sidered that the parents have consistently failed, without reasonable cause, to discharge their obligations to the extent as to be unfit to care for the child. These considerations also apply to a person who is subject to a resolution based on the grounds given above and who is, or is likely to become, a member of the household containing the child and his other parent.

When a child has been in the care of the local authority under section 1 (or partly with the local authority and partly with a voluntary organisation) for a period of three years, this constitutes grounds for the local authority assuming parental rights (Children Act 1975). Parents must be informed of their right to object, and any objection must be made within one month after receiving the notice. If an objection is made by the parents the resolution will lapse within 14 days unless the local authority applies to a juvenile court. A resolution under section 2 provides the local authority with similar powers to that of a care order and lasts until the age of 18 years. Both the local authority and the parents have a right of appeal to the crown court against confirmation or termination of the resolution by a juvenile court.

The police

It is the duty of any citizen to inform the police if he thinks that a child has received non-accidental physical injury; the police will then investigate. Whether they subsequently decide to prosecute is their decision, though, before deciding to do so, it is desirable that they should consult with other agencies concerned, preferably at a case conference. In most areas the police are invited to all case conferences on suspected or proved non-accidental injury.

There are difficulties for the doctor who is required to give to the police information which is supposedly confidential. It is difficult to retain the confidence of the parents with whom he is working, and it is not helpful for it to be thought that all suspected cases of non-accidental injury admitted to a particular hospital are automatically reported to the police. In practice, the consultant must decide whether the injury is accidental or non-accidental and whether he thinks there are sufficient grounds for informing the police. Where a child has received severe or potentially fatal injuries it is obvious that the police must be told. It is the duty of the police representative at a case conference (as it is also the duty of those representing other agencies) to take back to his superior officer the opinion of the case conference, but the corporate opinion of the case conference is not binding on the police, or indeed on any agency attending it.

Each area needs to evolve its own method of working, with procedures best calculated to safeguard the child. What has become obvious is that insistence on professional dignity, and action by one group without reference to others concerned, whether by doctors, social workers, the police, or the legal profession, may result in a disastrously wrong decision that may cost the life of a child.

It cannot be overemphasised that joint consultation at all stages between the various bodies concerned is of enormous importance and that the procedures agreed should be clearly defined and understood by all who have to carry them out.

Further reading

Clarke Hall and Morrison's Law relating to Children and Young Persons, ed J Jackson, M Booth, and B Hains, 9th edn. London, Butterworth, 1977.

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Letter from . . . Chicago

Coming of the stork

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At this time the American public remains preoccupied with the progressive cachexia of the dollar, the malignant hypertrophy of the cost of living, the disappearing energy disease, and the dark prospects of an involutional recession. The President, accompanied by his hand-picked Georgian house staff, conducts frequent economic grand rounds, dispensing smiles and reassurance and placebo therapy, periodically urging the patient to heal himself and get out of bed. But, despite vigorous exhortations, the ungrateful patient refuses to get better, petulantly complaining about the failure of effective leadership and the lack of a consistent political philosophy, and criticising Mr Carter for being neither liberal nor conservative but drifting through the political fog like a flying Dutchman.[1] And, with disgruntled Democrats throughout the States threatening to draft Senator Kennedy, it has become clear that the country wants solutions and not sermons, action and not rhetoric. So it was no surprise when—the fog momentarily lifting in Washington—a stork carrying a parcel suddenly appeared in the June sunshine, circled several times over the White House, fluttered his wings ostentatiously, stopped for a moment to have his photograph taken, promptly deposited his burden in the Presidential oval office, and immediately flew off to tell all and sundry that decisive action had been taken and that the long awaited baby had at last arrived.

With Mr Califano acting as wet nurse, the new national health baby was immediately whisked over to the Capitol building. It was hoped that Senator Russell Long, the leader of a powerful centre Democratic block, would become godfather, buy the traditional silver cup, and make sure that the infant was brought up in the right religion. It was also hoped that Uncle Kennedy

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would not be offended, despite the baby being catastrophic rather than comprehensive. Mr Califano explained that under this plan employers would have to purchase catastrophic health insurance for their employees; that Medicare and Medicaid would be merged into a single streamlined operation that would function efficiently, with sliding doors and piped-in music, rather like the transeuropean trains; that containing hospital costs and fixing doctors' fees would make the scheme remarkably inexpensive; and that at any rate the money would not have to be spent until 1983, by which time both he and his boss would probably no longer be around to sign the cheques. But the Republicans thought the baby was exceedingly ugly. Aunt AMA took one look and almost fell over the cradle. Mr Kennedy said the baby was too little, too late, and too expensive, and that greedy doctors and ravenous hospitals would have to be controlled.

