PAPERS AND ORIGINALS

The role of the hospital in primary care for the child in the community*

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I have moved from the hospital into the community more than once. Some years ago I realised that many children admitted to the ward on urgency nights came from homes where there was a difficult financial or social problem. As a result, we arranged that all parents of such patients would be seen by the ward sister or the registrar and a social inquiry was made in those cases in which parental care seemed inadequate. This pilot scheme was productive and two years ago the inquiry was extended to all cases admitted to the ward.

Pilot scheme

During the past 12 months, 87 cases out of 839 admissions (10%) were referred to the hospital social service department. Of this number, 319 were urgency admissions from whom 20 families were studied with the detection of five cases of non-accidental injury plus two more families where the diagnosis was queried and supervisory help given. Some of the referrals were for family support because the children were dying, some families were sent to the psychiatric social worker because the children were disturbed, and others needed financial aid for travelling or help with medical appliances. Several of the social problems were dealt with by the hospital office but in many cases the information was passed straight to the appropriate district or area social service department.

A further hospital study of recurrent outpatient non-attenders has identified families requiring help, and in the last six months 41 such cases have been referred to the liaison health visitors for follow-up in the community. Although some of these families and the children themselves are known to area or district department, many problems have been identified for the first time in this way. The presence of liaison health visitors in the hospital is vital, and this arrangement has become well established during the last few years. These health visitors come from the adjacent health authorities and are attached to the hospital, which they visit frequently; they are also readily

accessible by telephone, and their presence has facilitated communication between the hospital and the area health services.

Children at risk

Recently there have been reports of work relating to cot deaths and battered babies from Sheffield¹ and Oxford² respectively. In each city pathologists, paediatricians, and social workers reviewing the birth history and family background in these groups of children over a period of several years have been able to develop a predictive scoring system by which they can identify children at risk. In this way, the hospital team can alert the family doctor, and more particularly the local social services departments to this danger and allow them to plan closer supervision and support for the families concerned.

This information is obtained when the mother and her child are in the maternity department, which today can provide a standard of antenatal supervision and investigation and intensive care after delivery sufficiently high to allow a considerable reduction in the damage to the baby during the perinatal period. In this way, we hope to see not only a reduction in the numbers of children in the community suffering from brain damage but also of certain chromosomal disorders such as Down's syndrome and central nervous system disorders such as spina bifida.

Provision of primary care in cities

In the long-awaited Court Report³ the team has emphasised the necessity for good primary care in childhood with the bringing together of both preventive and curative aspects of disease. Although I agree with the broad principles of the Report, it contains some recommendations concerning the implementation of primary care which would be impossible in big cities.

SOCIAL CONDITIONS

The decline in the living standards in the centre of big cities has coincided with a sharp increase in the use of the accident and emergency services of the local hospital by the mothers of sick and injured children. This largely reflects the varying standard of medical services throughout the 24 hours due to maldistribution of general practitioners (who are often considerably overworked); the difficulty in obtaining medical help in the evenings and at the weekends; and the use by practitioners of the deputising services, which inevitably results in the appearance of a complete stranger who has no know-

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ledge of the child or the family. In addition, the concentration of surgeries with the creation of health centres has meant that in certain areas it is nearer and easier to go to the local hospital than it is to the health centre. The advent of smaller families with increased mobility has also meant the loss of the extended family system, so that young parents have had little experience of infants and young children growing up in a family, and have no older relatives on whom to call for advice in times of stress.

WEAKNESSES OF THE COURT REPORT

The lack of incentive for doctors to work in these areas is a real weakness of the recommendation of the Court Committee for the creation of general practitioner paediatricians, and I believe that an alternative arrangement must be considered for large urban areas. A second and immediately relevant concern is the implication by the Committee that the present clinical medical officers will be phased out slowly. These doctors, largely married women working part time, have been employed by the local authority in the maternity and welfare and school clinics, and their contribution to the primary care of children has been considerable; this has been especially helpful in urban areas and it would be disastrous if their work was discouraged. Nevertheless, there have been one or two drawbacks to their work in the past. Firstly, they had help from colleagues with long experience in their own preventive work, but had little access to clinicians working in acute paediatrics to whom they could turn for advice or instruction; and, secondly, their career opportunities were limited.

