random sampling, and their social and medical conditions were ascertained by home visits carried out by doctors. The questionnaire was detailed and the survey contains a wealth of information which builds up a detailed picture of the lives of the elderly in the Border Counties. Having some experience in filling in such questionnaires with elderly patients, however, I find it difficult to believe that the average interview time was only 30/40 minutes.

Neither of these volumes could be described as compulsive reading for general practitioners, but are more useful sources of information for those interested in the problems of the elderly.

R. V. H. JONES

Bedside Diagnostic Examination (1976). DEGOWIN, E. L. & DEGOWIN, R. L. Pp. 952. London: Bailliere Tindall. Price: £8·50.

It seems that including the word "bedside" in the title of a book gives it a certain attraction, as if the information in the book passes into one's mind during sleep by a strange process of osmosis.

Degowin and Degowin (father and son co-authorship) set out "key" symptoms and signs under the broader and traditional headings such as head and neck, thorax, abdomen. The key symptom is defined, the clinical situations in which it may be manifest are listed, and the key signs are described. There is therefore a naivety implicit in the book that clinical medicine is a matching of the symptoms and signs from your patient with the stereotypes in the book, a diagnosis then becoming apparent.

The sections of the book which deal with the examination of the patient starts with the anatomical considerations to be brought to mind when an examination is performed. However, the authors' style is unattractive. Such phrases as "Compare symmetric parts of the chest sequentially with the same hand", though they may be precise, may require a second reading before the meaning becomes apparent.

As well as sections on anatomy, examination, key symptoms, and signs, the authors cannot resist the temptation to stray into specific clinical syndromes and their possible aetiology. This creates some overlap with larger medical text books and at the same time blurs the boundaries of their own book. The final chapter is set out as a medical dictionary and the information in it is necessarily brief and somewhat redundant in a book of this nature.

As a dictionary, or book of reference, this may possibly appeal to some; others may feel is an inappropriate format with an indigestible content.

M. J. Y. FISHER

Taking the Rough with the Smooth: Dietary Fibre and your Health (1976). STANWAY, A. Pp. 250. London: Souvenir Press. Price: £3·50.

Unlike urbanised Western man, this book suffers from an apparently short creative transit time and excessive bulk in relation to nutrients. Dietary fibre hypotheses are clearly important, but the evidence is still not only conflicting and complex, but scanty and based on observations on very few people. The largest single group of free-living Western people whose individual large-bowel transit times are accurately known happens to be in a South Wales mining village; they were found to be intermediate between the transit times of urban and rural Africans, although the staple diet is chips, pop, and beer! Vast hypotheses are being erected on fragments of evidence derived from tiny populations, often not randomly sampled.

The useful things that may be reliably said to our patients on the subject can be conveyed in about three paragraphs. The claim on the dust-wrapper that "Taking the rough with the smooth may prove a landmark in twentieth-century thinking about our health" is hardly justified.

The book will not help doctors looking for a serious but simple discussion of evidence and current research trends. Although a long list of references is given, they are not linked to the statements in the text, and so cannot be verified. It cannot be recommended for a practice patients' library either: really good books for patients demand more time and care than those for doctors, not less.

JULIAN TUDOR HART

Social Policy and Public Expenditure 1975—Inflation and Priorities (1976). Pp. 193. ED. KLEIN, R. London: Centre for Studies in Social Policy. Price: £3·50.

The Centre for Studies and Social Policy is independent and non-partisan and its Council of Management includes Professor Ralf Dahrendorf, Professor J. N. Morris, Lord Seebohm, and Mr David Steel. The Centre was incorporated late in 1972, through the Joseph Rowntree Memorial Trustees, and seeks to look at social issues across departmental boundaries and academic disciplines, and to identify the social implications of issues which are often regarded as outside the scope of social policy analysis.

This issue is well worth reading, if only for its introduction, "Priorities in the age of inflation", and chapter four on the National Health Service. Both these are written by Rudolf Klein and I learnt a good deal from them.

He emphasises that Britain's level of spending on "social protection" per head of population is less than half that of Germany, Holland, and Denmark and a third lower than that of France. He goes on to underline the need for a complete reappraisal of policy in all the social services in

the light of the probability of there being no economic growth in the short-term future.

