PERSONAL PAPER

Paediatric care in general practice

Stuart Carne

I qualified in 1950 and, before I did my national service in the Royal Air Force, I was fortunate enough to get an additional year's experience as a rotating house officer at the Queen Elizabeth Hospital for Children in Hackney.

I was appointed medical officer to the RAF Medical Training Establishment where newly commissioned medical officers (like me, mainly national service) were taught how to be RAF officers and new airmen recruits were taught to be nursing orderlies. My main task was to take the early morning sick parade: 7.30 am on ordinary mornings; 6.30 am when the commanding officer had his parade.

Once a week I had to examine each new batch of recruits. They had all been examined at least twice previously: once before they were called up and then again when they arrived at the initial training centre at Padgate. Nevertheless, a few of them had quite severe disabilities—mainly orthopaedic or cardiac—and were clearly unfit for service duties.

As they were going to work as nursing orderlies, I also had to give them all a Mantoux test. Most were positive, to varying degrees. (The most violent reaction was in the son of a thoracic surgeon who, it transpired, had watched his father at work on many occasions.) Having already done two hospital ear, nose, and throat appointments (one adult, one paediatric) I had seen a lot of tonsillectomies—and even tried my hand at it, not very successfully! Cervical adenitis, much of it tuberculous, was not uncommon in those days and so, too, was tuberculous mesenteric adenitis. I wondered whether the Mantoux reaction was in any way related to a previous tonsillectomy or appendicectomy. A pilot study revealed no obvious connection but there did seem to be a connection between the frequency of these operations and the recruit's social class—though not between social class and the Mantoux reaction. Both operations were performed more frequently in recruits who came from a higher social background.

I therefore rewrote my protocol and decided to look at the incidence of tonsillectomy and appendicectomy. For good measure I added circumcision to my data. (As there was no national service for women, there were very few female nursing orderly recruits.) The RAF were extremely cooperative and provided me with statistical assistance. My hypothesis was confirmed and the editor of the *British Medical Journal* saw fit to publish my paper,¹ though he 'invited' me to change the title from 'Three popular opera-

tions' to 'The incidence of tonsillectomy, circumcision and appendicectomy among RAF recruits'.

My time in the RAF coincided with the evacuation by the British forces from the Suez Canal Zone. The wives and children were sent on ahead. Those without their own homes in the UK were housed in a camp outside Blackpool or lodged during the winter in boarding houses in the town. In addition to my duties as medical officer at the Medical Training Establishment, I was posted as medical officer to these families, presumably because of my paediatric interest and experience.

My experience with these families taught me a lot: dare I say, more than most of my previous hospital experience. The mothers were constantly seeking medical help for their problems, yet pathology as I had been taught it was scant. More often than not it was a child who was brought to me, not the mother; and very often the child or a sibling was brought back at fairly frequent intervals.

At first I thought that my clinical skills had failed me, probably because I was usually dealing only with the presenting symptom—which is what we tended to do in those days in primary care. I therefore arranged to see the more persistent attenders at special sessions in order to give myself time to carry out a proper hospital type assessment. Instead of taking a superficial history of the more physical aspects of the problem, I probed extensively into the family history and its social aspects. I discovered two things: the presenting medical problem of the child was rarely the mother's major worry; and secondly, at the end of a consultation, many mothers thanked me 'for listening'. Later I read Michael Balint's seminal textbook: *The Doctor, His Patient and The Illness* and, for the first time, found in print an answer to the conundrum that we call general practice.²

My first proper job in general practice was in All Saints Road in North Kensington where I spent three years as an assistant. In 1957 I got an Executive Council vacancy in Shepherds Bush—about a mile south of the Royal Postgraduate Medical School at Hammersmith Hospital and half a mile east of Queen Charlotte's Hospital. The previous general practitioner (GP) in the practice was age 75+ and terminally ill. His wife—an ex-nurse—had been running the practice for the previous year or so! Records were scanty as were the equipment and facilities for clinical examination. Now that I had my

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own practice, I could organise it in the way I believed best to improve the quality of care. I had shelves put in a corridor to store records and purchased an examination couch. I also bought a typewriter and my wife became my (unpaid) secretary/receptionist. All hospital letters were typed so that they were at least legible. By keeping a copy of all my letters, I was able to compare the outcome with my thoughts when I referred the patient: a sort of audit.

