An open letter to Doctors Mather and Bannon

T L Chambers

Nil desperandum

Cheer up! You are not alone in your concern for our specialty: the fall in recruitment to family practice residencies in the USA is sufficient for it to be overtaken by paediatrics and the declining attraction of internal medicine to US medical students was lamented by two American physicians who quoted a Texan saying “when the horse dies, get off”. Is (community) paediatrics dying or dead? If so, is it for resuscitation or the knacker?

What is paediatrics in the UK? It is the specialist medical care of children and young people. The unique responsibility of doctors is in diagnosis and treatment of patients—in our case those of a particular age. We might therefore ask ourselves if there is any sign of the public not wanting our skills? Far from it: an increasingly sophisticated and consumerist society is likely to have a lower threshold for having its children seen by a specialist if colleagues in primary care are not able to deal with their concerns adequately. General practitioners bring the holistic skills of family centred practice to the child and carers, but a physician who has had paediatric training and experience may be needed to shift the focus to the child, especially when assessing symptoms. Furthermore the approach to the sick child has changed: I recently saw a retired GP colleague’s grandchild who was referred to our acute assessment unit. She was amazed: “thirty years ago I would have given an injection of Ampiclox at home and nine times out of ten the child would get better”. True, but not so good for the 10th and whose family’s reaction to a delayed or incorrect diagnosis is now likely to be less accepting—and forgiving. No wonder our city centre children’s hospitals act as acute primary care providers of paediatric emergency medicine.

The same goes for out-of-hospital children’s medicine: parents want their children managed by trained specialists, particularly for chronic conditions. That specialist may be a member of a team but may not give treatment themselves: the problem may be of growth, development, disease, or disability, but

whether it is structurally or physiologically determined (or not) the expert medical contribution to care is pivotal. Not least is the importance of a sceptical mind, prepared to review givens in diagnosis or therapy and sufficiently open to spot complications or new disorders. There seems to be no indication that public demand for paediatric services is lessening and UK paediatricians should be proud of their clinical achievements. However, trust has to be earned, not assumed, and paediatricians would delude themselves if they thought the public’s confidence in them was unqualified. Recent difficulties in, for example, child protection, and factitious and functional illnesses should remind us that humility and authoritativeness are not antithetical—but respect and authoritarianism are.

Why then the angst? Recruitment into most branches of our highly successful specialty seems well maintained; the trainees I work with are no less bright or committed and in no smaller numbers than before. The evolution to a specialist provided service is challenging but being achieved, and contractual and employment legislation will mean that future paediatricians should have a broader and more rested outlook than their single handed predecessors. However the organisation, funding, and management of this country’s health services evolve I do not anticipate parents wanting less than the best healthcare for their children: they have a vote even if the children do not. (Incidentally, I meet more parents concerned about the quality of educational provision than their children’s health services.) The unattractiveness of community paediatrics appears to involve isolation, poor resources, large workload, a lack of self-esteem bordering on paranoia—and child protection. Why is this? I can identify at least two reasons.

The first is the false division of the general medicine of children and young people into hospital and community paediatrics. It is a whole. The days of a single paediatrician being simultaneously on call for unselected emergencies, responsible for sick neonates, and

toiling through an overbooked cerebral palsy clinic 30 miles away are gone. Access to, and possession of “beds” by paediatricians is becoming less of a preoccupation. With larger numbers of doctors and the formation of attending systems for acute in-patients and newborn care in smaller numbers of hospitals, there should be little difficulty in evolving departments of general paediatrics. These would be centrally organised, audited, and educated (to get over the isolation), but locally delivered by a multidisciplinary team whose clinical interests will mature during their careers. It would include commoner chronic conditions such as epilepsy and diabetes, which can have such profound implications for school and home life, as well as disability, behaviour, and other problems. The focus of general paediatric training will widen to include the work now done by community paediatricians as well as the traditional hospital/acute duties. An academic backbone will develop, enabling clinical research to profit from the rich pickings of the basic paediatric sciences.

