Unrelated donors

(2) When no suitable living consanguineous donor has come forward and in cases where cadaveric transplantation is not practical or possible a surgeon may, exceptionally, consider the transplantation of an organ from a living unrelated donor, provided that the following conditions apply.

(*a*) The donor is either the spouse of the recipient or a blood relative of the spouse (in law relative) or a friend who has a close and enduring relationship with the recipient.

(*b*) The donor has achieved the age of legal majority in the United Kingdom.

(*c*) The relationship claimed by the donor with the recipient must have been established beyond reasonable doubt.

(*d*) It may be necessary to seek documentary or collateral proof of the duration of the relationship.

(*e*) Any aspects of the relationship between the recipient and the donor or within the family that might indicate that the donor was the subject of pressure of whatever kind from the recipient, his family, or anyone else must have been completely investigated. If there is evidence of improper pressure the surgeon must refuse to perform the operation.

(*f*) The psychiatric and emotional suitability of the donor must have been established: he must understand the procedure and its attendant risks and be a suitably mature person for the act of donation. Due regard must have been paid to the social and family obligations of the prospective donor.

(*g*) Consent must have been freely given by the donor. He must have been given sufficient information to allow him to make his decision, and there must be clear evidence that he has understood it.

(*h*) There must be clear evidence that the motivation of the donor is both altruistic and charitable and that neither blackmail nor extortion is a motive for the donation; that the donor is receiving no money over and above his reasonable expenses and reimbursement of earnings lost through the act of organ donation; and that the donor does not seek publicity.

(*i*) The rules of confidentiality will apply to the treatment of both donor and recipient.

(*j*) There must not have been any advertising by the potential donor, the potential recipient, or any agency acting on behalf of donor or recipient.

(*k*) The diagnostic and operative procedures performed on the donor and the recipient must carry no undue risks, and there must not be any factors which are likely to decrease the chances of success of the transplant. All surgical and medical procedures are to be performed only in recognised institutions whose staff are experienced in transplanting kidneys from living related donors and cadavers.

Register and review panel for transplantations

The principle of acceptance of living, unrelated kidney donors, even rarely and in the exceptional circumstances described above, intensifies the need for a register of all organ donations and transplant operations in the United Kingdom; the society wishes all such activity to be monitored so that it may report developments to its members. To this end we urge the government to establish a compulsory register of all imports of transplantable tissues and organs into the United Kingdom, all exports of tissues and organs from the United Kingdom, and all transplant operations taking place within the United Kingdom. A record card should be completed at each such event to include not only relevant medical details but also a signed declaration by the responsible surgeon that the British Transplantation Society guidelines have been followed. A copy of each card will be filed with the Department of Health and Social Security.

A review panel will be elected by the society, the chief function of which will be to monitor this register, seek additional information from transplant teams as necessary, and report to the members of the society. In addition, the panel will advise any surgeon intending to transplant a kidney from a living unrelated donor or from a living donor whose blood relationship with the recipient is not clearly established. Donors and recipients should be informed that material identifying them may have to be made available on occasions to the panel.

The panel will consist of three members of the British Transplantation Society, but lay or professional members may be coopted in an advisory role. Transplant teams must be prepared to divulge relevant medical and personal information to the panel on request, but the panel will have no powers of enforcement.

The case of any person not acting in conformity with these guidelines will be reported to the appropriate authorities; if the person is a member he or she will be expelled from the society.

Health surveillance of preschool children

A F COLVER, H STEINER

Abstract

Discussions with every general practice, health visitor, and clinical medical officer in Northumberland Health Authority led to agreement about the content of preschool health surveillance, the ages at which it should be done, and referral pathways after a failed screening test. Each primary health care team now undertakes to do a basic minimum set of screening tests, and each team decides who in the team will do each test. The screening system agreed on should enable time to become available for the equally important aspects of surveillance—namely, developmental guidance, health education, and assessment and follow up of problems. The discussions also led to agreement about how the health authority should evaluate the effect of the surveillance programme on the health of children.

Beaconhill Children's Centre, Cramlington, Northumberland NE23 8EH

A F COLVER, MA, MRCP, senior registrar in community paediatrics

H STEINER, MD, FRCP, consultant paediatrician

Correspondence to: Dr Colver.

Introduction

The Court committee, the Royal College of General Practitioners, the Health Visitors Association, and the General Medical Services Committee of the British Medical Association all agree that health surveillance of preschool children is an important element of health care. There is no agreement, however, about the content of surveillance, the ages at which it should be done, or who should do it. This confusion has made it difficult to set up a programme of surveillance that is integrated within primary care, systematically applied, and amenable to evaluation. Nevertheless, we believe that there is considerable agreement about surveillance in primary care but that it has been obscured because professional reactions to national reports have highlighted areas of disagreement rather than areas of agreement. With this in mind we sought the common ground between family doctors, health visitors, and clinical medical officers in Northumberland District Health Authority.

