Middle Articles

GENERAL PRACTICE OBSERVED

Paediatric Care in General Practice: an Experiment in Collaboration

G. N. MARSH,* M.B., B.S., D.C.H., D.OBST.R.C.O.G.; A. B. TOMPKINS,† M.D., M.R.C.P.

British Medical Journal, 1969, 2, 106–108

Summary: A project of joint consultation between a paediatrician and several general practitioners serving a group practice of 15,000 patients has shown that outpatient clinics held at a group-practice centre (when 36 children were seen at 78 consultations over 18 months) reduced the overall work-load, eliminated dual care, and directly benefited the doctors, the children, and their families.

Introduction

The rigid tripartite structure of the National Health Service has somewhat militated against integrated care of the community by specialists and general practitioners working together. Nevertheless, Draper (1967), in outlining his arguments for decentralization of hospital outpatient departments into "community care units," believes that the advantages to be gained from joint specialist/family doctor consultation will be considerable. A paper from Winchester (Gibson *et al.*, 1966) on psychiatric consultations with general practitioners present showed what could be achieved in this specialty, though many of the advantages accruing to the patient were gained at the expense of an increased work-load for the doctor.

The present paper describes a system of joint consultation by paediatrician and general practitioner in the general practitioner's group-practice centre. In addition to outlining the advantages to child and parents it demonstrates the tremendous advantage to both paediatrician and general practitioner, not only from the point of view of the more holistic care of the patient and a deeper understanding of the clinical problems set in the whole family situation but also, and most important, the smaller amount of effort involved compared with the traditional outpatient referral system. With work-load falling in general practice principally because of the increasing devolution of work previously done by doctors on to other members of his ever-increasing medical team (Marsh, 1967), but also by the more effective organization of general-practitioner work in itself, the time is rapidly approaching when a scheme such as this can be accommodated within the general practitioner's working week.

Organization of Scheme

The idea emanated from the consultant paediatrician (A. B. T.), and had previously been carried out by him in a Nigerian setting when he had made it his practice to attend at a fixed time each day the surgery sessions of a group of general practitioners working in the same hospital. That scheme was less formal than the one described in this paper.

In simple terms the scheme outlined here was the transference of the normal hospital outpatient session for patients in the practice to the group-practice centre. In a practice of 15,000 patients the number of paediatric problems requiring a second opinion is not high, so it was necessary for the consultant to attend only about every six weeks. This he did on a Wednesday afternoon for a period varying between one and two hours, depending on the number of cases to be seen.

The group-practice secretary arranged for the patients to attend by appointment, and was responsible for sending them for follow-up. She liaised with the paediatrician's hospital secretary, who arranged for any hospital records and consultant notes to be available at the correct time at the group-practice centre.

Any urgent cases that the general practitioner wished the consultant to see were still seen at a hospital outpatient session or on the hospital ward, as had happened in the past. Any patients requiring follow-up after hospital admission were seen at the joint consulting sessions at the group-practice centre. The other paediatricians working in the area co-operated in that they permitted any cases that previously had been under their care, or who were under their care while in the children's wards, to be followed up by the paediatrician taking part in this scheme.

Whenever possible the general practitioner whose patient required consultation was present with the paediatrician. The joint sessions became so popular, however, that on many occasions more than one general practitioner sat in at these sessions. One of us (G. N. M.) attended almost all of the consultations and hence became increasingly acquainted with all the special paediatric problems in the group.

Thirty-six patients were seen between January 1967 and July 1968, and a total of 73 consultations took place—an average of two consultations per patient. Only seven of the 36 patients had been inpatients in the children's hospital.

Table I shows the breakdown in age groups of the children seen, and Table II shows a breakdown of the cases according to the system in which illness had occurred.

Age group (years) ..	<1	1–6	7–12	13–16	All Ages
No. of children ..	6	22	4	4	36

After the emigration of the consultant concerned the scheme has had to come to an end, but it is expected that when the Regional Hospital Board can again fill the paediatric vacancy the scheme will restart.

* General Practitioner, Stockton-on-Tees.
† Consultant Paediatrician, Hastings, New Zealand (formerly North and South Tees-side Hospital Groups).

TABLE II

Diseased System	Respiratory System	C.N.S.	L.M.S.	Alimentary System	C.V.S.	G.U.	Mental Defect	Congenital Defect	Failure to Thrive	Total
No. of children ..	9	4	6	3	1	3	4	3	3	36

TABLE III.—*Analysis of Salient Comments Made by* 21 *Parents*

Parent's Comment	Child Reassured Because of Family Doctor's Presence	Customary Surgery " Atmosphere " for Child	Geographical Convenience	" Collective Involvement "	Immediacy of Result	Family Doctor can Explain or Clarify	Better Appointment System
No. of times made ..	8	8	7	6	6	6	5

Advantages of System to the Child and Parents

In December 1968, about six months after the scheme had stopped, all parents who had taken part in it were sent a letter asking them to " jot down briefly any advantages this system of medical care had compared with the traditional method of seeing a specialist at the children's outpatient department." It was indicated in the letter that, " if you had seen Dr. Tompkins (the paediatrician) at the outpatient department he would have had a letter from your family doctor and would have replied in turn by letter." Those parents not wishing to make any particular comments were invited to indicate by a tick whether they thought the scheme was (1) a better scheme for their child's care, (2) a worse system for their child's care, and (3) a system offering no special advantages one way or the other.

