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SATURDAY 13 MARCH 1982

LEADING ARTICLES

- Vasodilators in heart failure** ALASDAIR BRECKENRIDGE . . . 765
Laser treatment of portwine stains J A COTTERILL . . . 766
Qinghaosu: a new antimalarial L J BRUCE-CHWATT . . . 767

- Explosive bullets: a new hazard for doctors**
 BERNARD KNIGHT . . . 768
Reorganisation à la carte . . . 769

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

- Value of computed tomography of the abdomen and chest in investigation of Cushing's syndrome**
 F E WHITE, M C WHITE, P L DRURY, I KELSEY FRY, G M BESSER . . . 771
Rebreathing in a subject wearing an integral crash helmet R GREENBAUM, A F MALINS, R DAVIES, P J F BASKETT . . . 774
Effect of aluminium hydroxide on serum ionised calcium, immunoreactive parathyroid hormone, and aluminium in chronic renal failure
 C K BISWAS, R S ARZE, J M RAMOS, M K WARD, J H DEWAR, D N S KERR, D H KENWARD . . . 776
Superiority of B locus matching over other HLA matching in renal graft survival
 P J DEWAR, R WILKINSON, R W ELLIOTT, M K WARD, D N S KERR, D H KENWARD, G PROUD, R M R TAYLOR . . . 779
Trimethoprim resistance in hospitals PENTTI HUOVINEN, RAUNO MANTYJARVI, PAAVO TOIVANEN . . . 782
Variations in cancer mortality among local authority areas in England and Wales: relations with environmental factors and search for causes M J GARDNER, P D WINTER, E D ACHESON . . . 784
Attendance for antenatal care ELIZABETH LEWIS . . . 788
Dose-related changes in vaginal cytology after topical conjugated equine oestrogens
 G I DYER, O YOUNG, P T TOWNSEND, W P COLLINS, M I WHITEHEAD, J JELOWITZ . . . 789
Paranoid psychosis after abuse of Actifed KATHERINE M LEIGHTON . . . 789
Low doses of factor VIII for selected ankle bleeds in severe haemophilia A A ARONSTAM, M WASSEF, Z HAMAD . . . 790
Study of stroke patients in a single general practice H J WATERS, J M PERKIN . . . 791
Pathology of Partnerships: Disappointments, seductions, and resentment PAUL FREELING . . . 793
Designing premises in a "shell" SIMON JENKINS . . . 794
Marital problems presenting to a marriage counsellor ALIZA SHAPIRO . . . 797

MEDICAL PRACTICE

- Falling rate of provision of residential care for the elderly** EMILY GRUNDY, TOM ARIE . . . 799
Incidence and detection of occult hepatic metastases in colorectal carcinoma
 I G FINLAY, D R MEEK, H W GRAY, J G DUNCAN, C S MCARDLE . . . 803
Letter from Chicago: Infectology comes of age GEORGE DUNEA . . . 806
Lesson of the Week: Pleuritic pain: Fitz Hugh Curtis syndrome in a man A C DAVIDSON, D A HAWKINS . . . 808
ABC of 1 to 7: Services for children: the community JUDITH WILSON, H B VALMAN . . . 809
Reading for Pleasure: Arbitrament of swords BRYAN WILLIAMS . . . 812
Any Questions? . . . 807, 813
Medicine and Books . . . 814
Medicine and the Media—Contribution from JAMES OWEN DRIFE . . . 805
Personal View S E SMITH . . . 818

CORRESPONDENCE—List of Contents . . . 819

OBITUARY . . . 830

NEWS AND NOTES

- Views** . . . 832
Epidemiology—Acute haemorrhagic conjunctivitis . . . 833
Parliament . . . 834
Medical News . . . 834
BMA Notices . . . 835

