an important part of each consultation, but its impact will be the greater when it is supported by government action.

References

Department of Health and Social Security (1976). *Prevention and Health: Everybody's Business.* London: HMSO.

Department of Health and Social Security (1981). *The Recruitment, Training and Development of Health Education Officers.* London: HMSO.

Royal College of General Practitioners (1981a). *Health and Prevention in Primary Care. Report from General Practice 18.* London: RCGP.

Royal College of General Practitioners (1981b). *Prevention of Arterial Disease in General Practice. Report from General Practice 19.* London: RCGP.

Royal College of General Practitioners (1981c). *Prevention of Psychiatric Disorders in General Practice. Report from General Practice 20.* London: RCGP.

Russell, M. A. H., Wilson, C., Taylor, C. *et al.* (1979). Effect of general practitioners' advice against smoking. *British Medical Journal,* **2**, 231-235.

Stott, N. C. H. & Davis, R. H. (1979). The exceptional potential in each primary care consultation. *Journal of the Royal College of General Practitioners,* **29**, 201-205.

Children's symptoms: what mothers do

THE paper in this issue by Pattison and colleagues (pp. 149-162) from the Riverside Child Health Project at Newcastle on mothers' appreciation of their children's symptoms is another nibble at the problem of understanding the reaction pattern between mothers and their children. The paper explores present concepts of health and disease, and mothers' attitudes to, and use of, their doctors.

The subject is difficult to study; we are dealing with largely untrained, self-taught observers at all levels of intelligence and education. Mothers have varying experiences of varying duration and observe with different levels of interest. They are all observing different children in differing environments, almost always in a situation that we cannot confirm, as we are unable to observe the children at the same time. The situation with children under the age of six months is further complicated in that the health and concentration of the mother is known to be variable, it being believed by some that post-natal depression affects a third of mothers to very varying degrees.

The current survey was stimulated by the observations of a series of workers on cot deaths. It has long been known that the histories as presented to coroners are unreliable (Emery and Crowley, 1956), and it is now known that a considerable number, though not all, such children exhibit symptoms before death (Stanton *et al.*, 1978). If the parents had taken action, some of the deaths might have been avoided. Does this mean that we have some dangerously inadequate mothers?

How has this current study helped us? Of a series of 58 mothers with their first child, 44 said that they were prepared to fill in daily diaries for eight weeks and 30 of them did so, stimulated by a visiting research worker every two weeks. On average, children were symptom-free on only one day in four. However, of these symptoms, the commonest were discomfort with teething and bringing up small amounts of food. When the paediatricians analysed the symptoms from the viewpoint of whether they merited a consultation with their family doctor, it was felt that 35 children had at least one episode of such severity of illness. I am a little surprised that they did not rate the non-specific symptoms (such as unusual drowsiness) as important, as others have noticed that these are missed in cot deaths (Watson *et al.*, 1981). In the Newcastle study, the probability of the parents seeking help was high. There were, however, two families where the symptoms predicted a consultation but where no such consultation took place. Both of these occurred in unmarried women not living with the baby's father. It is also probably significant that, of the nine mothers declining to take part in this study, four were unmarried, whereas fewer than one in four of those who took part in the trials were unmarried.

We find then that, while mothers notice many symptoms in their children, and the majority of mothers react correctly to these symptoms, two of the 44 did not notice, or noticed an episode but did not react correctly. If it is justified to generalize from such a small sample, we would see that 5 per cent of mothers are liable to have an ill child, should consult but do not do so.

Delay in reacting to symptoms is an important aspect of child care even in children reaching hospital. Oakley and colleagues (1976) showed that, of children they studied who died in hospital from acute disease, 80 per cent did so because they arrived at hospital too late for effective treatment. Such deaths would not be prevented by increasing hospital care. McWeeny, doing home interviews about these children (McWeeny and Emery, 1975), found that the duration and pattern of symptoms in the late hospital admissions were no different from those of the early admissions survivals. There were a variety of reasons for the delays in getting the children to hospital; these reasons included unwanted children, parents with too low a standard of health, parents

having difficulty in getting to see the doctor and parents not understanding the doctor's instructions.

Now, how does this relate to the cot death situation? Such deaths occur in about 1 in 400 children. If half of these are in some way due to inadequate observation or medical action by parents, it only requires 1 in 800 parents to be in a state of inadequacy at a critical moment in their child's life to produce this national figure. The study under review, though only a very small one, supports those who call for increased education of young parents in the care of their children and stresses the need for inadequate parents to be identified and helped.

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References

Emery, J. L. & Crowley, E. M. (1956). Clinical histories of infants reported to coroner as cases of sudden unexpected death. *British Medical Journal,* **2,** 1518-1521.

McWeeny, P. M. & Emery, J. L. (1975). Unexpected postneonatal deaths (cot deaths) due to recognizable disease. *Archives of Disease in Childhood,* **50,** 191-196.

Oakley, J. R., Hayes-Allen, M., McWeeny, P. M. *et al.* (1976). Possibly avoidable deaths in hospital in the age group one week to two years. *Lancet,* **1,** 770-772.

Stanton, A. N., Downham, M. A. P. S. & Oakley, J. R. (1978). Controlled study of terminal symptoms and action taken for them in first 100 sudden, unexpected home deaths in a DHSS multicentre study of postneonatal deaths. *Archives of Disease in Childhood,* **53,** 834-835.

Watson, E., Gardner, A. & Carpenter, R. G. (1981). An epidemiological and sociological study of unexpected death in infancy in nine areas of southern England. II. Symptoms and Patterns of Care. *Medicine, Science and the Law,* **21,** 89-98.

The under-fives

The number of children in Scotland being looked after by childminders nearly tripled between 1976 and 1980. The number of children attending pre-school playgroups dropped for the fourth year running.

Source: Scottish Office Press Notice, 787/81.

Management of patients after mastectomy

In most cases prolonged routine follow-up appears to be of limited value as far as the detection of recurrent disease is concerned, as patients with a recurrence are more likely to present to the general practitioner with symptoms. If this is so, perhaps the management of this problem might be dealt with more appropriately by the general practitioner rather than the surgeon.

Source: Clark, P. B. & Morris, D. L. (1981). Management of patients after mastectomy. *British Medical Journal,* **282,** 2095-2096.