At this stage, the President preached one more sermon and then shook the two middle pillars of the oval office so vigorously that the nurse disappeared forever in the rubble and had to be replaced by the lady formerly in charge of houses, giving rise to fears that the baby would never recover from the deep psychological trauma of so terrible a shock. But, by then, the stork had already flown back to his native Alsace, so there was nothing left to do but shunt the cradle from one smoke-filled congressional subcommittee room to another, and wonder whether the catastrophic baby would die of croup or smoke inhalation, grow up into a healthy child, or become a Frankenstein monster.

Ill-fated Andrew

On the very day when the stork delivered its precious gift, the *Atlantic Monthly* reported on another catastrophic baby, little 600 gramme Andrew Stinson, gestational age 24½ weeks.[2] For nearly six months a dedicated team of intensive care specialists worked relentlessly, at a cost of $104 403 and in opposition to the parents' wishes, to keep alive this ill-fated fetus that would not live but refused to die. Complications developed, affecting all organs of the body, and being mainly of a traumatic, metabolic, infective, haemorrhagic, and degenerative nature. The bones became brittle from rickets and broke in many places; the lungs were obliterated by hyaline disease; and the parents also tell of countless suctionings and intubations, gangrene, infections of all kinds, bleeding into the lungs and brain, cardiac defects and an iatrogenic cleft palate, stress ulcers, and many other complications too numerous to recount. The endocrinologist was fascinated; the neurologist had a field day; and the baby continued to "live" thanks to the dogged determination of a respirator that refused to disconnect itself.

One highly beneficial factor in this medical tour de force was the system, almost universally prevalent in American academic institutions, of rotating the residents and attending physicians as frequently as possible, to avoid boredom and too close a doctor-patient relationship. The interns and residents benefit greatly from this system, because, by changing firms as frequently as once a month, they sample all the pearls dropped by their various chiefs without developing indigestion. When rotating through the various subspecialty services they are constantly running around offering consultations to each other, so that you never know who is who, and so that last summer's houseman is constantly changing his spots—now advising on the treatment of arrhythmias, now offering help with the interpretation of thyroid function tests, now writing learned haematology notes. But, for the attending staff physician, this merry-go-round also has untold advantages: voluntary physicians who "donate" their services don't have to donate too much; salaried academicians keep their hand in by doing one month's service, and still have the remaining 11 months to recuperate, think, and enjoy their "protected faculty time," while leaving the less interesting ward work to their, by now, much more experienced residents.

Little Andrew's parents, who had considerable difficulty in obtaining information from the perpetually rotating medical staff, ended up by being labelled "difficult parents," especially after pointing out that the doctors had either misquoted or misread medical publications. In vain, they urged the doctors to stop the heroics, and after the baby died they remained sufficiently aroused to publish their trials in the *Atlantic Monthly* under the title of "Ordeal by Doctor."[2]

Even so, in all fairness, the problem of stopping treatment in a hopeless case remains as difficult as ever. That doctors do not always prolong life at all costs was recently shown in a study suggesting that antibiotics are frequently, and apparently intentionally, withheld from bedridden inmates of nursing homes who have no hope of reasonable recovery.[3] Nor is it surprising that decisions are often made quietly ("in the closet"), considering the many possibly legal implications, epitomised by the prolonged confrontation in the Quinlan case and by the more recent furore about the Saikewicz decision. And, even though the latter judgment may merely represent the courts' desire not "to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel, or group, ad hoc or permanent,"[4] the doctor wishing to turn off a respirator may be hard pressed to avoid legal entanglements.

News from the "Tribune"

More clearcut, unfortunately, was a recent exposé by the *Chicago Tribune* of a large undercover operation that, under the guise of offering treatment for stress or obesity, was, in fact, peddling huge quantities of methaqualone and amphetamines for enormous profits. Operated by an ex-convict and organised in attractive business-like surroundings reminiscent of the abortion mills, this so-called medical establishment was making available to their "patients" a regular supply of drugs at a cost of some $100 for 50 methaqualones or "Quaaludes"; and so wonderful was the "high" feeling induced by this potentially dangerous tranquilliser that people from all walks of life and from all parts of the city would come with their wives and their children and their maids to pick up additional supplies of the drug and enjoy that high feeling you get when you're all "luded up." Three doctors, working under the leadership of the 35-year-old ex-convict entrepreneur, provided the necessary legal and medical facade by languidly spending the day autographing pretyped prescriptions, ostensibly to relieve their patients' stress and promote weight loss. And, although the authorities moved promptly to close the "medical establishment" in question, the problem of drug abuse remains, and, according to the *Chicago Tribune*, an estimated seven million Americans are improperly using legal prescriptions for amphetamines, barbiturates, and tranquillisers—a sad reflection on those whose irresponsible prescribing perpetuates this unfortunate exercise.

