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Research in community child health

The Community Paediatric Group is the largest specialty group within the British Paediatric Association. The Group is growing, as is the number of consultants in the specialty, and the numbers of doctors in approved training posts. Since the publication of the *Court Report* in 1976, there has been a large increase in interest in the specialty, developments in terms of structure and process in the service, and an air of questioning the premises and practice of community paediatrics. In this atmosphere, it would be expected that the pages of journals such as this should be filled with good research in community child health. The reality is that this is not so, both in terms of volume and quality. This article attempts to explore some of the reasons for this and to recommend some solutions.

Problems

Much decision in community paediatrics has, I fear, been based on what one might call 'the biblical method of assessment', that is, 'they looked at it and saw that it was good.' This may have been adequate for our most distant ancestors but today would satisfy neither general managers, academic departments of paediatrics, or the editors of journals. The specialty has developed rapidly, sometimes running ahead of our knowledge.

An academic priority over the last few years has certainly been training. A survey from the Department of Health and Social Security in the mid 1970s showed that 75% of the full time doctors in community child health, and 85% of the part time doctors, had had less than six months training in paediatrics. The task, therefore, for many people, was to get existing knowledge into the heads of those who needed it and setting up training programmes, rather than expanding the volume of knowledge. The rapid service development has increased training demands as has responsibility for new tasks, such as work within child sexual abuse.

New senior registrar posts in community paediatrics have been created. Their numbers are not yet sufficient to meet the future needs for consultants in the specialty and their content often does not permit as much research time as would be allocated in an equivalent hospital senior registrar post. We are again troubled by the large service need. While hospital consultant posts in paediatrics, and supporting posts, increased by around 50% from 1975 to 1985, there has been little change in the staffing levels in community child health. It is certainly extremely difficult to take on new clinical tasks and to set up training posts, where time is needed for teaching and clinical supervision, as well as setting up ambitious research projects at a time when establishment has not risen. Posts have even been frozen to enable health authorities to balance their budgets.

Community paediatrics is not established in all academic departments of child health. This clearly imposes a limiting factor upon the promotion and supervision of research.

In its recent history, community child health has attempted to separate itself from community medicine and has aligned much of its professional and training structure with paediatrics. Although this can be seen as a necessary step in the development of community paediatrics, it has also lost the links with departments of community medicine who may well have the epidemiological skills necessary for many studies in community paediatrics.

Lastly, there are many methodological problems in terms of research which looks at whole populations as opposed to individuals with a defined medical diagnosis. There are numerous traps waiting for the unwary researcher in community paediatrics.

Some suggested solutions

More training posts in community child health are needed. These should include research time and adequate supervision of the research. Training in paediatric epidemiology would be a great asset for some of the senior registrars.

Expansion of academic posts in community paediatrics is needed. The first Chair of Community Child Health has recently been appointed at the Royal Free Hospital. The need for research clearly must be matched with the availability of research money. Specific research funds for community child health has not yet developed and sometimes the low profile of prevention, health promotion and surveillance makes it difficult for community paediatrics to compete for research funds with other specialties. Research money from commercial sources is also more difficult to attract.

Researchers in community child health would do

well to dip into the experience of other specialties and to look at mutual areas of interest to set up joint areas of research. Examples would be community medicine, psychology, sociology, pharmacy, education, nursing, and administration.

The Community Paediatric Research Group started life in 1978. These meetings and those of the Community Paediatric Group have provided the main national forum for presenting research in community paediatrics to a critical audience, and to organise seminars that can discuss issues related to research methodology. In some districts, funds for study leave for doctors in community child health are not available to enable doctors in training to attend relevant academic meetings.*

Some suggested targets for research in community child health

This represents a personal shopping list of research that I would like to see done in community child health. It is not intended to be complete.

OUTCOMES AND EFFECTIVENESS OF CHILD HEALTH SURVEILLANCE PROGRAMMES

Long term outcomes need to be looked at, as well as the effectiveness of initial identification procedures. Mortality and morbidity from disorders at which surveillance programmes are aimed, should also be examined. Much of our current surveillance programmes remain unsupported by any objective evidence.

INTERVENTION STUDY WITH DISADVANTAGED POPULATIONS

Cycles of disadvantage are well described but there are a lack of studies indicating the effectiveness of the services that we provide for these populations. These families are frequently the focus of intense health visitor and community paediatric involvement, and of innovative educational and other projects, but we know little about the effectiveness of these services.

DISTRICT HANDICAP TEAMS

Most districts now have a district handicap team with considerable involvement from community child health. Their working practices vary widely and there is little research to guide us into which model of service we should be favouring for the future.

INTERDISCIPLINARY WORK

Our effectiveness, or so it is believed, in community paediatrics depends upon good interdisciplinary work with a wide variety of other professions. Our failings, where they have been pointed out, for example, in enquiries, frequently indicate a lack of interdisciplinary working. The examination of interdisciplinary working in a wide range of issues in community paediatrics from child health surveillance through to management of handicap or child abuse, would be a valuable contribution to our knowledge.

HEALTH EDUCATION/HEALTH PROMOTION

These form a major activity within community child health. We are, however, often uncertain about the effectiveness of the programmes which we carry out.

USE OF SERVICES BY PARENTS

A total of 90% of illnesses are dealt with by parents rather than professionals. Hospital admission rates for children are rising. Parents are often more likely to bring their child to the accident and emergency department rather than to see the general practitioner. Our workload is governed by the decision making of parents, and the relative roles of services for prevention and services for treatment need to be examined.

THE SCHOOL HEALTH SERVICE

The school health services have existed since the beginning of this century. The pattern of services is changing from routine examination towards being more selective, to place more emphasis on health promotion and to expand the liaison role of the doctor. In many cases, we lack information about the operation of the school health services. With the 1981 Education Act, it is recommended that more children with special needs are placed in ordinary schools. It has been assumed that they will be better off, but studies aimed at looking at children with special needs in ordinary school, who might otherwise have attended a special school, would be most welcome.

INFORMATION SYSTEMS

Hospitals produce audit information on admissions and discharges. Community paediatrics needs information too, on its day to day activities and on the nature and distribution of handicaps within the community. We are only just beginning to do this. It is difficult sometimes for a service to march forward when it does not know exactly where it is at present.

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Conclusions

At such a time of rapid expansion, there are opportunities for research which must be taken before the pattern of service delivery solidifies and becomes impossible or difficult to change in the light of research findings. Every doctor in community paediatrics should have an opportunity, and the responsibility, to think about what they are doing, to ask questions and hopefully to obtain answers. Academic departments have the responsibility to nurture and help research in community paediatrics. Research funds need to be made available for this to be done. The National Health Service needs to support research and to plan for adequate manpower and training programmes to ensure that this can be done.

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