Twenty-five replies were received to the 30 letters sent out (six patients of the total of 36 had moved from the area). Everyone indicated that they thought this was a better system for their child's care, and 21 parents wrote a covering letter itemizing the points in its favour that they thought important. Table III shows what these points were and how frequently they were stated.

At might be expected, convenience of access to the group-practice centre was frequently mentioned by mothers as being an advantage. This in spite of the fact that the hospital was probably as near as one and a half miles (2·4 km.) to the majority of the patients' homes and no more than four miles (6·4 km.) from any of them. More important than actual miles to travel is the fact that reaching the children's hospital outpatient department involves the use of at least two different buses, whereas the group-practice centre is at the junction of several bus routes, and as a result of the geographical rationalization of the practice in 1967 (Marsh, 1968) hardly any patients change buses en route for the group-practice centre.

Somewhat surprisingly (it had certainly not been anticipated) the reassurance of the child by having his or her own family doctor present when seeing a specialist was the advantage in the system that received most frequent mention. On reflection it is probable that family doctors underestimate the value of the rapport with their sick children which they acquire progressively over several years, and according to the parents the presence of this familiar figure eases the child's approach to the consultant. The familiar surgery surroundings were also mentioned by more than one-third of the parents as being conducive to the consultation. All in all they considered that a " relaxed atmosphere " was important.

One-third of the parents replying by letter considered that the presence of the family doctor was of value in helping them to describe symptoms or incidents accurately and also in interpreting to them at the relevant level the questions asked by the consultant.

A quarter of these parents specifically mentioned the feeling of collective involvement that was engendered by the joint consultation. They appeared to appreciate a system in which opinion was arrived at jointly by co-ordinated discussion, and their confidence in the diagnosis and management was enhanced. This coupled with the immediacy of the result of the consultation (either opinion or treatment) and the accurate interpretation and communication to the parents of the consultant's views during discussions with the family doctor. Furthermore, because of the joint consultation and seeing paediatrician and general practitioner discussing the details of the case, they appeared to accept without hesitation further care by the general practitioner. It seems almost as though the parents invest the general practitioner with consultant knowledge once he has been seen to discuss the case fully with the consultant.

A minor advantage mentioned by one in four of the parents was that the appointment system at the group-practice centre, coping as it does with up to 1,000 appointments a week for normal surgeries, seemed to work more efficiently and effectively and with less waiting than the equivalent appointment system at the outpatient department. This was due at least in part to the outpatient clinic being overloaded.

Cutting Doctor Work-load

Letters were not exchanged between consultant and general practitioner. The traditional letter to the outpatient department frequently duplicates notes which are already on the patient's record card. Time did not have to be spent in reading letters, since the general practitioner was able to add the consultant's diagnosis and prognosis and management where applicable to his normal record card during the consultation. Moreover, the general practitioner's records staff had no carbon copies and hospital letters to file.

Dual care was eliminated. So frequently in the past, on referring a child with a recurring problem to the outpatient department for an opinion, the pattern has been for the child to be followed up at the outpatient department, and occasionally the child would disappear for a time from the general practitioner's surveillance and become a frequent denizen of the outpatient department. Perhaps worse from the point of view of efficient management the child would have frequent follow-ups, not only by the general practitioner but also by the consultant. Such dual management with all the unnecessary effort by specialist, general practitioner, and administrative staff—not to mention parents and child—plus all the conglomeration of extra records and letters to and fro is an extremely wasteful system of care.

Almost half the children were seen only once, and as many as two-thirds were seen only twice. By being able to discuss with the general practitioner, if necessary at length, diagnosis, prognosis, and future management the consultant could so often, and with an easy mind, pass back the management of the child to the general practitioner. This is more difficult and frequently impossible to achieve by a letter or series of letters from hospital outpatient consultations. So many paediatric problems nowadays are ones of management rather than diagnosis, and the system of personal discussion lends itself particularly well to helping the general practitioner to deal with these. In this context it is perhaps pertinent to

suggest that the consultant was happier leaving follow-up to the child's own general practitioner than to a multitude of changing senior house officers or registrars. The net result was that the patients had to have fewer attendances at the group-practice centre than they would have had at the hospital outpatient department. The consultant's work-load fell accordingly.

An important advantage to the general practitioner of this sort of session is that it gives him an opportunity to canalize his thought processes into only one field—in this case, paediatrics. One of the problems of general practice is coping with the mental gymnastics of the ordinary surgery. Here at least once every six weeks was some respite from this.

