integrating them, and beginning to answer the very
questions that are raised in this article—that is, what is the
need for protection, what is the need for work, who should
carry this out, and how should it be supervised?

If we follow the DHSS guidelines I will gladly be
handing over the chairing of such conferences to my social
work colleagues. I hope I will continue to be present and
that myself and my colleagues will still continue to do
assessment work with families that I hope will assist
conferences to make the sort of decisions that sadly do not
seem to have occurred in Drs Chapman and Woodman-
sey’s experiences.

References
1 Society of Clinical Psychiatrists. Case conferences for child
2 Hallett C, Stevenson O. Child abuse: aspects of inter-
3 Department of Health and Social Security Home Office.
Non-accidental injury to children: the police and case confer-
ences. London: HMSO, 1976. (LASSL (76) 2; CMO (76) 2p
(iv), 25.)
4 Chapman MGT, Woodmansey AC. British Journal of Ethical

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Sir,
The Society of Clinical Psychiatrists state that ‘case
conferences are inherently ineffectual’. I disagree. Child
abuse case conferences are often ineffectual, but not
inherently so.

The case conference is like a ship, and its aim should be
to reach a stated destination. It is 14 years since the
Tunbridge Wells study group made the child abuse case
conference its cardinal recommendation. Is it any wonder
that in that time the ship has acquired some barnacles? In
addition, too many passengers have come on board.

A case conference can exchange information, decide on
registration and the nomination of a primary worker, and
offer to the primary worker various forms of support.

Bearing in mind this aim, I believe:

(i) Too many people attend, including those who have
neither information nor an involvement with later
management.

(ii) Information is poorly given. It should be the aim to
circulate written information before the day of the
case conference.

(iii) Far too much discussion takes place on the details
of management. This can only be a matter for the
primary worker and even if a valid decision is made
at a case conference it is, as stated in the clinical
psychiatrists’ document, only valid for that
moment. ‘The decision cannot be made once and
for all’.1

(iv) Most minutes are inexpertly written, chairmen not
being skilled as committee clerks. The anxieties of
professional workers can be discussed without being
minuted. Minutes should record the location and
constitution of the meeting with the decisions taken.

The case conference is a working method. Without it
professionals would again begin to act in isolation. Without
it the choice of primary worker would be seen as arbitrary
and as setting one group of professionals above the others.

So I agree with much of the thinking of the Society of
Clinical Psychiatrists but not with their conclusion. With-
out the case conference cooperation in child abuse would
cease and the anxiety of professional workers would not be
allayed.

References
1 Society of Clinical Psychiatrists. Case conferences—for child
2 Tunbridge Wells Study Group. Non-accidental injury to chil-

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The sweat test

Sir,

Dr Littlewood’s annotation on the sweat test is to be
welcomed as misdiagnosis of cystic fibrosis is a continuing
and serious problem.1 We agree that most misdiagnoses
can be avoided if experienced laboratory staff perform the
sweat test with meticulous attention to detail and the
results are interpreted in the light of the clinical findings.

Two points arise from the annotation, however, that we
feel need further comment. Contrary to Dr Littlewood’s
opening paragraph, the sweat test in most hospitals does
not usually imply measurement of both sodium and
chloride. In our experience many centres measure only one
ion, and there is a need to reinforce to both biochemists
and paediatricians the importance of measuring sodium
and chloride. Secondly, we do not support Dr Littlewood’s
conclusion about the use of pancreatic function tests.

Diagnostic difficulty is more likely to occur in the 10% of
patients with cystic fibrosis who have adequate exocrine
pancreatic function, and it is in these patients that further
investigation of pancreatic function may not be helpful.

In our own prospective study of 344 patients over two
years 441 sweat tests were performed at our hospital, and
only nine fell into an equivocal group. One of these nine
was subsequently confirmed to have cystic fibrosis. The
other eight patients all had sodium values considerably
higher than the chloride values; they all had normal
pancreatic function as judged by normal results of faecal
chymotrypsin and para-aminobenzoic acid tests and, in two
patients, normal secretin-pancreozymin stimulation tests.

It was the interpretation of the results of their sweat test
together with their natural history that excluded the
diagnosis of cystic fibrosis rather than reliance on normal
pancreatic function tests. We think that it is misleading to
suggest that demonstration of abnormal pancreatic func-
tion is the gold standard for the confirmation of the
diagnosis of cystic fibrosis in equivocal cases. Until
deoxyribonucleic acid technology can identify the gene the
Case conferences-for child abuse

J H Keen

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Updated information and services can be found at:
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