LETTERS

Paediatric Surveillance

Sir,

While very much in favour of performance review and the kind of exercise carried out by Dr Wilmot, Dr Hancock, Nurse Bush and Nurse Ullyett, (March *Journal,* p.152) we should like to offer a critical analysis of their results.

Taking their figures from 1980 to 1983, the effort they put into surveillance can be reasonably quantified:

1. 2,356 formal examinations plus 'many children seen at other stages to discuss . . . problems or simply at the parent's request.'
2. Health visitor examinations carried out at home and in one well baby clinic a year. Doctor examinations carried out in two clinics a week—a total of seven hours every week.
3. Informal discussions after clinics, more formal team meetings every few months.

For this input, the possible gains to the 590 children under the age of five in the practice can also be quantified:

1. 159 children referred, 64 of whom received some specific treatment.
2. A practice vaccination rate 4—7 per cent higher than the district average for DT/polio and measles, with practice children more likely to have received their vaccinations at the correct time.
3. Easier discussion of emotional and social problems by attending mothers.

Let us look at the benefits in more detail. Nearly 27 per cent of the practice's children were referred to hospital—this figure is meaningless unless an objective look is taken at the outcome of such referrals. 60 per cent of those referred received no treatment, yet these referrals must have engenderd unnecessary anxiety in the parents and added an unnecessary burden on specialist services.

Of the 40 per cent who received 'treatment' (mainly for vision, speech and hearing problems) we should of course like to know to what extent the treatment affected the quality of life and the developmental progress of the children concerned. It is also vital to know what proportion of children who did receive objective benefit from referral had been identified solely as a result of the surveillance programme. How many had been identified by their parents as having a problem before any doctor or health visitor picked it up?

High vaccination rates may be achieved as part of a surveillance programme, but they can certainly be as easily achieved without one. The rates in our practice, for example, are higher than those quoted by the authors (except for measles) and are achieved by the use of a simple card index/health visitor follow-up system.

Finally, the assumption that emotional and social problems may be more easily discussed by mothers bringing their children along to surveillance sessions may not be correct. If it is correct, then perhaps it is a counterbalance to the anxiety and worry engendered by careful follow-up of poorly defined deviations from 'normality' and false positive findings.

Our practice effected a full surveillance programme from 1970-1974 and managed to achieve almost 100 per cent attendance. Our 'intermediate' review led us to the inescapable conclusion that our time could be much more productively spent elsewhere.

We could not persuade ourselves that we had picked up one significant remediable abnormality that we had not, or would not have (because Mum knew about it and, in fact, brought the matter to our attention—especially suspected squints) picked up anyway.

We decided that a comprehensive and *competent* medical examination of a new baby was essential, but that after that routine medical examination had very little to offer. Health visitors are perfectly competent to carry out routine tests of hearing and vision and to make reasonable assessments of developmental progress. It is much more important for mothers to know that they have easy access to their general practitioner, that their worries will be listened to and that the doctor is capable of making an overall assessment of the child rather than of just responding to illness.

So while we agree with the authors that the 'usefulness and place in general practice of surveillance are still debated' we disagree that the main reasons would be because of the technical problem of reaching the whole target population or doubts about the reliability and validity of some screening methods. No, it is far more basic than that. Their results, like ours, make out a very good case for their abandoning rather than continuing with their practice's surveillance programme.

Please can we have an unemotional and objective assessment of the value of screening/surveillance before, and not after, the small band of enthusiasts that seem to wield disproportionate influence in the College corridors of power push the profession into the wholesale adoption of this time consuming activity?

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Discarding Patients' Records

Sir,

I disagree wholly, flatly and profoundly with Dr Michael Jolles' comments (April *Journal,* p.244) on the need to preserve old records. I for one practise the massive culling of records at all times, except they be significant. And 80 per cent of records are not.

The fact that Barbara Jones, aged 23 and presently seeking a termination of pregnancy herself had a nappy rash at the age of six months is irrelevant. The fact that Bill Williams broke his fifth left toe in 1954 can now be consigned to the shredder. The fact that Mrs Burne has been booked to attend hospital for her third confinement in 1949 is really a pointless bit of information.

By all means let us carefully keep our *significant* records, but in the words of the famous trade unionist 'Everything else—out'!

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Time and the General Practitioner

Sir,

We were interested to read the response of Drs Wilson and Valentine to our paper (February *Journal,* p71). This paper has, as we expected, proved controversial: there was a favourable editorial comment in the Daily Mail (4 February) and many references in the medical press as well as private correspondence. One anonymous letter from a Newcastle general practitioner