Prenatal diagnosis and genetic screening

SIR,—I am disturbed by Tony Delamothe’s piece on prenatal diagnosis and genetic screening and, by implication, the Royal College of Physicians’ report.

We are told that most people will “do what they can” to avoid the birth of severely affected children—almost as if this were their responsibility as good citizens. This attitude is reinforced by the juxtaposition of graphic estimates of lifetime costs of caring for people with Down’s syndrome. Does the price of care reflect value? How much do we devalue human life by such inappropriate and irrelevant comparisons?

Many couples are said to be “failing to benefit from these advances”—is it not possible that some couples are able to resist the current subtle pressure exerted by society and the medical profession to choose positively to accept and care for the handicapped?

The consequences of couples being deprived of information is described by the royal college’s report as a loss “not only to them but society as a whole.” No one would deny the right to information and choice, but what kind of society is it that regards the birth of a handicapped child as “a loss”?

As a profession we must be aware of these shifting sands of medical morality, which promise a “final solution” to the “problem” of handicapped children, and instead value and support their lives and those who care for them.

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General practitioners and child health preventive services

SIR,—The government white paper has proposed that general practitioners should increasingly take over child health preventive services. Included in the proposed contract for general practitioners are training and incentives offered for immunisation and child screening and surveillance.1 This is the culmination of a series of reports recommending this pattern of care.2 The question of whether general practitioners are prepared to take on this role has not, however, been adequately addressed.

We conducted a survey of general practitioners in Barnet to inquire into the attitudes and practices of general practitioners in relation to a variety of issues including community child health during April 1986 to November 1987. This was done when general practitioners knew that incentives would be offered for undertaking immunisation and child health surveillance.

Barnet has a population of 305000 people, of whom 19500 are aged 5 years or less. All 162 general practitioners in the area were contacted, and 140 agreed to participate. They were all interviewed and asked about their attitudes and practices relating to many aspects of their work, including child health services. They were asked specifically about immunisation and child surveillance and welfare services.

Thirty per cent of all general practitioners interviewed ran clinics for children under 5 (well baby clinics). Sixty eight per cent per carried out some or all immunisations on children. Sixteen per cent offered some form of paediatric surveillance—that is, development checks at important stages in child development: at 6 weeks, 7-8 months, 18 months, and 3 years. Some did all and some only one or two of these checks. Only a further 8% indicated their interest in carrying out developmental checks until after they had become aware of incentives being offered. Thus 76% indicated their intention not to carry out this work, despite incentives.

There are many problems and part of the Department of Health to have general practitioners much more concerned not only with curative but also with preventive child health services. Our study of a single health district shows that, though many general practitioners are prepared to immunise, despite the introduction of incentives less than a third are prepared to undertake aspects such as surveillance and well baby clinics. This suggests that detailed research should be undertaken before such a scheme is implemented and child health preventive services are substantially reorganised.

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Time for radical change

SIR,—It is difficult to understand the motives underlying the government’s decision not to commit the medical profession before publishing the white paper.

Nevertheless, the BMA’s Neanderthal attack on the government obscures certain truths which those working in the NHS have recognised for many years. Firstly, the level of funding has been inadequate for at least 20 years, whatever the colour of the government. Secondly, successive administrative reorganisations have made the NHS less consumer oriented. And, thirdly, a full review and shake up of the service is long overdue.

Though certain of the proposed reforms for primary health care seem to be impracticable or counterproductive, the government allows hospitals to escape the dead hand of local politics and encourages a measure of clinical and administrative freedom, which gives exciting opportunities for hospitals to provide a more flexible system of health care geared to patient demand.

Hospital administration at present is designed to follow the path of least resistance and lowest cost. Decisions on capital spending and service development are made by archaic medical committees, probably randomly chosen from committee chairmen, often specialised in areas bearing no relation to the services under discussion and assisted by administrators whose financial concern is to reduce rather than increase the range, variety, and quality of services available.

The white paper may encourage a change in these attitudes but its main weakness is that it does not spell out precisely how hospitals that have opted out will be funded. If the old system of a closed budget is continued there is little hope for improvement; if, however, budgeting is made work sensitive the potential is enormous.

If the health service is to succeed in this new environment there must be a radical change in the way medical advice reaches the administration. The old cogwheel committee system is outmoded. Multidisciplinary clinical divisions must be set up to provide consumer oriented services. Clinical and community problems should be dealt with by a division comprising, perhaps, orthopaedics, rheumatology, rehabilitation, and geriatrics. This division would represent physiotherapy and occupational therapy and would probably include representatives from neurology and neurosurgery. Gastrointestinal problems would be dealt with by a division which would include gastroenterologists, general surgeons, gastrointestinal radiologists, pathologists, and nutritionists. Accident and emergency services would come from a division of urologists, nephrologists, genitourinary physicians, radiologists, pathologists, and so on. The chairs of these new divisions should report directly to management and be responsible for giving advice on the development of services.

This system has several advantages. The first is that patients’ clinical problems would form the focus of the service. Communication among different disciplines within specialties would be improved. There would be a greater incentive for specialisation with consequent provision of up to date and effective techniques. Postgraduate teaching and research would be encouraged. Clinical auditing would become simpler and more relevant. Hospital administrators could more easily identify areas of weakness in health provision.

Many new clinical divisions have geographical as well as administrative unity a team spirit would be generated in the smaller units, which would offset the disadvantages often experienced in large hospitals, which are sometimes perceived as being remote and impersonal by both patients and staff.

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BMJ: first published as 10.1136/bmj.299.6706.1033-a on 21 October 1989. Downloaded from http://www.bmj.com/ on 12 June 2022 by guest. Protected by copyright.