Correspondence

Use of the child health clinic

Sir,

We welcome the Thomas Coram Centre team’s success in achieving nearly 100% attendance at their inner city clinics.1 It shows that high attendance rates can be achieved without resorting to Draconian measures. However, we challenge whether it represents an ‘ideal’ service, or whether frequent attendance should be synonymous with ‘good’.

The team’s system of 7 formal physical, developmental, and behavioural checks by a doctor before age 5 years, in addition to non-routine consultations, uses a great amount of medical time. Our experience in less well-staffed clinics shows that such a system results in the doctor being too busy to spend sufficient time with a child with a difficult problem, and encourages the child most at risk not to attend. We doubt if repeated routine consultations reveal persistent (rather than transient) remedial abnormalities hitherto undetected; perhaps the Thomas Coram Centre has some data on this subject. In a group of 252 children (most of them under 2 years) routine examinations at an inner city clinic in Nottingham revealed only one child with an abnormality of clinical significance that had not previously been detected.

As practising clinic doctors we wonder to what extent routine checks duplicate, and therefore undermine, the work of health visitors and parents. Is the health visitor, parent, general practitioner (GP), or clinic doctor best at detecting abnormalities? In poor countries there would be no doctor available to make frequent medical checks on children; such primary care would be the responsibility of nursing staff with very basic training. In this country we deny well-trained health visitors such responsibility by insisting that checks are made by a clinic doctor. Surely primary detection is part of the role of the health visitor? We suggest that the clinic doctor or GP should have a secondary role; he should make fewer checks and look at problems identified by parents or health visitors. We are developing such a system in Nottingham.

Obviously this system will be successful only if there are sufficient staff and they are of adequate quality. Hart et al.1 make this point for doctors; we would make it equally strongly for health visitors. It is a pity that the DHSS does not have current guidelines on the patient load appropriate to health visitors. Hart et al. implied a norm of 1 health visitor for 200 families with children under 5 years, but this would not be adequate for inner cities. As the health visitor would also have older children and pensioners on her case load, we would prefer a ratio of 1 health visitor for 100 families if her role were to be enlarged to include primary screening.

Finally we are concerned that an ‘ideal’ service appears to exclude the GP. The role performed by Hart et al. would appear to be very similar to that performed by a GP (paediatrician), and we believe that a strong primary care service for children under 5 should integrate the GP and not bypass him.

Reference


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Dr Hart and co-workers comment:

We are grateful for the opportunity to make some slighty more polemical points than we did in our paper. We are not sure what Hendrickse et al. meant when they said that only one child with an abnormality of clinical significance was detected. We suspect that they were referring to abnormalities of those systems of the body that are morphogenetically fully developed in broad terms at or around birth, and not to those in which morphogenesis continues throughout the early years of life of which the main example is the central nervous system. It is therefore not surprising that the abnormalities one detects during the early years of life are associated with development and behaviour. For example, we do not find cases of congenital heart disease as these are detected on initial investigation. Developmental and behavioural disorders are common to all ages, 2 and as such problems are present in one in 5 of the population, regular assessment by a paediatrician seems reasonable to us.

We are not necessarily committed to each one of the 7 examinations we report. In fact we think that the 1 to 2 years assessment is of great significance, as we begin to try to understand why so many children have problems of the development of communication. We do not want drastically to reduce the number of times we see a child nor do we believe that the proposal to ask health visitors to do developmental assessments a sensible one; as we stressed, the developing functions are assessed as part of the overall paediatric examination of the child. If the health visitor were to take on this new function her other activities would have to be curtailed.

As more is learnt about the early problems of development it is likely that the health visitor will spend more
and not less of her time visiting toddlers, and if this happens she will simply not have time to take on new activities.

We believe that every health visitor should have a thorough understanding of child development and have a mental checklist each time she sees a child to make sure that all is going well. The health visitors we have worked with do paediatric work only and have case loads of about 200. They are busy, and we agree that a smaller case load would be better.

Of course we agree that in the future the GP in some areas may be the trained doctor who works at the clinic. We did not mention this because in our own inner urban areas contact with GPs has been restricted and difficult. This is because in our fairly small geographical areas a large number of doctors had been in touch with the children—namely 548 children had seen 72 different GPs in Camden, and 322 children had seen 80 GPs in Westminster.

We do not claim that our service is ideal; the point of our paper was to stress that families come readily to a clinic where there are trained personnel to assess the children, advise about problems with child rearing, and care for children who have difficulties.

Finally, this is a developed country and we believe it can and should afford a better primary care paediatric service than it provides at present.

References


Transient neonatal hyperparathyroidism secondary to maternal pseudohypoparathyroidism

Sir,

I read with interest the paper by Glass and Barr. When I studied the right distal femur I thought that this baby had rickets (congenital) owing to the long-term maternal anticonvulsant treatment that had been given for maternal pseudohypoparathyroidism. The results of the biochemical investigations carried out in the 1-week old baby seemed to me to be compatible with rickets including the low to normal plasma calcium level which would surely have been raised had the hyperparathyroidism not been related to congenital vitamin D deficiency. Although hyperparathyroidism is always present in vitamin D deficiency rickets, as it was in this baby, the reverse is not expected. Her very low 25-hydroxycholecalciferol values (4-8 ng/ml) would most likely be related to low maternal plasma 25 (OH) CC level. Therefore, should the title not be congenital rickets secondary to long-term maternal anticonvulsant treatment due to maternal pseudohypoparathyroidism?

This change in title is important for all pregnant women who are on anticonvulsant treatment.

References


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Neurological reactions to pertussis vaccination

SIR,

This is always an interesting subject but surely statistical studies, although fascinating, must be backed by scientific studies of mechanisms. What is the nature of the (presumably) immunological reaction? Has anyone detected anti-pertussis immune complexes in any of these children? Has anyone done fluorescent studies of the brain? Do immunological disasters affect other organs? Why should an immunological reaction be more likely in a child with previous brain damage (if this is statistically the case)? Surely the time has come for an intensive study of individual cases of immunisation reactions.

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Women in paediatrics

Sir,

I wholeheartedly support Dr Savage’s views; I think that the BPA should make much more effort to investigate the needs of married women doctors who wish to work in paediatrics.

Reference


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This correspondence is now closed. Any further letters should be addressed to Professor Sir Peter Tizard (c/o the British Paediatric Association) who has resolved to solve the problem.

Editor