

occasion even in public places despite "No smoking" notices.

Recently the Institution of Professional Civil Servants tried to get the employment side, the Civil Service Department, to take some action on this matter. The staff side put up three sensible proposals. They are worth setting out in full because other bodies representing employees may wish to take them up. The staff side asked the Civil Service Department to: (1) issue a general warning throughout the Civil Service on the health hazards of smoking; (2) separate non-smokers from smokers where practicable; and (3) institute no-smoking periods. Nobody familiar with the brainwashing induced by smoking will be surprised to learn that these proposals were rejected.

But the battle of clean air is worth continuing, for the non-smokers as well as being right will probably win in the end. The grip that tobacco has obtained on a substantial minority of the population shows some signs of weakening. And the careless disregard that smokers too often show for both the sense and the sensibility of non-smokers runs counter to a growing concern in other ways to behave in a healthier fashion. Spitting in public, for instance, once so commonplace as to go unremarked, has diminished in the last 50 years so greatly as to evoke distaste and even remonstrance nowadays. Again, people take more care than formerly to guard against the spread of infections—"Coughs and sneezes spread diseases." So that it is against this improved attitude to public health that smokers continue to puff carcinogens into other people's lungs as well as their own.

There are already too many people around saying No. And in relation to smoking the railways and airlines set an unfortunate example. Instead of "No smoking" compartments there should be "Smoking" compartments. So that as well as education in schools and public places on the dangers of smoking to the smoker, its possible risks and undoubted offence to people who must associate with him, and its evil example to young people, some official encouragement to keep the smoker in his place would be welcome. That smokers will exist in the community for the foreseeable future is undoubted. Let them be segregated so far as is reasonably practicable in offices, restaurants, pubs, village halls, lecture theatres, committee rooms, cinemas, factory floors, and workshops, as well as in public transport vehicles, by notices showing where they may smoke, if they must, among fellow addicts.

Early detection of growth hormone deficiency

When a child's short stature is due to lack of growth hormone, every year without treatment means a permanent loss of some inches in his final height. The indications for and the long-term effects of human growth hormone therapy are now well known. Only those children in whom the secretion of growth hormone is deficient will benefit from this treatment, but in such cases the regular injection of human growth hormone should be started at the earliest possible moment and continued until growth potential is exhausted with the closure of the epiphyses.

Growth hormone deficiency may be due to structural damage to the hypothalamus and pituitary—such as that due to craniopharyngioma—when it is usually associated with

defective secretion of other pituitary hormones. In practice, however, the most common disorder is an isolated deficiency due to a defect of either release or synthesis of growth hormone. This condition is not associated with any structural defect of the pituitary; it affects boys far more frequently than girls; and it may be familial. From birth onwards the rate of growth is very low, and the rate of bone maturation is much delayed. The absence of growth hormone makes the child relatively plump. Of all types of growth hormone deficiency this type responds the best to treatment with human growth hormone.

Early treatment is of paramount importance, for if left undiagnosed the child's height falls further and further below the norm, and later treatment can never compensate for all the height lost. Tanner has recently made an eloquent plea for early diagnosis,¹ pointing out that experience in the Medical Research Council trial had been that correct diagnosis often seemed to have been unduly delayed. Proper diagnosis of short stature should be possible by the time any child reaches the age of 5. By this age any sufferer from isolated growth hormone deficiency will have a body height that is at least three standard deviations below the mean. Doctors concerned with child care should ensure that all children as short as this have been referred to a paediatric or endocrine unit by the time they are due to start school. Although new methods of extraction have greatly improved the yield of growth hormone from human pituitaries, it will remain a scarce commodity. To ensure that the hormone is given to those who need it and that long-term treatment is monitored for success, the preparation and distribution of human growth hormone are still organised by the Medical Research Council, now with the co-operation of the DHSS.

¹ Tanner, J M, *Health Trends*, 1975, 7, 61.

Nucleus hospitals

Early next month the Department of Health will be explaining its plans for nucleus hospitals to the Joint Consultants Committee and will justify yet another change in direction in the hospital building programme on the grounds of financial necessity. The nucleus concept provides standard designs for the units required in the first phase of a district general hospital and is based on a standard module, two storeys high, with variations in ward design kept to a minimum. The economic arguments for mass production are familiar and convincing, and to that extent the proposals will meet with a general welcome. But there are wider implications of this revision of Department policy which have been given too little attention.

Quite why it took the DHSS more than 20 years to realise the practical advantages of standardisation of some features of hospital design must remain a mystery. In the early years of the NHS it was assumed that, just as gentlemen always had their suits made to measure, hospitals should always be designed from the site upwards, taking into account all the personal idiosyncrasies of the hospital staff and local traditions. Need we be surprised that while half the schools in Britain are post second-world-war—and so are half the houses—less than a quarter of all NHS hospitals were built after 1948 and indeed half of them go back beyond the Kaiser's war? The tortoise pace of hospital rebuilding in Britain compared to

that in most of Europe caused so much concern that in the early 1960s the great *Hospital Plan*¹ was published, revised in 1966 as the *Hospital Building Programme*.² These set out in detail the priority to be given to each project, dividing them into sooner (to be started by 1969-70) and later (no starting date suggested). The plans depressed the medical and nursing staff working in those hospitals which came low on the list, but they encouraged many medical communities into believing that a length had been fixed to the time they would have to go on working in half-converted Victorian workhouses. Further encouragement came with publication of the plans³ for the best-buy hospitals at Bury St Edmunds and Frimley: at last, it seemed, there were prospects for the rapid replacement of our decaying buildings by a new generation of semi-standard district hospitals.

