

adrenal haemorrhage is diagnosed it is important to ensure it is not part of a more general disease, the most important part of which is thrombosis of a renal vein, the inferior vena cava, or mesenteric veins. All these lesions have much more serious sequelae and are the commonest causes of death when children succumb with gross adrenal haemorrhages. Massive adrenal haemorrhage in newborn babies needs to be recognized for what it is, but the treatment of the child's general state is of paramount importance, and the mass can be left to look after itself.

¹ Snelling, C. E., and Erb, I. H., *Journal of Pediatrics*, 1935, 6, 22.

² Black, J., and Williams, D. I., *Archives of Disease in Childhood*, 1973, 48, 183.

³ Kissane, J. M., and Smith, M. G., *Pathology of Infancy and Childhood*, p. 695. St. Louis, Mosby, 1967.

⁴ Emery, J. L., and Zachary, R. B., *British Medical Journal*, 1952, 2, 857.

Sex and Social Class

More than a third of all pregnancies in married women are unplanned and half of these are unwanted, according to an assessment of the use of family planning services in England and Wales prepared for the Department of Health and published this week.¹ The report is based on interviews with 3,500 women and reflects current attitudes; and its most striking findings are the variations in those attitudes in women of different social classes.

Unplanned and unwanted pregnancies seem more common among wives and daughters of manual workers, and within this group the problem is greatest among those who marry before the age of 20 or who are pregnant at the time of their marriage. The report recognizes that pregnancy may still sometimes be seen as a means of precipitating marriage, but the interviews suggested that the greater frequency of unplanned pregnancy in single girls in classes IV and V might be due to a more casual attitude to contraception—perhaps because they were not as preoccupied with the consequences of their actions as are other single women with plans for a career.

Clearly any theories about motivation must be based on speculation; but the report does present evidence that women of all ages in social classes IV and V make relatively little use of the family planning services currently available and tend to rely on traditional methods such as the condom, withdrawal, and the safe period. Clinics still seem to have a predominantly middle class appeal, and while married working-class women go to their general practitioners their single daughters do not.

Further reduction in the number of unplanned pregnancies is an urgent need—as can be seen from the rising numbers of abortions carried out each year—but the report says that the problem will not be solved simply by increasing the number of clinics, for an important deterrent seems to be the lack of privacy—"everyone knows what you've come for." Accessibility is specially important in socially deprived areas, where few women have use of a car, and for that reason the general practitioner's role is vital. The reluctance of some women to approach him is partly due to shyness of discussing sex with a man, suggests the report, and partly a fear that he might not see provision of advice on family planning

as his job. An additional fear among single women seems to be that general practitioners may oppose the use of contraceptives by the unmarried. In all these cases propaganda by word of mouth can be effective—but only when the majority of doctors are convinced of the importance of fertility control in the care of their patients.

The most difficult problem is education of teenage girls in the use of contraceptives, particularly those in classes IV and V. To be effective advice must be given by the age of 15 or 16; and almost inevitably this means that advice should be given in schools. Unfortunately school sex education has received widespread adverse publicity through the activities of a few fanatical supporters of sexual liberation; the many well-balanced lectures given by sensible, experienced doctors have been ignored. Long-term, sex education holds out the best prospects for reducing unwanted pregnancies; but it must be good sex education, which emphasizes the importance of personal relationships as well as physical ones.

¹ Bone, Margaret, *Family Planning Services in England and Wales*. London, H.M.S.O., 1973.

Collaboration

The long-standing division of health responsibilities between the N.H.S. and local authorities has bedevilled the development of health services in Britain. In some areas the effects have been mitigated by goodwill and determined work by those working in the services. In others regrettably this has not always been the case. So it is appropriate that within a week of the N.H.S. Reorganisation Bill¹ finally receiving the Royal Assent—which coincided with the 25th anniversary of the N.H.S.—the Government should publish a report on collaboration between the Health Service and local government in England and Wales.²

Though styled as a report from a working party—one of a triumvirate^{3 4} set up after the 1971 Consultative Document⁵ appeared—it is really a series of reports from three subcommittees looking at different aspects of collaboration. These were personnel social services, school health services, and environmental health services. Other subcommittees studying financial arrangements and collaboration in London have yet to report. Much of the contents of the report is not new because the work of the three subcommittees was sent out for comment to interested bodies during 1972. Indeed, the conclusions on the School Health Service, with the main proposal that it should pass into the control of the new N.H.S., have already been accepted by the two Secretaries of State.⁶

Over fifty people from Whitehall, the N.H.S., and town halls, took part in this exercise, which was chaired by Mr. A. R. W. Bavin, a senior Department of Health official; so it is no surprise that one or two voices of dissent are raised in the pages, with several paragraphs bearing the scars of hard-fought compromises. Disagreement arose over the staffing of personal social services with two doctor members unhappy at the prospect of hospital social workers being transferred to local authorities, as suggested in the report. Doctors are worried about the effects of Seehohm,⁷ and the

working party asks that local authorities be statutorily required "to provide social work support for the health services" and that area health authorities should "provide medical and nursing support for local authority social services." This has already been written into the new Act, but it will require much more than a fine-sounding statute to provide the necessary staff, facilities, and co-operation to ensure that the correct social support gets to the right patient at the right time.

