LETTERS TO THE EDITOR

Parent initiated and conventional preschool health surveillance

EDITOR—I am worried by the article by John Dearlove and Su Illingworth.1 The topic is interesting for community paediatricians who have conducted studies on the routine checks of the child health surveillance (CHS) programme need justification if they are to continue. Good research to answer the question of whether parental concern is as good as regular professional contact in identifying abnormalities is urgently needed.

This study sample of 538 babies is small. Babies were randomised by practice, making this a cluster randomised trial. The sample size needed to give enough power to detect true differences between the groups runs into several thousands. In addition, 234 mothers (43% of the initial sample) were lost by the end of the first year. The numbers randomised to each group at the outset are not given. It is clear however that the study intervention was implemented in only 45 cases, 8% of the original sample.

Neither mothers nor health visitors were keen on mothers making their own appointments. Those mothers who did not comply with the intervention said they found routine appointments more convenient. Anecdotal evidence suggests that health visitors determined the intervention. It would have been prudent to seek health visitors’ views formally as part of the study.

A small study in Northampton (unpublished data) suggests that the CHS programme leads to identification of complex developmental problems in two ways. In a third of cases, the professional alone identifies the abnormality. In another third, the parent identifies it. In half those cases parents used the routine CHS check to raise their concern. In the other half, they raised concern outside the routine programme.

This paper’s conclusion is not proven because of small sample size and failure to implement the study intervention. Mothers and health visitors appear to value routine professional contact within a CHS programme. Our local evidence supports that view. More research is needed.

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Covert video surveillance

EDITOR—Shabde and Craft have misunderstood several issues addressed by Foreman and Farsides.1 Consequently, they make recommendations that could lead to children being exposed to unnecessary risk.

The biggest ethical difficulty in covert video surveillance (CVS) is that of breach of trust. It is the risk of harm to the child, who becomes a tethered goat, set to catch a tiger. These risks are not small. This makes CVS an investigation of last resort, as the “double effect” defence preferred by Shabde and Craft implies. Breach of trust is important to the extent that one must have good reason to break trust. Foreman and Farsides first demonstrated that covert techniques were effectively the same as the burden of proof for action under The Children Act.1 Therefore, all cases for which CVS may be justified can also be referred to covert techniques. Shabde and Craft’s ethical expertise lies primarily in securing children’s health, while children’s welfare determines protection issues. So doctors, while being important participants in the process, cannot claim a privileged position in determining the outcome of child protection procedures.

Shabde and Craft recommend that CVS be used to ensure that court action is sufficient to protect the child. The Children Act makes protection of the child of paramount importance to the court. Shabde and Craft do not know whether (a) the court will take the same view as themselves, or (b) whether the court will be incorrect if it takes a different view. Clearly, successful court disposal is safer than CVS, and must be preferred as a first choice. Of course, courts are not always right. Foreman and Farsides agreed that CVS was ethical in restricted circumstances. If there was good reason to think that a court disposal was failing to protect the child, CVS might then be ethical to obtain the evidence needed for additional action.

Finally, Shabde and Craft persist in the error of calling CVS a diagnostic investigation, when in fact it is a forensic investigation used to detect a crime. Doctors merely administer it. This leads them to claim that CVS might be used to “prevent the separation of children from innocent parents”. All a negative finding shows is that no offence was recorded while the cameras were running. In these circumstances, CVS may be providing no more than a false sense of security.

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We would like to reply to Dr Foreman’s comments. He seems to have misunderstood the thrust of our arguments for and against CVS.

We believe that if operated under a strict and rigorous multiagency protocol, the risk to the child undergoing CVS is minimal. Southall et al demonstrated justifiable use of CVS for investigation of a possible life threatening event in their series where abuse was revealed in 33 with attempted suffocation in 30 patients.

It has been suggested that The Children Act 1989 alone is sufficient to protect children with possible induced illness syndrome. It must be recognised that although there may be enough grounds for legal proceedings, courts may decide to make a supervision order or no order at all, unless an appreciable level of risk is shown and the child may be returned to his or her parents to face the same risk. We do not agree that if there was good reason to think that a court disposal was failing to protect the child, CVS might then be ethical to obtain the evidence needed for additional actions. Surely this is then too late.

Of course a negative finding on CVS shows that no offence was recorded while the camera was running but we strongly contend that CVS needs to be available as an investigative and assessment tool (not merely a diagnostic tool) that can be used for some forms of factitious/induced illness syndrome where there is serious risk of life threatening abuse. We reiterate that it must only be done in the context of adequate child protection procedures which include full child and family assessment, and that staff must be properly trained.

