after imferon injections in man, despite very extensive use over the past five years, and it may be that the hazard does not apply to all species. Nevertheless, until the risks to man have been elucidated it would seem wise to discontinue the use of iron-dextran in medical practice (*Brit. med. J.*, 1960).

CONCLUSIONS

Ferrous sulphate in relatively small doses (2 to 3 tablets of 0.2 g. daily, providing 120 to 180 mg. elemental iron) is the most economical form of oral iron for general use. It is not significantly inferior to more expensive organic salts and chelates with regard to efficacy or gastro-intestinal toxicity when given in the proper dosage, and it is much cheaper.

Alternative oral preparations may reasonably be tried in the small proportion of patients who develop intolerance even to small doses of ferrous sulphate, though such patients may often react similarly to other compounds. For these intolerant patients, and for some others who fail to respond to oral iron or for other reasons require parenteral administration, intravenous saccharated iron oxide may be given, a careful watch being maintained for sensitivity reactions. Parenteral compounds are, of course, much more expensive than equivalent doses of oral iron, but in practice the high utilization of the iron reduces the difference in cost, and, since iron should not be given parenterally in preference to orally unless a specific indication exists, economic considerations are not of importance here.

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The booklet, *Home Guide for the Diabetic: Diet Instruction, Recipes and Other Guidance* (Iliffe and Sons, Ltd., Dorset House, Stamford Street, London, S.E.1, price 3s., by post 3s. 3d.), is based on the handbook issued to patients of the Leicester Royal Infirmary Diabetic Clinic. General guidance is given on such subjects as the method of giving insulin injections, hygiene for the diabetic, social-service arrangements, and general principles of nutrition. There are further sections on alternative food values, a special list of foods with low caloric value, recipes, weight-reducing diets, and a list of proprietary names of medical supplies.

MEDICAL RESPONSIBILITY IN ADOPTION

BY

HILDA LEWIS, M.D., M.R.C.P.
Psychiatrist to the Children's Society

The number of official adoptions in England and Wales is about 13,000 a year. Most of these entail a medical examination for purposes dissimilar in several respects from other types of medical examination. With the coming into force of a new Adoption Act it seems timely to consider what part the doctor plays in ensuring that adoption is practised wisely and with due regard to the well-being of the adopted children and society.

A doctor may be asked to examine and report on the health of a child proposed for adoption, or of the persons who propose to adopt. The request to do so will come from either the would-be adopters, the adoption agency (local authority or registered adoption society), or the mother who wishes her child to be accepted by an adoption agency for adoption.

The point at which the doctor will be approached is as soon as the question of getting a particular child adopted has been mooted, or when particular applicants have decided that they wish to adopt a particular child. He will be approached to examine the prospective adopters (a) when they make a general application to an adoption agency without specifying a particular child, or (b) when adopters are about to apply to a court for permission to adopt a particular child.

The doctor's report on the health of the infant has to be detailed and comprehensive, as required by the Regulations. His report on the health of the would-be adopters for the court will be summary; to meet the minimal requirements of the Act he need only state that the applicant whom he has examined "is physically, mentally, and emotionally suitable to adopt a child." Most of the adoption agencies, however, will ask for much more than this, and their forms are correspondingly more detailed—rather on the lines of a health insurance report. They pay particular attention to the applicants' emotional stability and medical reasons for not having children of their own instead of adopting. Medical reports on adopters are not required, however, when the child's natural parent (usually the mother of an illegitimate child) wishes to adopt him or when he is past compulsory school age.

As some of these requirements, especially those regarding a medical examination of the adopters, are new since the passing of the Adoption Act, 1958, it is likely that difficult questions of procedure and clinical appraisal will occasionally arise for doctors asked to assist in an adoption.

Reports on Infants

The examining doctor is not asked to give his opinion that the child is or is not suitable for adoption when he fills up the certificate for the court hearing; he is asked only to say, first, that he has informed the would-be adopters of his findings on mental and physical examination, and, secondly, that the child is or is not

normal. The last can be a difficult task. Few doctors would like to assess a child's mental normality when it is only a few weeks old. Unless a defect is gross, it is impossible to detect when the infant is very young; but doctors are often asked to examine an infant for adoption purposes within the first two months, since as soon as the infant is six weeks old its mother can consent to its being adopted, and three months later the adoption can be made legal and final. Some doctors believe that the examination should be carried out in all cases by a consultant paediatrician, but the Act does not require this.

