Would primary care paediatricians improve UK child health outcomes?

YES

Present child health outcomes

We are failing our children and young people in the UK. Earlier this year, research showed that UK childhood mortality is higher than in a comparable group of wealthy countries for common infections and multiple non-communicable diseases.[1]

The UK, for example, has the highest rate of childhood asthma deaths in Europe due to poor chronic disease management despite good national guidelines.[2–5] Delays in diagnosis of Duchenne's muscular dystrophy in the UK are among the longest in Europe, being only marginally better than in the 1970s, mainly due to lack of recognition of delayed motor development in primary care.[6,7] Against this backdrop, my own recent experience of a late referral of a child now diagnosed with a brain tumour, who had been symptomatic with red-flag signs for 3 months despite seeking consultation on multiple occasions in primary care, has made me reflect that there is a systemic problem with health care for children in this country.

Healthcare system in the UK versus Europe

How does our healthcare system for children and young people differ from other countries with equivalent wealth but better health outcomes? The answer may well be that children in Europe see primary care paediatricians trained in primary care paediatrics (with a competency-based curriculum) and not GPs, who are generalists with variable training and experience in paediatrics.[8]

In the UK, when a child is unwell the first interaction with our health service is mainly via a GP who may have no formal training in paediatrics or minimal exposure of just 4 months in a hospital paediatric setting, which is too short.[9] Exposure to children will occur during GP training attachments but further reflective learning is reliant on GP trainers who will vary in paediatric experience and expertise. Once in practice a GP's paediatric knowledge and experience has to compete with the many demands in primary care, for example, mental health issues, adult chronic diseases, and demands of an ageing population. How can a GP with all of these demands of challenging patient groups be up to date with a plethora of guidelines in all areas of medicine?

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GP training and consultation time

Present GP training in paediatrics means that many GPs inevitably lack the skills, up-to-date knowledge, and experience to adequately assess and treat many of the common problems in children presenting to primary care.[9] This issue is also compounded by the typically short consultation times (average 10 minutes in the UK versus 22.5 minutes in Sweden), which is known to be associated with poorer health outcomes. Short consultations may just focus on detecting gross disease and become little more than a *'triage and issue of a prescription'*.[10] In paediatrics it is especially important that enough time is allowed to thoroughly explore concerns of parents, children, and young people, and to examine the patient. The consultation, if good and thorough, can be therapeutic, giving both children and parents/carers confidence in the clinical decision-making process. Without attention to carrying out an adequate consultation the patient's or parents' faith in clinical decisions is undermined, often leading to a demand for secondary care referral or search for further healthcare opinions. Our system has unrealistic expectations of what can be achieved during a short consultation; this is exemplified by the *British Medical Journal*'s 10-minute consultation series. A model assessment of the poorly controlled adolescent with asthma was expected to be completed in 10 minutes but in practice would take at least 30 minutes.[11,12]

Primary care paediatricians could revolutionise the workforce in child health

Primary care paediatricians would be a popular option for many doctors who enjoy paediatrics and child health but who do not want to pursue the long programme (8 years) of hospital-based training to become a paediatrician. I have met many excellent paediatric trainees who have left paediatrics, and who have expressed that they would have stayed in paediatrics if this career option with a shorter training period (2–3 years) was available. The recent Royal College of Paediatrics and Child Health (RCPCH) 2019 meeting had sessions on workforce issues, such as rota gaps, lack of doctors wanting to train in paediatrics, and burnout among trainee and consultant paediatricians. This is worrying for the future workforce, and radical change is needed to address these issues and improve the outlook for child health and paediatricians. One solution is to invest in a new type of primary care paediatrician (akin to our European neighbours) who can work within primary care to improve the standard and quality of care given to children and young people with common conditions such as asthma. Liaison of these paediatricians with primary care colleagues and secondary care paediatric departments could strengthen care pathways, easing the burden on hospital emergency departments.

Call to arms

We as paediatricians need to do something urgently and differently to address the shocking outcomes for children in the UK. Primary care paediatricians, I believe, are the way forward. I hope the Presidents of the RCPCH and Royal College of General Practitioners can work together to agree a curriculum and training schedule, and make primary care paediatric posts available throughout the UK.

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Introduction

Why did you become a GP or family physician? Whatever we call ourselves, one of the attractions is being a generalist physician who cares for families over time, rather than individuals or specific body systems in isolated encounters. Many GPs will have been particularly attracted by the opportunity to see children and their carers in the context of their community. The challenge of providing continuity is such that every household may not be known to us, but electronic records allow us to cross-check information about people registered at the same home address; and personal knowledge is shared between primary healthcare team members.

Around 11% of our consultations are for people under 15 years[1] and the idea of community-based paediatricians, rather than GPs, providing primary care to children is not new.[2,3] A mix of different types of providers is found in Europe, with paediatric primary care provided by GPs in only 41% of European countries;[4] and in the US, where a third of children are cared for by family physicians rather than paediatricians.[5] Yet, there are recurring calls for all paediatric primary care to be provided by paediatricians rather than GPs.

Better training is the real solution

We don't have any evidence that primary care provided by paediatricians rather than GPs in the UK would improve the care of children.[4] Reports have advocated better training of GPs and communication between GPs and paediatricians, but not a sea change to primary care paediatricians.[6] However, many GPs now work in systems that actively discourage referral and one-to-one discussion of patients with specialist colleagues (referral management systems, advice by email rather than by telephone).

Practical barriers to splitting care

Fragmenting primary care into paediatrics and adults would likely make things worse rather than better for children and their families, and begs several questions. Who would train the new cadre of specialists? Paediatricians, with limited experience of managing diagnostic uncertainty in the community? Or GPs, who are blamed for the poor care the new model is being introduced to address? Where would the age cut-off be between primary care paediatrics (infancy, adolescence, emerging adult?) and 'adult only' GP? How would care be safely and effectively transitioned from one provider to another? And what about the practicalities of providing appointments? Would primary care paediatricians work from the same building and share the same support staff? If not, then how would services be provided close to patients' homes and schools, with a trusted group of clinicians? Who would provide out-of-hours care? GPs who currently cope with a range of issues in such settings but who would become deskilled from lack of in-hours contact with children? And, finally, what about busy carers who previously would have booked a double appointment, one for themselves and another for their child, possibly for the same illness, who must now see two doctors at different times? Finally, would paediatricians really want to take on these roles, having previously 'extracted' themselves from this 'no man's land'?[2]

With increasing subspecialism, more than ever patients need a good GP to 'hold the whole', to coordinate and make sense of care for them. Rather than gatekeepers, GPs are 'gate openers' — facilitating and advocating for appropriate and timely care, while protecting our patients from overdiagnosis and overtreatment. In paediatric as in other patient groups, it is the work done by GPs that means bad things do not happen: immunisation preventing serious disease; identification of and provision of support for carers struggling with parenthood or adverse social circumstance; avoiding unnecessary referrals of children with self-limiting illnesses. And we don't yet fully appreciate the value of knowledge of the whole family in helping identify serious illness — the change in behaviour noted because 'mum isn't normally a worrier', prompting an urgent referral and timely diagnosis.

A way to improve standards

We're not arguing that standards of paediatric care are adequate everywhere or that more shouldn't be done to improve them. But we caution against further increasing specialism and plurality of

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