PERSONAL PAPER

Senior house officer posts in community paediatrics— an introduction to child health

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The need for paediatricians and general practitioners to have had experience in community child health during their training is acquiring a high priority. Training posts in community child health have been available in the Northern region since 1979. They are modules on the paediatric senior house officer (SHO) rotation, or open to individual appointment, and are described and their training value discussed.

The *Court Report* recommended that the tripartite health service for children should evolve into an integrated service, with preventive and surveillance aspects of preschool child health being undertaken by primary care teams, and specialist aspects of community child health becoming the responsibility of consultant led teams.¹ The concept of surveillance within primary care is now supported by both the new contract for general practitioners² and the report by Hall.³

This fundamental change has training implications for both primary care and paediatrics and programmes are being designed to meet their needs. Colver *et al* have described a programme for senior registrars in community paediatrics,⁴ and Polnay and More have described a three year general professional training in community child health.⁵

All trainees in paediatrics now are recommended to have some experience within the community. It is arguably more appropriate for those entering general practice to have experience in community than in hospital paediatrics, although a combination of the two is probably the most desirable. In fact at the present time 40% of vocationally trained general practitioners can be offered neither post-graduate hospital nor community paediatric experience.⁶

In the Northern region, full time community child health experience at SHO level, as opposed to comprehensive training,⁵ has been available since 1979. Seven districts have created 10 posts: eight for six months and two for one year. Three of the former and one of the latter have formal acute on call commitments in the local paediatric units. All the posts are funded from community health budgets.

The content of the posts, and hence their eligibility to be included in the scheme, is monitored by the regional education committee for community paediatrics. Supervisors who are specialists in community medicine or child health, senior clinical medical officers, or consultant community paediatricians must be approved by this committee. At the end of their appointment the trainees are asked to complete a questionnaire to ensure that standards of training and supervision are maintained.

Description of the posts

The paediatric experience of the trainees varies widely. Some are SHOs on a paediatric rotation or general practitioner trainees who have had experience in primary care, obstetrics, and on occasions paediatrics, while others are newly registered doctors joining a training scheme. The individual posts are not tied to any particular SHO rotation but those requiring an acute on call commitment attract and are given to doctors with previous experience.

SERVICE EXPERIENCE

The trainees are attached to and supervised by a senior community doctor and share in their service commitment. This includes preschool surveillance and immunisation in the local authority child health clinics and school health in mainstream and, where available, special schools, including assessments under the 1981 Education Act. Other service commitments vary between districts but experience in the care of children with special needs, in the field of abuse, and in liaison with social services are seen as important. Other experience, for example services to hearing and visually impaired children and fostering and adoption, varies with availability. At this level of training there is little if any experience offered in committee work, service development, or personnel management, but the philosophy and practice of good interdisciplinary work is emphasised. Small projects are encouraged particularly in the one year posts and have often proved to be of value to the districts.

ORGANISED TRAINING

The more formal training components of the scheme include a course for one week on child development at the beginning of the appointment, and a weekly afternoon seminar organised by a tutor who provides continuity. All trainees must be allowed to attend these sessions, participation in other courses being at the discretion of their supervisor. The initial course is designed to give a theoretical grounding in the principles and practise of child development and surveillance. The afternoon seminars cover a wide range of topics and give the trainees the opportunity to compare differences in service provision between districts. An important function of the seminars is to provide the trainees with the chance to meet regularly in what could otherwise be an isolated post.

Evaluation of the posts

Between 1979 and 1987, altogether 90 doctors

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passed through the scheme. In order to evaluate the posts questionnaires were sent to as many as could be traced. These asked for information about career intentions at the time of taking up the appointment and at the time of the survey, the relevance of the post to their career, the training value of the post, the adequacy of supervision, the appropriateness of the formal teaching, and whether they had enjoyed their attachment.

Forty seven doctors returned completed questionnaires; 38 had held six month posts, although nine of these stated that they would have preferred a year post. Twenty of the respondents were on a paediatric rotation. Of the 26 prospective hospital paediatricians, 20 had continued in their chosen career, five had moved into community paediatrics, and one had become a general practitioner. One prospective community paediatrician had become a hospital paediatric consultant. Twelve general practitioner trainees had continued in family practice and two doctors had moved into fields unrelated to paediatrics.

