MEDICAL PRACTICE

Contemporary Themes

The Community Paediatrician*

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The 'sixties have been called the age of analysis, and this has been as true in medicine as in other spheres, for much time and thought have been devoted to analysing the organizational framework and function of the health services set up so precipitately after the second world war. It has become increasingly clear that in forward planning patching up will not do, and we must return to fundamentals, asking such questions as What are the needs? and How can we best satisfy them? As the shape of the future services slowly begins to form further questions arise—What kinds of professional worker will be required? and How shall we train them? If we thus considered the 'sixties as the age of analysis of services and their functioning we may well look to the 'seventies as the age of role identification. A start has already been made by asking What is a doctor? and What is a nurse?, and it is evident from the report of the Royal Commission on Medical Education[1] and from the current work of Professor Asa Briggs's committee that such apparently naive questions are in fact extremely complex. In posing the question What is a community paediatrician? I therefore make no claim to have a simple answer which will satisfy everyone, still less to know what the pattern of future paediatric care will be. I should like, however, to put before you some of my thoughts on this subject with a view to stimulating discussion.

Nature of Paediatric Practice

In planning health services we no longer have to plead the case for special consideration of infants and children, for their requirement are now clearly recognized both in medical education and by the administrators of the National Health Service. This is not to say that the scope of modern paediatrics is understood by all doctors, and it is still sometimes necessary to spell out the different needs of children and adults to specialists in technological medicine who cannot see beyond the organ of their interest. I do not propose to consider the arguments here, for they have been stated on many occasions.[2 3 4]

If we accept that special expertise is needed in the medical care of children it follows that doctors must be taught the appropriate skills, and this is what a paediatrician is—simply a doctor trained to promote health and treat disease in infancy and childhood. As the needs of children change so also must his training and practice.

Thus the title "paediatrician" does not describe a particular kind of person with an instinctive knowledge of paediatrics, nor does it automatically confer the right to exclusive care of children. If it is claimed that children are better treated by a paediatrician the claim must be justified by the quality of service offered. It can be misleading to apply the unqualified title to every kind of specialist within paediatrics, for no single doctor can be expert in all aspects of child health and disease. The disillusionment with paediatricians sometimes expressed by social workers, local authority medical officers, and others may spring from failure to realize that some paediatricians are mainly or wholly concerned with clinical specialties in hospital.

While all paediatricians necessarily take into consideration the social and developmental history as well as the clinical condition of their child patients, many have not got the time, experience, or interest to consider social aspects in greater depth or to collaborate in trying to solve the problems of children in the community outside the hospital. In the future health service we shall continue to need general paediatricians in the hospital as well as specialists in such fields as neonatal paediatrics, paediatric cardiology, paediatric neurology, and the like. The bulk of the health care of infants and children outside hospital will still be undertaken in general practice, based to an ever greater extent on health centres staffed by

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health visitors and social workers as well as by family doctors, some of whom may have special interest and experience in paediatrics. These doctors will do most and perhaps ultimately all of the developmental screening of infants and children in the future,[3] for they will have had a far better grounding in developmental paediatrics than their predecessors of today. We must ask, therefore, whether there is any work for a specialist in paediatrics which cannot be undertaken by a hospital paediatrician or by a family doctor. The answer is plain—there are many kinds of personal medical service to children which require knowledge and professional expertise beyond that expected of the general practitioner and yet which must be provided outside the hospital.

In most instances professional services other than medical are also required, and the necessary close cooperation between various professional workers demands a degree of consideration for others, adaptability and willingness to compromise, that has hitherto not been a conspicuous feature of the medical profession.[6] Thus the assessment of handicapped children is a responsibility in which the kind of doctor envisaged must participate as a member of the assessment team, not seeking to dominate his co-workers or viewing them as his assistants but working with them as colleagues. His contribution is his knowledge and understanding of the intellectual, physical, and emotional characteristics of children and the ways in which these can affect one another when there is a deviation from normal. He must, of course, also work closely with medical colleagues such as the child psychiatrist and various paediatric specialists as appropriate.

The importance of greater paediatric participation in the assessment of handicapped children is already evident. It is becoming clear, however, that the changes at present transforming the personal social services throughout Britain will create further demands on paediatricians in connexion with the assessment of underprivileged, deprived, and delinquent children as well. Kingsley Whitmore[3] emphasized the need for comprehensive assessment centres to be established by cooperation between the educational, medical, and social services and not by any one of them unilaterally.

