Honey, we shrank the kids' health service

I went to talk to the deputy head of our local comprehensive the other week. An edge-of-inner-city school doing a great job half a mile from the practice. He told me that by far their biggest health concern was not obesity, smoking, or drugs but the mental health of their 11–14 year olds. Seven years ago he reckoned that about 5% of this group were depressed, self harming or disruptive — now it was closer to 40%. Their school nurse was doing sterling work ('I don't know where we'd be without her') but they had finally decided to set up a meeting with our local Child and Adolescent Mental Health Studies service to see if they could commission an on-site clinic.

I was astounded. A quick audit revealed that on average we see each child just once in the whole 4 years from 11–14, and this for largely self-limiting problems. What does this say about our service that we knew nothing about this level of distress?

As a profession we've long been harbouring delusions about our family-centred approach. At the same time all semblance of actually providing a family-friendly service is in tatters. Attendances at children's A&E have been growing for years. So how do we respond? We withdraw our services at precisely the times that modern parents, used to a 24/7 lifestyle, would like us to be there for them. Finding us lacking and driven by the legion anxieties of parenthood they turn to NHS Direct or direct access A&E services.

Another straw in the wind: I happened to look through the local telephone directory. At the back there were 40 pages of health-related algorithms courtesy of NHS Direct. What to do about rashes, abdominal pain in adults, headache in children; 31 common conditions in all — useful stuff when you're in a fix at 10.30 at night. I counted up the action points for all algorithms and 'Phone NHS Direct' won by a long chalk. People were also directed to see their pharmacist on 31 occasions, their dentist on 10, and a doctor or a nurse on five occasions. There was not one mention anywhere of general practice or any of its synonyms.

Of course this is not a conspiracy. We've campaigned not to have anything to do with NHS Direct. And we've been so successful that we're written out of the script for this state-sponsored service aiming to help our patients at a time of need.

We know what family-friendly policies mean because we apply them with some diligence to our own working lives. Look at practice schedules and ask yourself honestly why there are so few early morning slots, or why we were so eager to give up Saturday morning surgeries and weekend work. A large part of the answer is that — unsurprisingly and in some ways rightly — we want to spend more time with our own families. What we did not forsee was the growing resentment at 'over-paid' GPs and the risk of alternative providers doing more for less. Fifty years of state-sponsored monopoly has left us — despite our rhetoric — all too happy to provide non-continuous, episodic care when it suits us, which is most of the time. Our busy fractured lives mean that it is rare for one family to know one doctor. For our part, what we see is a collection of busy, fractured individuals whose commonality as a family only rarely comes into focus.

Alongside all this, a revolution in children services has been occurring under our noses as Sure Start Children's Centres have sprung up and provided huge new sources of support and help. Since 1997 the government has invested £17 billion in early years provision and by 2010 there will be 3500 Children's Centres across England — but how many of us have ever taken the time to visit one?

Meanwhile, the science has been accumulating; not just the wave of genetic knowledge that is about to hit clinical practice in the next 5 years, but also the neuroscience. I didn't know until recently that there is overwhelming evidence that chaotic parenting in the first 2 years of life leads to detectable differences in brain function that persist in adulthood. And that, just like hearing, there is a developmental window that if missed leads to life-long difficulties. If no stable, consistent parenting has appeared by the second birthday brain development is impeded and can never be recovered.[1] Intervene appropriately during early pregnancy and in the first 2 years of life and there is significantly better school performance, less ADHD, less child abuse, better educational performance, and less criminality when the children are grown up (yes, the RCTs have been following up these children for that long). Fail to get this right and the effects echo down the decades. If thousands of children were being condemned to deafness because of our failure to intervene during the developmental window for hearing it would be a scandal. But where have we been implementing this research? Where has the dialogue been between the RCGP and paediatricians? Why have we not been pressurising the government to do more for children?

So is it too late to put the family back into family medicine? Well, probably it is; certainly so far, as children under 10 years of age are concerned (parents increasingly prefer the certainties of hospital care) and of adolescents (who have never used our service much). The present generation of parents were beginning to be educated by us in these trends as they grew up, so are unlikely to change easily.

Of course we will have a fig leaf or two. Waiting rooms will never be child-free areas (although children may increasingly be seen by nurses rather than GPs), and some parents will continue to ask our advice about behavioural problems. Some health visitors will continue for a while yet to give immunisations under protest while we pocket the payments. But look at the

reality of what we do and our bluff is called. For the 80% of the population that live in towns and cities, the heart of children's medical services is on the move to A&E departments, short inpatient stays, and Children's Centres. We will still be family practitioners in the sense that we look after people enduring illness that touches all aspects of their lives – people who are dying, or giving birth, changing job or changing spouse. But children's services are going the way of community obstetric services. We're ceasing to know families as families. We're absent when it matters.

Lay waste a few illusions and it can be easier to see the wood for the trees. The temptation is to look to the past and to find ourselves muttering about continuity of care and tri-partite diagnoses. Reference to the old values of 'family medicine' may comfort our anxieties but appears merely self serving to the political classes when we have been so eager to give up so much: out-of-hours services, obstetrics, transfer of chronic disease management to nurses, and acquiescence in referral management systems. More importantly the shibboleths of the past are a poor guide to the future. When genetic knowledge is doubling faster than Moore's law, the focus must be not on ourselves as a profession but on what sort of 21st century medicine our patients want in the community.

The tools are at hand. Think what we could do with a cohort of specialist colleagues newly released from secondary seclusion. If together we provisioned ourselves with an income stream from the rapacious foundation trusts and accessed the imaging that's getting to be as cheap as chips, the metabanomics, genomics, and some advanced IT — what could we do? Or if we really set our minds to using all that social capital that lies implicitly strewn through all our consultations to release new forms of caring and social cohesion in our communities?

Why don't we — this newly emerging fusion of general practice and consultant communities — set ourselves some challenges that really matter? We could guarantee that we, not hospitals, diagnose everyone with cancer within 2 weeks of presentation? Or provide intensive support to that cohort of the most vulnerable young mothers to ensure that no child, absolutely none, suffers the irreversible developmental damage consequent from inadequate parenting? Practicing 21st century medicine in the community will demand us to be profoundly clinical and, at the same time, able to work with a networked citizenry to live our traditional values in new ways.

We're not a heritage industry — yet. If we are to avoid that fate, then we need to stir ourselves with dreams that will inspire not just us, but the families and communities whom we still serve.

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REFERENCE

1. Gerhardt S. *Why love matters: how affection shapes a baby's brain*. Hove: Brunner-Routledge, 2004.