Recommendations for the management of galactosaemia

EDITOR—I was concerned reading Dr Garden and Davidson’s paper on galactosaemia.2 With such a severe condition that has serious implications for life threatening illness, it is not surprising that a misdiagnosis could be potentially fatal. All too often we hear galactosaemia is not diagnosed early enough and that children are left with permanent sequelae. A recent study3 has shown that the mean age of diagnosis is 12.7 months and that date varies from 2 to 63 months. The authors of this study were also concerned by the lack of awareness of the condition among professionals.

We must ensure that clinicians are aware of galactosaemia and the importance of screening newborns. Dr Garden and Davidson’s paper on the importance of early diagnosis is therefore timely.


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Infanticide or SIDS, double jeopardy

A recent article by Meadow documented some clinical features of 81 cases of infanticide in an attempt to identify particular features that might help paediatricians differentiate between natural and unnatural infant deaths. In Table 1 we have documented the prevalence of some of these features, highlighted by Meadow’s study, in a contemporary SIDS database (165 cases of SIDS that occurred in the Republic of Ireland between 1994 and 1997) to give paediatricians, pathologists, and coroners, information to assist them in making a judgment on the likely cause of death.

Several features highlighted by Meadow’s study as possibly raising suspicions of infanticide are either very common in SIDS (death in the first 7 months, 91%) or, while less common in SIDS than in infancy, are sufficiently common to negate their use as markers of infanticide. These include no previous live healthy child (26%), time of death 1100–2200 (22%), an interval of <2 hours from last seen and found dead (30%). Blood was found in the mouth, nose, or face in 32% of cases of SIDS. However, the question did not distinguish between blood stained froth or frank blood and needs to be more rigorously framed in future. Death of a previous child and previous apnoeic episodes or apparent life threatening events were uncommon events in the SIDS group. These situations will undoubtedly raise concerns in the future.

Although we are unable to address all the issues raised in Meadow’s paper we agree that the way forward must be a thorough investigation of all sudden unexpected infant deaths by professionals experienced in this area, including paediatricians and paediatric pathologists. Anything less will allow the present situation of double jeopardy to continue, with cases of infanticide remaining undiagnosed and, increasingly, many newly bereaved SIDS parents wrongly suspected of fatal child abuse.

Table 1 A comparison of frequencies of certain features (identified by the Meadow study) in Irish SIDS (1994–1997) versus the Meadow cases

<table>
<thead>
<tr>
<th>Feature</th>
<th>SIDS 1994–1997</th>
<th>Meadow cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>No previous live child (%)</td>
<td>26</td>
<td>36/150</td>
</tr>
<tr>
<td>Death of a previous child (%)</td>
<td>5</td>
<td>5/250</td>
</tr>
<tr>
<td>Died in 1st 7 months of life (%)</td>
<td>91</td>
<td>150/165</td>
</tr>
<tr>
<td>Time of death 1100–2200 (%)</td>
<td>22</td>
<td>27/124</td>
</tr>
<tr>
<td>Interval between last seen and found dead (h)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;2</td>
<td>30</td>
<td>36/121</td>
</tr>
<tr>
<td>2–6</td>
<td>44</td>
<td>53/121</td>
</tr>
<tr>
<td>&gt;6–12</td>
<td>26</td>
<td>32/121</td>
</tr>
<tr>
<td>Blood in mouth, nose, face (%)</td>
<td>26</td>
<td>32/122</td>
</tr>
<tr>
<td>Previous apnoeic episodes (%)</td>
<td>4</td>
<td>5/125</td>
</tr>
<tr>
<td>Previous ALTEs (%)</td>
<td>2</td>
<td>2/125</td>
</tr>
</tbody>
</table>

Notes:
- **ALTEs** = apparent life threatening events.
- **SIDS** = sudden infant death syndrome.
The condition sought should be an important programme.1

(1) The condition sought should be an important health hazard. Recommended imaging tests aim to identify obstruction, vesicoureteric reflux, and renal scarring. All these conditions are potentially serious. Condition fulfilled.

(2) A latent phase of the condition must be recognised by a simple, acceptable test. While ultrasound can fulfil this requirement, isotope scans are more invasive and less acceptable. Micturating cystography is universally disliked by children and parents and is only acceptable in special, high risk situations. Condition not fulfilled.

