Child health surveillance lists

Doctors should decide criteria for admission to lists and standards of practice

Many reasons exist why health services for children are best provided by the primary health care team. General practitioners and health visitors have a long tradition of caring for families and visiting them in their homes. The consultation in general practice is the ideal opportunity to offer preventive and therapeutic care. And general practice is based on local communities, accessible to 95% of the population, and cost effective.

Recognition of this dates back to the Court report (1976), which advocated that child surveillance should increasingly take place in general practice (rather than in the community services).[1] Progress towards the two tier delivery recommended by Professor Court has, however, been slow.

Milestones along the way include *Healthier Children—Thinking Prevention*,[2] which advocated that child surveillance should be part of the core of general practice, and the *Handbook of Preventive Care for Pre-school Children*.[3] Later came *Health for All Children*, containing the views of a working party chaired by Dr David Hall, which looked critically at all aspects of child surveillance and recommended a core programme.[4] A second edition refining earlier recommendations and defining responsibility will be published soon.

Since 1 April 1990 the new contract has remunerated general practitioners for carrying out child surveillance provided that they have been accepted for this by their family health services authorities and their names appeared on the approved lists.[5] The Royal College of General Practitioners and the British Paediatric Association issued joint guidelines in December 1989, which were intended to help family practitioner committees (since renamed family health services authorities) in selecting general practitioners for admission to their approved lists.[6] These guidelines are currently being updated in consultation with the General Medical Services Committee and Joint Committee for Postgraduate Training in General Practice.

Yet Evans and colleagues report considerable variation in the criteria adopted by the managers of family health services authorities for admitting general practitioners to approved lists. Many general practitioners understandably resent the discrepancies that have led to approval by one family health services authority but not its neighbour (p 229).[7] Standard setting should be a professional exercise. The widely varying standards highlighted by Evans *et al* are a telling reminder that leaving this to managers is likely to produce as many criteria for accreditation as there are family health services authorities.

Children are an investment in our future; allowing them to achieve their potential is the main purpose of child surveillance. This is too important to be left to local prejudice—parents and children deserve a uniform standard of care wherever they live. With its recommended core programme of child surveillance *Health for All Children* was an important step forward. But a core programme is not enough: national standards should exist, from which all children should benefit. Standards are a professional not a managerial responsibility.

Of course our ultimate aim should be to ensure that all future entrants into general practice are appropriately trained so that an accredited list is unnecessary. This issue is currently being addressed by the Royal College of General Practitioners and General Medical Services Committee working within the Joint Committee for Postgraduate Training in General Practice.

C WAINE

Chairman of Council,
Royal College of General Practitioners,
London SW7 1PU

1 Committee on Child Health Services (Chairman Professor SDM Court). *Fit for the future*. London: HMSO, 1976. (Cmnd 6680.)
2 Royal College of General Practitioners. *Healthier children—thinking prevention*. London, Royal College of General Practitioners, 1982. (Report from General Practice 22.)
3 Royal College of General Practitioners. *Handbook of preventive care for pre-school children*. London: Royal College of General Practitioners, 1984.
4 Hall DMB, ed. *Health for All Children—a programme for child health surveillance. Report of a joint working party on child health surveillance*. Oxford: Oxford University Press, 1989.
5 Secretary of State for Health and Welsh Office. *General practice in the National Health Service—the 1990 contract*. London: HMSO, 1989.
6 British Paediatric Association and Royal College of General Practitioners. *Guidelines for the accreditation of general practitioners to carry out child surveillance*. London, RCGP/BPA, 1989.
7 Evans A, Maskery N, Nolan P. Admission to child health surveillance lists: the views of FHSA general managers and general practitioners. *BMJ* 1991;**303**:229-32.

When sex is a headache

Not funny but usually not serious

The term "benign sex headache" was coined to cover not the age old avoidance ploy but a headache that develops as sexual excitement mounts and culminates in a severe "explosive" headache at orgasm. It is analogous to "benign cough headache"[1] and "benign exertional headache"[2] in that it is applicable only to those patients without any structural neurological lesion. The term is preferable to "coital cephalalgia" because similar headaches may also be induced by masturbation.[3]

Hearing of sex headaches may bring a smile to the lips of the uninformed, but they are anything but amusing to those who have experienced them. The severity and abruptness of onset ("like a blow on the head") raises the fear of subarachnoid haemorrhage, which is not unreasonable—sexual intercourse was the precipitating factor in six of the 50 cases of subarachnoid haemorrhage studied by Lundberg and Osterman.[4] Fortunately, most headaches associated with sexual excitement do not have any sinister underlying cause, and the benign forms have a characteristic pattern that enables diagnosis in most instances.

Benign sex headache may have two components.[3] The first develops as sexual excitement approaches orgasm, usually as a dull, tight, or cramping sensation in the occipital region. This is probably related to excessive contraction of the head and