

The family doctor and children with special educational needs

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SUMMARY. *Twenty three of the 1548 children registered with a group practice were found to have special educational needs. Only half of these children were known by the health visitor attached to the practice to have such needs. Ten of the 17 children attending school had no reference to their special needs in their case notes. Irregular attendance and poor immunization records indicated a lack of anticipatory care within the practice. Children with a physical handicap, in particular, attended their family doctor much less frequently than normal children or those with a mental disability. Improved care in recent years coincided with the establishment of developmental surveillance within the practice.*

Introduction

BASED on the recommendations of the Warnock report,¹ the new education act of 1981 broadened the concept of handicap and encouraged children with such difficulties to attend ordinary schools. The term 'mental handicap' was replaced by 'learning difficulties' and all children with learning problems whether mentally or physically handicapped were to be classed as having 'special educational needs', thus reflecting the trend of recent years to manage the handicapped in the community.² This transfer of care must increase general practitioners' responsibility for chronic handicapping conditions of childhood which were previously managed by medical officers attached to institutions.³

A computer search of the literature revealed little published material on the present responsibilities of general practitioners in the care of children with special educational needs. In 1969 Pereira Gray emphasized the general practitioner's central role in providing continuity of care but made no assessment of current practice.⁴ Seven years later, the Court report suggested the development of 'general practitioner paediatricians' within group practices but again made no reference to prevailing non-specialist practice.⁵

An informal discussion with the partners in my training practice revealed considerable ignorance of the likely number of handicapped children registered with the practice. It was clear that there was no organized system of follow-up for these children, and a firm but unsubstantiated belief that their needs were being met by other agencies. These findings were echoed in discussions with other trainers in the area. This study aimed to establish whether the children with special educational needs in the practice were attending their general practitioner and if so, how often; how this compared with children who had no such problems; and whether they received the ongoing care required in chronic illness or acute 'crisis intervention'.

Method

The practice is in a semi-rural area and has five full-time partners and two trainees. Paediatric developmental surveillance is

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performed within the practice by two of the partners.

All children registered with the practice who were under the age of 15 years on 1 January 1986 were included in the study. Children with special needs were defined as children who had a statement of special educational needs or who had been placed in a special school prior to the 1981 act. Children under school age who might ultimately require special schooling arrangements owing to a major abnormality were also included. The index children were traced from the records of the community child health service and the health visitor. The district handicap team provided the names of children in contact with them. The next two children of the same age and sex following the index child on the age-sex register were taken as controls. It was not possible to control for social class as the parents' occupations were not recorded on the children's cards.

Immunization records were obtained for all index and control children from the case notes as all immunizations are routinely recorded by the doctor or nurse. Over the period 1 January 1986 to 1 January 1987 all medical consultations with a general practitioner were noted for both index children and controls. Hospital attendances and admissions over the same period were assessed from the correspondence. Casualty attendances were included in the study as the local casualty department always informs the general practitioner when a patient attends.

Results

Out of a total of 1548 children under 15 years of age registered with the practice 23 were identified with special educational needs — 18 boys and five girls. Thus, 1.5% of the child population required or would require special educational provision. Of the 18 boys, 11 were mentally handicapped, six were physically handicapped and one was both mentally and physically handicapped. Four of the five girls had a physical handicap and one had a mental disability. Six children were under five years of age; nine were in the 5–10 years age group; and eight were over 10 years of age. They were equally distributed between the partners.

The problems found are categorized in Table 1. Ten children were affected from birth — five had congenital abnormalities,

Table 1. Range of handicaps suffered by the 23 children (some children had more than one handicap).

	Number of children
<i>Mental handicaps</i>	
'Slow learners'	6
Specific language disorder	5
Educationally subnormal ^a	1
Hyperactive	1
<i>Physical handicaps</i>	
Cerebral palsy	3
Congenital heart disease	3
Deafness	3
Spina bifida	1
Subglottic stenosis	1
Epilepsy	1

^aModerate: IQ 50–75

three had cerebral palsy and two girls had sensorineural deafness possibly resulting from congenital rubella. The health visitor was aware that 11 children were handicapped and all but one of those affected from birth were known to her but she knew of only two children whose problems had come to light after school entry.

