Personal paper

Paediatric dialectics in a BPA Triennium 1985–1988

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Immediate Past President of the British Paediatric Association

Office imposes restraints. The President of the British Paediatric Association (BPA) may be the leader of the Association, may seek to influence, and also guide, its decisions, is often the Association's spokesman but is always the Association's servant and must finally reflect its views and proclaim its decisions. Release from such restraints provides a liberalising opportunity for re-examining issues of debate and controversy at a less official level.

Age and the BPA

During the triennium the BPA reached and celebrated its 60th birthday. It created the category of senior members—depriving all such of a vote and conveying to some of these erstwhile husbandmen of youth an uncomfortable reminder of their own lack of it—and, paradoxically, elected contemporaneously the oldest President in its history. Its members were saddened by the recent death of the last of its founder members; two of its members celebrated their 100th birthdays.

A comprehensive child health service—integration not agglutination

The revolution in the deployment of professional paediatric resources envisaged in the BPA report *Paediatrics in the Seventies* in 1972,¹ *Towards an Integrated Child Health Service* (the Brotherston report) in 1973,² and *Fit for the Future* (the Court report)³ in 1976 was largely brought to a conclusion during this triennium. Paediatrics took on a new dimension.

Over a century or more childhood mortality and the incidence of irreversible morbidity had fallen dramatically and the character of children's hospitals and hospital departments for children had changed. No longer was disease at an advanced stage the main criterion for hospital admission of children. Early diagnosis, early treatment, early discharge and the planned management of long term

disorders, with increasing emphasis on outpatient services, had become the primary role of the children's hospital service.

What of child health service outside hospital? Before the National Health Service (NHS), general practitioner care, subject as it was to professional fees, had not been available for many children for family economic reasons. The child health service then provided by local authorities had made an important contribution to child health in the community by providing assessments of health, protective immunisation, and often minor treatments. Local authority doctors providing this care were often involved also in hospitals run by local authorities. With the institution of the NHS, and exclusion of local authority doctors from it, responsibilities for primary and hospital care were largely devolved to NHS general practitioners and paediatricians leaving local authority doctors with a more limited screening, assessment, and immunisation role. As the NHS evolved, these activities too began to fall increasingly within the scope of general practice and the hospital service.

The NHS imposed agreed paediatric training programmes, defined academic standards, and there was open competition for posts. Doctors working in child health in the local authority service did not have to meet these standards and were usually denied comparable training experience derived from the wide range of clinical material, case discussions, critical environment, and auditing of results available in hospitals. Without primary responsibility for children who were ill in the community, or hospital responsibilities, they were left with an unduly limited repertoire of clinical tasks. Some of the most effective elements of the local authority child health service were those such as audiology, which had retained a hospital connection. The belated incorporation of local authority doctors into the NHS in 1974 changed their employer and their title—to 'community child health doctors'—but the service in which they were engaged continued much as before.

The portrayal so often presented, that these

changes resulted in general practitioner and hospital paediatric services engaged solely in curative medicine on the one hand and an ex-local authority child health service alone providing a preventive service on the other, is inaccurate. Long before the triennium in question hospitals were engaged in prevention. Hospital screening of newborn infants and the early diagnosis and treatment of diseases such as icterus gravis neonatorum, meningitis, otitis media, and congenital dislocation of the hip had an important place in preventing disabilities such as mental retardation, cerebral palsy, deafness, and disordered gait. Hospital consultants played a significant part in the amelioration of community problems such as physical and mental handicap, long term illness, speech and psychosocial disorders. Dedicated as was the work of the ex-local authority child health service, its isolation and enforced dissociation from the hospital based child health service and from primary care impaired its function and necessitated the reorganisation of its structure.

Now that a comprehensive consultant led integrated child health service has been agreed it is important that it should be appropriately deployed, unimpeded by the outmoded hospital/community dichotomy of the past and that there should be true integration, not a mere administrative agglutination of two otherwise discrete parts. Paediatric skills should be available according to how they are needed and can be most appropriately deployed. There will be paediatricians most of whose work is conducted in the inpatient ward, those who are essentially outpatient based, and those whose primary work locus is beyond the hospital walls, the whole including an infinite variation of these patterns. In this reorientation of skills two considerations need particular implementation. Community orientated paediatricians should have access to hospitals for such elements of their work as is necessary and, as advocated 20 years ago, the hub of a comprehensive, integrated child health service including its community component should be the children's hospital or paediatric department of the general hospital.⁴

Faculty or College?

BPA members are well aware of the recent arguments and decisions regarding a possible Joint Faculty of Paediatrics or College of Paediatricians. Why did the BPA, which in 1978 rejected the idea of establishing a College of Paediatricians, endorse this idea in 1988? The position that the majority of BPA members were Fellows or Members of the Royal Colleges of Physicians was unchanged and many BPA members still believed in the importance of

'unity among physicians' and felt a strong sense of allegiance to the Royal Colleges of Physicians.