(3) The natural history must be understood and beneficial effects of treatment must have been established. Some children with renal scarring who develop a few scars without screening will develop new scars if further UTIs develop, particularly if there is a delay in starting treatment, if the child is very young, and if there is high grade reflux. However, neither long term low dose prophylaxis nor surgery have been shown to influence the development of new scars. Condition not fulfilled.

(4) The costs of case finding and treatment must be economically balanced against the expenditure. Stark has expressed doubt about the cost effectiveness of imaging investigations in children following UTIs in childhood. Condition fulfilled.

Three of the four criteria for a successful screening programme are not fulfilled for vesicoureteric reflux and renal scarring. The natural history of obstruction is deteriorating renal function and a risk of severe UTIs. Obstruction can be readily identified by ultrasound. Relief of obstruction is an agreed form of treatment. Thus screening for obstruction using ultrasound may fulfil the criteria for screening.

There is evidence that UTIs in children under 2 years of age are under diagnosed in primary care.2 If we believe that scars are acquired and preventable then it would be better to put more effort into detecting UTIs in children under 2 years and ensuring prompt, appropriate treatment.

Prophylaxis has been shown to decrease the risk of recurrent infection in children with normal urinary tracts.3 We do not know if prophylaxis is superior to prompt treatment of new infections in the prevention of recurrent scarring.


Evidence in favour of NHS Direct

EDITOR,—In his annotation “NHS Direct: here and now”1 McElwee raises questions about the new service and highlights some of the criticisms levelled against it.2 We would like to offer some evidence in favour of NHS Direct.

Initial analysis of call volumes and caller awareness for NHS Direct in West Yorkshire reveals an interesting fact. Of the first 27 945 calls received (April to August 1999), 3945 (15%) had heard of NHS Direct from their local Accident and Emergency (A&E) department. Fatovich et al have shown that the average time to deal with a telephone call for medical advice to an A&E department is 3.9 minutes (range 0.25–25 minutes).3 To deal with 3945 such calls would take on average 15 385 minutes (256 hours). Over this five month period, this translates into a potential saving of more than six working weeks (assuming a working week of 40 hours) for A&E services across West Yorkshire. Even though this calculation ignores the time needed to tell a caller to ring NHS Direct, it still represents a substantial time saving.

We wonder what the saving will be nationally as the service grows?

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Children of the 90s

EDITOR,—The review “Children of the 90s: challenges for the ethics and law community”3 states that the study children are reaching an age when their own views and opinions will begin to eclipse those of their parents in importance. It emphasises the need to balance study benefits against research that is acceptable to the community.

Herman-Giddens et al have suggested that although the age of menarche has changed little in the last 45 years, the first signs of puberty are occurring earlier.4 We designed a pilot study to look at the age of pubertal change in the UK population. The study had local research ethics committee approval. A questionnaire was sent to the parents of 160 children aged 8–18 years. Parents were asked to pass the questionnaire to their child if they were happy for them to complete it. The young people were asked to complete the questionnaire themselves to obviate any difficulties that might arise in single parent families where the parent and child were of different sexes. The respondents were asked to assess their pubertal status using a “tick the box” format in relation to line drawings.

Respondents were encouraged to return the questionnaires even if they did not want to complete them. Seventy one per cent of the questionnaires were returned but only 59% were completed overall. Comments made by parents included: “I have been unable to persuade my daughter to take part in your study. She is at an age when she is extremely self-conscious of the rather rapid changes in her body.” “I find this all very fascinating and would clearly like my daughter to take part.” However she is too embarrassed and refuses.”

This study shows that:

• Parents may be happier about completing questionnaires about their children than the children themselves

• Children as young as 8, when given the option, may choose not to take part in a study.

The way we tried to carry out this study was unacceptable to many of our study group. Involving young people at the design stage may increase the acceptability in what is undoubtedly a difficult area to research.

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Economic disadvantages of palivizumab

EDITOR,—We would fully agree with Dr Sanjeev Deshpande’s appraisal of the economic disadvantages of palivizumab (Arch Dis Child 2000;82:88–90) and would also suggest that the financial disincentives are indeed greater than he suggests. He bases his figures on a five month course; however, a review of our figures in Rochdale,1 shows that there were significant numbers of consultations arising from respiratory syncytial virus infection as early as September and as late as March in 1999.

These results were not considered to be particularly atypical. It would therefore seem likely that to provide realistic “cover” for any baby considered sufficiently at risk, would require immunisations for at least seven months—a cost of £44 800.

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1 Documented cases of RSV January 1999 to January 2000 in Rochdale. Manchester Public Health Laboratory, Withington Hospital, Nell Lane, Withington, Manchester.