He calls for a greater examination of the losses and delays suffered by patients through rationing in health services and makes an interesting case for more local discretion in health service expenditure.

The chapter on the National Health Service begins with a logical analysis of the absence of any generally agreed objectives for the service and restates the well-known principle that demand is in effect controlled by doctors and nurses. He argues impressively the case for an inherent conflict between quality and quantity of nurses' (and doctors') salaries. If these professions are to be paid highly, it follows inevitably that they must accept restrictions on manpower. Mr Klein points out that the Halsbury Committee award for nurses would have cost an additional £170 million a year, i.e. more than the total increase in current expenditure planned for the National Health Service for 1975–1976.

I was interested to learn that over 50 per cent of male ancillary workers in the National Health Service were over 50, and as many as eight per cent were registered as disabled. "The NHS is therefore carrying out a social role quite distinct from the provisions of health care by providing employment for those who might well be redundant if the policy were to concentrate on improving efficiency by employing a smaller, better paid, more productive labour force."

He emphasises the well-known implication that an increasing number of elderly people will make highly significant increased demands on the National Health Service ("women over 75 who make up only three per cent of the total population alone occupied nearly 20 per cent of the NHS beds)".

My only serious disagreement with Mr. Klein came in his section on general practice, where he quoted from the Royal College of General Practitioners' third edition of *Present State and Future Needs of General Practice*, published by this *Journal*, and emphasised the significance of the falling consultation rate reported in general practice.

He goes on to question the wisdom of increasing support for primary health care teams and seems unaware of any evidence that they improve the care that patients received. Such evidence is, however, available (Bolden and Morgan, 1975; Marsh and Kincaid, 1976). The primary health care team may thus be one of the reasons for the fall in the number of *doctor*-patient contacts per patient per year.

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Marsh, G. N. & Kaim-Caudle, P. (1976). *Team Care in General Practice*. London: Groom Helm Ltd.

British Births 1970 (1976). A survey under the joint auspices of the National Birthday Trust Fund and the Royal College of Obstetricians and Gynaecologists. Volume 1: *The First Week of Life*. London: Heinemann. Pp. 278. Price: £5·85.

This is the third in a series of national cohort studies concerned with the outcome of pregnancy, and the second to be conducted by the National Birthday Trust Fund. The Royal College of Obstetricians and Gynaecologists has played a major role in each of the three. On this occasion, the Royal College of General Practitioners has been among the many other bodies making up the Steering Committee and contributing in working parties.

The last study, in 1958, was concerned mainly with perinatal mortality. The present survey deals primarily with the first week of life, and is thus concerned with morbidity more than with mortality. The perinatal mortality rate has fallen from 38·1 per 1,000 births in 1958 to 23·4 in 1970, and is still declining. With this indication of improved maternity care, it must follow that the level of morbidity also falls, and this report serves to highlight possibilities for further improvements.

Domiciliary deliveries were at 12·4 per cent in 1970 and have since fallen to about half that. Deliveries in general-practitioner maternity units at 15·4 per cent were falling, but those in general-practitioner beds in hospital maternity departments at 3·1 per cent were rising. This trend seems likely to continue because, as an increasing number of isolated general-practitioner units are being closed, more beds in hospital units are being made available to interested general-practitioner obstetricians. This trend is not commensurate, because these beds are concentrated in fewer centres and therefore accessible to a smaller proportion of practitioners. One lesson of this report is that a very high standard of care is to be expected of these practitioners; they must learn to work in close harmony with paediatric colleagues as well as with the obstetricians. Midwives still deliver or supervise delivery in the great majority of cases.

Stillbirths accounted for 54 per cent of the perinatal deaths, and intrauterine asphyxia was a factor in 27 per cent of these. Immaturity was another major factor—15 per cent of first week deaths were under 1,000 grams at birth; congenital malformations were present in 23 per cent. It is gratifying to note that infection and birth trauma now feature rarely. As the more readily preventable causes diminish, the hard core of the inevitable and less readily preventable will form an increasing proportion of what remains. This should not make us complacent, however, as we are still far from recording only inevitable losses.

A special study here is reported of the early minutes after delivery when breathing starts. The concept of *Respiratory Depression Ratio*