The B.M.A. welcomed the Government's decision to include the School Health Service in the reformed N.H.S. and the report explores the matter in some detail. Nevertheless, local authority organizations have opposed this move and judged by some dissenting paragraphs from three local government representatives (one a dental officer) there is still unease. They raise doubts about the extent of co-operation and "the degree of priority which the N.H.S. will be able to accord to the school health service." It will be up to doctors and nurses in the Health Service to allay these fears.

These notes of disagreement are a warning of potential hazards ahead. It will be the task of joint consultative committees, to be set up by each A.H.A. and the corresponding local authority(ies), to anticipate such hazards by planning and co-operation. This is important because, in giving helpful practical advice on their functions, the Working Party has decided that it is "unnecessary to provide formal machinery for resolving disputes"—either in the committees or between authorities. The work of these advisory committees should be helped by the proposal that any recommendation to their parent authorities should be made public. Too often the gestation of local authority and N.H.S. decisions affecting the community occurs behind closed doors and any publicity should be welcomed.

Traditionally environmental health has been a local government preserve and many authorities and their medical staff have some outstanding achievements to their credit in this field of medicine. It was not unexpected, therefore, that local authority organizations should resist the removal of this work from their orbit. Certainly, the chapter contributed by the subcommittee looking at environmental health manages to convey a feeling of disapproval for the new arrangements. Local authorities obviously do not relish the idea of a doctor working for the area health authority providing them with medical advice—despite their custom of split appointments and part-time medical advice. Thus after balancing the arguments for seeking general medical advice from an A.H.A. against the employment of a medical adviser with a detailed contract the Working Party takes "the middle way" and suggests secondment of a doctor from the A.H.A. at the invitation of the local authority. This type of appointment breaks new ground and it may take some time for the arrangements to shake down. Nevertheless, public health doctors will criticize the lack of any proposal for a statutory obligation on local Authorities to seek advice from the N.H.S. — a failure, unfortunately, that applies to all medical aspects of local authority work.

Sir Keith Joseph and his colleague in Wales, Mr. Peter Thomas, have commended this report to the "existing and new health and local authorities." It will be followed by more recommendations, as the "Collaboration Working Party" is likely to survive beyond April 1974. This news may bring a groan from those already stunned by the avalanche of official papers. But relations between reorganized local government and a changed Health Service may be quite

touchy for a while as both try to find their way in new territory. Patients will suffer if collaboration starts off on the wrong foot so this report and any future comments deserve more than just a passing glance from doctors.

¹ *National Health Service Reorganisation Bill*, London, H.M.S.O., 1973.

² Department of Health and Social Security, Welsh Office, *A Report from the Working Party of Collaboration between the N.H.S. and Local Government on its Activities to the End of 1972*, London, H.M.S.O., 1973.

³ *British Medical Journal*, 1971, 3, 439.

⁴ *British Medical Journal*, 1971, 4, 691.

⁵ Department of Health and Social Security, *National Health Service Reorganisation, Consultative Document*, London, 1971.

⁶ *British Medical Journal*, 1972, 3, 248.

⁷ *British Medical Journal*, 1973, 2, 623.

Childhood Obesity and Carbohydrate Intolerance

Obesity in childhood has emerged as an important challenge to paediatricians and family doctors. Its consequences are complex, and the serious effects may show overtly only in adult life in an increased morbidity and mortality rate. For too long there has been failure to recognize the relationship of obesity in childhood to the problems of the overweight adult. Degenerative vascular disease, job problems, and insurance premiums seem far removed from the overweight infant, toddler, or school child.

Recently attention has been focused on the tendency of some young infants to gain weight too quickly.¹ This has been attributed to overfeeding, which in part is the result of the unduly early introduction of cereals. With the excessive intake of calories there is evidence of simultaneous excessive intake of sodium.² The determinant of the final number of fat cells we have may be the number required for storage in early life. J. Hirsch and P. W. Han³ showed that forced feeding of rats during infancy permanently increased fatness and the number of fat cells. Thus we may be programmed for appetite at this early stage, and this programming could be set by both a central mechanism and a demand by peripheral cells. Studies of the number and size of fat cells have yielded information suggesting that overfeeding should be avoided in the first years of life, when the numbers of fat cells are finally determined.⁴ When a person loses weight after this time, fat cells do not disappear; they simply decrease in size.

Up to 80% of obese children are reported to remain obese as adults,^{5,6} and E. E. Eid⁷ showed that excessive weight gain in the first six weeks of life was related to being overweight at 6 to 7 years of age. Changes in carbohydrate metabolism in the obese have been extensively studied. The effect of insulin on glucose uptake by the subcutaneous tissue of the forearm is attenuated in obese people,⁸ and the enlarged adipocytes obtained from the obese are relatively insensitive to insulin in terms of glucose uptake and utilization.⁹ The secretion of glucagon in the obese is also altered.¹⁰ M. M. Martin and A. L. A. Martin¹¹ have recently published the results of a study of the relationship of obesity in childhood to carbohydrate tolerance in childhood. They investigated a group of 42 fat children and 30 of normal weight by performing five-hour oral glucose tolerance tests and also analysing samples of plasma for growth hormone and immunoreactive insulin. Their results showed chemical