The care of children

FROM THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

Comments on the Report of the Child Health Services Committee (1976)

1. Introduction

1.1 The Royal College of General Practitioners is pleased to offer further comment on the Report of the Committee on Health Services for Children in England and Wales. The College regards the Report as of immense importance because of its particular implications for primary care.

1.2 The College accepts the evidence of the Court Committee that the standard of care for children must be raised.

1.3 It endorses without reservation the objective of "a child and family centred service in which skilled help is readily available and accessible, which is integrated through seeing the child as a whole and as a continuously developing person, and which ensures that paediatric skill and knowledge are applied to the care of every child whatever his age or disability and wherever he lives".

1.4 The emphasis on the importance of the home and social background of children in relation to their needs, their illnesses, and as a factor determining the use of health services is especially welcomed since general practitioners as family doctors are particularly concerned with families and are the only clinicians who normally attend patients in their homes.

1.5 We endorse the aim of integrating preventive and treatment services for children and adults since this is in accord with the College's policy and with the practice of many general practitioners over a period of years.

1.6 The recommendation that a comprehensive integrated child and family centred service should be based upon general practice is therefore welcomed and the College believes that primary health care should normally be provided by functionally integrated teams of general practitioners, nurses, health visitors, and social workers. The College's evidence to the Royal Commission on the National Health Service has recently emphasized this point (*Journal of the Royal College of General Practitioners,* 1977).

General policy

2. General practitioners

2.1 The College holds that every person should be entitled to receive personal and continuing care, irrespective of age, sex, or complaint from a general practitioner who spends most of his professional time serving an undifferentiated practice population. The College is firmly committed to the belief that patients are best served by generalist doctors who are fully competent in the management of all the common illnesses. The College therefore rejects the concept of the general-practitioner paediatrician, as proposed in the Report.

2.2 The care of children constitutes a major proportion of the work of the family doctor. One quarter of the total work in practice is concerned with children under 15. Therefore it follows that skill in the care of children must be regarded as a basic competence of every general practitioner.

2.3 The College's aim is that every child shall receive a comprehensive curative and preventive service, including health surveillance, through general practice.

2.4 To achieve this aim, the paediatric training of general practitioners will be required to be raised in accordance with the recommendations contained in the Report of a Joint Working Party between the British Paediatric Association and the Royal College of General Practitioners (1976).

3. Paediatric nursing services

3.1 The College would wish to consult with representatives of the appropriate sister professions before making any firm proposals in regard to nursing services.

3.2 The pressure to raise the standard of paediatric nursing services is appreciated, but we have the same reservation about specialization in nursing and in health visiting as we do about general practice. Inevitably the specialist health visitor or nurse will have to refer to colleagues' problems involving other members of the family which at present generic health visitors and nurses can manage for themselves. There seems no reason why the attached nurse and health visitor may not, however, have an additional independent

geographical responsibility for identifying children in need of health care.

3.3 The College has over the years strongly supported the development of primary health care teams through which the work of general practitioners can be closely integrated with that of nurses and social workers in the community. We are aware of the criticisms of the effectiveness of some of these health care teams but we believe that where full functional integration has been achieved, there is evidence that the potential of the team has been realized in regard to the delivery of improved patient care. It has perhaps been inevitable that in the integration of the work of major nursing and medical services, a range of problems, foreseen and unforeseen, should have arisen. The nature of these problems is however now better understood and there is therefore every prospect that they will be successfully solved.

4. Medical services for children in schools

4.1 The College welcomes and supports the principle that health surveillance of school children should be incorporated with general practice. We accept the logic that general practitioners with their knowledge of children and of the community should carry out this work.

4.2 While much of the work of doctors in schools will be within the capability of the well-trained general practitioner, some children, for example those with complex learning disorders, will be more appropriately dealt with by specialists.

