ADDRESS FOR CORRESPONDENCE

Timothy Peter Newson

Paediatric Department, Kent and Canterbury Hospital, Ethelbert Road, Canterbury, Kent CT1 3NG, UK.

Email: timothy.newson@nhs.net

REFERENCES

1. Ward JL, Wolfe I, Viner RM. Cause specific child and young person mortality in the UK and EU15 countries. *Arch Dis Child* 2019; **104**(Suppl2): 4.
2. Levy ML, Fleming L, Warner JO, Bush A. Paediatric asthma care in UK: fragmented and fatally fallible. *Br J Gen Pract* 2019; DOI: <https://doi.org/10.3399/bjgp19X704933>.
3. National Institute for Health and Care Excellence. Clinical knowledge summaries: asthma. 2019. cks.nice.org.uk/asthma [accessed 27 Jan 2020].
4. British Thoracic Society, Scottish Intercollegiate Guidelines Network. *SIGN158 British guideline on the management of asthma: a national clinical guideline*. 2019. <https://www.brit-thoracic.org.uk/quality-improvement/guidelines/asthma> [accessed 27 Jan 2020].
5. Royal College of Physicians. National review of asthma deaths. 2014. www.rcplondon.ac.uk/projects/national-review-asthma-deaths [accessed 27 Jan 2020].
6. Van Ruiten HJ, Straub V, Bushby K, et al. Improving recognition of Duchenne muscular dystrophy: a retrospective case note review. *Arch Dis Child* 2014; **99**(12): 1074–1077.
7. Royal College of Paediatrics and Child Health. Recognising neuromuscular disorders — online learning. <https://www.rcpch.ac.uk/resources/recognising-neuromuscular-disorders-online-learning> [accessed 28 Jan 2020].
8. Newson T. Curriculum change in general practitioner paediatric training attachment: views from the coalface of professional practice. In: *AMEE 2010 abstracts*. 2010; 49. <https://amee.org/getattachment/Conferences/AMEE-Past-Conferences/AMEE-Conference-2010/AMEE-2010-Abstract-book.pdf> [accessed 28 Jan 2020].
9. European Confederation of Primary Care Paediatricians. *Curriculum in primary care paediatrics*. 2014. https://www.ecpcp.eu/fileadmin/pdf_doc_ppt/Curriculum_in_Primary_Care_Paediatrics_4.12.2014.pdf [accessed 28 Jan 2020].
10. Johnson E. Primary care consultations last less than 5 minutes for half the world's population. 2017. <https://blogs.bmj.com/bmjopen/2017/11/08/primary-care-consultations-last-less-than-5-minutes-for-half-the-worlds-population> [accessed 28 Jan 2020].
11. Connett GJ, Connett LA, Thomas M. Determining the reasons for poorly controlled asthma in an adolescent. *BMJ* 2019; **364**: l75.
12. Syme D. Rapid response. Re: Determining the reasons for poorly controlled asthma in an adolescent. 2019. <https://www.bmj.com/content/364/bmj.l75/rapid-responses> [accessed 5 Feb 2020].

NO

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 years¹ 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

"Fragmenting primary care into paediatrics and adults would likely make things worse rather than better for children and their families ..."

provision, in the absence of any evidence that this would be a more clinically and cost-effective way to improve outcomes. The burnout experienced by paediatricians and paediatric trainees mentioned by Timothy Newson earlier is highly unlikely to be solved by a shift to general practice: 'from frying pan to fire'. Rather, we suggest the following goals.

First, evaluate (and potentially adopt) flexible models of primary care professionals trained in child health working closely together,⁷ such as 'child health GP hubs'.⁸ This may include other ways of supporting GPs to provide paediatric care, such as: GPs with extended roles; the use of mid-level providers (nurse practitioners, physician assistants), who are a significant part of the primary care workforce in the US, for example; and expanding GPs' access to real-life/virtual opinions from specialists as needed.⁹

Second, GP training should be longer and postgraduate training in paediatrics mandated. What is debatable, however, is the setting and nature of this training. Traditional models of hospital or paediatric community clinic-based service delivery are unlikely to improve future GPs' ability to diagnose and manage the spectrum of disease seen in general practice.

Third, give GPs the resource we need to do our jobs properly — appropriate time for

ADDRESS FOR CORRESPONDENCE

Matthew Ridd

Population Health Sciences, University of Bristol, Canynge Hall, 39 Whatley Road, Bristol BS8 2PS, UK.

Email: m.ridd@bristol.ac.uk

consultations, access to diagnostics and specialist services, and technologies that facilitate (rather than add burden to) the efficient delivery and coordination of care.

By all means let's work together to provide better care for children outside of hospitals, but let's not 'throw out the baby with the bath water' by eliminating one of the core purposes (and joys) of being a GP.

Matthew J Ridd

GP and Reader in Primary Health Care, Population Health Sciences, University of Bristol, UK.

Matthew J Thompson

Helen D Cohen Endowed Professor in Family Medicine, Department of Family Medicine, University of Washington, Seattle, US.

Provenance

Commissioned; not externally peer reviewed.

DOI: <https://doi.org/10.3399/bjgp20X709289>

REFERENCES

1. NHS Digital. *Trends in consultation rates in general practice — 1995–2009*. 2009. <https://digital.nhs.uk/data-and-information/publications/statistical/trends-in-consultation-rates-in-general-practice> (accessed 4 Mar 2020).
2. Ni Bhrolchain CM. Who should provide primary care for children? *Arch Dis Child* 2004; **89**(2): 116–117.
3. Peile E. The future of primary care paediatrics and child health. *Arch Dis Child* 2004; **89**(2): 113–115.
4. van Esso D, del Torso S, Hadjipanayis A, *et al*. Paediatric primary care in Europe: variation between countries. *Arch Dis Child* 2010; **95**(10): 791–795.
5. Freed GL, Dunham KM, Gebremariam A, *et al*. Which pediatricians are providing care to America's children? An update on the trends and changes during the past 26 years. *J Pediatr* 2010; **157**(1): 148–152.e1.
6. Kossarova L, Devakumar D, Edwards N. *The future of child health services: new models of care*. London: Nuffield Trust, 2016.
7. Wolfe I, Thompson M, Gill P, *et al*. Health services for children in western Europe. *Lancet* 2013; **381**(9873): 1224–1234.
8. Montgomery-Taylor S, Watson M, Klaber R. Child Health General Practice Hubs: a service evaluation. *Arch Dis Child* 2016; **101**(4): 333–337.
9. Saxena S, Francis N, Sharland M. Primary care of children: the unique role of GPs. *Br J Gen Pract* 2012; DOI: <https://doi.org/10.3399/bjgp12X652166>.