community health councils and patients' organizations, to stimulate faculty activities. There will be the problem of choosing people to represent patients. Those faculties with patient participation groups will have some general practitioners with experience of dealing with the initial difficulties.

Whilst many of the activities will be in the areas of education and practice organization, others will be related to resources and to the hospital service. For this reason we recommend that Faculty Boards invite members of local medical committees to take part and that discussions should include any interested general practitioner, and not be limited to College members. People experienced in working in small groups will be important assets. We have already suggested examples of activities that might be appropriate, but believe that each area should do what it feels is most important.

Conclusions

We suggest that these proposals will be important for the College, since they are closely identified with Council policy. They will bring a new dimension to activities of Council and Faculty Boards. Equally we hope that they will be important for patients and that they will play their part in making general practice more relevant to patients' needs.

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CONTROVERSY

Our criticisms of *Healthier Children—Thinking Prevention*

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We are disappointed that this Report has added little to what previous reports have said. It makes a plea for action but comes up with few realistic solutions. If the belief that preventive care will lead to 'a better tomorrow' for children in the UK is to be upheld, a more detailed account of current training resources in general practice is necessary, and a more precise definition of general practitioners with special responsibilities for children is still awaited. Without this, the statement that "we have no doubt that from the point of view of children the immediate start of a comprehensive system of regular child examination through general practice across the country as a whole can be provided by general practitioners trained as they are now" is one which we find great difficulty in accepting. To expect all general practitioners to conduct child care in the manner prescribed is unrealistic. Before general practice can claim the right to increase commitments to child care, more objective evidence is required about the clinical and teaching capabilities within primary medical care in the UK.

ALMOST ten years ago the Scottish Home and Health Department's proposals (1973) for an integrated health service, and the Court Report (1976), suggested radical changes in the organization of primary care for children which included proposals for general practitioners with expertise in child care. The report of the College Working Party, *Healthier Children—Thinking Prevention,* is the latest attempt to rethink the primary care of children in the UK. While the effort put into the College Report is recognized, it must be regretted that it is at times superficial in its reasoning and lacking in sound evidence for many of its recommendations for preventive care. There are a number of specific criticisms which we wish to make.

Before going ahead with the widespread implementation of proposals for the routine screening of children in general practice, further careful validation from practices doing this is required. The College Report only quotes one reference from general practice in support of routine screening at selective ages. (Curtis Jenkins, 1976.) The belief that developmental examinations will *de novo* identify most health problems remains unproved, and more objective accounts of the outcome of screening examinations as well as methods of screening are needed. In some senses it is unfortunate that screening is presented as an activity which ceases at the age of five, when growth and development proceeds throughout the school years. In general practice

greater emphasis needs to be placed on the need for doctors to review constantly the overall development of their child patients. Questions also remain to be answered about who are best equipped to assess child development. In the practices which have introduced screening a large number of screening procedures are carried out by health visitors (Bain, 1977), and the function of health visitors is such that they will continue to make a major contribution to these activities.

The reproduction of screening and growth charts in the Report is unfortunately selective. Why no reference to the well-tested Denver scales, and to the more recently introduced Woodside system (Barber *et al*, 1976), both of which incorporate ranges of normality on a visual scale presenting a better profile of the child which can be readily understood by general practitioners, health visitors and students? Does the College really believe that payment for screening is necessary, and will this payment only be made to general practitioners who assume the complete responsibility for screening assessment and examination procedures? A recent report from the United States comments that such a "fee for service approach" is counterproductive. (*Harvard Health Project, 1977.)*

Providing the Expertise

A previous College policy statement *(The Care of Children, 1978)* recommended that every child in the UK should receive comprehensive curative and preventive health care through general practice, but at the same time made no specific recommendations as to how this could be achieved. Can we have comprehensive child care within general practice without recognizing the need for a corps of general practitioners with special interests and experience in child care? Both the College and the Working Party Report have ducked the challenge of the Court Report and the proposals for general practitioners with additional training in child care. We agree that age band specialization is not the answer, but the idea of extending skills within general practice is certainly not contrary to the philosophy of family care. The exploitation of additional developed skills remains a sensible one especially for areas of special need. If preventive services are to be integrated into general practice it is doubtful that all general practitioners would have an equal interest in their provision. Why not admit this, and accept that the clinical and administrative responsibilities for preventive care in a group practice should be delegated to a doctor with the training, skills and interest? The Working Party claimed that "the concept of systematic surveillance is not difficult to organize". This is certainly an over-simplification. The creation of well organized surveillance and preventive services can be difficult, and might best operate where there are well organized group and health centre practices. (Bain, 1974; Freer and Ogunmuyima, 1977.)

On the subject of the routine follow-up of both well children and children with chronic disabilities, the Report fails to mention district handicap teams, the advantages and disadvantages of combined general practice/consultant paediatric clinics (Stark *et al.*, 1975; Marsh and Tompkins, 1969), the role of the clinical psychologist in the management of children with behaviour disorders (McAllister and Philip, 1975), and the problem that while the care of handicapped children may be a primary responsibility of general practice, circumstances may dictate that this is not necessarily always the most practicable or best arrangement. It is easy to be critical of hospital outpatient clinics and the wide range of specialists that many handicapped children see, but unless general practitioners are prepared to contribute actively to multidisciplinary case management they cannot complain about being bypassed in management. In our experience most hospital paediatricians have as much interest in the physical, psychological and social factors influencing child care as do general practitioners.

