

The community paediatrician in an integrated child health service

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In a previous paper we set down our general view about the integration of child health services (Bamford and Davis, 1973). Their future is now being considered by a Departmental Committee under the chairmanship of Professor S. D. M. Court; however, it will be impossible for the committee to report for some time. In the interim it has been necessary for the responsibility for Local Authority Child Health Services to be transferred to the new Area Health Authorities and Community Physicians with responsibility for child health have been appointed. We presume that nothing will be done that will interfere with the implementation of any recommendations made by Professor Court's committee and consequently the final form of the service remains uncertain.

It is important that the role and status of 'Community Paediatricians' should be defined and that future training for this aspect of paediatrics should be reviewed. Much of it has been undertaken by experienced clinicians employed by Local Authorities and we are anxious lest their expertise is lost to children by administrative appointments. The purpose of this paper is to outline our opinions about these matters in the hope that they will provoke discussion at this very important time.

What is community paediatrics?

Several authors, notably Mac Keith (1969), Walker (1969), Simpson Smith (1970), and Mitchell (1971) have outlined their concepts of what has been called the 'Community Paediatrician'. These have varied from a doctor predominantly concerned with developmental paediatrics and the care of the handicapped to one who is additionally expert in epidemiology and the co-ordination of services. All of them envisage that a substantial component of the job will be to give advice to education authorities and in this respect its interests and responsibilities will overlap those of Community Physicians who, as described later, have nonclinical and quite different terms of reference.

We agree with much that has been written about the scope of Community Paediatrics but our emphasis is different. The identification, diagnosis, and care of the handicapped child is clearly of great importance and not contentious. Mac Keith placed first in his list of the functions of a Community Paediatrician the teaching of paediatric developmental screening to all first line doctors. Most people agree that he should be part of a multi-disciplinary team working in an Assessment Centre for handicapped children but not claiming ultimate expertise in paediatric neurology. An increasing use by education authorities of NHS facilities for the diagnosis and assessment of children with handicaps affecting educational progress is anticipated (Department of Health and Social Security, 1973) and their advisory function in respect of individual children will probably increase. The parents of handicapped children require not only diagnostic and therapeutic facilities for their children but also regular follow-up consultations after primary assessment is complete. We think that this should be by one doctor and that a Community Paediatrician would be the appropriate person.

The dichotomy of treatment and prevention in paediatrics has been justly deplored (Mitchell, 1971; Court, 1971). Fortunately this separation is diminishing and it is expected that family doctors will immunize and provide other prophylactic services for an increasing proportion of children. In a few cases they will require a second opinion, and in our view expertise in preventive techniques as applied to the individual child comes within the scope of Community Paediatrics.

There has been little emphasis on the contribution that paediatrics can make to the care of deprived, disadvantaged, and delinquent children. Over 90,000 children are currently in the care of Local Authorities, juvenile crime continues at a high rate, and baby battering is not uncommon. Protective and preventive actions based on sound diagnoses are required for many children and these should not be

taken in isolation. The child health and social work professions have common aims and it is important that there should be close and easy collaboration between them. Doctors with clinical ability and social understanding are needed and this work should form a component part, no less than any other, of the work of a Community Paediatrician.

Relationship of community paediatrics to other disciplines

Community medicine. There is an unfortunate and confusing similarity between the titles Community Paediatrician and Community Physician. The latter is responsible for planning, allocation of resources, and for information systems and is a specialist in administrative medicine. It is appropriate that the duty of co-ordinating the Child Health Services should have been assigned to Community Physicians because a knowledge of management techniques and of epidemiology will be of primary importance.

In our view the Community Paediatrician is a clinician and teacher concerned with individual children and he will therefore operate at district level. This contrasts with the Community Physician responsible for child health who will have the duty to care for groups or populations of children and will work at area level. He will need advice from Community Paediatricians and a close working relationship will be essential. We would, however, deplore a perpetuation of the present hierarchical arrangements or any system that failed to ensure clinical freedom. In this we are in agreement with *Management Arrangements for the Reorganised National Health Service* (Department of Health and Social Security, 1972), which makes it clear that specialists in Community Medicine will not have managerial authority over doctors giving personal clinical services but will assist them with information on needs and advice on the effectiveness of alternative approaches to care. Community health services for children should not be an exception to the rule. Another important principle that has not been generally safeguarded to date in this area of medicine is freedom of choice for the patient and this can be achieved under the arrangements that we envisage.

