*ABC of 1 to 7*L PETER
H B VALMANSERVICES FOR CHILDREN:
PRIMARY CARE

The general practitioner provides continuous care for the whole family, and his intimate knowledge of the fears and aspiration of each individual enables him to act as a trusted counsellor in both preventive and curative medicine. Specialists in the community or hospital provide the support he requests. About 25% of the work of the general practitioner concerns children, and he recognises that their needs are different from those of patients in other age groups because they are both dependent and developing.

The general practitioner just described is in the minority. The primary care of children is still divided: general practitioners provide a mainly treatment service (for those who seek it) while the clinical medical officers of the child health and school health services provide a surveillance, prevention, and health education service. General practitioners are performing an increasing amount of preventive work and this will lead eventually to comprehensive care. We describe here some aspects of care in an ideal practice.

Practice organisation

Illness in children often starts suddenly and arouses acute anxiety in parents. Practice receptionists need to appreciate this natural protective response and allow children to be seen promptly despite the planned appointment system.

Although the level of home visits is falling, this reduction is less sharp in the case of children. If there are other siblings or transport problems it may be difficult to bring the child to the surgery, and parents often wrongly believe that ill children should be kept in bed or that children with respiratory tract infections or a fever should not go out in the fresh air. A home visit is valuable in educating the parents.

A general practitioner is the doctor of first contact who provides continuing care and has a 24-hour responsibility for all his patients. Access should be simple. Some general practitioners dislike being interrupted by telephone calls during a consultation session, but speaking directly to an anxious parent may save time and increase confidence. Outside surgery hours and when the general practitioner's home telephone is not manned an alternative number should be available by a one-step method.

The best method is a recording machine which gives the telephone number of the doctor so that the patient can speak to him directly. Alternatives are the operator transfer and the general-practitioner answering service, both of which often have delays.

A rota system among group practices or singlehanded family doctors, in which the doctors share their out-of-hours work with colleagues, is the ideal method of sharing night duty. Deputising services provide doctors who are not aware of the family's background, do not have access to the medical records, and are not known to the family. The doctor who sees the child may have had no training in paediatrics or in general practice, and long delays may occur. At present about a third of general practitioners use deputising services. Doctors working in these services should have adequate experience of general practice and acute illness in children.

Preventive service

Age	Clinic activity
Birth	Home visit by GP
6 weeks	Screening check
3 months	1st immunisation DTP + Polio
5 months	2nd immunisation DTP + Polio
9 months	3rd immunisation DTP + Polio
7-10 months	1st hearing test + screening check
14 months	Screening check + measles immunisation
2 years	Screening check
3 years	Screening check
4 years	Preschool check + DTP + Polio immunisation

New entrants to general practice spend a year as trainees in general practice and two years in various hospital posts, which usually include six months in paediatrics. Some experience in the community services is essential, and ideally this would be in addition to the hospital paediatric post.

Not more than one in 10 general practitioners have clinics for the regular surveillance of infants. If a general practitioner is to run his own clinics an attached health visitor is essential. Antenatal care by the family doctor prepares the family for an unrequested home visit after the mother's discharge from the maternity unit. He can then observe for himself the conditions of the family and attitudes that will mould the child's life.

During the first few months of life mothers will readily attend an efficient, welcoming baby and toddlers clinic. The baby can be weighed, a growth chart maintained, and simple advice given which will resolve many problems. The clinic also provides an opportunity for the mother to meet other mothers and discuss mutual pleasures and problems. If she finds this clinic satisfying she will continue attending so that a full programme of immunisation can be carried out. All mothers are eager to know whether their infants have normal hearing, sight, and development, and they are more ready to accept preventive health care such as immunisation from a doctor who is known to the family. Developmental screening examinations should be performed only if the general practitioner has a special interest and training in this subject. If this aspect of paediatric care is to increase some vocational training schemes must allow time for the necessary skills to be acquired. During the interim clinical medical officers in the community health service could provide these preventive services in the premises of general practitioners.

