

doi:10.1136/adc.2009.172726

Martin Ward Platt, *Associate editor*

Behind the front door

The privilege of entering a family's home, and the surprises that often accompany such a visit, used to be the province of primary care in the UK. Home visits for children are now rare, and out-of-hours care is seldom given by a general practitioner known to the family, so most GPs know nothing of a child beyond what presents in their consulting room. Yet we know that the home environment in relation to the management of long-term illness is highly significant. Increasingly, paediatricians based in the hospital and the community, including sub-specialists, recognise this and either visit families in person, or ensure that a member of the team does so.

In this issue Braken *et al* report the effects of home visits by specialist asthma nurses to children with problematical asthma. Every reader who has ever made a home visit will instantly concur with their statement that "... in many children information gained at the time of the home visit was invaluable in their overall assessment." Indeed, reading between the lines and based on my own experience, the word 'revelatory' springs to mind. Their findings would apply just as much to other specialist outreach nurses. Where children's responses to their treatments seem 'problematical' – doses are escalated, control seems poor – the first place to go is the home, and we probably need to do more home visits, not less.

The home is a clinical territory that appears to have been abandoned by general practitioners in this country, yet it is where our patients spend most of their lives and where virtually all of their clinical care is delivered, mostly by parents and relatives. We cannot, and need not, go into the homes of all our patients, since for most of our patients it would not be of value. For children for whom it is likely to be beneficial, those of us fortunate to work with specialist nurses can delegate this task; those of us without may find that for a few patients, half an hour spent in their home will be worth any number of fruitless consultations in clinic that seem to take the situation no further forward.

See page 780

In the emergency room

Pursuing the theme of primary care services that may not quite do what they say on the tin, Williams *et al* studied the factors that brought children to the Accident and Emergency department for 'non-urgent' conditions. After all, everyone knows that these contacts are by definition inappropriate, and they need to be discouraged or prevented.

In fact, it turns out that what 'everyone knows' is wrong. In a study with a staggeringly high participation rate (over 97%), these authors show that, at least in Queensland, parents' behaviour in presenting their children to A&E was entirely appropriate, based on their assessment of their child's illness or injury at the time. In most cases the choice was positive, based on the perceived severity of the child's illness, the perception of hospital-based expertise, and the availability of investigations (the 'one stop shop'). The main negative factor driving these presentations was the unavailability of appropriate primary care services, but this accounted for only a minority of cases. The authors rightly urge us to abandon the concept of 'inappropriate' attendance, to which I would add that 'non-urgent' seems a rather unhelpful term as well.

From this we can see that however much resource is put into primary care to try to make it the first point of contact for so-called 'non-urgent' cases, most of the A&E presentations of such children will continue. And if they are going to happen anyway, they need to be properly commissioned rather than being regarded as the inconvenient behaviour of ignorant parents, which means that commissioners and policy makers need to read this work and re-define their goals. Sensible commissioning would enable paediatricians and A&E departments to provide appropriate services for these children: it would reflect parent choice, acknowledging that parents are actually pretty good at assessing the level of their child's needs. *See page 817*

Unwillingly to school

It's nice, within a single issue, to be able to look at the same problem from two opposite points of view. In this instance, Jones *et al* studied secondary school children

with frequent absences for medical reasons, and examined the underlying reasons for it; while Crawley and Sterne took children with chronic fatigue syndrome (CFS) and examined the relationship between their physical function and school absence. In addition, from the same CFS research group, Haig-Ferguson *et al* explored the problem of memory and attention problems in children with CFS, which has a clear link with school performance if not attendance. These complementary studies, from geographically opposite ends of the UK, afford a fascinating insight into both groups of children.

We learn from Jones *et al* that 2.2% (of almost 9,000 children) met their criteria, with wide variation between schools; while of those who agreed to participate only 8% had CFS to account for their absences. Of course, we also know that CFS is significantly under-diagnosed among school-age children, so this finding is not really comparable to studies that use case-finding to diagnose previously unknown cases of CFS in schools. The self-reported physical symptoms given as reasons for absence were commonly not medically explained, and were associated with high rates of psychological morbidity; yet most of these children had not been assessed by mental health services, and this is the key message of the paper. "Medical" absence is too loose a term to describe these children's situation, though some families might feel more comfortable with this word even if the underlying nature of the problem is psychological or psychiatric.

From the perspective of children with CFS, Crawley and Sterne found that the situation was the opposite: rather than anxiety being the main driver for school absence, it seemed that physical function was the main determinant of school attendance, though they acknowledge that low mood was related to physical function. This is not surprising; in both studies it would be easy, but fallacious, to treat the psyche and soma as separate entities when in truth they are constantly interacting and influencing each other. In managing CFS, physical rehabilitation is crucial, but psychological support is essential, and as in so many other conditions, better school attendance is a good marker of improvement in the condition as a whole. *See pages 752, 757 and 763*