Personal view

Community paediatrics: anxieties on future developments

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Since working in the community as a clinical medical officer I have had to alter a number of my ideas and beliefs built up over 25 years as a 'hospital doctor' even though I had regular clinics in special schools. In retrospect I realise my concepts of problems in the home, school, and community were limited and sometimes unrealistic. After working in school and community clinics for a few years I have come to recognise the expertise that is needed to provide an effective service to preschool and schoolchildren.

For those working among preschool children a detailed knowledge of developmental paediatrics is essential. Testing for the normal development of vision, hearing, and language in young children is often difficult, and special training is needed if reliable results are to be obtained. The complexities and uncertainties are well illustrated by a review of screening tests for squint and poor vision by Taylor.¹

When I used to see a number of so called clumsy children at the age of 10 or 12 they often fitted into my 'if only syndrome.' If only someone had done something about it a few years earlier it is probable that many of the present problems would not have arisen. It is not always easy, however, to assess the importance of failure of motor tasks at an early age. This may be due to specific learning difficulty but social and emotional factors may well play a part; and considerable experience is needed in sorting out an often complex condition. Disorders and delay of language development are also diverse in cause and effect. Such disorders are frequently associated with abnormal behaviour and these children are often referred to the school doctor. The children more at risk of being neglected are those who are labelled as very quiet in the nursery school because they say nothing, and some have little ability to do so, but cause no one any trouble. Some have deficiencies of social skills out of proportion to their language deficits.

In a recent review of outcomes of a random 1:7 sample of 1700 school entrants born in 1980 in the

Macclesfield health district it was found that 14% of the pupils had conditions previously undiagnosed, which warranted referral (C Jones, personal communication). Deafness was one of the most frequent disabilities found. Yet diagnosis and treatment of deafness in early childhood can make a very important difference to a child's development. Fifteen per cent of the parents indicated on a questionnaire that there were problems they wished to discuss at the time of the examination and 9% had their concerns confirmed. Also of importance is discussing a particular child's difficulties with the teacher and school nurse as soon after the start of school as possible. This emphasises the need to establish a good working relationship which can only be achieved by meetings on the school premises. There are arguments on the timing of the school entry examination² and how selective it should be.³ With limited resources, which are not likely to improve in the immediate future, there are strong reasons for concentrating the doctor's work on the neurodevelopmental examination and on certain aspects of the physical examination (for example, heart, chest, testes), and on children with appreciable growth and sensory problems found on screening tests done by paramedical personnel.

Now that there are more handicapped children, and even those with severe disabilities, attending primary and secondary schools, accurate assessment of the child's condition is even more important. If this is done at an early age plans can be made for providing any suitable help especially if there is progressive disability. The doctor working with handicapped children, whether in mainstream or special schools, must have adequate knowledge of paediatrics and related specialties. This knowledge should include what is known about the causes, natural history, and treatment of conditions, and when applicable the genetic implications. It is still surprising how often parents and older children have not been offered genetic advice. Twelve out of 70

pupils in a Salford special school were found with identifiable genetic disorders who had not been offered advice (I McKinley, personal communication). (They included children with congenital eye defects.) Referral to a clinical geneticist is usually required.

Often the families of handicapped children need skilled advice from several disciplines and this should be coordinated in the community. Realistic goals can be set with knowledge of home and family circumstances. Adequate resources and time must be devoted to this work.

At primary school many problems can arise that need expert attention and these often need to be discussed in detail with both parents and teachers. These include failure to acquire motor skills at the expected age and disorders of language development including all aspects of literacy with the implications of these for learning in general. Clumsy children can sometimes lead very unhappy lives at school.⁴ Assessment and management of children with learning disabilities needs the aptitude to work as a member of a team, and as a coordinator when appropriate, as well as a knowledge of learning disorders. The doctor working in the school is at an advantage when it comes to involving health professionals (therapists, nurses, orthoptists, audiometrists, dietitians, chiropodists, dental services, general practice, and specialist medical services). Advice for teachers will be needed on children with visual and auditory problems and long term disorders such as asthma, diabetes, and epilepsy.