When abnormalities are detected—for example, squints, hearing disorders, speech disorders, and varying degrees of delayed development—prompt referral to the appropriate specialist is necessary.

Equipment

Sutures and dressings to deal with minor injuries should be available because there is often a long wait in local accident and emergency departments and management by the general practitioner is more appropriate. Equipment for resuscitating the newborn and for performing developmental screening should be available, as should equipment for examining children. Toys and other items to help the doctor talk to the child are useful.

Primary health care team

The primary health care team consists of the general practitioner, nurse, health visitor, and midwife, with the receptionist and secretary. An attached social worker is an essential part of many teams. The team meets regularly to co-ordinate and improve care. The lack of social workers in many primary health care teams reduces their effectiveness.

The health visitor provides the mother with information on child care in the home and the clinic, and she is one of the most effective sources of health education. She also has the opportunity to teach the mother how to look after a sick child in the home.

Communication

The consultant's letter should not only be informative about the patient referred but should also contain information which will be helpful for managing similar cases in the future. Meetings at the postgraduate centre are helpful provided the general practitioners and clinical medical officers as well as consultant paediatricians give the talks and plan the meetings.

It is becoming increasingly common for doctors to meet in small locally based groups to discuss matters of mutual interest and a few general practitioners are leading the way in measures to audit the care that they deliver to children in their practices.

The general practitioner is inundated with free journals and advertisements and there is a temptation to ignore them all. One general and a specialised journal with a few standard textbooks will make reading more profitable.

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Constipation

Constipation is an alteration in bowel habit with the passage of hard stools and a reduction in the frequency of stools. Normal children may pass stools between four times a day and once every four days. Any child with an acute illness tends to eat and drink less than normal and he passes fewer stools. Apart from ensuring that fluid intake is adequate no treatment is required. If there is an inadequate intake of fluid the stools may become hard and produce an anal fissure. The pain produced during defecation by the fissure may make the child reluctant to pass stools so that he holds them back by crossing his legs. Several days may pass before the child passes a formed stool, which is then voluminous and may cause severe pain.

Colonic inertia with overflow soiling—If the child persists in refusing to pass stools chronic constipation follows. The whole colon becomes distended with firm stool and the reflex urge to defecate is lost as a result of the persistent distension of the rectum. At this stage enormous masses of faeces can be palpated through the abdominal wall and be detected on rectal examination. Liquid stool may trickle continuously around the masses and escape with gas through the anus. Parents may complain about this continual loss of fluid stool and call it diarrhoea without realising that there is underlying constipation. The doctor will not be misled if he examines the abdomen and rectum. In some children there is no obvious history of an anal fissure but bowel training has been attempted before the age of 2 years.

By the time the child is seen by a doctor the problem has often been present for several months or years and any emotional problems present may be primary or secondary to the physical problem. Most of these children can be managed by medicines, and a child psychiatrist should be consulted about those who do not improve quickly.

The cause of the problem is discussed with both parents and the child using simple diagrams, and they should be told that aperients will be needed for a prolonged period, at least for a year, otherwise relapse will occur. The following three drugs are given initially together:

(a) methylcellulose liquid (Cologel) 450 mg in 5 ml three times daily, (b) diocetyl sodium sulphosuccinate (Diocetyl-Medo) 12.5 mg in 5 ml three times daily, and (c) senna extract (Senokot) 5–10 ml at night. The first drug makes the stools soft, the second is a detergent and penetrates into the stool, and the third acts by propelling the stool. The child should be asked to sit on the lavatory at the same time each day to encourage reflex defecation. He must be seen initially each week and then at monthly intervals to ensure that the medicine is being taken. The doses of the drugs are gradually reduced after about three months and a regular habit has been regained. Relapse is common and the parents should be warned about this possibility. Suppositories and enemas and the manual removal of faeces can rarely be justified except in children with cerebral palsy.

Passing stools in unusual places such as behind curtains indicates a severe behaviour disorder, which needs referral to a child psychiatrist.