The First Year of Life

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HEALTH SERVICES FOR CHILDREN

The NHS Act of 1946 established a service in three parts: the community health services provided by local authorities, the general medical services provided by general practitioners, and the hospital and specialist services provided by health authorities.

The community health services were intended to provide care for expectant mothers, children under 5, and schoolchildren. The school health service, responsible to the local authority, was concerned with regular medical examinations, the formal assessment of mental retardation, and the provision of advice on managing behaviour problems. It also provided special clinics for speech problems and obesity, and chest, orthopaedic, and vision clinics. Facilities were provided for vaccination and immunisation, but the medical staff were debarred from prescribing drugs. General medical services were provided for registered children by independently contracted general practitioners, but these contracts did not explicitly cover preventive services.

Health visitors were provided under the 1946 Act to give advice in the home on the care of young children and of ill patients of any age. With the midwives they supervised expectant and nursing mothers. Their other main responsibility was for measures to prevent the spread of infection. A home nursing service was established at the same time.

Though the community and school health services have been administered by the area health authorities since reorganisation in 1974, the roles of the different services have remained much as they were in 1948. The various services in relation to children aim at providing preventive or curative medical care for those who need it, but parents often do not understand how the system works and what is expected of them; and when they need further help they may find it hard to reach the same doctor or the right one.

General practitioner services

Most parents turn first to their general practitioner when their child is ill. Every year three out of every four children aged under 15 years will see their general practitioner, and on average each will have four or five consultations. A general practitioner usually has about 500-600 children under the age of 15 years registered with him and they occupy 25-30% of his time. One to 10 per cent of these children are referred to hospital outpatient departments, although this varies with the doctor and locality. The general practitioner is responsible for providing a 24-hour service, but in large cities many rely on deputising services to provide cover at nights and weekends, particularly single-handed general practitioners.

Most general practitioners currently in practice have had no specific postgraduate training in paediatrics, though about 90% of vocational training courses for new general practitioners include up to six months' training in the care of sick children. Meanwhile the growth of group practices has provided increased opportunities for doctors to develop a special interest in paediatrics, though it is left to individual partners to decide whether and how this is organised within each practice. Some general practitioners take on sessional work as clinical medical officers in the community or school health services and as clinical assistants in hospitals.

One result of the growth of group practice and health centres has been the increasing attachment of health visitors, home nurses, and midwives to specific practices, who form, with the general practitioner, a primary care team. In the centres of large cities up to 20% of children may not be registered with a general practitioner, and some districts have provided geographically based health visitors to reach them.

Preventive health services: pre-school services

The community health services have the main responsibility for the developmental surveillance of young children, though an increasing number of general practitioners organise their own child health clinics for children registered with them.

A midwife is responsible for visiting the mother and baby at home at suitable intervals from the time of discharge from the maternity hospital until the 10th day (or, if necessary, until the 28th day). The health visitor then follows, building on her family contact during the pregnancy, and has a key role in the preventive services for pre-school children. Health visitors are state registered nurses who have taken an approved course in midwifery and a 12-month course in health visiting. They have a statutory duty to visit each mother and child within 10 days of birth. They also form part of the staff of child health clinics, which provide periodic surveillance of the pre-school population, education of mothers on maintaining their children's health, and immunisation against certain infectious diseases. Some of the large clinics also distribute infant foods. Parents have open access to clinics, but in many areas they are also invited to bring their children for regular developmental assessment. The doctors in the child health clinics are the clinical medical officers, the most experienced of whom are senior clinical medical officers; all are administratively accountable to the specialist in community medicine (child health). The clinical medical officers work closely with the health visitors, who refer children with particular problems.

The attachment of health visitors to general practices and the loss of a defined territory have made it harder for them to locate and help mobile families and others who make ineffective use of the health services. Acceptance of health visiting responsibility for all ages has increased their work with the elderly and reduced the amount of time they can spend with young children and their mothers.

School health service

The 1944 Education Act obliged local education authorities to ensure that free medical treatment as well as medical examinations were available to pupils. Since 1948 most have relied on the NHS to provide treatment, though some have maintained the facilities established before 1948—for example, chest clinics and clinics for enuresis and obesity together with provisions for audiology, ophthalmology, and speech therapy. In general the school health service has become a health advisory service paying special attention to the needs of handicapped children.

Hospital and specialist services

There has never been a national policy aimed at achieving co-operation among general practitioners, clinical medical officers, and school doctors, or at resolving the historical but unreal conflict between promoting health and treating illness. The lack of specific training and the past emphasis on regular medical examinations have restricted the ability of the school medical service to make a medical contribution to the understanding and management of educational failure, particularly to those children with "learning difficulties" and the problems of adolescence.

A quarter to a third of patients attending accident and emergency departments are children, but most senior and junior staff have had no postgraduate experience in paediatrics. In some inner city areas the casualty departments of children's hospitals have traditionally provided primary care for a large proportion of the child population at night and weekends. Many of these departments are now disappearing as small units close and the children's department is incorporated within a larger complex, served by one accident and emergency department.

