

## LETTERS TO THE EDITOR

### How many inpatient paediatric units do we need?

EDITOR,—In his article on paediatric inpatient units, Professor Taylor claims that many present paediatric units are too small to provide safe and cost effective care, do not meet required standards, and should combine into larger units providing specialist children's services.<sup>1</sup> We would disagree with him, at least with regard to rural communities.

In many small district general hospitals a very high standard of care is offered, frequently directly by the consultant and often at great personal cost. The service shares many of the better aspects of primary care delivered by staff who know the families and their backgrounds. Professor Taylor stresses the value of a good relationship with the tertiary centres; where this exists children can be referred to superspecialists when indicated. He does, however, make a good case for continuing update and education for all staff and the need for clinical commitments to be such that study and development of appropriate skills are possible.

In a country area almost all acute admissions are at the request of a general practitioner. The request to admit is not undertaken without thought, although the reason is rarely that the disease is life threatening; parental anxiety, inexperience, exhaustion, lack of transport or telephone, or even inability to carry out instructions may all be factors. Is it feasible that a visiting service could overcome these difficulties?

If rural units were to be amalgamated for financial reasons, children in Cumbria, for example, could have to travel 40 miles for inpatient care even if lucky enough to be left with a day centre. As most acute admissions occur in the evening and at weekends, few could be observed locally, even for a few hours. A massive increase in funding of the ambulance service, roads, and public transport would be needed. Sick children would need to travel for an hour before assessment by a paediatrician and family disruption would be extreme.

It would be a brave obstetrician who considered offering a service where unforeseen complications in even 'low risk' deliveries were the responsibility of obstetric staff or even nurse practitioners, if the nearest paediatric support was 40 miles away.

Professor Taylor's sad experience of district general hospital care for children is not universal. Even in today's climate of rising expectations and workload, some units are proud to provide a local and appropriate service. The equation should be restated; it is not 'quality versus access' but 'quality AND access versus financial expediency'.

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1 Taylor B. How many inpatient paediatric units do we need? *Arch Dis Child* 1994; 71: 360-4.

Using the words of Professor Taylor's article,<sup>1</sup> I am a *street corner Jack of all trades paediatrician*. Our district general hospital is too small, with just 112 schools in our catchment area, just 2400 deliveries on one site; just one community paediatrician (with no on-call or acute duties); and just one paediatric psychiatrist. This size does, however, allow me to know most of the GPs; most of the areas where children live; and most residents know where to find us. I also know all my senior house officers and while I don't write many papers, I do train plenty of GP trainees who, after parents, provide most of the medical health care needs of children. I work with my consultant colleagues to provide a consultant based service which sounds a bit like Calman to me.

Children don't seem to mind being seen by a street corner consultant rather than a training grade, and their parents seem happy too. It doesn't worry me too much that I haven't forgotten how to put a drip up, intubate, or that I can still remember what it is like to be a senior house officer. It can even seem holistic at times.

The view that you can somehow retain these local services and yet remove inpatient facilities is not something to be taken for granted. Nor is it necessarily true that bigger centres are better.

There are some data that show that big units do some intensive care services better – and it is rare for us not to use those services; but that doesn't mean that all inpatient services are better centralised. I would venture to suggest that in submitting work for publication all centres tend to report only that which is favourable to themselves. If a small centre does better, for some reason it is always ascribed to a healthier population than in the urban areas. In general, big centres seem emotionally cold, the staff look miserable, they tend not to stay, and are hard to recruit. It might even be said that such centres appeal mainly to microbes and professors.

We do have a duty to face quality issues and I would never support a unit that did not subscribe to an audit of their outcomes. My own view is that health care, like cow muck, works best if you spread it about.

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1 Taylor B. How many inpatient paediatric units do we need? *Arch Dis Child* 1994; 71: 360-4.

#### Professor Taylor comments:

Dr Carter and colleagues stress the benefits of local provision for children's hospital services. Children should not be subjected unnecessarily to inpatient care. In general, hospitalisation should only be for high dependency or intensive care. The most telling phrase in their letter is: *care is offered, frequently directly by the consultant and often at great personal cost.*

Such dedication can only be admired. The current problems with recruitment to paediatrics suggest that many young doctors see the need for a wider as well as a professional life.

Paediatrics is an evolving specialty. Change and the need to accept change is essential. Developments in child health care by general practice and secondary community services together with a change in disease patterns and current difficulties in obtaining paediatric medical and nursing staff all suggest that current inpatient arrangements for children need review. Consultant paediatricians should not be expected to work without a proper middle grade safety net, nor to work unsocial evening sessions, in an attempt to preserve the present pattern of hospital care, without looking at alternatives such as fewer, larger inpatient units, supplemented by local day care centres.

Dr Wilkinson tries heavy humour to justify his service. I agree that health care must be locally available – on a primary and community/day care basis. However, if a child is sick enough to be in hospital overnight he or she should be cared for in a properly structured, properly staffed unit.

Units must have sufficient throughput of serious problems to maintain experience. Competence of care is a quality issue for purchasers. Units must also meet required standards and follow guidelines including those for junior doctor's hours as well as provide adequate training and research experience.

### Reviewing earlier diagnoses of chromosome

EDITOR,—We describe a 15 year old Asian girl who was originally diagnosed as having trisomy 13 at birth. This diagnosis was reviewed because of her prolonged survival.

She was the youngest child of unrelated parents. She had been born at term after a threatened miscarriage at 3 months and her birth weight was 3370 g. She had multiple congenital abnormalities consistent with trisomy 13 which was confirmed by chromosome studies. Karyotype studies at that time were normal in her siblings and parents. Her mother had 11 pregnancies with five miscarriages. All three pregnancies in a maternal aunt resulted in miscarriages.

At the age of 15 years she was functioning at a 6-9 month level. She had the following abnormal physical features: short stature, small head, low anterior hair line, disorganised hair growth, hypertelorism, broad nose, anteverted nares, small jaw, short philtrum, prominent eyes, full lips, prominent teeth, small hands with short fingers, proximally inserted thumbs, clinodactyly, interrupted single crease on the left hand, umbilical hernia, rocker bottom feet, upper limb hypertonía, and truncal hypotonia.

Chromosomal analysis was repeated and this showed the presence in all cells of an additional marker chromosome, which was shown by fluorescent in situ hybridisation (FISH) studies to be a derivative chromosome 14 from a 4;14 translocation. The proband's mother and maternal aunt were subsequently shown to carry an apparently balanced translocation between chromosomes 4 and 14: 46,XX,t(4;14)(q13;q21.2). Her father's karyotype was normal.

Our case shows the importance of reviewing patients when the clinical diagnosis does not match the survival pattern associated with the reported chromosomal abnormality.