BRITISH MEDICAL JOURNAL

SATURDAY 13 MARCH 1982

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SUPPLEMENT

NO 6318 BRITISH MEDICAL JOURNAL 1982 VOLUME 284 765-842
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

ASTM CODEN: BMJOAE 284 (6318) 765-842 (1982)
WEEKLY. SECOND CLASS POSTAGE PAID AT NEW YORK NY

CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Correspondents should present their references in the Vancouver style (see examples in these columns). In particular, the names and initials of all authors must be given unless there are more than six, when only the first three should be given, followed by et al; and the first and last page numbers of articles and chapters should be included. Titles of papers are not, however, included in the correspondence section.

How effective are our child health clinics?

SIR,—In his article on child health clinics Dr W A Hendrickse (20 February, p 575) rightly points out that the value of routine child health surveillance has not been demonstrated. He also supports, as do I, the view expressed so well in the Court Report[1] that the best model for meeting the needs of children should be an integrated system based on general practice. Dr Hendrickse's survey is consistent with the view that routine surveillance is of little value, that acute medical problems could have been treated equally well by the family doctor, and that chronic problems have in most cases already been identified. However, the title of his article—"How effective are our child health clinics?"—and some of his remarks imply that he has shown that child health clinics are not effective. He did not show this.

In Dr Hendrickse's survey 36 attendances were explicitly for "advice and reassurance." Surely many of the other attenders came implicitly for this and received it. Only six attendances were for "social or parental emotional problems." Either the inner city in Nottingham is not typical or else the expected larger numbers of these problems are hidden in the other attendances classified by their medical category. It is in these behavioural, social, emotional, and developmental difficulties where the unmet needs of children and their families in inner cities reside. So for acute serious illness families quite naturally choose clinic or GP on the basis of accessibility and availability. Routine surveillance, long thought irrelevant by families, is at last being found wasteful of the doctor's time as well. The real needs, concerning behavioural difficulties, etc, are under-reported and under-discussed in this survey.

To Hart's view[2] that "medical care is least where medical need is greatest" and Brimblecome's[3] that "the families whose needs are greatest make least use of the services" may I add another—that "for families whose need is greatest the relevance of the services is least." To overcome this inverse care law the service should change, not the people served. A more appropriate and approachable service could be and sometimes is provided by the child health clinic or family doctor depending on local needs and the interests of local family doctors. What is not needed is uniformity of service—the very uniformity guaranteeing that it cannot be tailored to the needs of different communities.

In many inner cities services for children are not integrated. GPs have list sizes similar to elsewhere despite a higher proportion of social, financial, and emotional problems in their patients. The cultural and professional gap between doctor and patient, being widest in inner cities, militates still further against families with young children. Clearly, the aims of the child health clinic or of the integrated service based on general practice are to meet the needs of the children and families in that community. For the inner city community, a prerequisite is that the service be one which mothers feel to be relevant, which mothers feel they themselves can shape and influence, and which mothers feel confident rather than diffident in approaching. The kinds of facilities which might work in some areas are: (1) Flexible access without appointment. (2) Use of the clinic at other times for purposes mothers choose. (3) Encouragement to parents to form groups for increasing confidence in their own skills and discussing common childhood problems. (4) More outreach to home by professionals. (5) Involvement in the clinic and outside it of local people with knowledge of child-rearing or health issues—for example, a mother of three children may be in a strong position to advise and there is no reason why this role should not be recognised and