Harvey Marcovitch, *Editor in Chief*

IMPROVING OUR COMMUNICATING AND CONSULTING SKILLS

A few months ago the UK public and media were shocked by a report into the systematic torture and then murder of a child by her carers.[1] One consequence for National Health Service Trust Boards is that, by the end of next month, they will have to complete an audit into their child protection arrangements.[2] The report called for rigorous application of the "medical model" of history, examination, tests, diagnosis, treatment, and follow up to child protection cases. Also, it criticised the standards of note keeping of some of the doctors involved. Having read them, I doubt these were very different from many—if not most—of their colleagues throughout the country.

Serendipitously, therefore, this month's *ADC* has quite a lot to say about how doctors and families communicate—though not in regard to child abuse. Newton and Cunningham are concerned that so little attention is paid to teaching how to consult and how to communicate. They emphasise that, despite what many paediatricians may believe the unequal power relationship implicit in our dealings with patients can lead to confusion and misunderstanding. As an example, they recall a patient with diarrhoea and vomiting told to avoid green vegetables, which he assiduously did—for the next 20 years. Trainees (and those who think they've long ago jumped through all the hoops) seeking to sharpen up their interactions with patients could do worse than to browse the authors' reference list.

Chambers mischievously starts his paper thus: "Chambers defines semeiology as the study of symptoms." We assume the ambiguity is deliberate. His example is a child with "undiagnosable" aches and pains (at least using the standard medical model). His paper explains how to avoid unconstructive confrontation with those whose children's symptoms do not fit a pattern with which we are familiar—and thus feel comfortable. He paraphrases Voltaire: " . . .entertaining the patient while nature effects the cure," although I prefer the words of the late, great teacher of general practice skills, Paul Freeling: "if you can't send them out cured, at least send them out laughing."

Finally Colver and Sethumadhavan make a particular plea that we abandon the term diplegia, which they believe serves only to obfuscate. They call for descriptive terminology rather than shorthand. This change of approach could well be generalised throughout paediatrics; indeed, it might even prevent future tragedies of the type introducing this column.[3]

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PRECISION IN TREATING VULVOVAGINITIS

If you log on to www.archdischild.com, you will see on the home page a link for "Editor's Choice". This is the one paper in each issue to the full text of which we grant free access to non-subscribers. We choose it for its perceived value to practitioners and others. This month's choice is a retrospective review from Zurich, Switzerland of 80 prepubertal girls with vulvovaginitis, not suspected of having been sexually abused. The authors concentrate on the microscopy and microbiology of vaginal secretions. Pathogenic bacteria were isolated from 36%, the commonest organisms being Group A beta-haemolytic streptococci. The presence of leukocytes had a sensitivity of 83% but specificity of only 59% in predicting the growth of a pathogen. Antibiotics were used in 25 of the 29 from whom a pathogen had been isolated and, since thankfully the Swiss aren't absolutely as precise as rumour has it, in 1 other. All recovered. The authors caution against treating on the basis of microscopy alone.

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"LOOKED AFTER" CHILDREN MISS OUT

We already know that children looked after by local authorities in the UK are more than twice as likely not to receive meningococcal C vaccine than their counterparts living at home.[4] The authors recommended effective shared information systems as well as defined accountability.

This month, Ashton-Key and Jorge provide disappointing information on the first of these suggestions. They looked at the outcome of providing a local authority with information on the immunisation status of children in its care. They were able to access the records of 227 of 236 looked after children living within the authority's area. Only just over half of the children were up-to-date with the recommended immunisation programme, as opposed to over 90% for the area as a whole. A detailed account was supplied to the responsible senior social services manager. One year later the immunisation records were re-accessed. Of the 136, looked after by the local authority throughout the year, only 60% were up to date and none of the 54 originally identified as requiring catch-up immunisation had received it.

Curiously, the authors of the paper published in *BMJ* called for health services to be made accountable for immunisation uptake (which I thought they were already), whereas Ashton-Key and Jorge believe that local authorities—as corporate parents—should be responsible for addressing the health needs of children in their care.

Whichever is the right approach, both sets of researchers recommend close advice, support, and information sharing between health and social service departments—which brings up full circle to the Laming report.

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REFERENCES

1 **Laming LJ**. Inquiry into the death of Victoria Climbie. London: Stationery Office, 2003. www.victoria-climbie-inquiry.org.uk (accessed 14.2.2003)
2 **Personal communication from Commission for Health Improvement**. London.
3 **Marcovitch H**. Lessons from the Climbie Inquiry. *Qual Saf Health Care* 2003;**12**: (in press).
4 **Hill CM**, Mather M, Goddard J. Cross sectional survey of meningococcal C immunisation in children looked after by local authorities and those living at home. *BMJ* 2003;**326**:364–5.