Know the normal, or else . . .

Most babies are born in working order, and Douglas Gairdner,¹ writing about the not so private part of the new boy, in his classical and famous paper entitled 'The fate of the foreskin', described the normal separation of the foreskin from the glans, the age at which the separation normally occurs, and the undesirability of trying forcibly to retract the foreskin, at least in the first 3 years. But there are still many doctors and nurses who tell mothers that they must try to pull the foreskin back, causing pain while risking the development of paraphimosis, and clinic doctors who describe 'the redundant foreskin' or a 'pinhole meatus'. There are still many doctors who, not knowing the normal, cause defenceless boys to be circumcised. Douglas Gairdner mentioned the meatal ulcer as one of the untoward results of circumcision: Denis Browne added many others seen by him—such as urethral fistula and strange cosmetic results.² Now Annunziato and Goldblum add the staphylococcal scalded skin syndrome,³ and Sussman *et al.* the Fournier's syndrome of gangrene of the genitalia.⁴

Miller *et al.* drew attention to another 'sequel' by the 4th birthday; boys who had been circumcised were at least 7 times more likely to have their tonsils removed than were the uncircumcised.⁵ The Defence Organisations in Britain recently had to pay £18 000 in settlement for a circumcision which led to gangrene of the tip of the penis: and in the USA, where a higher price is placed on the organ, a settlement of approximately \$3 million had to be made for a similar disaster. Kaplan in his 33-page review, having remarked that circumcision is the most common operation on males in USA, and that the cost of newborn circumcision there is calculated at \$59 544 000 a year, devoted 16 pages to complications of the operation.⁶

Morgan, probably taking his cue from Douglas Gairdner, wrote two papers on the subject of circumcision—'The rape of the phallus', and 'Penile plunder', again emphasising some consequences of not knowing the normal.^{7, 8}

Children can suffer much harm at the hands of doctors who do not know the normal, and the normal variations which do not require treatment. One has seen young babies operated on for tongue tie, or cysts of the gum or palate, which disappear if left alone. One sees older infants operated on for a lipoma in the sole of the foot, for which treatment

is unnecessary. Although watering of the eye resulting from incomplete opening of the nasolacrimal duct almost always cures itself without probing, there are still some who attempt this. Müller *et al.* showed that the bends in the lower part of the tear duct make it impossible for a probe to penetrate Hasner's membrane so that probing inevitably produces a false passage; they recommend syringing if anything has to be done, but they state that the duct can open spontaneously as late as the 2nd year.⁹ Probing requires a general anaesthetic, and I know of a death which resulted. One hears of operations for toeing in, toeing out, curly toes, flat feet, knock knee, or bow legs, and in none is treatment generally required.^{10, 11} A physician's ignorance of the normal plays into the hands of over-active surgeons.

When Mueller inspected the tonsils of 640 children aged 5 to 16 and reported that only 14% had 'normal' tonsils,¹² one wonders how the word normal should be defined. Denzer and Felshin described a study in New York in which tonsils of 1000 11-year-old children were investigated: 610 of children were found to have had the tonsils removed, and when the remaining 390 were referred to ENT specialists, all but 65 of them were advised to have the tonsils removed because they were 'abnormal'.¹³

The observation of a click in the hip of the newborn causes innumerable babies to be placed in 'double nappies', despite the current opinion that the 'click' is of no significance and that double nappies are a useless form of treatment.¹⁴ According to Ramsey, Ortolani wrote that the important 'clunk' or 'jerk' is never found under age 3 months, an opinion with which Ramsey agreed.

One has seen many incorrect diagnoses of cerebral palsy because of failure to recognise normal variations in muscle tone, in the briskness of tendon jerks, or in motor development. This can be a tragedy for the child: I have seen a normal child rejected for adoption on the grounds that he was spastic. I am convinced that only an expert should be allowed to cause a child's adoption to be rejected on the grounds of some abnormality. One has seen children subjected to prolonged physiotherapy at enormous inconvenience to the parents and expense to the NHS for supposed cerebral palsy, when in fact there was no abnormality.

A bizarre feature of paediatrics in some quarters

is the widespread application of the terms 'brain-damaged', or 'minimal brain dysfunction' (or 'damage'), or the 'hyperkinetic syndrome', to children whose behaviour disturbs adults. Schmitt wrote that over 100 symptoms have been put into this ragbag diagnosis.¹⁵ Rutter,¹⁶ and Sandberg *et al.*¹⁷ showed that there is no justification for designating these symptoms a 'syndrome'. There is much to be said for making a diagnosis which no one can prove or disprove, as long as it does no harm. Doctors feel better when they have put a name to a condition, whether or not the name means anything, but the term 'brain damaged' is harmful to the child because it 'labels' him, with the risk that teachers will treat him differently from others, with the self-fulfilling prophecy effect. In certain countries these labelled children are given daily stimulant pills with side effects which include stunting of growth, while the child is started on the pill-taking pill-dependent track which may affect him for life. Furthermore, parents are greatly distressed when told that their child is 'brain-damaged'. No one can deny that an occasional child is truly 'overactive': but the diagnosis of the hyperkinetic syndrome, or slight brain damage, is often applied to normal children who have got nothing wrong with them (and need no treatment for taking after one or other of their parents). Many do not realise that there is no psychological or other test which proves that a child's symptoms are due to brain-damage.

Failure to know what is normal, or a mere normal variation not requiring treatment, may cause serious parental anxiety in many other ways. I have seen numerous normal children who had been said to be mentally defective, spastic, or hydrocephalic. I have seen mothers who were told that their normal babies were spastic because they were 'not showing the right responses', or had a 'persistent primitive reflex'. The mother of a 6-month-old baby was told by a health visitor that her child's head was 'too small'. The health visitor had failed to relate the size of the head to the size of the baby and, in fact, the baby was normal with an unusually high developmental quotient. A health visitor stated that she 'failed' 40% of babies at the 6-month assessment, and I found that she had told the mothers that their babies had failed. On the Continent I heard that at the 8-month assessment babies were being referred in considerable numbers to psychiatrists, psychologists, neurologists and others, and that in the 4-year-old assessment 40% were thought to be retarded. Many are insensitive to the psychological implications of referrals from assessment clinics: referrals for suspected defects of vision, hearing, or the hips are usually essential, but apart from those, referrals may cause much parental anxiety without

any advantage to the child. Many referrals are due to failure to recognise the range of normality, often because of reliance on charts showing the centile distribution of milestones of development or physical growth. In fact one can never draw the line between normal and abnormal, and the fact that a child's milestone, weight or height, is below a certain centile by no means proves that he is abnormal. Centile charts should be used with judgement. Unless a doctor uses clinical judgement and knows the normal and normal variations, many normal children will be subjected to unnecessary investigations which may be unpleasant, even dangerous, undoubtedly costly and which will certainly cause parental anxiety.

Conclusion

As a necessary preliminary to diagnosing the abnormal, it is essential to be thoroughly conversant with the normal, with normal variations, and especially the reasons for those variations. The result of not knowing the normal brings much suffering for the child, unnecessary investigation, unnecessary medical treatment and surgical procedures, with inevitable anxiety for the parents. Douglas Gairdner's famous paper drew the attention of the world to one aspect of the normal which is still not known to many.

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