained with their natural mothers.

About a third of children born illegitimate were adopted, and of the adopted children 89% were illegitimate. There were no differences of social background between mothers who decided to keep their children and those who offered their babies for adoption, and, surprisingly, there were no differences of background as assessed by the social class of upbringing between the mothers of legitimate and illegitimate children. But children in the latter group were at a disadvantage because a greater proportion of their mothers were very young and were primigravid. There were significant differences in attendance at antenatal clinics and in bookings for confinement, and adverse physical factors were present before, during, or shortly after birth relatively more often for illegitimate children. The favourable environment enjoyed by most adopted children enabled them to achieve normal development despite their greater vulnerability at birth.

Adopted children were the same in almost all respects as other children of their age. A physical examination including an assessment of vision, hearing, and intelligibility of speech showed no differences in the prevalence of defects between adopted children and all other children, but the adopted group contained relatively more tall children, which suggests that they received excellent nutritional care. Clumsiness, poor physical co-ordination, and fidgety, restless behaviour, as assessed by their class teachers, was found in a higher proportion of adopted boys than in all boys, but these differences were not found in girls. Ability in general knowledge, self-expression, creativity, reading, and arithmetic were