Method

The study was undertaken in the Northumberland District Health Authority, which is responsible for a population of 290 000. Geographically, it is the second largest authority in England. Two thirds of the population live in six towns in the south east of the county, where the decline of mining

has led to high unemployment, and the remaining third live in rural areas with local market towns. Health visitors are attached to general practices. Half of the preschool surveillance is done by clinical medical officers and half by family doctors paid on a sessional basis by the health authority.

In 1984 a coordinator (AC) was appointed after discussions between senior nursing officers in community child health, the local medical committee, paediatricians, and the specialist in community medicine (child health). The coordinator was to discuss with every general practitioner, health visitor, and clinical medical officer in Northumberland the content of surveillance, the ages at which it should be done, and appropriate referral pathways should a child fail a screening test.

The coordinator therefore visited every practice (53) and talked with all clinical medical officers (15 part time) and with 95% of the health visitors in groups. These visits, including the travelling time, took up one months work spread over one year. The discussions were two way, the coordinator often being able to supply objective data about surveillance and the primary health care team being able to point out what was realistic.

Results

Agreement was reached on seven aspects of surveillance; in some cases general principles were agreed, while in others the detailed content of surveillance was defined. We do not think that this is the place to discuss the evidence for and against each screening test.

Firstly, preschool surveillance is a broad concept; through it parents and professionals get to know each other to share and discuss a child's health, growth, and development. Surveillance is made up of three components: developmental guidance and health education; screening; and assessment of problems presented by the parents or health visitor.

Secondly, surveillance is best done within primary care. Thus the family doctor, clinical medical officer, and health visitor should take responsibility for it. Each team should decide who will undertake the successive elements of surveillance to avoid duplication, especially between doctor and health visitor.

Thirdly, a list was drawn up of topics that might be discussed as part of developmental guidance and health education (table I). The doctors and health visitors find this list useful, but it is not all embracing. They do not consider that this part of the surveillance should be done in a rigid way or that routine consulting is necessarily better than opportunistic consulting.

TABLE I—*Topics for discussion as part of developmental guidance and health education*

Age	General topics for discussion	Topics on safety for discussion
6 weeks	Feeding Recognition of ill baby Immunisation Husband and siblings Family planning Services for children	Bath Falling off table tops Carry cot restraints
8-9 months	Measles immunisation Parents' relationship	Stair gate Fire guard Cooker guard Glass at low levels Car seats Kettles and cups of tea
18 months	Behaviour difficulties—for example, sleeping, eating, potty training	Car seats Medicines and household chemicals Outside water Electric plugs
2½-3 years	Behaviour difficulties—for example, tantrums Dentist Nurseries and playgroups Separation of parent and child	Glass at low levels Roads
4-4½ years	Schooling Separation of parent and child Immunisation	Roads and bicycles Strangers

Fourthly, every child should undergo several specific screening tests. These tests are for conditions in which early diagnosis is beneficial. The tests should clearly distinguish pass and fail and be sufficiently important and easy to administer to justify the effort of ensuring that they reach every child. There should be a clear referral pathway if the test is failed. Table II shows the screening tests agreed by every practice, clinical medical officer, and health visitor. It was agreed that the concept of a "developmental screen," in which a battery of developmental tests are performed at a preordained age, is unhelpful because the range of normal is so great, decisions depend too much on the clinical judgment of the observer, and the tests may create anxiety in parents. Such batteries of tests may be useful as part of health education and developmental guidance to help parents understand their child's development and are essential for the assessment of children's problems.

Fifthly, assessment will always be problem oriented and require the clinical judgment and experience of the examiner; skills in assessment will inevitably vary. With training and regular contact with more experienced professionals we hope that more assessment will be done in primary care. Nevertheless, secondary referral of health and developmental problems will always be necessary.

Sixthly, when a primary health care team wants to do more detailed or more frequent checks than those shown in table II this is acceptable provided that all children receive the obligatory screening tests and there is sufficient time to undertake unhurried and effective developmental guidance, health education, and assessment of problems.

TABLE II—*Screening tests to be carried out*

Age	Test
6 weeks	Cataracts Palate Heart Testes Hips
8-9 months	Distraction test of hearing Sitting unaided for one minute Test for squint
18 months	Walking 10 steps Two words with meaning Test for squint
2½-3 years	Test for squint Two word sentences by age 2½ Three word sentences and intelligible speech by age 3
4-4½ years	Height Heart

Finally, health surveillance should be evaluated at population level. The health authority should regularly record and report: (*a*) the number of children who receive the screening tests. The percentage uptake figures will be reported to each primary health care team; (*b*) uptake of immunisation; (*c*) Hospital Activity Analysis figures for orchidopexy, removal of cataracts, congenital dislocation of the hip, and admissions after accidents; and (*d*) outpatient data and data from handicap registers on age at diagnosis of profound deafness, muscular dystrophy, treatable short stature, cerebral palsy, and severe language and learning difficulties; outpatient data about squint and congenital heart disease are not routinely available but will be sought in due course.