I have been impressed recently by the number of children showing evidence of nasal obstruction and suffering as a result of this. Apart from breathing through their mouths and snoring at night their school performance may deteriorate because they are so sleepy during the day.⁵ This information may only be available from their teachers, and no doubt there are other examples of conditions that could be improved as a result of collaboration between teachers and doctors.

If teachers are involved in the management of children with long term disabilities, especially those with epilepsy, this improves the lot of the affected child and the understanding of peers. This is only possible, however, if the teacher has reasonable knowledge which is likely only to be available from the school doctor. Several children have been referred to me by teachers who have been the first to notice petit mal. One of these children was obviously having non-convulsive status epilepticus, although the mother had been told there was nothing to worry about.

Close links will often have to be made with educational welfare, child guidance, and social

services when dealing with emotional and behavioural disorders, including the management of children at risk from physical, sexual, and mental abuse. Helping these children is time consuming and needs knowledge of how to recognise the suffering child, the best approach to child and parents to avoid doing more harm than good, and how to cope with follow up. These and other problems can be included under the term 'educational medicine', as they may all possibly interfere with the child's learning in school.

When it comes to secondary school education a particular skill is also required by the doctor concerned in trying to help with the complex emotional and behavioural disorders which can develop at this time of life. These include deficiencies in social skills, excessive anxiety or withdrawal, a variety of sexual problems, and all the complications of drug and solvent abuse. School doctors can assess and give primary care to these children before deciding on the need for psychiatric opinion,⁶ but this requires a degree of experience and training which at present relatively few doctors possess.

I was certainly impressed recently when attending a clinic in a secondary school run by a (women) senior community medical officer. The problems presented by the children were varied and complex, and although I thought that many of the girls would come and tell her their troubles I was surprised how often the boys did too. A school nurse can be a key figure in the secondary school and a number are, but I am amazed how often such schools do not have a nurse in attendance for long periods. The teachers and pupils need to see the doctor and nurse often enough to know who they are and to be willing to talk to them.

If intervention is to be successful sufficient time and commitment is essential, and the doctor recognised as a colleague by the school staff is at a particular advantage. Anyone who dismisses the importance of this work and of other tasks such as immunisation does a disservice to children, because the potential for prevention of disabilities and minimising their effects is great. Before working in the community I had not realised the extent of this work. Had I known I feel sure that my work as a paediatric neurologist would have been more effective. (This is the motivation for writing this paper, particularly with the anxieties over the plans for the future development of community services.)

Uniformity in planning services should be questioned. Needs and circumstances of children vary widely—for example, between a self contained rural community and an inner city area. Solutions may require maintaining a number of options.

A major problem is the relative lack or equivocal

outcome of research in community health. Policy decisions can be taken on financial grounds by people who have little direct, practical knowledge of this work. Abolishing the 'third force' and dividing medical provision for children in the community between the general practitioner and consultant paediatrician may not be a desirable development in all areas of the country. Community paediatrics lays a great deal of stress on preventative medicine which inevitably entails a lot of routine work. In discussions a distinction must be made between screening and health surveillance. The former is the identification of disease in a population and in the latter the concern is the health and development of a unique child; and this difference is not always made.⁷ Routine examinations do identify a variety of conditions from undescended testes to heart murmurs and defective sensory input channels but more information is needed on the cost effectiveness, sensitivity, and specificity of these exercises.

There is still controversy over who should test, particularly in screening tests, and at what age they should be carried out. Hopefully establishment of consultant posts in community child health will facilitate studies to clarify the role of the school nurse and the doctor giving primary care. What is not in doubt is the need for all practitioners to be well trained, and in the case of those not medically qualified, they must be adequately supervised and willing to refer children with particular problems when these occur. There are questions of responsibility if errors should occur.

Concentrating primary care for children in general practice should be evaluated by pilot studies. In many areas this may work well as the doctor will know the families, which is often so important, and can prescribe when necessary. When the administrative boundaries of education and health are roughly the same there should not be organisational problems, but in large conurbations with mobile populations this may well not be so. Also there must be an adequate number of doctors interested in community paediatrics and adequately trained. Even more important is their commitment to the work, for example it seems essential that the clinics must be held in the schools and not in the surgery so that there can be full cooperation with teachers who are directly involved with the child's progress.