The second unattractive prospect is overreach. Community paediatricians appear to be at the beck and call of everyone and to have named responsibilities put upon them with little power to discharge them. This must change. The consultant contract and explicit commissioning contracts from local authorities should mean that paediatricians be expected to do the doctor’s job of diagnosis and management—and little more. Whether from a primary or provider NHS Trust, forthright clinical management will be needed to ensure a rounded, realistic, and resourced portfolio of work is negotiated for a department of general paediatrics. The current management, provision, and delivery of community paediatrics will seem as archaic and anarchic as does the memory (to some of us) of single handed hospital paediatric practice. Overreach? Just say “no”.

And child protection? All of us has a civic duty to report suspicions of crime and to provide factual accounts of incidents. No doctor is exempt. The gathering of expert medical evidence, especially forensic, preparation of reports, and attendance at court is vital and time consuming. Some paediatricians may wish to specialise, perhaps obtaining postgraduate qualifications (although, regrettably, a paediatric forensic qualification does not exist) which could be open to non-paediatricians. The importance is to be able to do forensic work in the context of the child and its family and their experiences. The non-forensic paediatrician can then deal

with the medical needs of the child and carers without the barrier of due processes. The late Dr Leonard Arthur and colleagues in Derby pioneered such an arrangement 30 years ago. The rest is a matter for local authority social services and the criminal justice system.

I am aware of the deplorable state of child public health statistics (some of which have not improved during the century of community paediatrics, in sharp contrast to the spectacular successes of individual child ill health statistics: take the survival from acute leukaemia as an example). But is this a responsibility for clinical paediatrics? Should not these and other population

burdens that community paediatricians have assumed or had thrust upon them be returned where they belong: primary care, public health services, politicians (local and national)—and the Treasury.

I conclude that paediatrics, in or out of the community, is not dying: it may need more an apothecary's restorative than resuscitation. Nearly 20 years ago a thoughtful Bristol psychiatrist wrote a paper¹ entitled "What should psychiatrists be doing in the 1990s?", speculating how colleagues might adapt to change: running down of mental hospitals and the psychiatrist's place in the developing community based multi-disciplinary mental health teams. He

concluded "Keep up with your general medicine and be more open about yourselves". Not a bad prescription for paediatricians either, nor for the specialty I love still.

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IMAGES IN PAEDIATRICS

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Intra-cardiac Burkitt's lymphoma

A 9 year old boy presented to our paediatric emergency department with a three week history of breathlessness, generalised body swelling, and an abdominal mass (fig 1). On examination he had signs consistent with right heart failure and a smooth, non-tender epigastric mass separate from his liver. Ultrasound examination of the abdomen suggested this mass to be nodal Burkitt's lymphoma, which was later confirmed by histology. Echocardiography revealed a 3.94 cm diameter mobile solitary intra-cavitary homogeneous mass, which appeared to be arising from the postero-medial wall of the right atrium, and prolapsing in and out of the right ventricle in addition to a global moderately sized pericardial effusion (fig 2). The mass impaired right ventricular diastolic filling and right ventricular outflow tract ejection.

Clinical improvement was rapid and dramatic following chemotherapy for Burkitt's lymphoma (fig 3). Repeat echocardiography four weeks after initial presentation showed the intra-cardiac mass had become much smaller and was no longer impairing right ventricular haemodynamics (fig 4). Our patient had been referred to us as a case of congestive cardiac failure, which is common in sub-Saharan Africa and often secondary to rheumatic heart disease, where symptomatic control with diuretic therapy is the mainstay of treatment. Diuretic therapy in our patient could have worsened his symptoms and caused a delay to diagnosis. Although a rarity outside Africa, Burkitt's lymphoma is the most common childhood malignancy in sub-Saharan Africa. Early recognition of its varied presentation is essential if

Figure 1

Figure 2 FRV, free right ventricular border; PE, pericardial effusion; RAM, right atrial mass; LV, left ventricle.

Figure 3

Figure 4

avoidable morbidity and mortality is to be prevented.

Consent was obtained for publication of figures 1 and 3.

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