LETTERS TO THE EDITOR

THE CARE OF CHILDREN

Sir,

May I thank the College for its clear statement of policy on The Care of Children (September *Journal,* p.553) and the *Journal* for its thoughtful interpretation (September *Journal,* p.519). Together they state principles and proposals of such importance that I hope they will be published in a form which could be widely circulated to all involved with the health of children.

As I see it, we have moved from the stage of general debate and honest difference of view to one of local experiment and evaluation which alone can provide the facts on which rational, adaptable plans can be based. In this process the report of the Committee on the Child Health Services (1976), the Government's response in Health Circular HC(78)5 (DHSS, 1978), and the policy statement of your College, used selectively and in a constructive spirit, can point the way forward.

We all start with the needs of the child and we agree that "the standard of care for children must be raised". That is the central task. We accept the "need for progressive integration within the child health services, in particular of preventive and therapeutic care and of community and hospital services" (HC(78)5).

We believe that such a comprehensive and integrated child and family-centred service should be based in general practice, with primary care teams working in effective partnership with paediatrics and the allied specialties.

With such firmly agreed objectives what will delay and hinder progress? First let us take the issue of training in child health. If this is a necessity for all general practitioners then surely it should be an essential, not an optional, element in vocational training. It should also provide for those with a 'special interest' in paediatrics to acquire and maintain a more thorough knowledge, and so provide an 'enhancing' effect in the groups where they practise.

There are two serious limiting factors: the failure of the Department to accept the need for an expansion in the number of senior house officer posts to which you refer, and the complementary need for an increase in paediatricians and child psychiatrists to carry the increase in specialist as well as general practitioner trainer teaching. The Department remains unhappily silent on both these crucial points.

The special significance of trained general practitioners in the teaching programme supports your conviction that "It is particularly important that special competence in the provision of child health services is achieved within those general practices used for undergraduate and postgraduate training". We must hope that these points are acceptable to the Working Party of the Council for Postgraduate Medical Education.

The claim for a realistic increase in the paediatric establishment is also necessary if "the specialist paediatric services are increasingly to extend into the community" (HC(78)5). In fact joint clinics in group practice premises and in health centres are one form of mutual education which would be severely limited without additional manpower.

The second component of integration, between prevention and treatment, will take longer; and here I am glad that the College has recognized the contribution of the clinical medical officers to preventive paediatrics and agrees that "where general practitioners are unable or unwilling to provide full preventive paediatric services for their patients, then the present clinical medical officers should be invited to carry out this work in collaboration with general practitioners".

I hope that in this important and urgent matter the goodwill not only of the College but also of the British Paediatric Association will provide a lever to combined action. The Department is even now considering the future career structure of clinical medical officers (the Child Health Services Committee preferred the title 'child health practitioner') and as far as I can tell this is being negotiated with the Community Medicine Committee of the British Medical Association without the Association of Clinical Medical Officers, the Royal College of General Practitioners and the British Paediatric Association being continually represented. The danger here is that decisions vital for the future welfare of children and the development of general practice will be made by a body concerned with the collective health of the community rather than the clinical care of children and families.

Two major issues remain: the daunting task of creating a convincing pattern of services for the inner cities, and the development of educational medicine and a progressive school health service. Both call for determined collective study.

Indeed they and all that has gone before confirm the need for the College "to maintain a continuing dialogue with the British Paediatric Association . . . To consider the many new issues which have now arisen and which can be solved only by a joint approach."

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References

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GENERAL-PRACTITIONER OBSTETRICS

Sir,

I was interested to read the article by Dr Zander and colleagues (August *Journal,* p. 455). However, I was somewhat surprised that the results of the survey comparing the outcome of pregnancy in hospital and general-practitioner groups should be summarized as being "essentially similar". I would have thought some reference to the fact that there were two stillbirths in the general-practice group should have been made. This is particularly relevant as stillbirths could obviously have resulted from a system of poor antenatal care and a failure in liaison between general practitioner and hospital.

Whilst I am very much in favour of the sort of antenatal care described in the article, I suggest that such an article does little to further the idea of such care when the results are glossed over in such a way as to give more emphasis to the psychological benefits of the

exercise, while failing to mention such minor details as stillbirths and neonatal deaths.

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Sir,

It is somewhat sobering that an article describing a successful experiment integrating the primary and secondary health care services should provoke the obvious antagonism and anger shown in Mr Vass's letter (November *Journal*, p. 700) and I should like to reply to some of the specific points he raises.

The statement that the average district general hospital is just as accessible as a health centre is clearly unjustified whether accessibility is measured in terms of distance or the provision of consulting hours.