The laboratory tests now needed to ensure that certain specific or hereditary disorders are not overlooked make considerable demands on the doctor. Among them is a serological test for syphilis, to be carried out six weeks or later after birth. There has been some comment about the practical difficulties encountered in getting this test done on a very young infant. An adoption society sometimes wants to place a child before it is 6 weeks old in the care of a couple proposing to adopt, the mother having given provisional consent. They may do so if the medical examination, apart from the serological test, is satisfactory; the serological test can in such a case be postponed until the child has reached the stipulated age. The responsibility for seeing to this rests with the adoption society.

The doctor's problem of getting blood from a very small infant is met by the technique described in the *Lancet* (1959): "Immerse the child's foot in hot water for a few minutes. Dry and apply a light tourniquet round the lower leg. Sterilize the skin of the fleshy part of the heel with spirit. After a few minutes stab the heel with a Hagedorn needle or make a small snick through the skin of the heel with a sterile safety-razor blade. The blood flows freely and can be collected in a test-tube; 2 ml. of whole blood is sufficient. The clean cut made by the blade is practically painless; bleeding soon stops when the tourniquet is removed, and healing is prompt."

The urine has to be tested for phenylpyruvic acid as well as for sugar and albumin. For this a fresh specimen is needed when the child is at least three weeks old. To get a specimen the doctor has to rely on the co-operation of parent or nurse. Simple techniques for this and the possibility of using the freshly wet napkin need to be further explored. Gibbs and Woolf (1959) found, after an extensive investigation of tests for phenylketonuria, that the "phenistix" strips put up by Ames & Co. provide a quick, easy, and reliable method. They suggest that routine testing may be carried out as early as 3 weeks but that a retest should be made at 2 months for complete safety.

These problems are small, however, in comparison with the difficulties of judging whether a newborn infant is and will be mentally normal. Paediatricians with special experience in this field feel able to express such an opinion only after the baby is 3 months old and even then with caution; nor can any but gross defects be detected with any confidence during the first year of life. It is therefore no easy matter for the doctor who has to examine the infant to explain to adopters the significance of what he has found, as the regulations require.

Explaining the Significance of the Findings to the Adopters

Any physical abnormality in the child—for example, a cardiac anomaly—is of course important, but the commonest question which the doctor will be asked has to do with the child's intellectual potential. Adopters of the professional classes often want to know not only that the child is free from definite mental defect but that he will not be dull or backward. Guarded as any prognosis on these matters must be, particularly where an infant is concerned, it is helpful in attempting it to take into account the following factors: (1) the prenatal and parnatal history; (2) the occupations and achievements of the child's parents and near relatives; and (3) the evidence from long-term follow-ups of adopted children.

If the health of the mother has been perfectly normal during pregnancy, and if the infant's birth, birth weight, and behaviour during the first three weeks were normal, the chances of its showing a serious mental disability are small. The elaborate studies of Knobloch and Pasamanick (1959) in the United States and of Douglas and Blomfield (1958) in this country lend powerful support to the view that children judged to be premature because of low birth weight tend to be backward in their education later on, and that any child who shows signs of cerebral damage in the first year of life has a poorer outlook for intellectual development. In these two groups of children, therefore, an expert opinion may be helpful to the practitioner who has to advise the would-be adopter.

The occupational status and achievements of the child's parents and their relatives, together with an appraisal of their health, are commonly taken into consideration, in an attempt to exclude familial types of mental illness, defect, or dullness. It is tempting in view of the fairly high correlation between the intelligence of children and that of their parents to assume that a child will grow up to be roughly the equivalent of his parents in intellectual stature, and that this will provide a guide when selecting a child for would-be adopters who would prefer him to be of their own sort. There are, however, many pitfalls in this reasoning, especially if, as is commonly the case, the parents' intelligence is inferred from their occupation. Moreover, the children available for adoption—practically all of them illegitimate—come from families covering a much wider occupational and social spectrum than do the adopters. In an analysis I recently made of 100 consecutive children offered for adoption to a large adoption society and of 100 consecutive applicants wishing to adopt a child, the distribution of social class in the family of the child's mother (recorded from her father's occupation and in 10 cases from her own occupation) was the same as that in the general population in the 1951 census, whereas the adopters showed a predominance of persons in social classes 1 and 2 (see Table).

There is a good deal of evidence that children of inferior social backgrounds placed early with good adoptive parents of superior socio-economic status show a significantly better achievement than would be expected from their natural parents' performance, and a substantial number are found by adolescence to have developed average or above-average intelligence. In one

Social Class of Adopted Child's Parents; and of Male Adopters in 100 Consecutive Cases of Each Reaching an Adoption Society in 1958

Social Class (Registrar-General)	Child's Mother Assessed from Her Father's Occupation	Child's Putative Father Assessed from His Occupation	Male Adopter Assessed from His Occupation	Population of England and Wales, Census 1951
1	3	7	15	3
2	19	5	38	15
3	53	57	36	53
4	13	13	11	16
5	12	12	0	13
Unknown	—	6	—	—

of the well-known Iowa studies by Skodak and Skeels (1949), based on 63 natural mothers and their children placed early in superior adoptive homes, the average I.Q. of the children at adolescence was 20 points higher than that of their true mothers. In another study from the same research centre (Skeels and Harms, 1948) the illegitimate children of mentally deficient women placed in infancy with socially above-average foster-parents were found when tested at about 5½ years to have a normal range of intelligence, some with subnormal and some with very high I.Q.s, but most of them developing normally and not according to prediction.

