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.

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[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.

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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.

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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.

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[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.

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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

advantages of the midwifery service in attachment to GPs is the continuity of care throughout the pregnancy (including delivery) —badly lacking in the hospital service and much appreciated by mothers.

I suggest that in urban areas there should be a change to a system whereby a midwife continues to be attached to a GP but takes over full care of the pregnant patient, with no involvement of the GP. The deliveries undertaken within the consultant service that do not require consultant care would be taken over by the midwives. The midwife's rota should be made so as to give adequate nights off, as with GPs. Midwifery training would need some adjustment but the biggest hurdle for the midwife would be to become accustomed to unfettered care. I am sure that very quickly midwives would welcome the freedom to practice midwifery under their own responsibility.

In Oxford there are about 6000 deliveries annually. Of these, 600 are deliveries under the GP obstetric service; with the 1000 women at present coming under the care of the consultant who could be delivered by the midwives, 1600 of the 6000 would be under midwife-only care. Since about 70% of all deliveries are entirely normal, there is clearly scope for a further reduction of the numbers delivered in the consultant unit and transferred to the midwives. The consultants would be left with the genuinely complicated pregnancies, and community midwives with the remainder (probably the majority). The midwives could conduct their own antenatal clinics at health centres or surgeries, as at present in many GP practices, and the deliveries would be in hospital.

I would be interested to know of any good reason why this scheme should not be implemented.

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Sleep problems in young children

SIR,—Dr H B Valman (8 August, p 422) advises that babies who persistently cry at night can be reconditioned by withdrawing attention either abruptly or gradually. However, the problem with most parents is to know for certain whether or not the crying indicates genuine distress or whether it is merely a device for seeking attention.

A good test is to advise the parent to pick up the crying infant. If the crying ceases immediately then the baby is seeking attention and can be put down immediately and left to cry it out—preferably with two doors separating it from the parents. This pick-up test is a fairly obvious solution to the problem but it is surprising how many parents have never thought of it.

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Urinary tract infection in young children

SIR,—I was rather surprised that Dr H B Valman in his article "Urinary tract infection" (1 August, p 363) named co-trimoxazole as the drug of choice when immediate treatment is necessary. There is an increasing volume of evidence which suggests that trimethoprim alone is equally effective, with a lower incidence of side effects.[1-4]

Dr Valman mentions co-trimoxazole and nitrofurantoin as being ideal for prophylaxis, but again trimethoprim alone may be even more appropriate. It has been shown to be very successful in this role,[5] and one paper reported lower recurrence rates with trimethoprim alone than with co-trimoxazole or nitrofurantoin.[6] Much of this success has been attributed to the fact that trimethoprim eliminates coliforms, the predominant causative organisms, from the faeces[7] but only very rarely induces resistance.[8] A study conducted in Finland,[9] where plain trimethoprim has been used for long-term prophylaxis against urinary tract infection since 1973, showed that the incidence of resistance is no higher than with co-trimoxazole or nitrofurantoin.

Since the arguments for favouring trimethoprim alone are so persuasive,[10] perhaps it is time that its use is recommended in articles such as that by Dr Valman.

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Tonsillitis and otitis media

SIR,—I quite agree with Dr George Morris that children with tonsillitis and otitis media should be treated with initial intramuscular penicillin (8 August, p 435).

With associated tonsillitis one would expect subclinical infection of the submucosal lymphoid follicles of the whole gastrointestinal tract and as such anything by mouth does not get well absorbed, and if absorbed at all takes a longer time. This is not the case with infection in other parts of the body, where one would expect normal absorbtion from the gastrointestinal tract.

I am sure that inadequate treatment of otitis media and associated tonsillitis is partly responsible for the increasing incidence of "glue ear" in children, which I think is a condition of delayed resolution of suppurative otitis media.

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Prostaglandins in gel for abortion

SIR,—We have read with interest the paper of Mr D H Smith and others (20 June, p 2012). We studied the effect of a single extra-amniotic injection of prostaglandin E_2 in Tylose gel in 30 teenage nulliparous patients in the first trimester of pregnancy. The purpose of our study was to evaluate whether or not cervical dilatation could be achieved prior to suction termination in these potentially at-risk patients with an immature cervix.

Twenty-three (76·7%) of our patients aborted incompletely within nine hours. In the remaining seven (23·3%) the cervical os was found to be open and a suction catheter, size 8-10 mm, was used without any resistance.

Our results show that in the first trimester of pregnancy a single extra-amniotic injection of prostaglandin E_2 in Tylose gel can facilitate either incomplete abortion or cervical dilatation. Thus the method can be employed in young nulliparous patients prior to vacuum aspiration in order to eliminate cervical trauma and its subsequent complications.

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The pill at the menopause

SIR,—In his recent letter Mr J Guillebaud (8 August, p 439) states that the progestogen-only pill is a reasonable alternative to the combined pill in women over the age of 35 and "is rightly being increasingly used in this age group." This may be misleading. There is now evidence to suggest that progestogens may be associated with elevation of blood pressure[1] and a decrease in high-density lipoprotein levels,[2] both of which increase the risk of cardiovascular disease. The progestogen-only pill cannot therefore be unreservedly recommended for older women, particularly if they smoke cigarettes.

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1 Royal College of General Practitioners Oral Contraceptive Study. *Lancet* 1977;i:624.
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Living with one eye

SIR,—Suffering from the same disability as Sir George Godber (20 June, p 2042), I recognise my own little problems and embarrassments in his excellent article "Living with one eye." But I would add one important inconvenience.

Although driving is indeed no great problem, this is true only when visibility is good. As distance is largely estimated by experience of the size of surroundings, difficulties arise in darkness or foggy weather. In those circumstances one can no longer rely on the empirical knowledge ratio of dimensions to distance. Lights certainly can help but their power is more related to the density of the fog than to the size of the light source and as such they are unreliable indices of distance.

The one-eyed road user thus should drive more slowly and keep larger gaps than normal drivers, realising he is king in the land of the blind, not on the road.

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The air rifle: a dangerous weapon

SIR,—The recent article (6 June, p 1834) and correspondence (4 July, p 56) on injuries from airgun pellets provide an opportunity to