Also in the *Chicago Tribune* (29 April), we read that Ms Om Seti (alias Dorothy Eady) lived happily in her native Plymouth until the age of 3, when she fell down a flight of stairs and was pronounced dead by the local doctor. She remembers that, as the doctor was coming back with the death certificate, the body was sitting on the bed playing while she was crying that she wanted to go home. And home she went to her parental house in Abydos some 24 years later, and, having immediately found herself in the familiar surroundings of the temple of Seti I, she wondered what had happened to the gardens that were so beautiful a mere 3200 years ago. Settling down near the ruins of her familial home, she spent the next 40 years or so gossiping about some of the more boring high priests and about her favourite pharaoh, Ramses II, who was a wonderful man, though somewhat too fond of putting his name on other peoples' monuments.

Yet, moving from the twentieth dynasty to the twentieth century we still find people appropriating each others' monuments, or succumbing to ideas that "affect the embraces of virgins, swearing they are ours and ours alone." Thus it was reported that the popular Mr Alex Haley borrowed much from *The African* while researching in Africa for this Pulitzer prize-

winning *Roots*. This brings memories of that night of the winter of 1966 when we gave intravenous phenytoin to a patient with atrial flutter and 2:1 block, only to find ourselves a few minutes later frantically fumbling around for the digoxin to slow the 1:1 ventricular response. I would gladly have let this experience be buried in the yellowing pages of this journal[5] had I not been stopped short about a year later by a report of the untoward effects of lignocaine in atrial flutter with 2:1 block.[6] As soon as I began reading I felt, not like young Keats on first looking into Chapman's *Homer*, nor like stout Cortez staring with eagle eyes at the Pacific, but rather as if Ms Seti had accidentally bumped into Ramses himself in a thicket by the Nile. But, as the authors had gone to the extensive trouble of substituting lignocaine for phenytoin throughout the text while scrupulously leaving most of my sentences intact, I took another leaf from the journal,[7] concluding that what Dr Samuel Johnson might have defined as "a theft in literature" was in fact a compliment, a gift from the literary stork who all too rarely brings along the grudging recognition of our critical peers.

References

[1] Kilpatrick, J J, *Chicago Sun Times*, 4 June 1979.
[2] Stinson, R, and Stinson, P, *Atlantic Monthly*, 1979, **244**, 64.
[3] Brown, N K, and Thompson, D J, *New England Journal of Medicine*, 1979, **300**, 1246.
[4] Glantz, L H, and Swazey, J P, *Forum on Medicine*, January 1979, p 22.
[5] Grissom, J H, *et al*, *British Medical Journal*, 1967, **4**, 34.
[6] Adamson, A R, and Spracklen, F H N, *British Medical Journal*, 1968, **2**, 223.
[7] Hubble, D, *British Medical Journal*, 1974, **3**, 623.

What is the best type of tranquilliser for attacks of agitation in old people with liver damage?

Liver size and functional capacity show some decline with advancing years but there is normally plenty of reserve.[1] As a rule it is renal rather than hepatic failure that determines the need for lower doses of many drugs given to old people. No tranquilliser is wholly contra-indicated even in patients with liver damage. It would, however, be prudent to avoid chlorpromazine, which can cause cholestatic jaundice in a few patients. Promazine and trifluoperazine have also been incriminated but much less often. Other members of the phenothiazine group, such as thioridazine, may safely be given to old people with liver damage, though it is wise to monitor liver function. Haloperidol is safe so far as the liver is concerned, though there is a considerable risk of Parkinsonism as a side effect. Benzodiazepines also are safe, and chlormethiazole is widely used in alcoholic patients with liver damage and is a useful drug in the elderly.

[1] Hyams, D E, in *Textbook of Geriatric Medicine and Gerontology*, ed J C Brocklehurst, 2nd edn, pp 385-9. Edinburgh, Churchill Livingstone, 1978.