It is clear that the character of the home in which the child develops strongly influences his final intellectual functioning whatever advantages he may bring from his genetic endowment (evidence about which is usually scant) and that the emphasis should be placed on the character of the adopters and their capacity for parenthood in the fullest sense.

The Adopters

Medical examination of the adopters will normally be straightforward or difficult according to the degree of the doctor's acquaintance with their medical history in all its aspects. But two problems confront him in every case: What medical criteria are suitable for judging whether people can be entrusted with an adopted child? and What right has he to disclose to an adoption society or other body confidential information about the "physical, mental or emotional" condition of his patients? Since in almost all cases the adopters give the doctor permission to supply to an adoption society all relevant information, the latter problem seldom perplexes the practitioner; but in judging whether persons with such-and-such psychological troubles or chronic physical defect can be considered suitable as adopters, he must rely on his common sense and insight, for there are few assured principles based on systematic follow-up inquiries and research. His dilemma in most such cases is less awkward if the doctor is dealing with an adoption agency rather than himself acting as the "third party" arranging the adoption.

The larger adoption societies have much accumulated experience, and have medical advisers specially acquainted with these issues: so long as the practitioner provides details of his examination findings and, wherever possible, data bearing on the applicant's past medical history, both physical and psychological, the adoption society takes the actual decision to accept or to refuse the application without disclosing its reasons. In thirteen years as a member of an adoption committee now dealing with more than 500 adoptions a year, I have been impressed by the fullness and value of the reports, often embodying consultants' opinions, supplied

by doctors, which make fairer decisions possible. This has been helped by the society's use of detailed medical forms. It is, of course, not only the medical findings that have to be taken into account and carefully weighed, but also social data ascertained by the adoption society's social staff. Sometimes utterly unexpected and disconcerting information turns up on what seems a medically impeccable applicant, to the effect that he has a criminal record or has even been found guilty of cruelty or sexual offences against children.

Third-party Adoptions

Doctors sometimes act as intermediaries in an adoption, without a registered adoption society or local authority being involved in the placement. The Adoption Act recognizes such activity, whether by doctors or any other person, and stipulates the procedure then appropriate. A doctor is so clearly in a strategic position to know about both a newly born child whose mother wants it adopted and about a couple who would like to adopt a child that he is under strong temptation to act as "third party." Even though he must in any case give notice to the local authority of his intention to place the child and, under the new Act, could be called on to appear before the court when the adoption is to be ratified, the long-established role of the doctor in these matters will probably not be given up wholesale. It must, however, be admitted that the system has not worked very well in certain areas, and that it has intrinsic weaknesses. The B.M.A. drew attention to some of them when it offered evidence to the Hurst Committee.

Light was thrown on this matter by the replies to a questionnaire distributed by the Standing Conference of Societies Registered for Adoption last year. Nineteen societies replied. They had been asked to indicate how third-party adoptions through doctors and nursing homes had worked within their knowledge. Their replies described three categories: (a) intervention to effect an adoption which had been refused by an adoption society; (b) "two-way traffic," especially by obstetricians and gynaecologists who knew both of a child to be adopted, and of a couple who wished to adopt; and (c) hasty placements direct from hospital or nursing-home, in which the doctor acted without making adequate inquiries into the fitness of the adopters or full inquiries into the circumstances of the infant's mother.

There is clearly room for difference of opinion between a doctor and an adoption society about the suitability of applicants, and no one is entitled to question the conduct of a doctor who acts on his convictions, provided that he takes due care to satisfy himself that the future welfare of the child is safeguarded.

There are other considerations, too. Moral welfare workers associated with adoption societies often undertake social work with the unmarried mothers of adoptive children to assist them to meet the material and emotional stresses of their situation, and are thereby often able to lessen the chance that they will fall again into the same predicament. Doctors acting quite independently as third parties—especially when they are not the regular medical advisers of the would-be adopters or of the unmarried mother—have not the resources needed for such work, and are, in many

instances, meeting only the immediate demands of the mother or of the adopters.