Discussion

We have reported these agreements because we believe that similar common ground may already exist in primary care elsewhere in Great Britain. If national committees or the Department of Health and Social Security wish to make recommendations about preschool surveillance we invite them to consider these agreements, which were reached between health visitors, family doctors, and clinical medical officers, the professionals who do the work. We also believe that the manner in which these agreements were sought fostered integration and understanding within primary care.

Several views were expressed repeatedly in the discussions. The doctors and health visitors were pleased that agreement was sought rather than imposed. This would not have been possible without the preliminary discussions with senior nursing officers and the specialist in community medicine. Furthermore, the doctors and health visitors liked the idea of a screening test with a clear referral pathway if a child failed. As Northumberland is a large county with several specialist referral centres efficient pathways will depend on geographical location, but each primary health care team should have its agreed pathways. In some primary health care teams most surveillance will be done by the clinical medical officer and health visitor. It is in these teams especially that the agreement of the family doctor is essential. It is damaging to integration within primary care when one team member thinks that what another does is a poor use of time.

The agreements are not intended to replace the regular work of health visitors and doctors. In particular, health visitors will

continue to visit children on a regular basis and to concentrate on families with problems.

We do not report this agreement in Northumberland because we think that it should be the blueprint for Britain or that we have discovered the ultimate truth about surveillance. The omission of some screening tests means not that they should not be done but rather that there was insufficient agreement about the test in Northumberland for it to form part of the scheme for evaluation. We do not know whether primary health care teams in Northumberland will do what they have agreed to or, even if they do, whether it will help children. We can, however, start to answer these questions because for the first time there is agreement between health visitors, family doctors, and clinical medical officers about what they should offer all children and what measures should be used to evaluate the effect of this.

We emphasise that the discussions with those working in primary care were stimulating and educational. Great interest was shown in surveillance as a concept and in its detail. It took the equivalent of only one month's work to obtain the agreement of all the primary health care teams in the district, and the agreements were introduced in January this year.

We thank all the family doctors, health visitors, clinical medical officers, and nursing officers in Northumberland; Dr F S Rogers (specialist in community medicine); Miss G Charlton (director of nursing, preventive child health); the Northumberland Local Medical Committee; and Mrs A Robinson for preparing the manuscript.

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Letter from . . . the Himalayas

The central dilemma: destroy or develop

T E LANKESTER

The high caste village of Badra is spectacularly perched on a mid-valley saddle with commanding views of more than 20 settlements north and south. At the invitation of local leaders, a village meeting was in progress. The object of the evening was to draw a crowd through showing a film and to explain our health programme to as many as possible. The key question was this: how would the local deity, whose temple juxtaposed the meeting site, react to the infringement of her proprietary rites? We need not have worried. After a couching ceremony accompanied by bells and smells she was temporarily forgotten as the village gathered with unconcealed excitement. The silhouette of the projector against the moon draped semicircle of hills was magically surreal. The evening went well. As the last stragglers left the arena, having soundly participated in the evening's discussions, we realised that the first seeds of understanding about community health had gently been sown.

Setting up a health programme

Towards the end of 1984 I was asked jointly by local leaders and by an Indian health association to set up a health programme in the mid-Himalayas. Seven years as a suburban general practitioner and three years' exposure to Himalayan health problems failed to warn me how difficult this would be.

The hills and valleys of the Indian Himalayas are the home of many million hardy farmers, scattered in more than 50 000 villages. Although generally not as remote as their Nepalese counterparts, such villages are often miles from the nearest road and cut off for weeks by snow in the winter or landslides in the monsoon. The Indian government has an ambitious and commendable plan for building roads up many of the inhabited side valleys of these mountains. Already, north of the hill station where we live, villages which had been cut off for centuries now have access to the outside world with all the development and dangers which this implies.

Some of the most striking features of these mountain people are the simple pastoral logic and intelligent fatalism, which enable them so effectively to celebrate life's joys and to cope with its hardships. The resilience of family structure acts as a powerful insurance against the traumas of old age and bereavement. Indeed, in terms of social cohesion and its chief derivative, mental well being, these mountain farmers have much to teach our so called urban élites with their fragmented lifestyles.

Into such quiet and integrated communities the development worker arrives, his brain bulging with notions and his forms hungry to record the statistics of village backwardness. How much value would accrue to him and how much sadness would be avoided if someone were to explain that the timeless wisdom of rural centuries would enrich his life in measure exceeding that of the improvements he would share with his hearers.

Dangers of development

With each village community reflecting a delicate and finely tuned human ecology should any changes be introduced at all? In the equation of change might not the dangers of introducing hidden seeds of self destruction in the development package outweigh the benefits of correcting malnutrition, treating tuberculosis, and encouraging temperance?

Even the presence of a national outsider in a village community introduces a hidden suggestion that his unfamiliar clothes and lifestyle are intrinsically better than their village counterparts. The sadly mistaken notion that city ways are superior to village ways may

North India
T E LANKESTER, MRCGP, physician in community health