In addition to personal medical services and by virtue of his skill in these areas the doctor will be called on for advice on preventive paediatrics and on the environmental health of children—at school, in social contacts, at play, and in the family. He will be consulted about the effect of these on the child's aspirations, abilities, anxieties, and limitations.

Such functions are at present discharged, at least in part, by doctors employed by local health authorities, and it may reasonably be asked why this pattern of preventive paediatrics should not continue, as suggested, for example, by McGregor.[8] This raises the basic question: Should preventive and social paediatrics be the concern of one doctor and clinical diagnosis and treatment that of another? The answer must surely be No, because the skill and knowledge gained from caring for sick and handicapped children are complementary to expertise in the epidemiological and environmental aspects of child health, and each enhances the other. Indeed, the almost total separation of these functions has been one of the most damaging features of paediatric practice in Britain.

A New Kind of Paediatrician

We must think, therefore, not of a hospital paediatrician taking a greater interest in affairs outside his hospital nor of a local authority medical officer acquiring some hospital experience but of a new kind of doctor trained for a specific purpose. He must be broadly educated in all aspects of child life and health and must have a working knowledge of other disciplines which relate to child life—education, social work, psychology, epidemiology, and so on. He must be competent to take clinical responsibility for ill and handicapped children both in and out of hospital, working with specialist colleagues in hospital as necessary and sharing responsibility with the family doctor when the child is outside hospital but still requires specialist supervision. In much of his work outside hospital this doctor will be working in a team with social workers, psychologists, teachers, child psychiatrists, and others. He will have a thorough knowledge of child development and may take responsibility for the teaching of screening techniques to general practitioners and others. Nevertheless, I do not visualize him as being the ultimate authority on developmental paediatrics in a region, for this is properly the field of the paediatric neurologist. In areas where a paediatric neurological opinion is not readily available, however, he may well act as reference consultant for the more difficult problems thrown up by developmental screening, as envisaged by MacGregor.[9]

The Community Paediatrician

Such then is my concept of a community paediatrician—the community being the whole social unit and the hospital an integral part of it. He is a consultant in that he advises family doctors on difficult problems and treats children in hospital, these activities occupying perhaps one-third of his time. In the care of mentally, physically, and emotionally handicapped children he collaborates closely with family doctors and with paediatric colleagues specializing in developmental neurology, care of the mentally subnormal, and so on. He thus provides general paediatric services in hospital and personal medical services for children outside hospital when they are beyond the single-handed competence of the family doctor. He acts as an important link between hospital and general practitioner services for children.

By analogy the community physician should provide similar services for adults. Whether such are necessary outside hospital is not for me to say, but Richardson[10] suggests that there is a place for a general physician working both in the hospital and in the community. I do not consider that the title "community physician" should be applied, as it has been, for example, by Morris,[11] McGregor,[8] and the Department of Health and Social Security[12] to the doctor who will in the future advise health authorities and perform other public health duties broadly comparable with those at present carried out by medical officers of health, though considerably extended by the unification of the health services. This nomenclature has given rise to confusion and misunderstanding of both the terms "community physician" and "community paediatrician." Of course all doctors are physicians in one sense, but the word has come to mean a doctor practising clinical medicine at an advanced level as a consultant physician, who generally confines his practice to adults. A doctor responsible for advising on the provision and functioning of health services is a specialist in administrative medicine and not a physician in the accepted sense. He will, of course, also have professional skills related to public health, epidemiology, and health education in addition to administrative knowledge and experience, and perhaps some new title should be coined, though personally I do not see anything wrong with "medical officer of health."

In addition to personal medical services for children the community paediatrician will give advice on health matters concerning children in the community as a whole, being especially knowledgeable about school health and medical aspects of educational difficulties. In this advisory capacity his interests will meet and sometimes overlap those of the specialist in administrative medicine, who will have overall managerial as well as advisory functions,[13] and in many instances they will no doubt confer together in order to give joint advice. Usually the knowledge of child life and health possessed by the one will complement the other's knowledge of public health services, but the pattern will no doubt vary in different communities and with different individuals. I do not see any reason to define their respective spheres too precisely, since the

keystone of their relationship will be team work. In large communities there will obviously be room for subspecialization, each of several community paediatricians being especially skilled in a branch of the work. It would seem undesirable, however, for the specialist in administrative medicine to subspecialize in the childhood aspects of his field, for the disadvantage of practising preventive paediatrics without clinical responsibility has already been pointed out.