Family medicine. Primary paediatric care is provided by general practitioners and we regard health education, immunization, and developmental screening as essential components of that care. Much of this work has been done by Local Authority Medical Officers and there will be a need for tran-

sitional arrangements during the next decade. Paediatrics in the community must not be confused with the role of the Community Paediatrician. It is not his function to provide primary care of this type though he will be involved in giving appropriate undergraduate and postgraduate instruction. His chief role is to provide secondary consultation and to use facilities both inside and outside hospitals for assessment and diagnosis. In addition it would be appropriate if he were the School Doctor to special schools for handicapped children in his district.

Not all the requests for consultation will be initiated by family doctors though all should be with his knowledge and consent. A number of problems, such as those relating to adoption, child abuse, or delinquency are likely to be the primary concern of social work or other professions. The paediatrician should have the duty to ensure that there is adequate communication with family doctors on these matters where it does not already exist.

Consulting paediatrics. Court and Jackson (1972) in *Paediatrics in the Seventies* call for the development of a second type of consultant paediatric practice involving community, as well as hospital, knowledge and skills. Some paediatricians are concerned with, and are expert in, the areas that we have defined as Community Paediatrics and few have made major contributions to its study. They might, quite rightly, state that there is no essential difference between their interests and those of a Community Paediatrician, but not all consultant paediatricians have special knowledge of the social and preventive aspects of their subject. The difference between the two types of paediatrician is one of emphasis rather than of kind and is analogous to the difference between a general paediatrician and one having a concern for a special area of care, such as neonatology. It is not an independent speciality allied to paediatrics and it is clearly different from the paediatric system specialities.

There is general agreement that a consultant colleague should be provided for every single-handed paediatrician and steps have already been taken to alleviate the difficult situation that recently prevailed in several parts of the country. In a few districts it may be appropriate for one of a partnership to be responsible for community paediatric work and in order to do this he may need additional training. We anticipate that in most districts the appointment of additional personnel will be required to meet the likely demands from educational and social services.

Recruitment and training

Paediatrics is a unit of which Community Paediatrics is a part and we think that there should be a common basic training up to and including registrar level. We are opposed to rigidity in training schedules, but the suggestion that nearly all senior paediatric registrars should spend a quarter of their time in learning the community aspects of their subject seems sensible. This would appropriately include experience of primary paediatric care in the general practice setting.

For those likely to have responsibility for this aspect of paediatrics a new training pattern at senior registrar level will be needed. So far such a programme has never been implemented and those who at present discharge many of the duties that we have outlined have acquired their knowledge from long experience and occasional short courses rather than by supervised training. The subjects to be embraced are very wide ranging indeed. A sufficient knowledge of several of them such as paediatric neurology, audiology, ophthalmology, and child psychiatry could be obtained by clinical attachments to appropriate specialist units. This would only be practicable if the trainee provided a service since most of these units are already overburdened with other training commitments. Additional necessary components such as genetics, immunoprophylaxis, social administration, child law, and educational theory would have to be acquired by more formal instruction in university centres.

The difficult problem is not in defining the extent of training but in arranging facilities for the number of trainees required. If our premise is accepted that a Community Paediatrician is required in each Health Service District and that in England, excluding London, there will be approximately 150 districts, then it becomes clear that there is no prospect of training anything like the number of required personnel in the short term. The only practicable possibility is to use those people who already have substantial knowledge of this part of paediatrics.

It would be misleading to suggest that senior clinical medical officers at present employed by Local Authorities could immediately undertake all the duties that we have defined. Nevertheless, we agree that with the report of the Scottish Home and Health Department (1973) that a 'number of doctors of wide experience and acknowledged skill in the field of child health and educational medicine should be eligible for consultant status from the outset'. We do not propose a simple transfer of

their present activities to the new Area Health Authorities; our view is that there should be a new type of paediatrician who will combine clinical care with personal preventive child health. It is in the former that most Local Authority Medical Officers will require additional experience. This is possible with suitable clinical attachment schemes, though the shortage of paediatric neurologists makes arrangements for this aspect of training difficult and practical experience may not be possible for many.

It is important that there should be an early statement of intent with respect to senior Local Authority clinicians so that their services will not be lost. They cannot fulfil all the requirements of Community Paediatrics immediately but neither can anybody else. There is an ideal to which we must aim, acknowledging that it will not be achieved for a decade or more but that interim arrangements can be made that will provide a better service for children than anything that has been available in the past.

Summary

A concept of Community Paediatrics has been described comprising clinical care to individual children including identification, diagnosis, and care of the handicapped child, expertise in preventive paediatric techniques, and the provision of investigation and advice in connexion with social and educational problems. Its relationship to Community Medicine, General Practice, and Consulting Paediatrics has been discussed and a long-term training scheme is outlined. In the immediate future the deployment is envisaged of senior clinical Medical Officers now employed by Local Authorities.

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