For the first five years in Shepherds Bush I lived above the surgery. I introduced a well baby clinic, which was held once a week on Wednesday mornings. I announced the fact on the plate in my front garden. The local BMA secretary wrote me a stern warning about advertising and I had to remove the notice of my clinic!

I met the local London County Council divisional medical officer and she offered to send one of her health visitors to my weekly baby clinic. So began a 16 year relationship with the same health visitor. The time she spent in my practice steadily increased till she became full time. Indeed, as the practice expanded we found it necessary to have two health visitors attached full time. The practice itself has grown from the original list of 1400 which I took over in 1957 to 14 000 patients with seven GP partners, four of whom had been trainees in the practice. In 1967 we moved into the Grove Health Centre, which was only the second purpose built health centre in London. We are now in the process of planning a new building, about three times the size of the present one. Such is progress: though I believe that small can also be beautiful.

In the early years of undergraduate training in general practice, almost half the St Mary's Hospital Medical School students came to the Grove Health Centre. Among that group were two who are now consultants at Hammersmith Hospital: one is a neonatologist, the other a geriatrician (which must, surely, say something for the generality of general practice!).

For many years I was a GP trainer. Later I became the first course organiser at the Royal Postgraduate Medical School, with the title of 'Senior tutor in general practice'. (The only privilege which went with that appointment was parking rights in the front of the hospital!) The post of course organiser is now filled by one of my partners who, himself, had been the first GP trainee at Hammersmith Hospital. In fact, the practice now has such a heavy teaching commitment elsewhere, and space is so limited in the health centre, we can no longer have a trainee in the practice and have to look outside for the stimulus that postgraduate students bring to medical practice.

I have a special interest in paediatrics, whether it is dealing with the children when they are sick or dealing with children when they are well, such as at a child health clinic (which I still prefer to call a well baby clinic). Indeed, as I frequently tell the mothers (and now, also, the fathers): 'How can I look after your child properly when he is sick if I do not know what he is like when he is well?'

Until my presidential duties restricted my

time, I ran the well baby clinic in the practice. We have three sessions a week devoted specifically to children under 5 years. The first is for routine child health surveillance and is run jointly by one or two of the GPs together with the health visitors. The second session is organised by the health visitors. Parents always have direct access to the health visitors whenever they are there (that is, office hours). Because we are in the same building, referral from doctor to health visitors—and vice versa—is uncomplicated.

Immunisations are done at a separate session. I am often asked why immunisations are not given at the child health surveillance or health visitors' sessions. Would it not save mothers' (and doctors') time? My answer is that health surveillance clinics should be conducted in a happy relaxed atmosphere. Mothers are coming to be reassured that their baby is normal and that they are doing a good job as mothers. (True disabilities are rare—as opposed to the number of *normal* children referred from clinics to a specialist, which reflects not a need for treatment of the baby but better education of the clinician conducting the clinic.) Immunisation sessions are often traumatic. Waiting mothers are anxious: 'Is it going to hurt my baby?'; and the baby, seeing other infants leaving the room crying, is also likely to be upset.

Nevertheless, if a baby attending a surveillance clinic is overdue an immunisation, we will offer it on the spot but—probably because of close health visitor and GP collaboration—attendance rates for immunisation are, by inner city standards, good.

Though I have a special interest in child health, I do not see all, or even the majority of sick children in the practice. I am not a GP paediatrician who—when we think about it—is neither GP nor paediatrician. Occasionally I am asked by a partner to comment on a child health problem but I am as likely to be asked my views on clinical problems not related to children. If and when we want another opinion, it is from a specialist that we want it (which is why we will sometimes complain that a child referred for a consultant opinion in outpatients is seen by a registrar or even a senior house officer).

Expertise is a combination of knowledge and experience. Knowledge we can all acquire, either by reading the literature or attending (didactic) lectures. We have to wait for experience to be available. In Britain there are, roughly speaking, 100 GPs for every paediatrician. A British paediatrician is therefore 100 times more likely to have had to deal with a rare problem than a GP. Similarly, for every paediatric specialist in the UK there are—proportionate to the population—almost 50 paediatricians in the United States, most of them delivering primary care paediatrics.

The British specialist paediatrician can thus justify his claim to expertise because far more of his time is devoted to the less common problems. Either we dilute his experience or we retain the present division between GP and specialist.

It is no loss of status in the eyes of my patients for me as a GP to seek a second opinion. Were I

called a paediatrician, I would have to explain why I need another paediatrician to advise me. A GP referring a patient to a specialist is no different from one specialist referring to another specialist.