The community paediatrician will work in close liaison with general practitioners who have special paediatric interests.[11] He will need a supporting staff of assistants and trainees, both inside and outside hospital, who may be either community paediatricians in training or trainees from other branches of paediatrics or from public health administration seeking some experience in the field of community paediatrics.

Training for Community Paediatrics

I have briefly outlined the role of the community paediatrician as I see it, and I should now like to turn to the question of how to train doctors to carry out this work. But, first, more fundamental questions must be posed: Will the doctor of the future be sufficiently interested in the kind of work I have described to undergo training? Will he be capable of profiting from such training? In short, What kind of doctor will be available for training?

FUNCTION OF THE DOCTOR

The Royal Commission suggested that changes in the medical curriculum since the second world war have been too small and too slow and that its relevance to current medical practice is open to question. It is high time, therefore, that we looked more closely at the real function of the doctor. He is of course concerned with the maintenance of health and the curing of disease. During the past century, however, he has become increasingly confronted with people's personal difficulties as church influence has waned and family ties have loosened. In dealing with such matters he has tended to adopt an authoritarian role, which may have served when society and its problems were relatively simple but has become progressively less adequate as they have increased in complexity.

The present-day doctor is essentially a man of action, for he is trained to be decisive and to look for answers rather than to pose questions. He approaches a problem simply and directly, looking for one obvious cause and seeking to remove it, with little real appreciation of the interplay of physical, emotional, and social factors which have created the difficulty. Indeed, the evidence shows that the doctor limits his own perception of psychosocial problems in order to focus his attention on disease.[6] As a result he is inept and ill at ease in the role of confidant and comforter which he has inherited and he prefers to brush aside emotional difficulties with cheerful reassurance rather than to become personally involved in such sensitive areas as bereavement, loneliness, or fear of death. Parents of handicapped children find that outside the strictly medical sphere doctors have little to offer but, at best, conventional expressions of sympathy.[15]

We are therefore faced with a dilemma—should the doctor continue to develop his technical skills and leave human problems to the social worker or should he fit himself for the role of friend and counsellor? Recently an eminent surgeon said, "What the public wants is someone who will recognize disease and put it right, and we ought to be training people to do just that and stop talking about psychology, sociology, and all that." He had a point of view, and perhaps doctors should become technologists and leave personal relations to other professions. Indeed this is exactly what has been happening in recent years. As people are subjected to greater stresses by the pressures and temptations of an increasingly complex society they are turning more and more to the social case-worker for understanding and satisfaction of their emotional and personal needs, often with the encouragement of doctors. So the status and professionalism of social workers are rising, and a future could be visualized where authority would rest with them and doctors would merely be their "health assistants," dealing with the purely technical side of physical disease.

Perhaps the idea of the technical medical scientist does appeal to some, but it too carries a threat to the medical profession. Hitherto the conventionally-trained doctor has been able to keep up with technical advance, but he is being outstripped by the science-based technologist—the chemist is becoming better at clinical chemistry, the physicist more expert at isotopic investigation and the application of ultrasonics, and the computer programmer more expert at the analysis of symptoms. The doctor runs the risk of becoming a health assistant to the technologist as well.

We can see, therefore, that medicine is moving in two directions—towards increasing involvement in social and personal problems and towards greater technical skills, and this again raises the question, What is the function of a doctor? I would suggest that it is primarily a synthesizing and co-ordinating role, taking a wider view of man and his health so that he can both utilize the skills of the technologist in patient care and participate in the broader aspects of psychosocial management. He must be more capable than he has been of posing questions, less dependent on clear-cut answers, and more sensitive to qualitative human values. He must lose the arrogant self-sufficiency which makes him try to dominate the other caring professions. As Brotherston and Forwell said,[16] the stereotype of the prima donna and his individual clinical tour de force is obsolete. The doctor must be prepared to work as a member of a team, recognizing professionalism in others and able to adapt his ideas to theirs in order to achieve solutions acceptable to all. Such a role demands wide training in the behavioural sciences as well as in the physical sciences, not to make the doctor a psychologist or social worker but to enable him to understand their points of view and the ways they work. Thus the future doctor will emerge as the health member of a group of caring professionals with differing backgrounds but a common interest in the individual and the problems created by his interaction with his environment.