Fifteen of the 23 children had been fully immunized (65%) compared with 71% of the 46 control children. One handicapped child had no immunizations recorded and the other seven had an incomplete record. A total of 10 handicapped children did not receive pertussis vaccine — two on the advice of the consultant paediatrician they attended. One of the 10 has had definite pertussis and a further two have had a pertussis-like illness. Seven children did not receive measles vaccine and four are recorded as having had the illness. All six children under five years of age have been fully immunized except one child who had pertussis vaccine excluded on the advice of a consultant. He had received measles vaccine with immunoglobulin cover because of neonatal convulsions.

The number of consultations with a general practitioner is shown in Table 2. Children with a mental handicap had a similar pattern to the control children but considerably fewer children with physical handicap attended their general practitioner during the year. One physically handicapped girl attended her general practitioner regularly.

The number of hospital attendances is shown in Table 3. All except one of the children with a physical handicap had attended at least one hospital specialist over the year and eight had attended a regional unit. Most of these children attended the regional unit only once a year with further follow-up by the local paediatrician or at local joint clinics with the regional specialist. Only two mentally handicapped children had attended a hospital specialist.

Table 2. Number of consultations with a general practitioner over the period 1 January 1986 to 1 January 1987.

Number of consultations	Number (%) of children		
	Mentally handicapped (n = 12)	Physically handicapped ^a (n = 11)	Controls (n = 46)
0	3 (25)	5 (45)	8 (17)
1-3	5 (42)	1 (9)	24 (52)
>3	4 (33)	5 (45)	14 (30)

n = total number of children. ^aBoy with both physical and mental handicap is considered as physically handicapped.

Table 3. Number of specialists attended over the period 1 January 1986 to 1 January 1987.

Number of specialists	Number of children	
	Mentally handicapped (n = 12)	Physically handicapped (n = 11)
0	10	1
1	1	2
2	1	4
3	0	4

n = total number of children.

Five children (four physically and one mentally handicapped) had been admitted to hospital during the year and three of these admissions were elective. There was no evidence of self-referral to hospital except in one case which was appropriate (a greenstick fracture).

Only three children (all physically handicapped) took long-term medication: one took carbamazepine, another digoxin and the third digoxin and asthma prophylaxis.

The information about educational needs contained in the case notes varied. Six children were under five years of age and were therefore not attending school although one attended a nursery. Six older children had no information recorded and a further four had only indirect reference to education included in other correspondence. In only seven cases had the general practitioner been directly informed of the child's educational problems. This number included two children in contact with the district handicap team and the information had come from them. Six children attended special schools while the remaining 11 attended special units or classes within ordinary schools.

Discussion

This project indicates that on average, a general practitioner could expect to have four or five children with special educational needs on his list. The variety of problems suffered by the children in this study was as expected from the general population. The incidence of confirmed epilepsy in childhood is four per 1000 children with one third requiring special education⁶ — only the child requiring special education was included in this study. There were no children with Down's syndrome in the study practice, but a previous study revealed that this is the case in 40% of practices.⁷ The number of mentally handicapped children is considerably lower than the expected 20 per 1000⁶ and this may reflect the favourable socioeconomic base of the practice but is more likely due to chance.

The health visitor attached to the practice was unaware of the handicap in over half the children especially when the problem had been discovered after school entry. A register of the children discovered by this study has now been established and the health visitor has taken responsibility for this. New cases will be added as they arise. It would be helpful if the education authorities routinely informed the general practitioner when a statement of special educational need is made. This statement follows a statutory assessment of the child's educational problems and requirements. Parents, teachers, psychologists and other interested parties are informed of, and participate in, the assessment but general practitioners, at present, have no role. The realization that a hitherto 'normal' child needs special education may place an additional stress on the family, leading to increased consultation with the family doctor. He is at an obvious disadvantage if he is unaware that such a decision has been made. The child may also have employment difficulties in later life in which the doctor may become involved.