The history of the establishment of separate Colleges shows that if major segments of medicine, particularly expanding developing subjects with changing needs, cannot within existing Colleges achieve the conditions that they consider essential for the proper regulation and conduct of their affairs they will set up separate Colleges. Past experience suggested that such developments tended to follow when Colleges failed to understand and meet reasonable, responsibly formulated requests that were within their power to grant and not incompatible with wider College interests. Paediatricians, dealing with a section of medicine covering a quarter of the population and patients with the longest period of life before them have long felt that the needs of their discipline were inadequately met by the existing College structure. In the Royal Colleges of Physicians they are constrained by a system in which ultimate authority in all aspects of medicine, including paediatrics, is vested in committees controlled by physicians concerned with adults and in which the interests of adult medicine predominate. The needs of paediatrics and child health cannot be met adequately in this way.

There was nothing new in the idea of a College of Paediatricians about which discussions had been going on for 45 years. The 1978 referendum, although it rejected separation, had shown significant evidence of dissatisfaction with the position of paediatrics within the Royal Colleges of Physicians. The Colleges responded by establishing the Joint Paediatric Committee of the Royal Colleges of Physicians and the British Paediatric Association. This was seen by many as an arrangement that would give paediatrics the voice and authority it needed if paediatrics was to be appropriately represented within the Royal Colleges of Physicians, in the higher councils of medicine, and in dealing with statutory authorities. The BPA responded positively to this initiative by declaring a five year moratorium on further discussion of a College of Paediatricians.

The early achievements of the Joint Paediatric Committee, for instance in bringing the chief medical officers of Scotland, England, and Wales to one of its meetings—providing the opportunity for expressing paediatric views backed by the authority of the Royal Colleges of Physicians—and the achievement of representation of paediatrics on some of the important higher councils of medicine, seemed to augur well for the Committee's success. Unfortunately this early promise was not maintained. The concept of the Joint Paediatric Committee as an arm of the Royal Colleges of Physicians, progressively exercising paediatrician centred influ-

ence and authority in the name of, and with the support of, the Royal Colleges of Physicians was not allowed to develop. The current role of the committee is largely confined to 'approving' non-controversial BPA business.

The establishment of Faculties brought within the Royal Colleges of Physicians branches of medicine, such as Community Medicine, in which most of participants were not Fellows or Members of the Colleges. This gave these branches of medicine rights and privileges regarding standard setting, self regulation and representation not accorded to paediatrics, for which the Royal Colleges of Physicians carry a higher responsibility because most paediatricians are Fellows or Members of the Colleges.

Despite the somewhat 'peripheral' nature of Royal Colleges of Physician Faculties, however, many BPA members, anxious to preserve unity among physicians and loyal to their Colleges, felt that, given appropriate understanding and support from the Royal Colleges of Physicians, the needs of paediatrics and child health could be met by the creation of a Joint Faculty of Paediatrics of the three Royal Colleges: others felt that evidence from the past indicated the need for more radical solutions and that only a separate College of Paediatricians would suffice.

As a preamble to decision the BPA engaged in discussions with Royal Colleges of Physicians Office Bearers and formulated specific objectives regarding regulatory rights, standard setting, representation and authority which a Faculty of Paediatrics or College of Paediatricians would require to achieve. These objectives were communicated to the Royal Colleges of Physicians. The acceptance by the Royal Colleges of Physicians of a Faculty in principle but only limited acceptance of the BPA objectives, followed unfortunately by some retrenchment by one of the Colleges, did not, in the eyes of many, constitute an adequate response or assurance that the needs of paediatrics and child health as perceived by the BPA would be met. On the negative side, a well publicised Presidential response from one College to an inquiry from the BPA President regarding the actions which that College would take in the event of the establishment of a separate College of Paediatricians also disturbed many BPA members and discouraged confidence in that College's concord.

The outcome of these developments was that in the 1987 referendum the BPA members fully endorsed the need for change but were evenly divided regarding the Faculty or College issue. Six months later, at the Annual General Meeting, there was an almost unanimous vote for a College of

Paediatricians interdependent with the Royal Colleges of Physicians.

To a democratic organisation like the BPA whose decisions and submissions are based on full discussion in its Council and, in respect of major issues, on full consultation with its members, the apparent paucity or absence of such discussions and consultations in the Councils of the Royal Colleges of Physicians and the statutory or special meetings of Fellows was a matter of considerable surprise. That the possible dissociation of a significant body of Fellows and Members, the physicians of children, from Colleges whose charters embraced all physicians, could be contemplated without ensuring that all College Fellows and Members were fully informed of the issues involved and given the opportunity of engaging in full debate and decision taking about these issues was disconcerting, particularly to those paediatricians who had worked hard to retain paediatrics within the Royal Colleges of Physicians. It appeared that as far as the Royal Colleges were concerned the matter was largely being left to resolution in default.