Clinical Advantages

It would be expected that new diagnoses would be produced by the consultant—and this was the case in 6 out of the 36 patients. In two cases, however, it was the family doctor who indicated the correct diagnosis to the consultant (one an autistic child who at least initially might have been labelled merely as a case of mental retardation, and the second a child with a somewhat inexplicable toxic arthropathy, which was initially diagnosed erroneously in hospital as an attention-seeking device). Repeated contact with these children over several months made it easier for the general practitioner to achieve the correct diagnosis than the consultant seeing the case only once or twice.

The general practitioner's knowledge of the whole family was frequently of value. The asthmatic child with unhappy parents, the slow child with the psychopathic father, the puny child with urinary infections and a chronically ill mother, the epileptic child with overprotective parents, the social class I mother desirous of being admitted to hospital with her child during his surgical operation, the backward baby whose mother's brother is severely spastic—the details of such problems are difficult to commit to paper, but can be readily understood by on-the-spot discussion and are valuable in putting the illness into the perspective of the family setting.

The educational value of these sessions to the general practitioners was considerable, and as time went by they were looked on rather as a short paediatric refresher course occurring every six weeks at the group-practice centre. Frequently more than one general practitioner attended. As a result he saw more than just his own cases, and this had an educational value. After the occasional individual case, and certainly after each joint sesion, there ensued a discussion on general paediatric care and specific paediatric problems. Topics ranged from the age for operation of inguinal hernias in infancy to the use of new drugs—for example, A.C.T.H.—and to the advisability of investigating urinary tract infections in boys and girls. The general practitioners tried to investigate and work up the case for presentation to the consultant in a more intensive way than they might have done had they been referring the child to the outpatient department. The sequel to this was that if the case had been fully investigated then the consultant opinion could be arrived at straightaway.

Once the scheme had been running for a few months the consultant was able to make it possible for contrast media *x*-ray investigation (especially intravenous pyelography) to be available at the hospital at the request of the general practitioner. Similarly, access was given to the physiotherapy department (with special reference to breathing exercises for wheezy children). Growth charts were left at the surgery.

Knowledge of Group Practice

To the consultant this scheme gave an insight into the working of a group-practice centre. It showed him the facilities and interests of at least one group of general practitioners. This aspect of consultant knowledge will achieve increasing importance in the future as groups develop, as their teams grow, and as their strengths and weaknesses become more apparent. Groups of the future may well widen their scope of care both materially and academically into differing fields at different depths. Consultants will need to know of this. This scheme at least singled out for one consultant five general practitioners from the amorphous mass.

Possible Developments in the Future

With the increasing employment of nurses, health visitors, midwives, and social workers in group practices (either attached by the local authority or privately employed personnel) the family doctor is becoming a much more significant person in the care of the community than he has been in the past. With such a team paediatric care in the community will be increasingly his. Child welfare and well-baby clinics within the curtilage of the group-practice centre are becoming commonplace. Health education sessions (Hasler, 1968) primarily utilizing the expertise of the health visitor will no doubt increase. With the co-operation of a forward-looking local authority routine school medical examinations could well be carried out by the general practitioner (Buchan and Jones, 1967). It would seem a logical development to phase into this the specialist paediatrician when he is required. With the increasing tendency for general practitioners to group together (a group of 10 is already scheduled for this area) it will be increasingly easy for paediatricians (and some other specialists) to devolve the majority of their outpatient work on to these large group-practice centres and health centres. Doctors at such centres are at present busily intensifying their expertise in providing primary medical care. Nevertheless, there is a danger that these doctors will find their academic and clinical skills deteriorating by being geographically divorced from the hospital where now and presumably for long enough in the future the pure clinical developments will take place. One method of preventing this deterioration will be to devolve the specialist and his outpatient work on to these centres as described in this paper.

This structure of community care brings increasing possibilities of specialization within groups of general practitioners. One generalist having attended all the paediatric problems with the paediatrician over a period of time may well be able to give a higher standard of care to the "difficult" paediatric cases than his colleagues. Link this with attendance at paediatric ward rounds and possibly some inpatient responsibility for the paediatrics from his group and the ideas of the Royal Commission on Medical Education (1968) appear to be practicable. This pattern could well be repeated in other specialties.

From the community care unit (with devolved outpatients) could well emerge various methods of community medical care, and the careful evaluation of each method would provide factual guide lines for future planning.

We acknowledge the co-operation of Drs. K. G. Wilmot, W. C. Moonie, A. C. MacDonald, and R. G. P. Hall in analysing their referred paediatric problems for us.

REFERENCES

Buchan, A. R., and Jones, A. P. (1967). *British Medical Journal*, **4**, 797.
Draper, P. (1967). *Lancet*, **2**, 1406.
Gibson, *et al.* (1966). *British Medical Journal*, **1**, 1287.
Hasler, J. C. (1968). *British Medical Journal*, **3**, 366.
Marsh, G. N. (1967). *British Medical Journal*, **1**, 489.
Marsh, G. N. (1968). *British Medical Journal*, **1**, 633.
Royal Commission on Medical Education (1968). *Report, 1965–1968*, Cmnd. 3569. London, H.M.S.O.