Thus I believe that the British system of having a generalist deliver primary care and leaving specialists to concentrate on secondary (and tertiary) care has much to commend it.

There are a number of diseases I almost certainly see more often than my hospital based colleagues—for example, upper respiratory tract infections and all the associated complications such as otitis media and tonsillectomy. (Yes, I do mean the complication of tonsillectomy, not the indications for that operation, which I believe to be very rare.)

The ritual sacrifice of parts of Waldeyer's ring has remained a special interest ever since my RAF study. What are the criteria for saying that surgery is necessary? There are very few absolute indications, now that tuberculosis of this part of the respiratory tract has virtually disappeared; malignant disease is equally as rare and quinsy in children is also uncommon. (Perhaps GPs were right, after all, to prescribe penicillin for 'ordinary' sore throats!) Probably the most frequent indication is recurrent tonsillitis but, in my experience, recurrent true tonsillitis is also not a common problem. What is seen frequently can best be described in the following scenario: the child has a cold, the nose is blocked, and the child mouth breathes. Mouth breathing causes a sore throat, which may then become the symptom presented to the doctor. If the doctor fails to appreciate what is happening, he may fall into the trap of making the diagnosis of 'tonsillitis'. Subsequently, every recurrence of nasal catarrh is honoured with the same diagnostic label. Sooner or later—often depending on the frequency of visits from relatives or comments from 'helpful' friends—somebody is going to 'want something to be done'. If the story were correct, what else can be done for recurrent tonsillitis other than remove the tonsils? Indeed, I would agree with that approach—if the story were correct. But does the child have recurrent tonsillitis? or is he just one of the many children known in inner city areas as 'snotty nosed little brats'. Mouth breathing is not an indication for tonsillectomy; nor does adenoidectomy help in most cases, especially if—as is now so often the case—there is an underlying allergic rhinitis.

If we look at the bridge of the nose of these children, we will see that it is still flat. In fact, it does not start to acquire the adult shape (and an airway inside which is adequate enough to let the child blow his nose) until the child is 7–9 years old; which, by some coincidence, is the age when tonsillectomy seems to be less necessary.

Eczema, dermatitis, and seborrhoea—call them what you will, the terms are often interchangeable^{3 4}—are also a common problem. What interests me is the effect of the attitude of the patient (and/or the parents) on the skin eruption. To some, one spot on the face which almost requires a magnifying glass to be seen, becomes 'this disfiguring rash'; while,

to others, limbs or trunk covered with a seborrhoeic eruption are accepted as part of life. Also relevant may be the attitude of the doctor. The authoritarian physician who would expunge all pathology off the skin is likely to prescribe medication that is both more potent and more expensive, though this does not necessarily lead to an improved dermis.

Young children who have frequent spells of coughing, especially at night, are seen frequently both in hospital and general practice. Inquiries of other mothers reveal that there are even more children who cough frequently and are not brought to the doctor. Often asthma lies at the root cause but, in infants, treatment of the bronchospasm is not very satisfactory in eliminating the troublesome cough. I always ask the mother how much the child's night time cough worries *her* and how much it disturbs the baby.

Not infrequently the child is also feverish. We know that antibiotics are frequently prescribed by GPs for these feverish coughs: and, regrettably, even in the absence of a fever. How wrong is this approach? It would be easy to condemn it, yet I have to say that I know few of my colleagues in general practice who—faced by a coughing child with a persistent temperature of 38°C or higher—would not prescribe an antibiotic. I know that my hospital colleagues do not take this view but, equally, I have to say that quite often the only justification for the diagnosis of a lower respiratory tract infection on a discharge summary is the prescription of an antibiotic in hospital.

What do I myself do? In a coughing child who is well—feverish or not—and in whom significant signs relevant to the lower respiratory tract are absent, I temporise. If the fever persists I may write out a prescription for an antibiotic, instructing the mother not to 'cash' it until the next day, by which time the child is usually much better. I find this technique particularly useful when mothers bring their child the day before they are going away on holiday. Most of these postdated antibiotic prescriptions are not taken to a pharmacist.

Some families believe that antibiotics are a 'cure all' and expect a prescription every time their children are feverish and also for every exacerbation of nasal catarrh, with or without a fever. In feverish infants in whom I can find no significant physical signs, a ploy I sometimes use is to say: 'Let us see if this is the start of roseola?'. By the third day the child is invariably better or, occasionally, the rash will have appeared. Either way I can justify to the family my not having prescribed an antibiotic.