5. District handicap teams

5.1 We welcome the concept of specialist rehabilitation services extending their activities into the community and we commend the idea of co-ordinating and integrating these various services into teams with a geographical responsibility. We believe that the concept of the district handicap team is a sound one capable of bridging the resources of the hospital and the community.

5.2 We believe that the individual services available from such district handicap teams should be directly available through the normal process of referral to the general practitioner who should continue to be responsible for ensuring the co-ordination of the appropriate services in the interests of his patient.

5.3 We strongly oppose any attempts to modify the normal referral system, as this would represent a fundamental change in the basis of medical care in this country and have wide-ranging implications. The Court Committee's proposal that parents, school authorities, and others should have direct access to the district handicap team, so bypassing the general practitioner, is writing a recipe for duplication of care, confusion of communications, and a loss of continuity.

5.4 Although district handicap teams will be geographically based, general practitioners must retain the right to refer to any specialist of their choice. It is not necessarily in the best interests of the patient to limit referral to local resources.

5.5 The need for continuing health care of the 'socially disadvantaged' can best be met by an efficient primary health care team and should not become the responsibility of the district handicap team. The role of the district handicap team, which is essentially a consultant service, cannot provide continuity of care.

5.6 It is the right of every family to have a generalist looking after them, even after referral. The College realizes that this will require ready access of patients and colleagues in other professions to general practitioners involved in the care of children. This raises contractual and manpower implications which will have to be faced.

6. Consultant paediatricians

6.1 We have considerable reservations about the proposal for the establishment of consultant community paediatricians.

6.2 We believe, as a general principle, that primary health care teams should be supported by specialists who are highly competent in their field. We believe that to achieve such competence paediatric consultants, now and in the future, should have a wide experience of acute and chronic illness, both in hospital and in the community.

6.3 We believe that the system that has evolved whereby children are looked after by a combination of their family doctor and a paediatrician with related support from other health professions forms a sound basis for the provision of child health care. We are reluctant to see the intrusion of what may be seen to be another tier of specialist services interposed between the family doctor and his choice of appropriate specialist paediatrician, who should be capable of providing comprehensive care for children whether acutely ill or chronically handicapped. We feel that it would be right to improve the training of the specialist on the one hand so that he may have a better understanding of the work and responsibilities of the family doctor and, on the other hand, to improve the training of the general practitioner so that he may have a better understanding of the work and responsibilities of the specialist.

6.4 The College welcomes the proposed integration of the child guidance and the child psychiatric services as part of a comprehensive psychiatric service for children and adolescents. We accept that, in certain circumstances, direct access to an adolescent counselling service would be useful provided that this did not extend to the initiation of treatment without consultation with the family doctor. We do not believe that these services should form part of those provided by any district handicap team.

7. Clinical medical officers

7.1 The College accepts the recommendation that the responsibility for preventive paediatrics which is at present discharged by general practitioners and clinical medical officers should be incorporated in general practice. Where general practitioners are unable or unwilling to provide full preventive paediatric services for their patients, then the present clinical medical officers should be invited to carry out this work in collaboration with general practitioners.

7.2 For the foreseeable future, the role of the clinical medical officer will continue to be an important one and we will welcome a closer association with general practice of these doctors.

Implementation

8. Vocational training

8.1 We recognize that in general practice today there are wide variations in practice which reflect widely differing attitudes to the work and responsibility of general practitioners. This problem will not be overcome within a short period, especially amongst doctors who have been established for some time. Given this situation, we believe that our most effective contribution to the improvement of primary paediatric care can be made through the provision of better training rather than by trying to effect wholesale changes in the profession within a short space of time.

8.2 It is particularly important that special competence in the provision of child health services is achieved within those general practices used for undergraduate and postgraduate training. Many general practices already provide comprehensive integrated services for children and the experience of these practices must be used to explore further the content and responsibilities of child care in general practice. We believe such practices should provide a major training resource for all doctors who will have responsibility for the care of children. As a matter of urgency, these practices should be identified and training programmes developed based on them but linked with teaching in the hospital and community services.

