Correspondence

Child health services after re-organisation

Spir

The annotation by Dr Wilson was interesting but I think that her message of gloom is too strong.

Child health area specialists were an essential part of the last reorganisation; they acted as catalysts in setting up child health services on a firm paediatric (as opposed to public health) basis, but these having been created can now move on to new fields and fresh challenges.

Dr Wilson only gives one model for the organisation of the child health services from 1 April 1982; the British Medical Association sees a different model and I suggest that every district should press for the second option. I quote (Dr Wilson’s model is first):

First, the model which exists in many areas at present where SCMOs and CMOs are managerially accountable to the authority through a community physician.

Secondly, accountability to the authority through one SCMO (often titled Principal Medical Officer) with a community physician monitoring and coordinating their work, and responsible for evaluation . . .

In Scotland this person is called the ‘Clinical co-ordinator of child health services’ and such a doctor works closely with consultant paediatricians to ensure that appropriate training programmes are carried out (until such time as national programmes are implemented) and suitable doctors appointed. The community physician will expect to be consulted and to have his approval sought for such decisions, but surely he will be fully occupied elsewhere if he has a competent SCMO. However, one very real concern is the community child health representation at district level and where this will come from.

The managerial change of accountability for work is not in itself important. I was pleased that Dr Wilson stressed that CMOs and SCMOs are clinically autonomous; this fact has not been recognised by many people, which has not enhanced the image of the child health doctor.

Four years ago the community child health services were at serious risk of becoming part of a generic third force but with the valiant help of consultant paediatricians (many of whom confessed that they had never before given the community service a thought), and with the help of GP colleagues, we fought off that threat. Some of those paediatricians have since built up departments of child health (closely integrated with community services) which no reorganisation can destroy. In particular I would mention the supreme efforts made by Professor Forfar on behalf of the training of CMOs and SCMOs, and the clear recommendations which his committees have made towards a unified service. In the last four years we have come a very long way, which is why I feel optimistic about the future.

Although Scotland always seems to be one step ahead, there are exciting developments in child health services in inner cities, Nottingham and Newcastle to mention only two. These changes have been initiated by paediatricians who can see that paediatrics without prevention is like treating an overdose while the patient is still swallowing the tablets. Their vision is the same as that of the hard-done-by, hard working Court committee who said it all many years ago, but unfortunately that report was far ahead of its time. However, slowly but surely we are all beginning to recognise that the Court report was wise and that it recommended practical solutions to our problems, many of which may still be relevant.

If we have the foresight and the courage needed to set up integrated child health services in our districts, and if we play our cards right, no management structure can destroy what we build, but if we hesitate and fail to grasp the opportunity then gloom may well be justified.

References


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Congenital villous atrophy

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Dossetor described a patient with presumed congenital villous atrophy not secondary to intraluminal events. However, barium follow-through showed a dilated small-bowel and very slow passage of barium. We suggest for this child the diagnosis of intestinal pseudo-obstruction, a term that is used for the syndrome in which there are symptoms and signs of intestinal obstruction without any evidence for an actual lesion obstructing the intestinal lumen.

Chronic intestinal pseudo-obstruction exists in two forms, primary and secondary. The latter can be the result of many diseases. Primary chronic intestinal pseudo-obstruction is a primary disorder of gastrointestinal motility. Manometric and myoelectric studies