SUPPLEMENT

- The Week** . . . 836
Sad day for preventive medicine WILLIAM RUSSELL . . . 837
From the Council . . . 838
A new form of community hospital service for the elderly
 D L BEALES . . . 840
NHS London Weighting increased . . . 841
New Minister of State for Health . . . 842
FPCs: arrangements from 1 April . . . 842

CORRESPONDENCE

How effective are our child health clinics? A F Colver, MRCP; Gillian M Bryant, MFCM; R E D Simpson, MRCP; Rosalind P Garnish, MB; A C M Abra, MB; Patience A Karsenas; P Rowlands, MRCP.....	Cost-effectiveness study of outpatient physiotherapy after medial meniscectomy J E Woodyard, FRCS; D P Forster, MFCM, and C E B Frost, BSC.....	Recurrent cancer after restorative resection of the rectum R J Heald, FRCS, and R D H Ryall, FRCR..
819	824	826
"Now, you need an x-ray examination...." P L T Ilbery, FRACR.....	Acute pharyngitis: a symptom scorecard and microbiological diagnosis J A McSherry, MB.....	Children's accidents H W S Francis, FFCM.....
821	824	827
Policies and postures in smoking control F Lawrence.....	Chronic inflammatory bowel disease in childhood D H Shmerling, MD.....	Do patients cash prescriptions? J A C Winter, MRCP.....
821	825	827
Stress and illness B D Lask, MRCPsych.....	Community care compared with hospital outpatient care for hypertensive patients R Jones, MB.....	Acknowledgments to departments of pathology D N Baron, FRCPATH.....
822	825	827
Endogenous opioid poisoning? K H A Murray, FRCS.....	Paracetamol-induced acute renal failure A L Harris, MRCP.....	Tailoring hospital facilities to needs A J M Cavenagh, FRCP.....
822	825	827
Confidential Enquiries into Perinatal Deaths A C Walsh, MB.....	Sexually transmitted disease surveillance C B S Schofield, FRCPED; B H O'Connor, MFCM, and others.....	Consultant numbers Margaret L Heath, FFARCS.....
822	825	827
Do general practitioner deliveries constitute a perinatal mortality risk? E J Shaxted, MRCP; H G Nicol, MRCP.....	"Home brew" compared with commercial preparation for enteral feeding Mabel Blades, BSC, and others.....	Defects in proposed regional advisory machinery A G Donald, FRCP.....
822	826	828
Captopril-associated lymphadenopathy H Åberg, MD, and others.....	Jogger's blockade M Lim, FFARCS, and others.....	Part-time training Ruth E M Bowden, FRCS.....
823	826	828
Inaccuracy of London School of Hygiene sphygmomanometer J G Evans, FRCP.....	Stopping the haemorrhage from peptic ulcers T C Northfield, FRCP, and others; G T Layer, FRCS.....	Medicine in South Africa and Britain R Gude, MRCP.....
823	826	828
Episiotomy Margaret Polden, MCSP; Sheila Kitzinger..	Changing attitudes in the management of urinary incontinence—the need for specialist nursing C A C Charlton, FRCS.....	Another death in detention in South Africa A Stein, MB, and others.....
823	826	828
Intravenous amiodarone in atrial fibrillation complicating myocardial infarction D B Barnett, FRCP, and others.....		Correction: Oestrogen receptors (Howat)...
823		828
Pseudomembranous colitis in a 5-week-old infant E Scapa, MD.....		Points: Case clustering in pityriasis rosea (M G Philpott); Alcohol and alcoholism (A B Alexander); Cold in the jaw (R Cutler); An anachronistic treatment for asthma (Phyllis W R Elliott); Little new for audiologists (J A Davis); Part-time training at senior registrar level (Lotte T Newman); Part-time medical training—and afterwards (G T Watts); Doctors' pay (K M Dickinson and Margaret A Wignall); Jogger's blockade (J M Moore).....
824		829

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 Report¹ 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 attendances 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 view² that "medical care is least where medical need is greatest" and Brimblecome's³ 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