Length of waiting time is a generally recognized problem even if in Mr Vass's own clinic this difficulty has evidently been overcome—although he provides no factual information for comparison.

The possible number of different doctors seen by the patient clearly relates to the size of an obstetric team, but no evidence is provided for the *ex gratia* statement that there is a surfeit of staff at St Thomas' Hospital.

We regret that Mr Vass resents the incontrovertible suggestion that his responsibility for the general care for the pregnant patient differs from that of the general practitioner. Who does he consider is most appropriate to treat the expectant mother when she suffers from bronchitis, or depression, or when her child is presenting behaviour problems at the prospect of a newcomer in the home? Mr Vass states that he undertakes integrated care and if he defines this term by using the same criteria as we do, it is difficult to follow his overwhelming objections. The results given clearly relate just to our own experimental findings but it would be interesting to see how they compared with the results of similar studies in other situations.

Dr Bahrami (November *Journal*, p. 700) rightly stressed the prime importance of safety. Our findings showed that the differences in outcome between the two groups were not statistically significant, but perhaps we were amiss not to state that both patients who had stillbirths had received full antenatal care. The cause of death in one case was multiple abnormalities and the other followed premature rupture of the membranes at 32 weeks.

It was never stated or intended that this form of management was relevant or appropriate for all situations but rather that it had been found to be feasible, in the case of not just one, but a number of practices concerned with the provision of care in an inner city area. It is important to remember that the majority of the population live in large urban conurbations and it is here that some of the major problems facing the delivery of medical care, including the difficulty of establishing satisfactory contact between the general practitioner and his specialist colleagues, exist.

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TREATMENT OF MINOR RESPIRATORY ILLNESSES IN GROUP PRACTICE

Sir,

Dr Brennig James' letter (June *Journal*, p. 372) on the treatment of minor respiratory illnesses deserves comment.

The situation he describes is that of a (presumably) basically healthy individual with a dry nocturnal cough due to a viral infection. It will eventually get better on its own, but meanwhile the patient (not to mention his/her spouse) has a job to do and needs a night's sleep.

How to treat it? The prodigal use of antibiotics is certainly to be deplored. The use of "an electric kettle or some similar device" to increase humidity seems to me to be impractical and unsafe:

1. Most electric kettles boil a lot faster than the stated requirement of 70 ml/hour; getting up to switch on and off, and refill the kettle, hardly seems conducive to a good rest.

2. Falling asleep with the kettle left on would be a good way of blowing the fuse (with luck) or starting a fire if the wiring is faulty.

3. Many older houses do not have electric points in the bedroom; running a kettle off the lighting circuit would be a fire officer's nightmare.

4. What is a "similar device"? Slow-boiling electric heaters are not commonly available; the use of other fuels would present an even greater fire hazard.

5. Steam ruins bedroom furnishings; this is not likely to be regarded as trivial.

There are many different 'cough bottles' available, which on the whole stop coughs; the use of a *British National Formulary* one is likely to be cheaper but a proprietary one may tactfully reinforce the idea that these illnesses can be treated by going straight to the chemist in the first place. The amount of sputum they suppress in a healthy adult is not likely to be a hazard, and once they are found to work the demand for the 'magic' of antibiotics will die down.

What happens if nothing is prescribed? The patient who wants medicine will on the whole get it, and one of the functions of a prescription is to discourage the use of anything else. The more sensible patient will buy a bottle over the counter for about the same as the cost of a prescription charge. Others unfortunately borrow something "to do my cough good", which might mean a couple of days of antibiotics, digoxin, diuretics, or even antimitotics! In this part of the world truly amazing 'native' medicines may be obtained, and even in the UK this may be worth remembering among immigrant communities and the more eccentric members of fringe society.

In solving this common problem a scientific approach is, regrettably, in direct conflict with safety, economics, and common kindness. It is up to the general practitioner to find a balanced answer.

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GENERAL PRACTICE IN MEDICAL LIBRARIES

Sir,

Your editorial on "General Practice in Medical Libraries" (July, *Journal* p.387) was well timed and, as far as it went, made plain that the general impression that general practitioners are infrequent users of medical libraries is correct but has a multiple and complex aetiology. As well as the reasons given in the editorial, others are also important: for instance, many general practitioners are quite unaware of the services that today's medical libraries can offer; whilst, equally, most medical librarians do not know what it is that general practitioners require. Current research will, one hopes, help to throw light on this subject: in the meantime the majority of general practitioners will no doubt go on assuming that a medical librarian exists almost solely to