The increased use of the accident and emergency department by the parents of sick children is most noticeable in the late afternoon and at night, when the staffing of the department is reduced. Although every hospital has its list of known problem families in the area, most of these patients and parents are strangers to the members of the department. The doctor who sees the ailing child often is young, and may have had little paediatric training; in addition, it may be difficult for him to seek experienced help. It is therefore easy to see how the occasional tragic clinical error can come about. Some hospitals are trying to meet this responsibility but usually have inadequate staff and accommodation to enable them to do so.

This unfortunate and disturbing picture is only one example of the many socially disadvantageous conditions that are to be found in the centres of our big cities, and which will not be improved until a more enlightened planning policy with appropriate financial support is put into effect by government. Until such time, it would not be possible to implement many of the recommendations of the Court Committee for primary care in these areas, and I suggest that the hospital must take an active responsibility for primary care in these areas and that some relevant pilot trials should be started as soon as possible.

Proposed scheme

This should be a combined university and National Health Service responsibility; the project should be based on the paediatric department and the children's section of the accident and emergency department of the hospital concerned. When possible, the team should be in the charge of a reader or a senior lecturer in social paediatrics, or an NHS consultant with designated responsibility for community problems, who together would work with the consultant physician in child health of the area or district concerned. The team would include a registrar and a senior house officer, and these special duties would be part of the hospital rotation training programmes. This hospital-based team would work in close relationship with two groups of doctors to be described later. The sector within which the hospital would exercise general supervision should contain a population of some 50 000–75 000 people, which means approximately 11 000–14 000 children.

GENERAL PRACTITIONERS

So far as I can ascertain, there would be between 16 and 20 general practitioners working, on average, in six practices of varying sizes but largely of the three- or four-man variety. One would hope that from this number five or six general practitioners with a particular interest in the problems of childhood would agree to take part in this scheme,

and that this number should not be difficult to achieve when more doctors enter general practice from the new vocational training programmes. These general practitioners, my first group of community-based doctors, would accept responsibilities additional to those in their general practice; these would include primary care such as immunisation and advice on the minor problems in infancy, assessment of development, and occasionally a school medical officer post. These doctors would probably require some further training in these aspects of paediatrics. They would be known to the district or area authority and this would allow the specialist in community medicine (child health) to deploy the members of the second group, the child health practitioners, more efficiently.

CHILD HEALTH PRACTITIONERS

These doctors, currently called clinical medical officers, would spend much of their time in the various clinics in the area, but could also give help by being attached to large practices. Each child health practitioner should also be the designated doctor for one or two schools in the area. The child health practitioners would be responsible to the community physician in child health for the administration of their clinic and school work, but would look to the hospital consultant paediatrician for clinical help and supervision. Again, special training should be offered to these doctors to fit them for these responsibilities.

Both these groups should have a recognised attachment to the hospital unit to allow their members to visit patients and attend ward rounds and clinical meetings in their own right. Although it is unlikely that the general practitioners could spend much time in the hospital, I hope that the direct link between themselves and the hospital staff would improve two-way communication. As the child health practitioners would be immediately responsible to the consultants for the standard of their clinical work a few would probably want to be attached to the district handicap team or to become clinical assistants in the hospital and help with the long-term care of children and their families in units such as I have described earlier in this lecture. They would learn much from their regular contact with the consultant paediatricians and from the experience gained in the special clinics, and this could be augmented from time to time by organised post-graduate teaching courses. This would enable these people, almost certainly married women, to move either into general practice should they wish to do so, or in certain cases take higher degrees for consultant practice when they are freed from many of their domestic responsibilities.

THE HOSPITAL

Although the hospital outpatient clinics would continue as at present, arrangements should be made for a consultant to visit each health or group centre every second month to see non-acute problems with the practitioners. These would be both new and also old cases who have been referred back from the hospital outpatient clinic. Not only would this reduce the outpatient attendances, but in addition it would be a useful opportunity for discussion and teaching with the practitioners and the accompanying residents and students. It is unlikely that this would affect the attendances in the accident and emergency department in the daytime, although the late afternoon traffic should be reduced. The night calls would be taken by the central hospital department and the telephone for these incoming calls would be in the accident and emergency department. This telephone number should be readily available to the public and in this way one would hope to cut out the delays and frustrations experienced at present by anxious and bewildered parents when they seek help. One or more of the practitioners on duty could be on call at the hospital, and this night and weekend duty could be shared by the general practitioners, child health practitioners who had agreed to join the rota for experience, and the senior house officer on rotation. Thus this work would not be a heavy commitment.