Doctors acting as third party and placing a child within its first six weeks are likely to be influenced by the widespread belief that psychiatrists have demonstrated serious consequences to ensue whenever a baby is not steadily in the care of the same mother or "mother substitute" from birth: deprivation of love from a mother figure in the first year of a child's life is supposed to be fraught with danger of a warped affectionless personality, delinquency, or mental disorder in later life. These fears are exaggerated and still without solid foundation. Though there are some advantages to both the adopters and the child to be derived from early placement, the risks of entrusting a possibly handicapped child to unsuitable adopters are at least as great as letting a child be with its natural mother for a few weeks or months after birth, while the adoption arrangements are being proceeded with.

Kindness of heart plays a large part in prompt third-party placings. The doctor, or it may be the nurse, wishes to relieve the unmarried mother's distress, and promises during the pregnancy to get the child adopted as speedily as possible, perhaps undertaking that the mother will never see the unwanted and unwelcome child. The baby placed with adopters hastily a day or so after birth is often insecure. The adopters may be overanxious when they get a newborn child, and, at the first sign of its being sickly, wish to reconsider its suitability: conversely, the child's mother may have taken the decision without reflection or guidance, immediately after the baby's birth or in the late stages of pregnancy, during which she was anxious and ashamed. She was perhaps mistaken in her gloomy estimate of how her family would react to her situation; she may now wish to keep her child. If the adopters, on the other hand, return the child she is confronted unprepared with the problem of finding accommodation for herself and the child; she may be driven to hand the child over to some casual foster-parents. It is a predicament less likely to occur when the adoption has been effected more deliberately and with fuller preliminary inquiries. The child hurriedly dealt with is in a worse position than if, before the adoption had been put in train, there had been a few weeks of supervision of the child's condition and behaviour, with its mother or in a foster-home or nursery developed for the purpose, as would commonly be the case if an adoption society were responsible.

It is, of course, true that third-party adoptions effected by doctors immediately after the baby's birth sometimes turn out well, and that adoption societies' adoptions sometimes turn out badly. There are, however, grounds for believing that the risks for the child, and for the adopters, are greater when a third-party adoption is effected a few days after birth, or when the adoption is arranged without adequate inquiry into the natural mother's situation and into the social and psychological as well as medical characteristics of the adopters. The practitioner acting as a third party is therefore on much safer ground if he calls in the help of a trained social worker. Such steps are, however, superfluous if he is acting as medical examiner under the provisions of the Adoption Act, or forwarding his report to an adoption society or local authority. The closer the contact between doctor and adoption agency the better for the child, its mother, and its adoptive parents.

It is a regrettable fact that the adoption societies do not cater for the whole community. Almost without exception they are supported by religious bodies and restrict their placements to applicants who declare themselves to be practising adherents of some religion. Facilities for would-be adopters who have no religious affiliation are insufficient, no matter how well suited they may be otherwise to fulfil the obligations of an adoptive parent. The new Act encourages the children's departments of local authorities to act as adoption agencies: it may be that their activity will remedy the defect, though, of course, if the child's mother has expressed a wish for the child to be brought up in a specified religion her wish must be implemented.

The adoption societies are broadening their views in some respects in accordance with changing standards and fresh knowledge about children's development and heredity. While this advance is occurring, there is unfortunately no concurrent lessening to be discerned as yet of the activities of those third parties who place children for adoption in large numbers. They are often people in charge of private nursing-homes or organizers of "centres," who arrange for the children of unmarried mothers delivered in their homes to be adopted, and who appear to do this on such a large scale that it could almost be regarded as a business (though doubtless the provisions of the law, which forbids payment for an adoption, are observed). The administrative officer of the children's department of the Surrey County Council (Pring, 1958) has drawn attention to this trouble, which is well known to children's officers, the moral welfare associations, and to the National Council for the Unmarried Mother and her Child. Though, of course, doctors are not involved in this type of third-party activity, it is probably in their power to discourage it actively if it comes to their knowledge in the case of girls who are under their professional care during pregnancy or afterwards. The requirement in the 1958 Adoption Act that the mother of a child placed for adoption must name the person who introduced her child to the adopters—that is, as third party—will militate against wholesale adoptions of this kind or, at least, enable them to be detected by the magistrate or judge, who is entitled to call on such persons to appear at the court hearing.

Conclusion

The new Adoption Act offers opportunities for helpful collaboration between practitioners and social workers in using the ancient and humane device of adoption. In the past there has been some misunderstanding about the doctor's role in this field. This article is designed to outline some relevant features of the new Act which will affect him and to stress the advantages of collaboration between the doctors and the adoption agencies. It would be a step forward if more doctors were to serve on the case-committees which each adoption society must appoint to examine all proposed adoptions.

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