provided by the paediatrician or psychologist, or both, who may also be needed to help with the behavioural results of head injuries, and to modify the family response to the child. Litigation features prominently in many cases, and as after other types of accident, it is essential to keep the parents informed of the details of the child's condition and the possible long term outcome, to concern them in management plans, and to put them in touch with helping agencies.

WHEN CHILDREN PRESENT AT A LATER STAGE

From time to time children are referred with developmental, behavioural, or learning problems who have apparently fully recovered from a previous head injury. As one in 15 children has had a head injury 'which caused parents serious worry' there are many who present in this way.⁸ It is important to attempt to establish the relative importance of the injury to the current problems, and this can only be achieved by detailed assessment of the child and his or her home and educational environment.

FOR THE 'LOST CHILDREN'

There is a third group of children who, having recovered from what would be categorised as 'minor' head injuries, are discharged from follow up. There is growing concern that some of these children 'in fact suffer from specific cognitive deficits that significantly hamper their academic progress and life adjustment and that, in some cases, behavioural deterioration may occur long after injury.'⁶ Although there is good

evidence that such minor injury can produce serious brain lesions, the extent of subsequent problems is as yet unknown.^{9 10} It has always been difficult to assess premorbid functioning retrospectively, even in adults, and this difficulty becomes greater in younger, and therefore less well documented, children. It would be unrealistic to suggest detailed assessment and follow up of all cases of minor head injury, but community paediatricians have the network to inform parents and those professional people who come into contact with children in the community of the nature of potential problems, the diverse ways in which they may present, and how to obtain help.

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LETTERS TO THE EDITOR

Terminology in community child health—an urgent need for consensus?

SIR,—Annotations in *Archives* should not be ignored; perhaps that is what makes Dr Stone's semantic agonising,¹ ostensibly on behalf of community child health, so irritating. His suggested consensus on terminology is probably unattainable. It was ever thus: what on earth makes Dr Stone think that 'ambiguous technical language' is peculiar to community paediatrics?

Such an 'urgent' consensus is not even wholly desirable. We should certainly invoke Humpty Dumpty's rule of word usage—'when I use a word, it means just what I choose it to mean, neither more nor less'. Pro-

vided that people define their use of terms and are precise, differences of meaning, emphasis, and nuance which emerge can be useful catalysts of constructive debate.

Whatever the merits of Dr Stone's proposed definitions, his view of community child health is weird, his use of expressions such as 'terminological impasse', 'chronic linguistic malaise', and 'outdated and misleading jargon' is unhelpful, and his conclusions are frankly silly. Community child health does not suffer from 'chronic linguistic malaise', but from the effects of the 'professional and organisational vacuum' within which it has hitherto had to operate (I certainly agree about that). It also suffers from the failure so far to grasp and act upon the organisational and staffing implications of what a consultant led service really means.

If community child health did not already exist, something like it would need to be invented to fill the 'intermediate position between hospital based therapeutic paediatrics, and community based public health', which Dr Stone describes as uncomfortable, but which is in fact extremely stimulating,

highly relevant to the health needs of children, and of potential benefit to all three disciplines.

As an academic community paediatrician I dissociate myself completely from Dr Stone's concluding remarks, particularly the 'we' referred to, whoever they may be. Community child health does not need to be dragged anywhere. It has momentum and a sense of direction, and community paediatricians are well aware of the reality of children's health needs in the community. I am confident that precision in terminology will also improve as we continue to focus on the practical issues involved. Semantics should never become a preoccupation.

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- 1 Stone DH. Terminology in community child health—an urgent need for consensus. *Arch Dis Child* 1990;65:817-8.