SPECIALISTS IN COMMUNITY MEDICINE

I have emphasised the inclusion of the SCM (child health) in the team and I expect that this person's contribution will be very largely administrative. This post will probably be a career-grade post with many of the occupants moving on to more senior positions in the service. Similarly, there may well be doctors appointed to this position who have had little experience in the care of the sick child and of preventive paediatrics but whose general administrative ex-

perience is thought to fit them for this more senior appointment. Nevertheless, the SCM (child health) should become fully aware of hospital activities and development through correspondence, attendance at clinical meetings, and by virtue of his position in the "cog-wheel" paediatric division.

RECORDS

It will be essential to arrange for the children's records to be kept in triplicate in the sector and for constant revision to keep them up to date. The hospital, as well as the general practitioner, will need a copy for easy reference when the child comes directly to the accident and emergency department or the outpatient clinic, and one will be required for the SCM (child health). I would hope that the records could be brought up to date every three to four months by the designated member of the clerical staff. There is another way in which this centrally based unit could help. In addition to the medical establishment that has been proposed, there should be a few child health visitors—say four—and two or three child health nurses attached. The former would be concerned only with the children in the sector, and one of their important tasks would be to identify the families without a general practitioner and the parents who are incapable of sensing illness in their children. This important social information will complement that obtained by the hospital social-service team as described earlier, and will require the child health visitors to work closely with the health visitors attached to the hospital.

These people could also help in the development of a home nursing scheme by advising the general practitioners and the hospital about the feasibility of nursing a sick child at home rather than in hospital, or of allowing an early discharge from the ward for continued nursing supervision at home. We know of the value of the home nursing scheme at St Mary's, Paddington, as this has been in existence for some years; recently, Dr Hugh Jackson and his colleagues in Gateshead¹ have reported on an encouraging pilot trial in that city where the hospital provided background support by giving consultant advice when requested and also giving some extra training to the nurses participating in the scheme. The proposed hospital-based team could easily offer consultant advice, health-visitor supervision, and nursing care to any general practitioner in the sector wishing to look after his sick patients in their own homes.

Future developments

It should be possible for simultaneous sector trials to be started in the Manchester metropolitan area, based on three

major children's units. The detailed arrangements in each sector could be varied to allow for critical comparison after three or four years. I hope that the demand on hospital beds and outpatient space would be reduced, and better communication would strengthen the links between general practitioners and the child health practitioners on the one hand and the hospital on the other. A better service and a corresponding rise in the standard of care of children in the community would therefore result. The experience gained by the participants, both medical and nursing, would in itself be educative; but an inservice postgraduate training programme should also be incorporated as well as an opportunity to attend a course outside the hospital from time to time. This would also provide a great opportunity to teach the undergraduates paediatrics, both in the hospital and in the community. The scheme should not be expensive as some of the team would already be employed within the authority; neither would it be necessary to build expensive departments from which to run the trial.

The arrangements for smaller towns would be much simpler, and in many areas of the country there would be no need to implement a scheme of this type. In many of the industrial towns, however, it would be advisable clearly to identify the general practitioners prepared to undertake special clinics and to plan the work of the child health practitioners accordingly, ensuring that they have a close relationship with the local consultant paediatricians, who would be responsible for overall clinical supervision and postgraduate education.

In this way the primary care needs of these underprivileged areas could be met, while providing a greater incentive for general practitioners to work in the area and a more interesting clinical experience as well as a training structure for doctors who can only give part of their time to medical practice. The movement of the hospital into the community should also provide training experience for students and residents, and I hope reduce the demands on hospital beds and outpatient services.

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Prospective trial of oestrogen and calcium in postmenopausal women

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Summary

In a prospective trial in 72 postmenopausal women to compare the effects on bone loss of no treatment, treat-

ment with oestrogen, and treatment with calcium the women were followed up for at least two years and examined densitometrically and morphometrically.

Women in the untreated control group continued to lose bone during the two years, whereas the oestrogen-treated group lost none. Loss in the calcium-treated group was intermediate. Oestrogen appeared to inhibit endosteal bone resorption and may have stimulated subperiosteal bone apposition.

Introduction

The relation between the menopause and the onset of bone loss is well documented,^{1 2} and several retrospective trials have

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