The general practitioner must also become more involved in the care of the handicapped child. In this practice children with a mental handicap attended their family doctor as often as the controls but the children with a physical handicap attended much less frequently. Only one handicapped child attended her general practitioner regularly (she had a physical handicap). The others were seen by many different doctors with no one taking overall responsibility. The lack of ongoing care was reflected in the poor immunization records, although it was heartening that all those under five years of age had been fully immunized. Children with a physical handicap, in particular, should be fully protected against childhood illnesses. Parents of such children may be concerned about the risks of vaccination but a consistent policy by the practice and the hospital specialist should help to allay such

fears. The fact that two of the deaf children might owe their handicap to congenital rubella adds further impetus to the immunization campaign.

It is salutary to note that almost half of the physically handicapped children had not attended their family doctor at all during the previous year. This included two children with severe handicaps attending special schools. Their day-to-day needs may be met by the school medical officer but the general practitioner still carries responsibility for out-of-hours care. This may create problems if he is not aware of their current management. Further study is needed to examine why such children do not maintain contact with their general practitioner and whether their needs are indeed being met by other agencies. Discussion with other practices confirmed that the findings of this study are not unique.

The district handicap team attempts to coordinate all the services involved with a particular child. In this area, general practitioners were invited to all meetings concerning their patients but their attendance rate was low (Pugh R. Personal communication). Health visitors, in contrast, saw it as part of their role to attend each meeting. The general practitioner has no grounds for complaints of exclusion if he cannot make the effort to attend when invited. A study in 1984 of children with Down's syndrome and spina bifida confirmed the reluctance of many general practitioners to get involved.⁸ This may reflect present paediatric training which concentrates on acute and life-threatening illness to the virtual exclusion of chronic handicaps. More community paediatrics and less 'high technology' should be incorporated into postgraduate training in paediatrics for future general practitioners. This has already occurred in adult medicine and geriatrics with increasing awareness of the aids and services available to keep the elderly in the community.

It appears that, in terms of immunizations, the care of pa-

tients in this practice had improved in recent years, probably as a result of holding development surveillance sessions within the practice. This facilitated regular contact with all pre-school children, whether normal or otherwise. Failures of communication were reduced as referrals were made by the practice and a rapport established with hospital and community specialists. Purely educational problems will still slip through the net but the community child health service is improving its correspondence with general practitioners. If general practitioners showed a little more enthusiasm perhaps the appropriate authorities would be encouraged to meet them half way.

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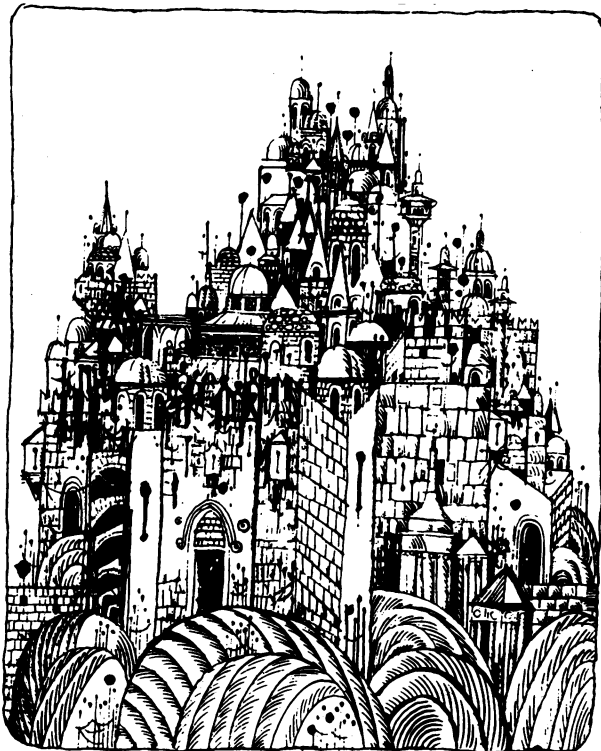
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