Women in paediatrics

Sir,

It took an Act of Parliament in 1876 to enable women to graduate from British medical schools and at the present rate another Act will be required now, 100 years later, to give them realistic opportunities to complete their postgraduate training.

Your editorial¹ gives hope that attitudes may be changing although, in general, this is not the impression gained from my paediatric colleagues. I do not believe that there will be any appreciable change until women are on national committees in sufficient numbers to influence decisions, for I do not think enough men are seriously motivated to change the *status quo* (after all it works to their advantage).

I hope this will be one of many letters requesting that the British Paediatric Association appoint a committee, on which at least half the members are married women, to examine their particular needs in paediatrics so that suitable adaptations to career grades and instructions to appointment committees will give those struggling in the system a fairer deal.

Reference

- 1 Anonymous. Women in paediatrics. *Arch Dis Child* 1981; **56**: 409.

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Perinatal mortality

Sir,

Other readers who were surprised by Dr Robertson's letter¹ should re-read what Pamela Davies actually wrote in her review of the Short Committee Report.²

I failed to find any suggestion that 'money would be better spent in primary care and prevention of prematurity'. The actual comment was 'prevention of preterm labour would of course lead to a reduction in neonatal mortality . . . but preterm labour and low birthweight are to a large extent part of the basic problem—poverty', a statement with which all but the most blinkered would concur. Nor could I find any implication that 'as money is in short supply . . . we should not complain bitterly about lack of perinatal provision', described as 'an amazing council of inertia'. On the contrary Dr Davies made constructive suggestions about deployment of existing medical staff to ensure that 24-hour supervision of mothers and newborns was provided; she acknowledged that deaths could be prevented and gave as examples the decline in spastic/ataxic diplegia in low birthweight infants, the two achievements of improved perinatal facilities about which there is little dispute.

In view of the extravagant claims made before the Short Committee, and widely publicised in the media, that 20–50 % of childhood handicaps could be prevented by an increase in highly sophisticated neonatal facilities

(a claim based on very little evidence), I suspect that the real cause of Dr Robertson's anger was Dr Davies's statement that 'the bulk of severe disabling handicap in childhood is not caused by perinatal factors', and her reservations about the proportion of time in special care units spent on 'keeping ever smaller and more immature infants alive (for a future of uncertain quality sometimes)'.

A study of a total population of Dundee-resident children born 1974/1975, in whom the incidence of handicap is very similar to that reported in other surveys, confirms that genetic or early embryonic factors are implicated in most children with severe handicaps and that social factors are predominant in children with mild mental retardation, and particularly in those of normal intellectual potential who are failing in normal schools. Although only a few severe handicaps could be attributed in any way to adverse perinatal factors, there was among children with less severe disabilities a highly significant excess of complications of pregnancy and delivery, associated with later evidence of neurological dysfunction in many cases, which could be explained only in part by socioeconomic factors. It is possible that minimal damage resulting from such complications renders the child more vulnerable to adverse factors in the postnatal environment. Dr Davies's comments about antenatal care and supporting health services for mothers and infants are most pertinent at this point.

Too seldom do neonatologists emerge from their highly specialised cocoons into the real world of childhood disability and handicap, but when they do, attention should be paid to the plea that paediatricians responsible for newborn care should 'urge with all the force at their disposal that available resources should be used where they can do most for the health of all children'.

References

- 1 Robertson N R C. Letter: Perinatal mortality. *Arch Dis Child* 1981; **56**: 484–5.
- 2 Davies P A. Perinatal mortality. *Arch Dis Child* 1980; **55**: 833–7.

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Recurrent croup and allergy

Sir,

I congratulate Zach *et al.*¹ on their report of a highly significant association between recurrent croup and allergy/airways hyperreactivity. In a group of children admitted for adenoidectomy² we found that out of 202 without recurrent croup 44 of them had had atopic disease, whereas out of 21 with recurrent croup 10 had had atopic disease ($P < 0.01$).

Perhaps an old debate between ear, nose, and throat and paediatric departments may soon be settled. Recurrent croup should be included among unspecific symptoms of an atopic constitution together with—for example, recurrent wheezy bronchitis and follicular hyperkeratosis. High total IgE concentrations are often found to be