

One of our best issues in years

Our goal has been to ensure that Archives is a “good” read. What do we mean – we want every issue to have 4–5 articles that interest you. If the Journal is collecting dust in the corner we are not doing our job. This issue is one of the best in recent memory. Professor Terence Stephenson, current President of the College, comments on the article by Diego van Esso who describes which physicians provide primary care for children in Europe. There is a policy piece that focuses on the international code of marketing of breast-milk substitutes. A slew of research reports are outstanding, a surveillance study that describes the incidence of MRSA bacteraemia in children, an RCT that details the best way to prevent feeding errors in children with metabolic disorders, a descriptive study about informed consent in children with leukaemia, a retrospective review of 10,454 children with asthma treated with either LABA/ICS or LABA + ICS, and the occurrence of oronasal haemorrhage in infants. I actually could go on, but I suggest you scan the titles and decide what you should read. Hopefully you will find these and the other reports informative.

Who should care for children?

The vast majority of children in the US, particularly those in the pre-teen years, receive primary care from paediatricians. The UK system is the polar opposite. Primary care at all ages is provided by general practitioners. In a survey of 29 of 31 countries that belong to the Primary-Secondary Working Group of the European Academy of Paediatrics, van Esso and colleagues report that in 12 countries a family doctor/general practitioner provides primary care for children, seven have a paediatrician-based system and 10 a combined system. These 29 countries have ~80,000 paediatricians, the same number as in the

U.S. The definition of the paediatric age varies widely from country to country, and sadly in most the amount of training for GPs/FDs in paediatrics is less than 5 months. Professor Stephenson, in his wide ranging comments, correctly points out that this study raises more questions than it answers, although he details the ongoing issue of whether GPs in the UK receive adequate training in paediatrics.

Is the care provided by paediatricians superior to care given by GPs? Although a few studies describe better immunisation rates and adherence with guidelines if care is provided by paediatricians, I am unaware of any information that over the course of childhood, health outcomes are better if care is provided by a specific group of physicians. I doubt those data will ever be reported. In most countries the health care system is well-established and it is unlikely that who provides primary care for children will change – few healthcare systems are willing to entertain dramatic reform. That said, if I was designing a healthcare system all families would have choice, but would be guaranteed a medical home with a GP as their primary care physician. Training specifically in paediatrics would be a minimum of ~ 18 to 24 months, and all GPs would have ready access to paediatricians who would serve in a consultant role. For technically dependent children, and those with complex medical conditions, primary care would be provided in specialised comprehensive clinics in which both primary and specialty care was available. *See page 791.*

Consent for clinical trials

We receive many papers that focus on the ethics of research with children. Most are too specialised for the Journal. Chappuy *et al* from France describe the results of interviews one and six months after consent was sought for children to participate in a protocol for

acute lymphoblastic leukaemia. One in five parents did not realise that their child was participating in a research study; 39% did not understand the concept of randomisation; and half could not explain the objective of the study. Most agreed to participate because they trusted the medical team. I have always wondered if parents completed a short questionnaire after a research study was explained to them how many would actually be qualified to provide consent. My entire group is involved in clinical investigation. Over the past 15 years, I have watched consent forms become longer and longer, with more detailed explanations of all of the potential consequences of participating in a research project. More recently, with guidance from our institutional review board, the consent forms have become somewhat simpler. I am not sure we know the right amount and correct format of information that parents need to be truly informed, knowledgeable, and able to consent. *See page 800*

Is their risk from common medical procedures?

Most of us assume that most common medical procedures are safe. I doubt there are any long term consequences from venipuncture, injection, or even lumbar puncture. However, I have always wondered about head ultrasound and neonatal phototherapy (NNP). In an excellent study from Edinburgh and Aberdeen, Brewster and colleagues linked the medical record of 77,518 adults, 5868 who had neonatal phototherapy, with a cancer registry and mortality records. There conclusion – “there is no statistically significant evidence of an excess risk of skin cancer following NNPT...” They acknowledge that their study had limited statistical power and duration of follow-up. These authors are to be congratulated for beginning to answer an important question. *See page 826*