One of the problems of inner city practice is the close proximity of teaching hospitals and the magnet effect of a walk-in clinic staffed by 'paediatricians', the average experience of some of whom is only three months (that is, half their six month appointment as a senior house officer). That many of these young doctors will, in a year or two, themselves be GPs, seems not to be acknowledged by those who organise the service.

Nor am I enamoured with case conferences, especially those which start: 'I am Mary Jones:

I am deputising for Mollie Smith, the district nurse who cannot be here today'. 'I am Dr Bloggs: I am standing in for Dr Snooks, the paediatrician who is away at a conference this week'. Nor do I regard it as reasonable to expect a GP to attend a case conference at what is, for him, a particularly busy time in the practice, such as 10 am on a Monday morning.

Furthermore, I cannot automatically be bound by conference decisions. As a GP I have to make up my own mind. I am personally responsible, both within the NHS and in law, for all my actions. It is no defence for me to say: 'I acted on the advice of X, a specialist in that field'. (I was recently at a Department of Health meeting when a consultant paediatrician was surprised to learn that GPs do not have to comply with hospital recommended prescriptions unless they themselves are in agreement with the decision. The choice of medication is that of the paediatrician or the GP who actually writes the prescription: neither can order the other what to do.)

'Emergency' housecalls to children loom large in the traditions of general practice; many of my hospital colleagues always assume this to be a major part of my work. Parents do worry about their children, some more than others, and especially with their first child. The problem for many is aggravated by the absence not only of a nuclear family but also of an extended family. I suspect—though I cannot prove it—that close collaboration in my practice with the health visitors adds to the feeling of protection we can offer these mothers. I long ago realised that if good quality care is available 'in hours', the number of 'out of hours' calls falls considerably.⁵

We run an appointment system which is valued as much by working class mothers as it is by the 'yuppies' who now live in Shepherds Bush. It is resented by an equal proportion in both groups. But we also accept 'walk-in' consultations—without (I hope) the patient having to justify the request with a receptionist.

Occasionally there are unnecessary requests for emergency house calls. A common variety belongs to the 'dad's home from the pub syndrome'. Father comes home late for his supper, rather more inebriated than is good for him. 'Where is my meal?' he demands. 'There isn't any meal'. 'Why isn't there a meal?' he asks his wife, now herself becoming a bit defensive. 'Because the kid's been ill all day'. At this point husband and wife (or wife and 'partner') recognise an opportunity for reconciliation. 'Let's call the doctor'. On my arrival at the home, the healthiest person I see is often the child; but this is not the occasion for berating the parents for calling me out unnecessarily.

Having examined the child I say: 'Fortunately baby is not very ill. If you are still worried about him in the morning, why not bring him round to the surgery?' What I certainly do not do is offer them a sachet of an antibiotic or Calpol, for that action would convince them that medication was necessary and therefore they were right to have called me. (I always remember the teaching of the great Carlisle Potter on the subject of fractious babies: 'a large dose of

sedative is the best remedy' he would say; 'no, not for the baby but for the mother!').

In my first weeks in general practice, I saw one child with tuberculous meningitis and another with pyloric stenosis. Since then I have seen only one other baby with pyloric stenosis: and that was about 25 years ago. I have not seen another case of tuberculous meningitis. I have seen three cases of meningitis and—by the grace of God—I diagnosed all three. In one, I recognised the high pitched cry—and had an argument over the phone with 'the duty paediatrician' about its significance. I hope that if, and when, I see my first child with epiglottitis I will remember not to try and examine the throat with a tongue depressor.

Appendicitis *seems* to be getting much rarer. I have not seen a case for over two years, though one of my younger partners sent a child to hospital with that diagnosis a few weeks ago.

We have always to remember that, in the NHS, if a GP does miss a diagnosis, sooner or later the hospital discharge summary—however the child got to hospital—will bring the error to light.

