Insurance figures of sickness benefit do not include spells of absence of three days or less, which do not attract benefit and are usually uncertificated. Industrial experience suggests that these spells have increased more than the certificated spells and that the change is even greater among younger persons.

Managers recognize that some members of the staff are more likely to have spells of sickness absence than others. Typical figures show that 28% of men have no spells of absence in the year, whereas 31% have at least three spells and 7%, at least six spells, and the same individuals appear to repeat their same pattern in consecutive years. Some are more liable to "sickness absence" than others, and this appears to be particularly true of short-term absence. It would be a great advantage if those who were liable to have more than average numbers of short-term spells of sickness absence, which are very disrupting to industry, could be identified by other factors.

Professor P. Froggatt has now analysed the distributions of one-day and two-day absences among 2,300 male and female workers, both salaried and hourly paid, in two light engineering works and two Government departments in Northern Ireland. He tested the abilities of five hypotheses to explain the distributions—"chance," "prone," and three of "true contagion." From closely reasoned arguments he draws the conclusion that "prone" (a stable liability to absence) plus several unquantifiable factors constant for each individual over the period of study largely explain the data. But he emphasizes that some of the other hypotheses cannot be entirely rejected. Froggatt suggests that two-day absences are more like long-term sickness absence (and hence have "medical causes"), whereas one-day absences appear to have "non-medical" causes. But one-day and two-day absences are themselves associated, other factors should operate. He concludes that "prone" does successfully explain the pattern of short-term sickness absence of the people he studied.

In attempting to identify and measure the characteristics of the people prone to one-day absence and those prone to two-day absence he shows that the strongest absence pattern in the period he studied is, for each group, related to their sickness absence experience in previous periods. A reasonable prediction of the average future experience, especially for one-day absences, could be made from study of the past, though perhaps not to an extent which would justify executive action. He suggests that, whatever reasons the workers concerned may give for them, short-term absences may simply be the overt expression of a desire to work discontinuously. And this inclination, though it can be mitigated in some circumstances, will still be stronger in some individuals than others. This work is a valuable confirmation of subjective impressions of managers and occupational physicians.

Froggatt implies that the pattern of one-day and two-day absences in individuals is immutable, and this is probably true when it has been established for many years. In these circumstances the individual's excessive sickness absence must be accepted or employment terminated. However, there is a small group of them in whom, after investigation, no apparent cause for repeated absences can be found but who are unaware of the number of their absences. The sickness absence of some of these people will diminish after explanation, especially if they are seen within a year or 18 months of the beginning of their poor pattern of absence. Perhaps the manager, the family doctor, and occupational physician can collaborate in identifying early those who are starting to have frequent short-term absences to try to reverse the trend before it becomes an established pattern. The manager and the occupational physician can also collaborate in trying to find out reasons for the proclivity to discontinuous work in particular occupations. Are capacities being underemployed? Are workers being made to feel inadequate? Are their failures and successes going unrecognized?

In Time of Need

Arranging charitable help for their patients is something most doctors have been concerned with at some time in their professional lives. Less commonly, fortunately, a doctor or his family may have to seek such help themselves. Nevertheless enough medical families run into unforeseen difficulties to prompt a steady stream of requests to the profession's own charities. Until now the largest of the funds devoted to helping doctors and their families has been the Royal Medical Benevolent Fund, with its offspring, the Ladies' Guild. The Epsom College Foundation supports pensioners as well as schoolchildren, and the B.M.A. too has its established charities—the Sir Charles Hastings and Dain Funds. In addition there are a number of local charities of varying size which do excellent work.

A newcomer is rare, and the launching of the Cameron Fund with a capital of £800,000 is a welcome arrival. The fund's capital, which was the amount outstanding when the general practitioners' group practice loan fund was wound up, should provide it with the largest investment income of all the medical charities. The trustees are fortunate in starting life with such a substantial foundation, and it will leave them free, at least in the early stages, to concentrate on their objective of assisting family doctors and their families in need.

Of the two basic functions of a charity—raising money, and distributing it fairly—the first is usually the more publicized. However, identifying suitable applicants and assessing their real needs are obviously as important and can be surprisingly difficult. Smaller funds are especially vulnerable, since they cannot really devote sufficient money to employing staff on what is often a delicate and time-consuming task. Furthermore, the financial limitations of a small charity probably make the trustees reluctant to advertise its availability too vigorously.

The country's economic inflation now makes it imperative that the money available should be used to greatest effect. There is much informal co-operation already among the existing national and local medical funds. The arrival of the Cameron Fund and the threat of continued inflation prompts the question whether more co-ordination in administration might usefully be achieved, particularly in the expert assessment of applications. And perhaps the profession itself could play a greater part locally on behalf of all the charities by identifying and assessing those in need.

These are only a few of the problems which will no doubt be considered by the Cameron Fund's trustees. They will have behind them the good wishes of the whole profession, and at the same time they will be the first to agree that their presence will not lessen the importance of existing charities nor the need to support them. With the approach of Christmas doctors will no doubt wish to help with their customary generosity all the funds which help members of the profession and their dependants in time of need. In particular readers are reminded of the R.M.B.F.'s annual "Christmas Gifts" appeal (see letter p. 435).