In considering integrated care, the experience of the Livingston Primary Care Scheme in Scotland (now in its fourteenth year) (Stark *et al.*, 1975) goes unmentioned, yet the main conclusions of the Livingston system are that child care can be extended within the primary care team, given general practitioners with additional training and experience in child health practice. The care of children in this system is not the exclusive prerogative of general practitioners with special experience in child health, but very much a collaborative effort on the part of individual general practitioners, hospital consultants, health visitors and community nurses. General practitioners with special interests need be no less generalists than any other general practitioners. On the contrary the exploitation of the special skills of individual practitioners benefits the general experience of the several members within group practices.

Education

The Report correctly identifies the problem of training, but training in child care is not merely a matter of creating more junior hospital posts. This achieves little if there are fewer children being admitted to medical paediatric wards. It is to be regretted that the very considerable potential of general practice as a base for teaching community child health and clinical paediatrics has not been adequately stressed. It would seem to us important to identify practices where there are general practitioners with training and ability to provide comprehensive child care and who are competent to pass on these skills to trainees and students. The Working Party made only passing mention of the efforts in Lothian Region to provide experience and training in child health in practices identified as having a particular interest in child care, linking this with attachment to the School of Community Paediatrics in Edinburgh. (Donald *et al.*, 1979.) Albeit there are at present problems in this training scheme, the basic approach is sound. It is an honest attempt to provide training which includes experience of community services, district handicap teams and the full range of health services available to children.

We share the Working Party's concern that no study has been set up to review practices which provide integrated preventive and curative services for their child patients, yet was this not the type of information the Working Party should have gone out and sought? This would have made available a more realistic appraisal of current facilities. The following statement in the report requires challenging: "Doctors are qualified and going into clinical practice without a proper appreciation of common childhood complaints." This may well be true but may not be so widespread as the report infers. Certainly in the teaching of undergraduates it is our experience that group practices providing comprehensive child care can provide clinical experience of common childhood complaints which is certainly denied to students by conventional inpatient teaching.

The Report raises many important issues and we would certianly support the views about immunization, the reappraisal of the child care content of the MRCGP and the content of vocational training. One omission requires explanation: amongst the profusion of statistics there is no mention of the problem of dental caries, still a major challenge to preventive medicine in this country.

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A challenge for general practitioner research
Support for the elderly at home

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OVER 94 per cent of those aged 65 years and over live in their own households and are not in institutional care. Partly because many health problems and a number of common *chronic* diseases are age-related, meeting the needs of the elderly has long been an essential part of the care general practitioners provide. Such care is often directed to supporting those members of the family (and others) who look after the elderly as well as the elderly themselves. During the last decade, there has been an increase in the number and in the proportion of the elderly in our population—and old people are living longer.

It would be surprising if these facts were not reflected in the work of general practitioners, yet the evidence is conflicting. For example, Wilson (1982) found no increase in workload related to the elderly over a period of 18 years, while Knox and colleagues (1982) found an increase roughly proportional to the increase in the practice populations of Dundee doctors in the 1970s. Such evidence suggests that general practice may be responding to the challenges of an ageing population in a somewhat passive manner. It is now over ten years since the publication of the Brotherston Report (1971), with its call for a change of attitude of the profession and of the service, both of which are conditioned to work mainly 'on demand' and in relation to the individual's demands rather than the requirements of the whole population served.

Of course the nature of general practice is such that time devoted to meeting the needs and demands of one 'client group' is likely to be made available only at the expense of other patients, and although the current capitation system is intended to provide some incentive, resources are finite.

So what needs to be done? Social policy must be based on valid and reliable information. How far is general practice in fact meeting the challenges of the elderly? In the context of the wider situation of a given practice, what is a reasonable balance in deploying scarce resources?

Research literature, with its emphasis on institutional care, on the more severe forms of morbidity and on the pathology of service function is in danger of promoting a distorted impression of age, ageing and welfare services. This imbalance was only partially redressed at a recent seminar concerning research on 'support for elderly people in the community', organized by the Department of Health and Social Security. Participants at this seminar themselves recognized the need to chart the largely unknown territory of 'normal ageing'. There was general agreement that research effort, much of which had hitherto been of a 'cross-sectional' nature, should in future be supplemented by 'longitudinal' work. Cohort studies were needed of groups of elderly people in their own environment, to be undertaken by those in close contact with old people over a period of years—and all to be accomplished with a maximum of economy. Where else, other than in general practice, could such conditions be met?

This is not to say that general practitioners must necessarily themselves undertake all this research—though an increasing number, by education, experience and training, are well-placed to contribute. There is plenty of scope for professional collaboration with workers in disciplines relating to social sciences and biomedical sciences. Yet before such teamwork can become a reality a number of conditions must be met. A secure basis in service to the elderly must be provided, purposeful training in teamwork for service and research (preceded by a more appropriate undergraduate preparation) is ever more urgently required, and resources are needed to make room in general practice for researchers, to ensure security and continuity of tenure, and to provide the necessary back-up. It might then be possible for general practice to make a more substantial contribution to meeting the needs of of our ageing society, both in practical and theoretical terms.

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