Acute attacks of asthma are distressing to the doctor as well as to the patient and the parents; they can also be life threatening. I am not in favour of the current vogue for nebulisers, which seem to me to be underused by some and abused by others. I believe that if nebulisation is necessary, a course of oral steroids is almost always also needed. The various 'spacer' devices which can be attached to an ordinary inhaler are, anyway, almost as effective as a nebuliser—and far less dramatic. My own preference (going back to my days at Queen Elizabeth Hospital almost 40 years ago) remains a short, sharp course of *oral* prednisolone, followed a few days later (when the child and the family are more relaxed) by better education on how they should manage the disease with ordinary inhalers. In most cases I find it quite safe to leave the family with a small supply of prednisolone for use in a future emergency. In my practice we do not issue repeat prescriptions without seeing the patients each time. We then issue enough medication to last until the next time it is *clinically* necessary to see the patient. Therefore it is easy to monitor the frequency and the quantity of steroids consumed and, hence, to recognise when to introduce inhaled steroids on a regular prophylactic basis.

From a general practice point of view diabetes in children is rare. The majority of us will have, at most, only one diabetic child on our list during the whole of our 30–35 years as a GP, and many will never have that responsibility. However, for 15 years I had the privilege of being medical officer to Palingswick House hostel for diabetic children, which was situated less than a mile from my surgery. At any one time there were 40–50 children with diabetes resident at the hostel, including some of the most difficult cases from all over the country. Before coming to Palingswick House, most of them had been absent from school for frequent and prolonged periods and in and out of hospitals. In most of the children the main problem was emotional: they and/or their family had not yet

come to terms with the illness.⁶ Without realising it was offering the service, what Palingswick House did was provide group therapy. The children supported each other. All of those who had not yet learned how to do it, including those of preschool age, were taught to administer their own insulin injections (but a nurse always checked the quantity loaded into the syringe). We taught them how to manage their own diabetes. In particular, we taught them how to reduce the frequency of 'hypo' attacks by understanding what was likely to bring one on and what preventive action to take. We relied on oral glucose or, in the early stages of an attack, any carbohydrate. It was rarely necessary to use glucagon; it was used less than five times in all the 15 years I was there. We never used intravenous glucose. Palingswick House closed for financial reasons. I hope its lessons have not been completely forgotten.

Urinary tract infections in children are also rarely seen in general practice. (Before my critics berate me for my ignorance of this problem and failure to diagnose it correctly, let me again remind them that the average paediatric unit in Britain covers the practice areas of about one hundred GPs. For the *average* GP to see one case a year, the hospital would have to see two a week.) I cannot recollect ever having seen a prepubertal child with a urinary tract infection present with the classical symptoms of frequency and/or dysuria. Dysuria in young girls—when it does present—is usually associated with a vaginitis, often accompanied by oxyuriasis infestation. In boys the most frequent cause of dysuria is balanitis.

Secondary enuresis always arouses my suspicion of a possible infection; but in *primary* enuresis investigation of the urine is usually a waste of time. I cannot estimate how much money I have wasted in confirming the normality of the urine in children who have never been dry at night. My preference for the treatment of primary enuresis remains imipramine: why I cannot explain, but in my patients it usually works!

Diarrhoea—in patients of all ages—is a very common presenting symptom in general practice. There are significant differences in the management, both in the diagnosis and treatment, of acute and chronic diarrhoea. Chronic diarrhoea is not seen frequently in children. It is the acute, and generally short lived, variety which causes the most problems. The 'illness' could be dismissed as little more than a nuisance were it not for the risk of dehydration, especially in infants. Much literature has appeared on the subject, all too often by hospital doctors who are critical of the management by general practitioners.⁶ It is therefore worthy of comment by someone from general practice.

The diagnosis of diarrhoea should be obvious but, in fact, much of what is presented to the primary care physician as 'diarrhoea' in infants, as much as in older children, is only a minor and temporary upset of gastrointestinal motility. Assessment of the consistency of the stool is as important as an assessment of the frequency and, certainly in the early stages, more important than an examination in a pathology labora-

tory for infectious contaminating organisms (the result of which tests, anyway, will not be available in most cases until after the child has recovered).

In some cases, diarrhoea is attributed to a systemic infection, in particular of the respiratory tract (23% in the series of Conway *et al*⁷). Otitis media (generally classified with respiratory tract infections) is one of the most frequently blamed systemic infections for the cause of diarrhoea. The treatment is often an antibiotic. (Views differ as to the appropriateness of this treatment. Nevertheless, there are many doctors both in general and hospital practice who regard an antibiotic as the first line treatment of otitis media.) Conway *et al* showed that 7% in their series of children admitted to hospital with a diagnosis of gastroenteritis had been given an antibiotic before getting to hospital.⁷ However, the authors do not indicate how many of these children were being treated for an associated systemic infection.