Whitmore stresses that to be effective the school doctor must visit each of his schools at frequent intervals.⁶ In many areas this may be unrealistic for a long time to come but the reasons he gives are certainly persuasive. They include making a comprehensive check on the health and development of each child on school entry; discussing the results of this examination with parents and teachers; offering

advice, as seems necessary, on the child's continuing health care and education; examining or interviewing children, or both, on request and at a stated time soon after starting at secondary school; offering to organise treatment for any physical or developmental disorder found on examination; and being an accessible source of advice and support to the school nurse in her contribution to an agreed programme of health surveillance and health education. Bax has pointed out that during term time the school child spends more time with teachers than parents, and if the doctor who is trying to help cannot visit the child's school this is likely to limit the role he can have.⁸ He may be unable to assess the child's needs and to integrate the medical aims with those of the teachers. This inevitably takes up a lot of time and may not be possible for general practitioners who are already hard pressed by the other calls on their services.

To maintain the help that children so often need it seems that, particularly in cities, the work of the clinical medical officer should continue, at least for a considerable time. If this is so there will be some community medical officers who will work from group practices, but some may wish to remain independent as they did not enter the field of community paediatrics to be part of the general practitioner services but to advance to a higher grade in community paediatrics. This seems a reasonable ambition and in my opinion such a career structure should be maintained. Also some part time posts should be kept, despite administrative difficulties, to enable those with special skills to continue working while their own families grow up.

Few would disagree that community paediatrics should be consultant led, and that with few exceptions future senior community medical officer posts should be regraded at this level, with the appropriate experience and training that this implies. There are problems to be solved in the grading of those at present in post, and there are many such doctors who have an exceptional expertise to offer and do not wish to undertake the necessary training and examinations to be a consultant. It would therefore seem reasonable to allow some of these posts to continue at a non-consultant grade, perhaps on a personal basis.

It is obvious that any consultant paediatrician working in the community must have a major commitment to the community services. There are arguments favouring the involvement of consultant community paediatricians in acute paediatrics and of their being in charge of hospital beds but by the nature of the work acute paediatrics must take priority at times over all other duties, and time must be allowed to keep up to date with the rapid

advances in this field. There may well be advantages in being in charge of some beds in hospital so that a child can be admitted for medical or social reasons, but not being on any rota. Although the number of beds allocated to a particular consultant is no longer the status symbol it used to be, an involvement in the work of the hospital wards may help to place the consultant community physician on an equal footing with other colleagues. There are certainly a number of precedents for such an arrangement.

The concern of those already working in the community seems to be the danger of acute paediatrics being the main interest, with community paediatrics being a secondary one, while among hospital based paediatricians who may not realise the full variety of work involved there may be a feeling that this is a perfectly rational arrangement. Perhaps the strongest argument against an involvement with acute paediatrics is the amount of work that needs to be done in the community and the attitudes that have to be developed if this work is to be successful.

If standards are to be maintained and improved and people of the calibre needed are to be attracted to community paediatrics it is essential to establish better training, better conditions of work (at present often fragmented and carried out in unsatisfactory circumstances), a better career structure, and better facilities for research. The interests of doctors differ considerably. Whether they are general practitioners or consultants they will have concentrated their training in different ways. For example there is no guarantee in a group practice that one member wants to be involved in paediatrics. Opportunities for training in community paediatrics are not the same in all parts of the country and there is no doubt

that training others takes up a lot of time of people who are already hard pressed by service duties.

In summary, my concern for the future is that, accepting that reorganisation is needed, this may lead to a loss of commitment to community paediatrics and a loss of some of the skills developed over the past few decades. If improvements do not occur it is the children who will suffer. Managers must be convinced by those with practical experience that depriving children of such services will in the long run be a false economy. Changes must not only serve the interests and claims of the doctor but must first of all be able to answer the question in the affirmative: does it help the children? If the needs are so variable, a number of options must be maintained.

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