On the whole the responding doctors had enjoyed their appointments, valued the training input, and felt that the experience had been beneficial to their subsequent careers. There was, however, a mixed response to the questions about supervision and formal training. Some trainees commented on a lack of supervision and support. From these replies those districts where supervision was a problem were identified and their difficulties addressed. The education committee has also recently developed and recommended a system of counselling, the trainees being seen formally by their supervisors twice in a six month period for a semistructured assessment and discussion.⁷

There seemed to be two possible contributing reasons for this lack of satisfaction. The first is the contrast for trainees between the traditional hospital model of consultant led supervision with readily accessible support, and the relative isolation of doctors working in the community. The second is the inexperience of many community doctors in teaching and supervising junior staff.

The one week introductory course was much appreciated, though response to the afternoon seminars was variable probably because of limited time to cover all important topics.

Trainees appreciated the opportunity to gain experience in developmental paediatrics and to work in depth with children with special needs. Working within a multidisciplinary system and gaining a new perspective about the influence of social and environmental factors on health and illness were also seen as valuable. Being away from acute hospital commitments and having time to read and reflect were noted to be extremely educational and liberating.

On the negative side it was felt that there was insufficient opportunity to participate in the long term management of children with special needs and those suffering child abuse and neglect. Trainees also felt the need for more structured training in epidemiology and would have liked to carry out a research project. These criticisms are acknowledged but are difficult to address within a six month appointment. Some trainees perceived a failure of the system to tackle behaviour problems

and the lack of integration and liaison of the community service with the hospital service and primary care.

THE RESPONSE OF THE SUPERVISORS

Supervisors were questioned about the impact of a trainee on the district service. On the whole the response was favourable, the presence of the trainees being thought to be stimulating. The usefulness of the SHO in service was small in the early months, however, and short lived in the six month appointments. Continuity, particularly in school health, is often vital and so the contribution of the SHOs to that service was thought to be limited.

The one year posts were much more valuable to the community service, but the education committee are anxious to maintain the six month appointments to ensure availability of community experience to the maximum number of trainees. It is also of note that normally only six months of community paediatrics is recognised as contributing towards general professional training.

Conclusion

Experience in community paediatrics is considered to be of value in the training of paediatricians and family practitioners. A system of providing this experience has been used in the Northern region over the past 10 years, utilising the existing community child health services. It cannot be and does not claim to be a comprehensive training programme. It does allow the development of basic skills in community child health, however, and gives insight into children in their normal environment and also into the paediatric services in the community.

The pattern of training is evolving. As consultant led community child health takes on more of a secondary care roll, these appointments are beginning to include some sessions with primary care teams carrying out preschool prevention and surveillance. However, we anticipate that they will continue to provide useful and valid training experience for both general practitioners and paediatricians.

We acknowledge with gratitude the role of many senior community doctors who have been supervisors and at some inconvenience have welcomed a series of SHOs into their team. These include: Dr A Carruthers, Dr AF Colver, Dr MJ Danskin, Dr P Halse, Dr KM Kirby, Dr RJ Menzies, Dr R Mitchell, Dr FS Rogers, and Dr A Waterston.

Sadly Professor JM Parkin died on 11 February 1990.

- 1 Committee on Child Health Services. *Fit for the future*. London: HMSO, 1976. (Cmd 6684) (Court report.)
- 2 Department of Health and the Welsh Office. *General practice in the National Health Service. A new contract*. London: Department of Health and the Welsh Office, 1989.
- 3 Hall DMB, ed. *Health for all children: a programme for child health surveillance*. Report of the Joint Working Party on Child Health Surveillance. Oxford, Oxford University Press, 1989.
- 4 Colver AF, Danskin MJ, Parkin JM, Rogers FS, Walker JH. Training programme for senior registrars in community paediatrics. *Arch Dis Child* 1988;63:63-5.
- 5 Polnay L, More EJ. General professional training in community child health. *Arch Dis Child* 1986;61:917-20.
- 6 Styles W McN. Analysis of the hospital experience completed by general practitioner trainees during 1984-87. *J R Coll Gen Pract* 1989;39:320.
- 7 Ward Platt MP, Parkin JM. Performance appraisal and career counselling for senior house officers. *Arch Dis Child* 1990; 65:796-801.