Is trichomonas infection always a venereal disease? Does its presence in one member (or both) of a couple imply past or present sexual contact with another infected person?

Trichomonas vaginalis is a parasite of the genitourinary tracts of both sexes. It is quite distinct from the protozoa found in the intestine, *T hominis*, or those found in the mouth, *T buccalis*. Infestation with *T vaginalis* is a disease of the reproductive period of life, and its incidence is highest in those who are very sexually active. It often occurs with other sexually transmitted diseases, such as gonorrhoea, in the same patient, and if the regular sexual partner is not investigated and treated reinfection is common. Men are often symptomless carriers and can transmit the organism from one woman to another sexually, without developing any symptoms of the disease themselves. Most infestations result from sexual contact, although other means of infection may occur, but they are rare. There is no positive evidence that infections occur from bath or swimming-bath water, lavatory seats, splashing of lavatory water, or internal sanitary towels. The finding of *T vaginalis* in one member of a couple could be interpreted as indicating past sexual contact with another person, but care should be exercised in making such judgments as the parasite may have been transferred from the apparently non-infected partner in whom the disease may have subsequently disappeared spontaneously.

[1] Catterall, R D, and Nicol, C S, *British Medical Journal*, 1969, **1**, 765.

Should vitamins be added to a baby's normal diet and if so in what dosages and for how long?

The answer depends on what is meant by "normal diet" and the baby's age. If he is fully breast-fed it is wise to give child health clinic vitamin drops—three drops daily for the first month, increasing to seven drops daily at 4 months, and continuing until the child is on a good mixed diet. There is no rule about this: I would stop giving the drops at about 1 year of age. In fact a fully breast-fed baby is most unlikely to develop rickets, and if the mother is taking enough fruits and greens the breast milk will contain sufficient vitamin C to prevent scurvy. If the baby is having fortified milk it may not be necessary to give any additional vitamin drops, and I personally do not prescribe them: but the usual advice is to give two drops of the clinic vitamin preparation daily, increasing to four drops at 4 months, and seven drops when on a mixed diet.

Is vitamin D of any value in the treatment of bandy legs in infants?

It is normal for infants to have some bowing of the legs, and no treatment is necessary unless the child has rickets. Sharrard[1] advised that if with the child lying down there is a gap of over 5 cm between the medial femoral condyles when the internal malleoli are in contact, one should take a radiograph of the wrist for rickets. Severe bowing is occasionally due to Blount's disease or osteochondrosis deformans tibiae, found especially in Negroes and Finnish children. In the vast majority of infants bowing is normal, and no treatment is needed. It would be very wrong to give extra vitamin D for treatment unless the diagnosis of nutritional rickets had been properly established.

[1] Sharrard, W S W, *British Medical Journal*, 1976, **1**, 826.

What is the risk of a recurrence of thromboembolism in subsequent pregnancies after an episode during pregnancy in a woman under the age of 30 in whom there is no evidence of any causative systemic disease?

There is not enough evidence in the question or in published reports to be dogmatic about this. The risk of antenatal deep thrombosis is under 1%. In one series[1] it was 0·175%. Yet in England and Wales during 1970-2 there were 14 deaths from pulmonary embolus during pregnancy,[2] and hence it is dangerous. Probably a person who has had a thrombosis in pregnancy is predisposed to another, but by how much it is not possible to be sure. Maybe the patient could have a full investigation of her venous system by radiography and then anticoagulant treatment throughout pregnancy and well into the postnatal period (for perhaps three months), with surgery in reserve to tie off various veins if she suffers from emboli. Whether this is sensible depends on the particular patient and whether she thinks that the case for another pregnancy is overwhelming. But in general the best advice is probably not to run the risk again.

[1] Duncan, D, Coyle, M G, and Walker, J, *Journal of Obstetrics and Gynaecology of the British Commonwealth*, 1971, **78**, 904.
[2] Confidential Enquiries into Maternal Deaths in England and Wales, 1970-2, *Pulmonary Embolism*, p 30. London, HMSO, 1975.

Has any association been found between smoking and senile dementia?

I am not aware of any evidence linking smoking and senile dementia, nor of any reported search for such evidence. Nor has any evidence been reported about vascular or multi-infarct dementia; studies of cigarette smoking and stroke disease could be relevant, but the results of such studies have been inconclusive.[1]

[1] Nomura, A, *et al*, *Stroke*, 1974, **5**, 483.