paediatric admission most of these adolescents would then find their way into adult units.

Southampton General Hospital has a catchment area with a population of roughly 66 165 school-aged children.

R B CROSSLEY

Southampton General Hospital,
Southampton SO9 4XY

[1] Kreitman N. *Parasuicide*. London: Wiley, 1977.

Child abuse: the swing of the pendulum

SIR,—Over a few weeks two local children had suffered immensely at the hands of most or all of the following: (*a*) mother, (*b*) cohabitees of (*a*), (*c*) aunts, (*d*) grandfather, (*e*) female cohabitees of (*b*), (*f*) male cohabitees of (*e*), (*g*) cohabitees of (*c*). Collating information from the 24 agencies concerned with this family, in order to help the two children and their six brothers and sisters, took more than 14 hours and required goodwill and reciprocation. Any doctor inclined to be dismissive, suspicious, or hostile towards these other agencies would have just become dismayed, angry, or exhausted—or all three.

Child abuse registers in north-east Wiltshire were started well in advance of national systems. Mistakes have occurred, will occur, and do occur, but we are in a better position than most to criticise several statements from your leading article on child abuse (18 July, p 170).

(1) In families such as the above, how can the doctor effectively protect the children by establishing a "relationship" and "rapport" with the parents?

(2) The original editorial in 95 lines expressed immense concern over the *feelings* of some heads of households and the *feelings* of certain aggrieved doctors. There was fleeting concern expressed on behalf of brain-damaged or dead children, but none on behalf of other cruelly treated children. Though the title was "Child abuse," the preoccupation of the article was with adults.

(3) What evidence is there for "an overdemanding clamour for information by the community services?"

(4) What justification is there for the categorical statement "Only clinical experience and acumen can solve the problem" of child abuse?

(5) Why do you see the need to "support an at-risk or handicapped family" or encourage "the delicate process of repairing a bruised family" as ends in themselves? The health and wellbeing of the children is the aim, which may be helped but could be hindered by keeping the family together.

(6) Are children without pathognomonic evidence of abuse, who may yet live in circumstances comparable to those found in concentration camps, to be protected solely by the personality of the doctor?

(7) Are only doctors to be trusted to protect families (and thereby children) in a confidential relationship, with minimal reciprocation of essential information with other professional colleagues? Of the 26 or more agencies wholly or partly connected with child protection, organisations such as the National Society for the Prevention of Cruelty to Children have a better record than the medical profession over the last 35 years. We are not above them.

The biological purpose of the "family" is the successful rearing of children. The unperceived philosophy underlying your leading article was that children are mere subunits of the family: every family must remain inviolate, however cruel and damaging the behaviour of the head of the household towards his or her dependants. This is wrong.

J E OLIVER

Burderop Hospital,
Wroughton, Swindon SN4 0QA

SIR,—The implication of your leading article on child abuse (18 July, p 170) that the rapport between GP and parents is seen to be more important than the safety of the child fills me with profound misgivings.

The suggestion that GPs should undertake "intensive and prolonged counselling" in order to preserve what may be a "fragile relationship" is to promote unilateral decision making in circumstances where full knowledge of the parents and their functioning in society, and the child's behaviour, may not be obtained. It is only by the case conference system that a global picture can be obtained. and only in the light of such shared knowledge that the most effective decisions can be made. If the doctor can make a decision on his own, then so can the social worker, health visitor, and others involved. If we are in the business of protecting children from abuse and neglect by unsuitable parents or caretakers, unilateral action can lead only to fragmentation of services with inappropriate decisions being taken. It can also be said that the police may wish to be involved as the parental acts could be criminal. One of the factors common to all the published reports following a child abuse tragedy is that information was not adequately gained, pooled, and recorded when it was available, and that if it had been it could have alerted those involved. Interpretation of the evidence is then best undertaken at the case conference, with all parties acting in the best interest of the child.

J N TOWLER

Community Health Services,
Bradford Area Health Authority,
Bradford BD1 2SY

SIR,—I am a convert. I used to have a horror of child-abuse case conferences. Hearsay evidence about families is bandied about by professionals without the family being there to defend themselves. Sometimes these professionals hardly know the family involved. My unease about this sort of invasion of privacy has, however, been overcome by learning at an occasional case conference startling information about families whom I thought I knew well. In the last year I have been confronted by the fact that I missed one case of sexual abuse of a 5-year-old and also violent physical abuse of a 3-year-old.

To "forego the supportive services of a social worker," as you suggest in your leading article (18 July, p 170) that doctors may feel they should sometimes do, really means that doctors are putting themselves above workers in other professions, who may in fact turn out to be better informed. The family doctor is responsible not only to the parents but also to his other patients, the children. He owes it to his young patients to attend as many case conferences as possible. He may find, as I do, that he is the only voice at the conference speaking out for the civil liberties of his patients. He will sometimes also learn extremely important information. He can also even earn himself £20 these days!

The lesson from the death of John George Auckland[1] is clear. Social workers came and went in the short life of this child. Health visitors and other workers were equally transitory. There was only one person who was involved with this family from the murder of the first child to the murder of the second, and that was the GP. However, at no stage was the GP involved in any of the case conferences or any of the decision making on whether the stepfather should take back the children.

Multidisciplinary work may take a lot of time and seem to be a lot of useless discussion. However, doctors are neglecting their patients if they do not involve themselves in it.

RICHARD STONE
Vice-chairman, Area Review Committee for Child Abuse, Kensington, Chelsea, and Westminster

London W2 4LD

[1] Committee of Inquiry into the Death of John George Auckland. *Report*. London: HMSO, 1977.

SIR,—As a former health visitor, I was disturbed by your leading article (18 July, p 170) on child abuse and can only hope that it is not representative of the views of many doctors. Even worse is the pessimism expressed by Dr R H Hardy (8 August, p 435), who surely is guilty of a logical fallacy. In judging the efficacy of intervention in child abuse, we should look not only at the number of fatal cases already known to agencies but also at the many cases of abuse which do not end in death and are successfully resolved. Admittedly these are harder to quantify, but then preventive medicine usually is.

LIZ MEERABEAU

Bedford College,
London NW1 4NS

Home deliveries and British obstetrics

SIR,—Dr Anne Savage's Personal View (18 July, p 227) suggests that uncomplicated pregnancies should be conducted by midwives. After 10 years of practising general practitioner obstetrics in Oxford I strongly support this view.

As practised in Oxford, GP obstetrics is in fact midwife obstetrics with a GP as an appendage. Very few GPs now do deliveries, which are carried out by the midwife. A competent midwife shares the antenatal care and does nearly all the practical postnatal care. In the event of complications requiring an assisted delivery, it is usual to hand over to the consultant unit (in practice very simple in Oxford as the delivery rooms for GPs and consultants are adjacent). I regard my function as superfluous, and all antenatal, intranatal (including putting up drips and doing episiotomies), and postnatal care could equally well be done by the midwife alone. This is the current practice in Holland, where 50% of deliveries are at home and the pregnancy is assisted by the midwife with no GP involvement.

In Oxford one midwife will cover several GPs, so that on average a GP is involved with 10 deliveries a year and one midwife with 50-70 a year. There is a gradually increasing number of GPs who do not do GP obstetrics, whose patients therefore all have to be delivered under the care of the consultant. It is estimated that about 1000 deliveries a year now under consultant care could be covered by the GP obstetric service. One of the great