By now it should be universally recognised that fluid replacement, plus electrolytes where there is any risk of a salt imbalance, is the mainstay of treatment. Nevertheless, there is still a difference of opinion as to whether ordinary milk feeds—in particular breast milk—should be continued. Indeed, Conway *et al* were giving bottled milk to some of the infants in their series.⁷ My own practice is to continue milk feeds in mild cases, but usually weakening the strength of bottled feeds. In those cases where the *consistency* of the stool is unaltered, I do not usually recommend any alteration in the feed.

Most children with diarrhoea—and that includes infants—are being treated, and being treated successfully, by GPs outside hospital. I believe that this should continue: if anything the proportion being treated by GPs should be increased. It is equally my view, however, that all infants with a gut upset require careful and fairly close follow up. How frequently they need to be seen, by whom (GP, health visitor, or nurse) and whether telephone contact is adequate will depend on the circumstances of the case and the individual family. If there are to be district policies on this (and other clinical problems that are dealt with mainly in general practice) the policies can only be effective if they are written by GPs, albeit with comments from their hospital colleagues.

Emotional problems are seen very frequently. Indeed it is an axiom in general practice that every problem we see has a clinical, a psychological, and a social component; the proportion of each varies from case to case, with the clinical element being the most significant in some, the social or the psychological in others. Major psychopathology is relatively uncommon. Most of the disorders seen in children are intrafamilial and therefore it is not unreasonable to expect that the *family* doctor should be able to deal with a large proportion of these.

Most families are well known to their general practitioners. A family of four will, on average, consult 16 times every year—and even more frequently if the mother is pregnant and/or there are infants in the family. The home circumstances are also usually known to the doctor from

his house calls.⁸ Stress can, therefore, often be detected in more subtle ways than it might be in a family seen for the first time.

Not infrequently, an acute emotional breakdown in the family will be presented as an apparently *medical* illness in one of the children. I have described elsewhere puerperal depression in the mother presenting as vomiting in the baby,⁹ to which clinical picture I later gave the name of the 'Azazel syndrome' after the biblical story of the scapegoat who was sent into the wilderness of Azazel.¹⁰ Equally, we always have to remember that, because there is emotional illness in a family, it does not mean that we can exclude a physical cause for the current presenting problem.

The care of children is a fundamental component of general practice. It is virtually impossible to do proper general practice—family medicine—without being involved in the treatment of sick children. It logically follows that if properly trained GPs are able to look after children when they are ill, they are also able to examine children when they are well. I therefore anticipate that the additional knowledge required for child health surveillance will be accepted as part of the core content of good general practice.

I have left to the last the issues that surround referral of children to hospital. Regrettably this is, all too often—especially in an inner city area—the only interface between GP and specialist.

The reasons why patients are referred for a specialist opinion are complex.¹¹ It is often assumed that the GP is passing a problem he cannot manage to a more senior member of the medical hierarchy, but that view is incorrect. Very often the specialist is being asked for his support in the management of a chronic condition for which there is no cure, such as catarrh or eczema. It is also to reassure the family that there is no need for active medical or surgical treatment, for example, most children with recurrent abdominal pain. If referral is to become rational and, hence, more cost effective it will be necessary for all three partners in the process—GP, specialist, and patient (or parents)—to understand the process more fully and its nuances.

We need to understand the difference between a 'consultation' and a 'referral'. A 'referral' is the handing over of the management of that illness by the GP to a specialist and his hospital based team. A 'consultation' implies the seeking of an opinion from a specialist with the intent that the ongoing management of the problem will be left in the hands of the GP. (The word 'consultation' is also used to describe what happens when a patient seeks the opinion of a doctor, whether it is GP or specialist.)

A 'second opinion' is, strictly speaking, not synonymous with either referral or consultation with a specialist. It was originally used to indicate the obtaining of another (and possibly different) opinion from a second specialist in the same field. If the term 'second opinion' is to be used to denote an ordinary referral or consultation, then it is important to remember that it is not possible to have a second opinion without having a 'first opinion', which should be provided by the general practitioner.

Early in my career I realised that, if I wanted to help sick children, I needed to know a lot more about their families. Furthermore, this was a field in which—to use the American expression—I felt comfortable. So I chose general practice, and I have never regretted it.

I would like to thank Professor Denis Pereira Gray and Dr Colin Wayne for their helpful comments.

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