In planning a College of Paediatrics, however, paediatricians still desire continuing functional relationships with the Royal Colleges of Physicians and, conscious of the mutual benefits to both paediatrics and the medicine of adulthood of close collaboration, the BPA is hopeful that its proposal to establish a College of Paediatricians interdependent with the Royal Colleges of Physicians will be met with a favourable and active response.

Balancing achievement against Achieving a Balance

The BPA supported *Achieving a Balance*. Contrary to the misconceptions entertained by some BPA members, *Achieving a Balance* was offered as an integrated package, taking account of certain demands that the profession had made (such as an increase in the number of consultants) which the profession could accept or reject. It was not within the terms of the offer to negotiate major alterations to it and even if that possibility had been included it would have been quite impracticable for different clinical groups to conduct separate negotiations relative to their own specific interests within the context of a scheme dealing with the whole profession. This was not an 'opportunity the BPA missed'. The judgment the BPA had to make was an all or nothing one—whether or not the package was one whose provisions as they stood were of benefit to paediatrics—and it was decided that at least one of the provisions, the 'safety net', was of considerable value as it provided the opportunity of declaring the number of junior staff required. Accepting the

provisions of *Achieving a Balance* the BPA then produced a document which enables paediatricians to define the 'safety net' as it applies to paediatrics.

Achieving a Balance is a bargain that the government has made and is under an obligation to keep. Already there are rumblings that the bargain is not being kept. It is important to balance the achievement of the terms of that bargain against the terms the bargain offered.

Fellowship not sovereignty

The day of the medical suzerain is largely over, certainly in paediatrics. As the character of paediatrics changes and its scope widens paediatricians become increasingly dependent on colleagues in other branches of medicine and in other professions such as social workers, psychologists, health visitors, teachers, therapists, and play ladies.

The paediatrician's role varies according to the nature of the problem in which he (or she) is involved. Often he is the leader, carrying the prime responsibility and deploying the major part of the expertise required for the task in which he is engaged. Sometimes the paediatrician's role is not a primary one. There were formerly many examples in adoption work where, wrongly, a medical veto against adoption resulted in a child being deprived of a much better life and prospective adopters of an opportunity for parenthood they dearly sought.

Differences of view and concept between paediatricians and others where responsibility is equally held usually bear hardest on the parents and children concerned. This was so in the differences between paediatricians and social workers which led to the BPA jointly with the Association of Directors of Social Services producing guidelines on the management of severely handicapped infants. These guidelines have proved helpful in making a balanced approach to this potentially contentious subject. The serious difficulties that are encountered in respect of child sexual abuse emphasise how essential it is to develop an agreed and effective modus operandi between all of the individuals and agencies which have a part to play when a medical/social/legal problem of this complexity presents.

Harmonising with Harman and currying favour with Currie

If the BPA is to fulfill its role as advocate for children and pursue the 'Aim' in its constitution which mandates it to act, 'for the benefit of the public' it has to involve itself with those who represent the public, namely politicians. It cannot involve itself in party politics but the British system

of government means that at any moment in time one party is in power and another in opposition. Opposition, in large measure, concentrates on deficiencies in the ruling party's management of affairs and on proposing policies that are considered better.

Against this background the senior officers of the BPA had a meeting with the Shadow Junior Health Minister, Ms Harriet Harman, at the House of Commons a few months ago. The BPA group was most courteously received and had the opportunity of putting forward BPA views on a range of important subjects and of answering questions. The matters which the BPA raises on such an occasion are naturally those which in its view are not being dealt with by government as the BPA would wish, or new developments or plans which the BPA wishes introduced. Not surprisingly, given this scenario, the opposition, receptive of informed criticism, usually finds itself in harmony with BPA views.

Shortly after the meeting with the Shadow Junior Health Minister the BPA Officer group had another meeting at the House of Commons, this time with the Junior Health Minister, Mrs Edwina Currie. Again the BPA was courteously received and given a generous period of two hours of the minister's time. Governments have to defend their policies and it would not be too far from the truth to say that Mrs Currie believes that attack is the best form of defence. She questioned the BPA on what it was doing about drugs, smoking, and alcoholism in the young, she thought that the BPA had an important part to play in seeking to ensure that children had a proper diet and adequate exercise, she hoped that the BPA would give its full support to the government's immunisation programme, particularly the need to promote the measles, mumps, rubella immunisation programme to be introduced in October. That was the first hour. The second was devoted to the BPA's submissions, the need for full integration of the child health service, the inadequacies in the acute paediatric services including neonatal care, the need for children to be recognised as a comprehensive patient group with an appropriate priority, the impropriety of classing paediatric specialties with adult specialties, and the need for global (including community child health) paediatric budgets.

