

General Practitioners and the care of children and young people

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The contents of this paper represent the author's views and are not those of any position or organization, which the author might work with.

The GP, together with the health visitor have been the main stay of care for families and children for decades and children make up a significant part of the GP workload, with around a quarter of all less than 18 years olds attending their GP per year. This central role is at risk.

A recent publication, *Children and Young People's Health In London (2009)*¹ sets out the vision for children's services in the Capital, describing networks of polyclinics, Children's centers, Community children's nursing teams and local hospitals, led by paediatricians ("generalist paediatric practitioners") and general practitioners with special clinical interest in paediatrics providing much of the care.

The accompanying text in the document notes "over the longer term there needs to be a new kind of paediatric primary clinician who plays a heightened role in the unplanned and planned care of children and young people in the community. The proposed development of ambulatory care services at most hospitals, bringing together the primary and secondary workforce, creates an opportunity for such roles to be developed in future."

What this implies is a future where those providing community children's services, including general practitioners, sit within polyclinics, with the generalist GP's role seemingly limited to signposting patients to the polyclinic. This model is promulgated under the guise of "Safe and effective" care, implying that the current model, where the vast majority of care to children and young people is delivered by generalist practitioners, is not safe, and not effective.

The concept of the generalist paediatric practitioner is not new. As far back as 1976, the Court Report "Fit for the Future"² introduced the concept of the GP Paediatrician, intended to be a GP with additional training providing services to children. Three decades later, the Royal College of Paediatrics and Child Health³ suggested that paediatricians should take over the care of all children, and follow the United States and European practice in developing the concept of primary care paediatricians.

Of course, we must all be in favour of providing safe, high-quality integrated care delivered by a workforce trained to appropriate standards in a clinically appropriate location, as close to home as possible. However, it is the belief of the author that these principals can only be achieved by the continuing role of the generalist GP at the centre of the child's care and it is important that we must resist the increasing fragmentation of the general practitioner and the removal of what is core to family medicine, that of providing continuous care across different physical psychological and social domains.

The arguments for the generalist practitioner are well rehearsed. At population levels strong primary care improves patient care, outcomes and reduces over treatment. At individual level, primary care is especially valuable with families where intergenerational issues can be weaved into the social context of the patient's presentation. Primary care is the point of first contact for children and their families and there is significant evidence that GPs and Health Visitors do

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good job, with over 90% of children seen in general practice remaining in general practice. Children are an integral part of a family and must not be seen as an isolated population and it is vital that the general practitioner is able to maintain a holistic and family centered approach to the care of children and families. Moreover the change in family structure, with increasing lone parent households, and complicated family networks means that it is even more important that there is a single point of access and continuity for all those who might be involved with the child. This cannot be done where the child is seen in a stand-alone service, separated from his or her social network.

It has been argued that the increase in hospital admissions for acute illness is linked to primary care problems being managed by secondary care doctors and that admissions are more likely following self-referral to accident and emergency⁴.

It would seem inconceivable that we should be moving to a situation where the vast majority of care of children is done by highly trained paediatricians or by developing a cadre of general practitioners with special clinical interest.

This is not to say that the author is against the development of general practitioners with additional skills, training and expertise able to provide enhanced services within their primary care community. There is a long tradition of general practitioners in education, clinical, medico-politics and other areas. The NHS Plan (2000)⁵ set a target of 1000 "specialist" GPs who would take referrals from other GPs for conditions such as orthopaedics, headaches and women's health and many GPs have embraced these new roles and take on additional roles within their PCT. These general practitioners with special clinical interest (GPwSI) provide a valuable role in reducing demand on acute trusts. However, there is a thin line between GPs working as an additional level of expertise to their local colleagues and dictating that only GPs with additional training beyond Membership of the Royal College of General Practitioners can see certain age groups, genders, diseases and so on, or as with the vision for children, placing all the care within a single setting, delivered only by general practitioners with special interest, working as generalist paediatric practitioners rather than general practitioners with or without a special interest in paediatrics.

Systems of care must value both the generalist and specialist care and foster integration. This however does not however mean a hierarchical relationship between GP, GPwSI or Consultant paediatrician or that the general GP cannot or should not continue to be the centre of care for children and young families. Having specialist practitioners co-located with generalists can help improve the care of patients with chronic disease as well as improve continuity of care through enhanced communication that goes beyond the simple exchange of letters. Primary Care paediatricians and general practitioners with clinical interest in paediatrics can, and should play an important part in the delivery of safe and effective community based services but they should be an adjunct to current services and not replace them.

REFERENCES

1. HealthCare for London. Meeting the health needs of children and young people. NHS 2009
2. *Fit for the Future: The Report of the Committee on Child Health Services*. Volume One. London: HMSO, 1976
3. Royal College of Paediatrics and Child Health Old Problems, new solutions. 21st Century children's health care. London: RCPCH, 2002
4. Macfoul R. Stewart M, et al. Parental and professional perception of need for emergency admission to hospital: prospective questionnaire based study. *Arch Dis Child* 1998; 79: 213 -18
5. Department of Health, The NHS Plan: A plan for investment and reform

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyandGuidance/DH_4002960
2000