Controversy

Shared care in paediatrics

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I work with one consultant colleague in a district general hospital about 50 miles from the nearest regional centre, which is Leeds. All children in the district with a serious illness initially come to us, and an important principle in our work is the need to be aware of our limitations and when to ask for help. A good working relationship with regional colleagues is vital.

The life blood of this relationship is the telephone. When you are worried about a child with an unfamiliar or deteriorating illness it makes all the difference if you discuss things over the phone with a specialist colleague, preferably someone you already know well so that you are at once on the same wavelength. For example if you are watching a child with acute renal failure an early call to the nephrologist will enable you to make calmer decisions about dialysis and less rushed arrangements for transfer; parents too will be reassured to know that you are in touch with a specialist from the outset. For the relationship to thrive the regional specialist must make himself accessible to phone calls; if he dislikes carrying a bleep he must have a sweet voiced secretary who can track him down and persuade him to phone back without delay.

In chronic conditions the sharing of care between a peripheral and a regional paediatrician involves the same principles as it does between a general practitioner and a consultant. At an early stage it is helpful for the specialist to carry out a comprehensive assessment; thereafter there may be routine periodic reassessments and help during crises. The local man, however, should remain responsible for overall management and day to day care. He is in a far better position to assess the family and social background, to organise various support services, and to cope with any coincidental problems.

With these principles in mind we have developed arrangements with regional specialists in cardiology, endocrinology, respiratory disease (especially cystic fibrosis), nephrology, and paediatric surgery. We usually refer the children to Leeds for initial assessment and sometimes institution of treatment.

They then come back to our care, but have specialist reassessment at intervals varying from three months to two years, according to the type and severity of their problems. Whenever possible these reassessments are done at a combined clinic at our own hospital. These combined clinics are a vital ingredient of shared care, and have advantages for all concerned: the families do not have to travel so far and perceive that their local paediatrician and the regional specialist are truly in concert; the local paediatrician learns a lot and feels more involved in major decisions; and the regional specialist has a pleasant outing in the country—and ensures himself a steady flow of referrals and research material.

Shared care of neonates calls for particularly close understanding. As a matter of policy our unit maintains a capability for only short term ventilation, and babies likely to need intensive care for more than a few hours are transferred to one of the two regional units. An ability and a willingness always to accept such transfer is an essential basis to the relationship. The regional units send out highly efficient teams to collect very preterm babies who have evaded transfer in utero. The team takes about 90 minutes to arrive, during which time we do our best to get the baby in good condition for travel and to support the parents. The handover, usually from peripheral consultant to regional registrar, calls for tact on both sides, the former bowing to the other's sharper skills, the latter not flaunting them too aggressively. If the units know and respect each other's capabilities, babies can be transferred back as soon as intensive care is no longer needed, freeing the regional unit cot and making life easier for the family. After discharge routine follow up can be at the district general hospital, with an occasional visit to the regional unit if it wishes to monitor outcome.

Some specialties, for example oncology and renal transplantation, call for continuing close supervision by the regional unit, though here too there is a place for a local contribution. It is thoughtless to get a child to make a 100 mile round trip for a routine blood test when there is a district general hospital

just down the road. Regional units sometimes justify this behaviour by saying 'The family prefers to come to us'. In fact this denotes a failure on the part of the regional unit to encourage trust in the district general hospital; it is only too easy, and extremely damaging, for the regional unit to give the impression that the district general hospital cannot give the required standard of care. When tempted to make such an aspersion the clever regional registrar should remember that the consultant at the district general hospital was once in the same position.

What peripheral paediatricians dislike most is having their patients taken over by a regional specialist who cuts them out of management. Such a specialist must not be surprised if he gets only one referral from each colleague.

I once phoned a supraregional unit over 200 miles away for advice on a rare illness and was instructed to send the child to them forthwith; another unit, soon contacted instead and always used since, helpfully guided me in managing the child on my own ward. It is also annoying for a paediatrician in a district general hospital to be bypassed, either by a general practitioner who refers direct to the regional unit, or by one regional unit referring on to another when the family moves house; the remedies here are in the first case a quiet chat in the bar, and in the second acknowledgment by the regional unit that the local man should also be involved. I am always happy for a colleague with a special interest to see my unusual cases—so long as he does not poach them—and to write them up if he wishes; it is gratifying to be asked first, and even more gratifying

to be given the opportunity to decline joint authorship.

As a frequent recipient of helpful advice I have come to appreciate the art of imparting it tactfully. I want my knowledge extended and my errors put right for the future, but if my nose is rubbed too hard in my ignorance and mistakes I might take fright next time. I am irritated by the hypocritical 'as you knows' and 'of courses' with which medical letters are larded. I prefer my advice cold turkey, but for those who like some dressing, a useful ploy is to shift the imputation of ignorance and preface information with 'I told the parents that . . .'.

Taking politeness one stage further, one much respected regional colleague always starts his letters 'I quite agree that this is . . .' no matter how wildly different one's suggested diagnosis: he gets a lot of referrals.

A good relationship between peripheral and regional paediatricians has to be worked at. It requires mutual respect and courtesy, and a proper humility. The local man must acknowledge that it is his duty to obtain for his patients the best knowledge and skills available and that in this day and age these cannot all reside with him. The specialist must accept that his omniscience may not extend beyond his specialty and that many things may best be done locally. Once achieved a good relationship will be rewarding for both sides, and above all will bring the greatest benefit for the families they are trying to help.

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