Consultant paediatricians used to confine their work mainly to the newborn and acutely ill children, but the changing pattern of childhood illness means that they must now take an increasing part in the care of the physically, mentally, and socially handicapped. Child development centres in district and university hospitals provide facilities for investigating, assessing, and managing children with handicaps in partnership with parents and teachers. The basic team consists of a consultant paediatrician, a senior clinical medical officer, a psychologist, a health visitor, and a social worker with special experience in handicaps. A paediatric nurse with experience in the care of the handicapped, a remedial teacher, a senior speech therapist, a physiotherapist, and an occupational therapist may also be concerned with appropriate children.

There are now paediatric subspecialties in neurology, cardiology, and nephrology and the number of paediatric surgeons is increasing, but most children's surgery is still done by surgeons whose main activity is adult surgery.

Paediatricians try whenever possible to prevent children being admitted to hospital. Day care is being used more and more for both medical and surgical conditions, but a separate treatment area, appropriate staff, and scrupulous organisation are needed. When a child needs nursing at home it is normally the responsibility of the mother, assisted in a few cases by the district nurse, who generally has little experience in nursing of young children.

The established policy of the DHSS (HC(71)22) is to bring all children needing inpatient care together in a paediatric department. While the clinical care remains in the hands of the appropriate specialist, the unit as a whole is under the surveillance of a paediatrician and staffed by registered sick children's nurses under the control of a paediatric nursing officer.

Sadly for the children and their parents, professional resistance and financial restraint have resulted in only a limited achievement of this objective. For inpatients most paediatric units have unrestricted visiting, but many still have limited or no facilities for parents who want to stay overnight with their sick child. Only the child's mother can interpret the surroundings and events of a ward to a child and prevent the added injury caused by separation.

Psychiatric services

Child psychiatric services are provided by hospital departments of child psychiatry and by child guidance clinics in the community. Children are referred to the hospital service by general practitioners, and the departments are staffed by child psychiatrists, clinical psychologists, psychiatric social workers, and therapists employed by the health authority. The child guidance service receives referrals from schools and social services departments as well as from general practitioners. The health authority provides the consultant psychiatric sessions and the local authority employs the educational psychologists, therapists, and social workers. Many problems are not identified or appropriate help sought until they cause behaviour problems at school or difficulties with learning.

The future

The distribution and the quality of care for children can undoubtedly be improved and the present divisions put together in a child-orientated service. Parents want to take a more active, informed part in their children's health but they find the present pattern of services confusing and difficult to use. If the same doctors could provide both preventive and curative care for children, parents would no longer be confused. Vocational training schemes will ensure that most family doctors have some postgraduate training in paediatrics, but without a change in the priorities for care it will be difficult for them to devote time to the preventive aspects.

A recent proposal that certain family doctors in a group practice would have a special interest in developmental and preventive paediatrics has been rejected, but in a growing number of practices the concept has taken root. Planned postgraduate education and a defined career structure for clinical medical officers will enable them to give more effective care. Yet unless they are first linked with and then absorbed into the comprehensive primary care service or the specialist services, a fragmented tripartite service for children will persist indefinitely.

Circumcision and undescended testis

In 95% of babies the foreskin and glans of the penis are still united at birth. It has been found that the foreskin can be retracted by the age of 1 year in about half the babies and by the age of 3 years in nine out of ten. But no attempt should be made to retract the foreskin until the baby is about 4 years old. Attempts to retract the foreskin earlier are likely to injure the mucosa, causing bleeding followed by adhesions, and circumcision may later become necessary. Mothers often request circumcision to be carried out because the prepuce orifice appears small. In most cases the adequacy of the orifice can be shown by stretching the foreskin *distally* and no attempt should be made to retract the foreskin. Before the age of 4 years the only medical indications for circumcision are recurrent *purulent* balanitis and ballooning of the foreskin at the beginning of micturition.

Most circumcisions are performed as a religious ritual, in Jewish families on the 8th day of life and in Moslem boys between the ages of 3 and 15 years.

About 2% of testes are undescended at term and spontaneous descent rarely occurs after the age of 4 months and never after 1 year. After the neonatal period an active cremasteric reflex can easily pull the testis out of the scrotum especially if the examiner's hands are cold. The mother will often have noted whether the testes are both in the scrotum after a hot bath, and a retractile testis will descend into the scrotum when the thigh and knee are maximally flexed on that side.

Preventable causes of death

Two preparations of drugs are especially associated with avoidable deaths in children.

Ampoules of digoxin for use in adults should never be supplied to children's wards. Ampoules of digoxin made specially for children ensure that a fatal overdose cannot be given.

Penicillin given intrathecally has no therapeutic value. Errors are often made in dispensing the correct dose of penicillin for intrathecal use, with fatal results. This route should therefore never be used for penicillin.

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The articles in this series have been collected into a book, which is now available from The Publisher, *BMJ* (Price: Inland £5.00; overseas US \$12.50 (£4.50 or US \$11.25 for BMA members)).

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