That was in 1968. Since then it has been downhill all the way. Repeated revisions to the building programme have pushed starting dates further and further into the future, and all the worst features of planning blight have operated—once a hospital is scheduled for rebuilding any expenditure on maintenance is reduced to a minimum, with a depressing attitude of make-do, botched repairs, and temporary solutions.

At the same time as economic pressures have slowed hospital rebuilding, increasingly the broad strategy of its programme has come under challenge. Small cottage-style hospitals had been closed during the 1960s, but by the end of the decade district general hospitals were being criticised as too large and too impersonal, and by the early 1970s the tide of ministerial opinion had turned far enough for Sir Keith Joseph to be extolling the virtues of community hospitals. In part this represented the general disenchantment with technology that occurred after the moon-landings had proved so futile and expensive; in part it was due to the greater emphasis on the personal and social needs of patients and on attention to their opinions. Nevertheless, while there was public discussion of a move towards community hospitals, the district hospitals remained the centrepiece of official policy—even if the optimum number of beds had declined from the original ceiling of 1000 and over. Then, most recently, the virtual halt in hospital building that was forced by the oil crisis was accepted, unwillingly but resignedly, by the staff of the hospitals affected. They were not told—nor did they expect—that many of these projects had been cancelled for ever.

For that is what has happened. Dr Owen's speech to the Medical Practitioners Union in December⁴ made it absolutely clear that he was touring the country "telling numerous people that their much-needed and much-desired district general hospital cannot be built. . . . Large district hospitals built in one phase are no longer a feasible policy," he went on, and suggested that "The community hospital concept offers a way of meeting many of the wishes that have often been expressed about hospitals by patients and consumers generally." He explained that by limiting the size of new hospital building projects to 300 beds many more starts could be made (in the financial year 1978-9); and that the other beds needed could be found in community hospitals. He saw no reason to suppose that general practitioners in cities were not just as keen as their rural counterparts to work in their local hospitals.

Many of our cities—especially in the north of England—have plans to scrap their current miscellany of ageing hospitals and replace them with a single, new district hospital. The new scheme envisages that, instead, a small acute unit should be built on the site of the district hospital, retaining the old inner

city hospital as an urban community hospital. As Harvard Davis has pointed out,⁵ this proposition betrays a dangerous confusion between the use of community hospitals as an extension of primary care—a cause supported by many family doctors—and the use of these hospitals as a cheap way of bolstering up inadequate hospital services. Transfer of the "convalescent" patients from acute wards to so-called community hospitals carries a danger of creating chronic units with the worst features of our present geriatric hospitals. Community hospitals should surely be used by local doctors for the admission and treatment of patients not needing specialist care. They must not be used as an overflow for the patients "blocking beds" in acute wards.

Progressive patient care in multiple small hospitals, as suggested by the new scheme, represents a major shift in policy: and it may well prove to be disastrous. The technological clock cannot be turned back completely, and all patients admitted on medical grounds to hospital nowadays require the kind of support from laboratory and technical services that can best be provided in one large unit rather than half a dozen small ones. Furthermore, effective use of community hospitals requires rehabilitation services backed up by enthusiastic domiciliary community care; these services are still virtually non-existent in many parts of the country.

More important, however, is the way in which the Government policy has been changed. The reorganised NHS was said to be designed to facilitate consultation and effective management, yet time and again in the last few years of economic stress the NHS staff actually concerned with treating patients have had new schemes of organisation, administration, building, and staffing imposed on them from above. Whose advice was sought before this radical change was announced? What consultation or discussion took place with the professions concerned? Virtually none.

¹ *A Hospital Plan*. London, HMSO, 1962.

² *The Hospital Building Programme*. London, HMSO, 1966.

³ *British Medical Journal*, 1968, 2, 113.

⁴ *The Times*, 7 December 1975.

⁵ Harvard Davis, R, *Lancet*, 1976, 1, 86.

Problems of childhood

The care of children is unusually subject to the vagaries of fashion—changes in feeding methods and diets and views on pot-training and discipline have always mirrored social changes in our society. More recently, however, dogmatic opinions on these topics have been challenged by research findings, and there is now a growing body of hard fact on which doctors can base their advice. This is true, too, of the management of behaviour disorders and the other myriad medical problems that bring children to the doctor—and occupy one-quarter of the time of the average general practitioner. This week (p 266) we start publication of a new series of articles on the diseases and problems of children, designed to explain the advances that have been made in the last few years and their practical significance for clinicians. At all levels paediatrics is one of the most rewarding medical disciplines: we hope this series will help doctors to give and get more out of their contacts with children.