UNDERGRADUATE MEDICAL EDUCATION

What relevance has all this to the training of a community paediatrician? Simply this, that medical education is at present so heavily biased towards technology that behavioural and social aspects have low status in the eyes of students and many of their teachers. As a consequence young doctors are ill-prepared to understand personal and social problems and many have little interest in them. I believe that this requires fundamental changes in the medical curriculum which will influence the education of doctors right back to their childhood, for the entrance requirements of medical schools largely determine the pattern of teaching in the later school years. The flexibility suggested by the Royal Commission is to be welcomed but is unlikely to be wholly acceptable to a profession already shaped in a rigid mould. It is understandable, of course, that doctors trained in chemistry and physics have difficulty in visualizing a curriculum in which, for example, these subjects take second place to anthropology, mathematics, and psychology. And yet it is surely an unwarranted assumption that the system which produced us is necessarily the right one for all time. We cannot be sure what the pattern of training for the next generation of doctors should be or whether doctors created by a radically different system would be better or worse than those of today. Nevertheless, the failure of doctors to understand and satisfy the personal needs of the people in their care must to some extent be an indictment of the present form of education and suggest that other patterns should be tried.

I have dealt at some length with fundamental problems of education because the kind of doctor we produce in future will largely determine the success of postgraduate education in community paediatrics. If his training has already stimulated the young graduate's interest in social and personal problems and has made him aware of their relevance to medical practice, he will be attracted towards community work at least as strongly as towards technological medicine. Much of the work which will be undertaken in future by the community paediatrician may sound uninteresting to the medical graduate of today as it has seemed dull to some doctors working in public health in the past. But the doctor of the future, with his sound grounding in the behavioural sciences, his far richer understanding of interpersonal relationships, his willingness to work with others, and his questioning approach without compulsion to find an easy answer, will find constant stimulus and interest in dealing with people as persons and not only as patients.

In building on such a foundation there should be little difficulty in training the future community paediatrician to the level of competence required for work in the epidemiological and social aspects of child health and for co-operative team work with other professions, as well as to the full level of consultant paediatric practice in hospital. Even if the new priorities in medical education could be fully implemented now, however, it would take 10 years for the products of a revised curriculum to reach the stage of training for community paediatrics. Until such time as early education matches up to future professional activities, therefore, we must do what we can to select and train young doctors who have the vision to see what the future holds and the ability to shake themselves free from the limited frames of reference which have been imprinted during their early professional training.

While I do not know what the ultimate pattern of training for community paediatrics will be I can outline the plan we have evolved in Aberdeen as an interim stage towards fully-integrated training. Our paediatric registrars regularly conduct child health clinics for the local authority, and this introduces them to the staff and procedures of the community health service. The plan provides for a four-year rotational training programme at senior registrar level, consisting of a year of general paediatrics, a year of neonatal paediatrics, a year of community paediatrics, and a final year of general paediatrics. During the third year the senior registrar works in local authority health departments, his duties being assigned to him by the medical officers of health. He receives training and practical experience in school health, the care of the mentally subnormal, the assessment of physically handicapped children and the provision of their requirements, and the organization and practice of the many activities of the local authority in child care. Part of this year is spent with the City of Aberdeen Health Department and part with the County Health Department to give experience of both urban and rural conditions. This is only a beginning, and it will be easier to integrate training when there is a unified area health authority and trainees can work under the supervision of a fully-established community paediatrician. I have no doubt that similar experiments in community paediatric training are being undertaken in many other parts of the United Kingdom.

Conclusion

In discussing the role of the community paediatrician in an integrated child health service I have been looking into the future, perhaps the distant future, since the organizational changes and staff required for such a comprehensive service are large and will be achieved only gradually. Even if the reconstruction of the child health services and the training of community paediatricians are given top priority, as they should be, there will inevitably be a transition period during which doctors now working in both local authority and hospital services, with such additional training as necessary, will play an active part in establishing community paediatrics as a reality.

There must be greater flexibility to allow experienced child health doctors, especially those who are skilled in the school health field, to gain experience of paediatrics in the hospital, to which they will bring new ideas and a wider outlook.[17] Nevertheless, though the interests of these doctors must be safeguarded and their experience used as the foundation of future services, neither their existence nor the present divisions of responsibilities between local authorities and the National Health Service should be allowed to prejudice the concept of the community paediatrician as a new kind of doctor. The pattern of the past must not be used as a blueprint for the future. The community paediatrician will be trained in clinical paediatrics and in all aspects of child life—not to make him a psychologist, a teacher, or a social worker but to enable him to understand and work with these other professions on an equal footing. He will take a dynamic view of child life, questioning and if necessary destroying many of the traditional concepts on which medical care has been based. He will bring fresh perspectives to the practice of child health, and I believe that such a new kind of paediatrician will command increased respect from colleagues in other professions—a respect which paediatricians are at present in some danger of losing.

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