8.3 The College recognizes the major constraints which prevent the educational objectives of the Joint Report of the British Paediatric Association and Royal College of General Practitioners (1976) from being realized. In particular, the shortage of suitable training posts within vocational training programmes in hospital is regretted in view of the recommendations of that Report.

8.4 We know that there are not enough posts in hospital to provide the kind of experience that the College and the British Paediatric Association recommend. We support the Court Committee, and refer also to our own evidence to the Royal Commission, in stressing the urgency in providing funds for such appropriate posts. Expansion in the number of senior house officer posts, as recommended by the Court Committee, should be given priority in areas where such training posts are inadequate in number. The co-operation of consultant paediatricians should be sought in ensuring that these appointments are for such periods as would enable the maximum number of doctors to benefit from this training experience.

8.5 Until adequate facilities for training are available, the number of general practitioners who, through training and experience, can provide a full range of preventive paediatric services to a satisfactory level of competence will remain limited.

8.6 We attach such importance to the adequate training of future general practitioners and paediatricians that we propose to maintain a continuing dialogue with the British Paediatric Association. The Joint Report by the Association and the College formed a useful foundation from which to consider the many new issues which have now arisen and which have shown can be solved only by a joint approach.

8.7 If they are to be accepted for the purpose of its membership examination or College accreditation, the College will require training programmes to include satisfactory training in child care. The College examination will require all candidates to demonstrate adequate knowledge of the principles and practice of child care reflecting the increased responsibilities of general practice.

8.8 In addition, the College intends to offer accreditation in general practice. The purpose of accreditation is to demonstrate clinical competence amongst those who have been vocationally trained.

9. Continuing education

9.1 Collaboration between general practitioners and paediatricians involved in training has led inevitably to a further consideration of the knowledge and skills of those practitioners already established. There are numerous and exciting examples which suggest that such initiatives will recast continuing education for both disciplines and will bring about improvement in the quality of patient care in the joint approach to the recognition of posts which the Royal College of General Practitioners and the Royal College of Physicians have already embarked upon.

9.2 The Royal College of General Practitioners, like the Royal College of Physicians and its paediatric members, is actively engaged in the evaluation of self-assessment, as assessment linked with continuing education is seen as the desirable way forward by our two branches of medicine.

9.3 Priority should be given to courses on developmental surveillance and preventive paediatrics in postgraduate medical centres.

9.4 The College's main contribution will come through the provision of resources to relevant courses, the introduction of monitoring through peer group review, and in the criteria of assessment and accreditation we hope our members will meet in future to maintain their competence in general practice.

10. Research

10.1 An intensive study of general practices which are recognized for vocational training and which are providing an integrated service should be mounted to determine and evaluate practice organization and the clinical content of the child care provided. The information so obtained should be made available to all those with responsibility for training of future general practitioners.

10.2 The College will sponsor an intensive study of general practices that are providing an integrated preventive and curative service for their child patients. The object of this study will be to examine the aims for the provision of these child care services and to evaluate the efficiency with which they are achieved.

10.3 Urgent attention should be devoted to the provision of agreed developmental schedules and improved record systems.

References

British Paediatric Association and the Royal College of General Practitioners (1976). *Journal of the Royal College of General Practitioners,* **26,** 28-136.

Committee on Child Health Services (1976). *Fit for the Future.* Vols 1 and 2. Cmnd 6684,6684-1. London: HMSO.

Royal College of General Practitioners (1977). *Journal of the Royal College of General Practitioners,* **27,** 197-206. Paras. 2.4 and 2.10.

Addendum

Members of the Working Party of the Council met during 1977 and 1978. They were: A. G. Donald (Chairman), S. J. Carne, D. J. Pereira Gray, D. H. Irvine, M. J. Linnett, C. Waine, and J. H. Walker.

The document was referred by the Council to all the faculties of the College for comment and this final version was approved by the Council on 10 June 1978.