Both Mrs Currie and Ms Harman were presented with a copy of the BPA's Diamond Jubilee book, *Child Health in a Changing Society*.

All Party 'Pro-Life' Parliamentarians' action discredited

In a human race whose desire for life is almost universal there is something vaguely presumptuous

and self righteous about a self styled group which arrogates to itself the title 'Pro-Life' and by implication categorises those whom it chooses to condemn as 'anti-life'. When a misleading, irresponsible press release entitled 'Inhumane Baby Operations Slammed' was issued by the All Party Parliamentary Pro-Life Group censuring a paediatric research study which had received particular BPA approbation at its Annual Scientific Meeting, BPA members who were dedicated to advancing humane methods of treating handicapped newborn infants and paediatric departments which were in the forefront of the battle to improve the quality of child life the matter was one of grave importance for paediatrics. Lurid headlines such as 'Barbaric! MPs' anger over baby operations' graced the next day's press. The BPA's President and the Chairman of its Ethics Advisory Committee condemned this damaging, ill informed press release and called for a public retraction and apology by those responsible for it.⁵ Over a year later the chairman of the Parliamentary Pro-Life Group issued a public apology in his own name.⁶ While this is to be welcomed the question remains as to why the apology was so long delayed and the factors which finally motivated it. Disconcerting, too, was the absence from the apology of the names of the 13 co-signatory members of parliament who had so publicly associated themselves with the press release.

Paediatric hospital facilities: concentration not fragmentation

In an earlier era when the hospital care of children amounted to little more than competent surrogate mothering and the environment for childbirth compared with that in the home was greatly improved for many if it could be conducted in the cleanliness, orderliness, and relative privacy of a small cottage hospital, small paediatric and obstetric units proliferated throughout the country. Today the highest standards of paediatric care, whether for the infant and child or for the newborn infant, require highly sophisticated, usually expensive, equipment, intensive care facilities, laboratory services, and a wide range of specialty departments, and medical, nursing, and ancillary staff competent to deploy the skills required in such departments.

Essential for an effective service is a proper paediatric 'substrate'. The substrate of a hospital paediatric service (including specialised departments dealing with children) consists of the specialised training of the doctors and nurses who work there, a suitable physical environment, no nursing of children in wards along with adults, staff competent to deal with children in the hospital's ancillary

departments, free visiting, accommodation for parents, play ladies, and a play service. The equipment, intensive care facilities and laboratories which a modern hospital admitting children requires must be such as to meet the specific needs of children—how many infants and children are deprived of proper investigation because laboratories designed for adults demand blood samples of an amount greater than infants and children can supply? Appropriate hospital facilities for children cannot be provided in small paediatric units or in a few isolated beds attached to specialised adult units—the care of children, whose illnesses so often involve multisystem disorders, requires to combine a holistic with a specialised approach.

Misguided campaigns by local pressure groups demanding retention or creation of paediatric units for populations far too small to justify more than a small ineffective collection of children's beds without proper services are fragmenting the hospital services for children when concentration is necessary. All too often, vote catching politicians endorse parochial demands for local services when the true interests of their constituents lies in properly staffed and equipped central units rather than inadequate token units in the constituency. Few parents hesitate in choosing the best standards of care for their children, despite having to travel, when it is explained to them that a small local alternative is unsatisfactory. A reported comment of a senior manager under political pressure to incorporate a small children's unit in a new hospital less than 20 miles from a major children's hospital, that he would make the new children's unit so good that parents would wish their children to go from the major children's hospital to the small peripheral unit, would illustrate either expedient misinformation or an alarming depth of ignorance and misunderstanding.

An important factor contributing to the frequent crisis transfer of newborn infants requiring intensive care and the inability so often to find hospitals with neonatal intensive care facilities which will accept them, is that far too many infants are born in small obstetric units.

Current planning for children's hospital services too often ignores paediatric advice. The BPA has played, and can continue to play, an important part in defining appropriate hospital facilities for children.

References

- ¹ Court D, Jackson ADM. *Paediatrics in the seventies*. Nuffield Provincial Hospitals Trust, Oxford: Oxford University Press, 1972.

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² Scottish Home and health Department. *Towards an integrated child health service*. London: HMSO, 1973.

³ Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976.

⁴ Forfar JO. Children's hospitals, children's departments, and hospital child-health community centres. *Lancet* 1968;ii:674-6.

⁵ Forfar JO, Campbell AGM. Medicine and the media. *Br Med J* 1987;295:659-60.

⁶ Braine B. Medicine and the media. *Br Med J* 1988;297:865.

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