Editorials

Child health care:

adequate training for all UK GPs is long overdue

LITTLE CHANGE IN GP TRAINING FOR 40 YEARS

General practice has long been viewed as the 'jewel in the crown' of the UK health service, with the image of a friendly Dr Finlay or an avuncular Dr Cameron still coming to mind with the phrase 'family doctor'. But much has changed in the 60 plus years since general practice in the UK was created and the job of the GP is now very different. Here we consider whether general practice has evolved sufficiently to meet the needs of infants, children, and young people.

When the NHS was formed in 1948 GPs took on the responsibility of providing front line care for the whole population, and providing a gateway for access to specialist services. Rather than becoming salaried employees, GPs remained independent self-employed practitioners and outside the NHS. The Collings Report in 1950 (the first examination of the quality of GP care) found poor standards and working conditions and isolation from other healthcare professionals. The subsequent years brought better premises, support staff, and a growth in professionalism, cemented by the creation of the College of General Practitioners in 1952, which gained its Royal Charter in 1972. However, it was only in 1976, after much discussion about the adequacy of training, that a mandatory 3-year postgraduate programme was introduced for doctors aiming to become GPs. This initially included only 12 months of actual general practice experience. Although the period of training out of hospital in the community has now increased to 18 months, the UK GP training programme has remained essentially unchanged for 40 years.

LACK OF PAEDIATRIC TRAINING: A SERIOUS PROBLEM FOR GPS

Children make up about one-fifth of the UK population. Caring for them is an important part of a GP workload. Around one-quarter of all patients aged <18 years visit their GP each year, and on average the majority of GPs see around 400–600 children in a typical 6-month period.[1] However, in the UK today only about one in three GPs has received any postgraduate specialist paediatric training. Concurrently, over the years, undergraduate exposure to paediatrics has shrunk to around 5–6 weeks. Thus by any stretch of the imagination, GP training in the UK in paediatrics is woefully inadequate.

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It can be argued that all GPs in training get paediatric exposure as they will spend a considerable amount of time seeing children. However, can GP trainers be expected to teach trainees with little or no prior paediatric exposure all that they will need to know about child and adolescent health, within the limited time they have available? Furthermore, chronic complex conditions and serious acute illnesses in children are thankfully relatively rare in the community. On average, a GP will see a child with meningitis once every 4–10 years, and the average GP will have just two or three children registered who have severe, complex, long-term medical conditions. Therefore it is difficult to gain experience in these important areas during training practice placements in primary care.

A paediatrician receives on average 10 years of postgraduate training and will see a large number of sick children over that time. How can a GP who has received such limited paediatric exposure be considered competent to coordinate, let alone deliver care to children with chronic and often very complex long-term conditions, or recognise life-threatening acute illness? While scoring systems, such as the National Institute of Health and Care Excellence traffic lights system for feverish illness in the under- 5s, have gone some way to address these issues, they are no substitute for clinical experience and judgement.

ATTEMPTS TO ADDRESS THE DEFICIT

This problem has been universally recognised as serious. In 2011, in a widely supported move,[2] the Royal College of General Practitioners (RCGP) announced plans to include mandatory paediatric training in their curriculum.[3] However this has yet to come about, with progress stalled while awaiting the *Shape of Training* review[4] and the responses of the Royal Colleges. Further uncertainty came from the ongoing GP recruitment and retention crisis, adding to difficulties in extending training, and the creation of the controversial Health and Social Care Act 2012, from Health Education England (HEE), a body awarded responsibility for commissioning health education and training in England.

There have been other attempts to improve exposure to paediatrics during GP training. Broad Based Training was a promising 2-year structured core training programme, comprising 6-month placements in medicine, general practice, paediatrics, and psychiatry, followed by entry into further training in one of the four specialties. This was introduced in 2012 in recognition of the need for flexibility in training, and the types of care predominating in a GP's case load. Trainees liked the scheme and it was successful in providing doctors with flexible career options. Yet at the end of 2015, despite being very well received by local health and education boards, the four involved Royal Colleges, and the General Medical Council, HEE precipitately announced that the Broad Based Training programme would cease immediately, citing as the reason as '*... prioritising our investment decisions*'.[5]

It is worth noting also that the Department of Health invited the RCGP to submit a case on extended training for general practice as recommended in the 2008 Tooke Report.[6] The RCGP originally proposed an extension to 5 years but was forced to compromise, with extension to 4 years because of 'the current financial climate'.[7] This is despite UK general practice having the broadest curriculum of all specialties, the shortest training programme in Europe, and also the shortest of all UK medical specialities. Is it right, therefore, that the health, safety, and wellbeing of children are being compromised because of the ideologically-driven imposition of austerity measures upon the health service when the UK already spends far less as a proportion of GDP than any equivalent European country?

MEASURES OF QUALITY OF CARE ARE NEEDED

Are GPs doing a good job despite these

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difficulties? It is difficult to be certain; indices of quality in paediatric primary care are scant[8] but several studies have identified areas where improvement is required. These include the timely recognition of childhood cancers, management of chronic conditions,[9] and reducing the number of children presenting to accident and emergency departments[10] or admitted to hospital.[11] Perhaps of greatest concern is that the 2008 *Confidential Enquiry into Maternal and Child Health*[12] identified failure to recognise serious illness by healthcare staff not trained in paediatrics as a recurring factor in childhood deaths.

WHAT DO WE WANT FOR THE FUTURE?

These considerations notwithstanding, we suggest that it is only by specialist paediatricians and GPs working together with HEE that we can make progress. The introduction into the UK of a 'primary care paediatrician' akin to existing models in Europe and the US has been proposed in the past by the Royal College of Paediatrics and Child Health. Certainly if a magic wand could be waved to introduce such a cadre of health professionals immediately, this would be an improvement upon the current situation.

However we think the UK can do better. The social determinants of health and disease are now increasingly understood and accepted. The UK GP is conversant with the dynamic between fathers, mothers, children, and grandparents, an expert on the family and thus in a unique position to understand the out-of-context symptom, recognise serious illness early, and manage chronic conditions holistically, thus, a truly family doctor.

We are both mothers; one of us a UK paediatrician, the other a UK GP; both of us would prefer children to be seen first by a GP who knows and understands the family, but only if this GP is competent in primary care paediatrics. GP training must change; children are being failed by the perpetuation of the status quo and 40 years is far too long to be still waiting.

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