Crying babies

Sir,

Although I am a general practitioner, all my patients are children and many of these are 'distressed infants'. Over the past four to five years I have come to recognize a pattern of symptoms in a series of 150 such infants.

1. A desire to be upright — many of the infants are carried over a shoulder for hours at a time.
2. Difficulty settling to sleep and frequent waking.
3. Feeding difficulties. Many breast feeding babies appear to have discomfort when sucking, pulling away from the breast distressed or even arching their backs and refusing to attempt to feed, although apparently hungry. Other breast fed babies want to stay sucking at the breast all the time — although many mothers recognize the difference between sucking to feed and sucking for comfort. Bottle fed babies may only feed comfortably if using a soft, fast flowing teat. A few infants actually squeezed the teat while feeding. Some babies appear more comfortable after learning to suck a dummy, thumb or fist. Taking solids is not a problem with these babies.
4. Gastro-oesophageal reflux is common — this may be typical small curdy results well after the feed, or gulping and swallowing without frank vomiting.
5. Atopy is common in the infants, their siblings and parents. Food intolerances are also common in these infants.
6. Ear problems are extremely common. It has been noticed that some babies rub or scratch their ears. Otitis media often develops and many infants progress to frequent recurrences of otitis media or serous otitis media. Distress is usually present long before otitis media develops. If ear problems are severe and bilateral, hearing distortion or frank hearing loss may lead to slow speech development. The ear drums are usually dull or granular, if they are not already inflamed. The tympanograms often have a wide base and/or round top, and often show moderately negative pressure and/or low compliance, or the flat type B picture of middle ear effusion.

I suspect that the problem results from chemical irritation of the pharyngeal opening of the Eustachian canal from refluxing gastric acid, causing swelling and mucus production and making it difficult for the infant to equalize Eustachian canal pressure to atmospheric pressure, especially when lying down.

Symptoms usually resolve when the infant is treated with propping up, decongestants, antacids, and if necessary, antibiotics. However, recurrence of symptoms is common, usually related to an increase in regurgitation, upper respiratory tract infections or teething. Insertion of grommets may eventually be necessary for infants with frequent recurrences of otitis media, inadequate response, intolerance of medication, or persistent hearing loss. Early recognition and treatment may reduce the need for grommets.

A full study of this problem, is currently in the planning stage. I would be interested to know whether other readers have experience of distressed babies who fit this pattern.

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Consultation length debate

Sir,

I believe that the debate about consultation length is confused by the fact that there are at least two distinct factors involved, which are usually treated as if they were synonymous.

The first factor is that of booking interval, or time available. When discussing the relationship of booking interval to the process or outcome of the consultation, this factor should be regarded as an independent variable.

The second factor is that of actual consultation length, and this should be regarded as a dependent variable when discussing the process of the consultation. The immediate determinant of length is the events taking place in that consultation, which are in turn related to different doctor and patient characteristics.

These two factors are interlinked. Howie and his team looked at the effect upon consultation length of different administrative circumstances (February *Journal*, p.48), and found that the proportion of longer consultations fell when the doctor was under more pressure. In intervention studies[1-3] altering booking interval was found to be followed by alterations in consultation length. Similarly, most general practitioners in practice will adjust booking interval if it is grossly out of step with average consultation length, though, as Wilson points out (March *Journal*, p.119) it tends to remain rather shorter than mean consultation rate so that surgeries commonly run late.

Changes in the booking interval have remarkably little effect upon the process of the consultation. As Wilson notes, the main effects reported from increasing the booking interval have been an increase in opportunistic prevention and health promotion, and an increase in doctor–patient communication; it is understandable that these items get squeezed out of the consultation when time is short. It should also be noted that the doctors taking part in the studies reported by Wilson are presumably highly motivated, since they took the trouble to perform the studies.

Howie and colleagues, looking at the second factor, actual consultation length, found that 'slower' doctors had not only longer mean consultation length, but also a wider distribution of consultation length, and speculate that this may result from doctors adopting the model of Stott and Davis,[4] that is, taking up opportunities to expand the consultation into areas other than the presenting complaint. Indeed their paper does suggest that these doctors are more likely to recognize and take up such areas than their faster colleagues. Howie and colleagues are planning to examine the factors which contribute to the different doctor styles they have identified.

I would like to suggest that one such factor may be education, and that education which results in changes in the doctor's style of work and work culture, will cause changes in the process of the consultation. This in turn will result in changes in the mean length and range of lengths of consultations. This hypothesis is supported by the work of Byrne and Long,[5] who found that after attending a course in which they learned to increase patient centred behaviour, the mean consultation length of general practitioners increased by up to 20%.

The question to be answered may not be 'How long should a consultation last?' but rather 'Which doctor style produces the best outcome for the patient?' If a doctor with the preferred style requires more time (because their consultations last longer, and/or they encourage a higher consultation rate), then the profession should lobby the government to facilitate a further fall in list sizes. Trying to reverse the direction of causality, by lengthening booking interval without prior education to change the doctor's style could be unproductive.

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