TALKING POINT

A career for child health doctors

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The Court Report¹ was a prescription for more competence in child health care, more emphasis on prevention, and the integration of therapeutic and preventive child health services. These represented the underlying philosophy and spirit of Court that was accepted and commended,² and recently reaffirmed³ as a starting point for alternative patterns of health services for children, after the rejection of the Court proposals in 1978.

Since then little progress has been made in the application of this philosophy and fears that have been expressed for the future of the child health services⁴⁻⁸ have not been unfounded. There have been many signs that the unity of the community child health services is breaking up as the school health service is being allowed to run down. The use of changes in organisation to help achieve integration has been abandoned; instead it is anticipated that integration will happen as a result of training.⁹ No one has dared to predict how long this might take. Consequently general practice with ambivalence and community medicine with relief have together ensured the indefinite continuation of a third force of doctors to staff these community services. This in itself need not be a totally unmitigated disaster for children since at least their community health care could still be provided by doctors with special interest and expertise in paediatrics. Sadly, the needs of children have been submerged beneath the ambitions of factions. At the Annual Representative Meeting of the BMA in 1981 a motion that aimed to enhance the training and expertise of clinical medical officers (CMOs) as a holding operation was defeated, and only grudgingly was another motion adopted calling on the Central Committee for Community Medicine (CCCM) to continue to negotiate a career structure for community health doctors.¹⁰

The CCCM has now responded by approving in principle a report by its Community Health Doctors Subcommittee,¹¹ which exceeded its remit in discussing training and like a bull in a china shop has overturned the delicately poised understandings already reached. It defiantly turns its back on any trend towards integration. It goes back on the principle of specialisation in the community health services, and it seeks to give back to senior clinical medical officers (SCMOs) the archaic and unethical function of "clinical management of CMOs both full time and sessional." The report shows a lamentable interpretation of the Health Service needs of children and of self-preservation on the part of community health doctors. While general practice and hospital services need only one grade of trained clinician it is proposed that there should be three grades in the clinical community services. The principal justification for this is that it is "financially logical." It is also said to be essential in order to accommodate doctors who do not want consultant status but no explanation is offered as to why this should be so in one branch of primary care and not in the other.

The case for retaining a generalist grade CMO seems to rest naively on a description of the range of care provided by the community services as a whole, though no CMO exists whose practice spans this range. It could be (though the report

does not say so) that this grade is a justification for the next one, since no reason is given for retaining the SCMO grade. It seems from their proposed training that it has to do with a role in administration and management, teaching and research; but skills in administration and management are irrelevant to clinical grading, SCMOs depend on CMOs to provide much of the practical training for students, and research is not the prerogative of any one grade of clinician. And how can a career grade be taken seriously that visualises senior doctors, after six years of postgraduate medical training, specialising in child psychology or psychometrics, or a national training whose content is allowed to "vary according to local needs?"

We are surprised that this report has been accepted in principle and we can only hope that this is a euphemistic expression for the need for major modifications in detail before implementation. We submit once again⁴ that a career structure for child health doctors must be based on an accurate job description that must stem from the kind of service that children and their parents need. When this has been done the necessary training can be considered.

Work and responsibilities of child health doctors

There is astonishing ignorance about what child health doctors really do in their clinics and schools. We have recently completed two studies of child health services, one in the preschool period¹² and one in primary schools.¹³ These studies show that it is not correct to think of the work of these doctors in simple terms of traditional, preventive health. The alternative term "anticipatory care" has been coined¹⁴ for just this reason. Health surveillance more often than not shows up problems of development and behaviour alongside disorders of health, many of which need some kind of intervention. For instance, young children who frequently have upper respiratory tract or ear infections are quite likely to have intermittent hearing loss and speech and language problems that make them more prone to behaviour problems, temper tantrums, and management difficulties than children who do not. Whereas general practitioners will usually treat adequately episodes of acute illness they do not always appreciate the functional disability or handle the developmental and behavioural consequences. Furthermore, children in school are frequently referred by parents and teachers for diagnosis and advice about ailments and ill health as well as behaviour and learning difficulties. Of course, an understanding of these latter problems is a crucial part of the school doctor's work.

So while it is true that child health doctors spend some of their time on traditional preventive health work—for example, immunisations and regular physical and developmental assessments, much more of their time is spent on clinical matters that arise from the concern of various adults about physical symptoms and signs, behaviour and learning delay in the children they look after. They are frequently called on to examine children who may have special educational needs and to advise educational psychologists and education authorities on the medical aspects of such children's difficulties in school. In addition, they advise head teachers on health matters that affect their school as a whole; and they examine, and give advice about children of all ages for whom social service departments are considering for adoption or fostering, or are anxious about because of non-accidental injury. These are all aspects of liaison with other professional staff that is such an important function. Territorial appointment carries with it obligations to gather basic epidemiological data with help from community physicians and periodically to monitor the service they are providing. Finally, the more experienced child health doctors are concerned with the training of doctors, medical students, and nurses in community paediatrics.

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It is in the ordinary clinics and schools that community paediatrics is largely practised at the primary level and, like the general practitioner, the child health doctor needs sufficient competence to deal directly with most health care needs and problems in development and behaviour as and when he meets them. He will refer children needing medicinal treatment to their family doctors, except insofar as special arrangements may have been made between individual GPs and child health doctors for the latter to provide this—and we believe there is a real need, especially in the cities, for the work of child health doctors to be organised as a supplementary rather than a complementary service to that of the family doctor. But only a minority of children require specialist opinion or investigation and these need referral to the hospital-based secondary services. Once child health doctors are trained to the level necessary to meet the primary needs of their patients there will be no need for a second grade (SCMO) clinician in primary community paediatrics.

Terms and conditions of service

Terms and conditions of service are an important aspect of any career structure and never more so than in the case of child health doctors. They should be under contract solely to provide a primary community paediatric service for a given population of children, specified in terms of the clinics, day nurseries, schools, etc, they attend. They should provide some continuity of care by being on call to health visitors, school nurses, teachers, and social workers with whom they may work. For this reason they should be based at a clinic and associate with two or three other child health doctors with whom they can have locum arrangements. The methods of health care they employ, such as the frequency of surveillance, should be a matter for them to decide in consultation with their colleagues, health visitors, and school nurses. This is a commonly overlooked aspect of their clinical autonomy. Indeed, in drawing up their contract it might be as well to emphasise that they do have such autonomy¹⁵ since this is obviously not generally known. Community physicians have won their fight to retain administrative responsibility for the community child health services but we would hope they will see the folly of supposing that this gives them the right to manage child health doctors. The guidelines recently drawn up by the CCCM for the organisation of health services at district level¹⁶ are equivocal on this issue; the Community Health Doctors Subcommittee got it wrong, and the guidelines need to be clarified. Evidence of appropriate training must be the assurance to which district medical officers are entitled that child health doctors in future would have the necessary competence and initiative to fulfil their responsibilities and organise their own work. As a separate group of clinicians they should have their own representative on district health authorities and district management teams, alongside GP and hospital consultant representatives.

Training

The Clark Committee was quite right to recommend a basic three years' training for all primary care doctors and a final year in either community paediatrics or general practice, as a trainee, according to whether they chose to specialise in primary community paediatrics or become principals in general practice.⁹ The Royal College of General Practitioners was right to recommend that some evidence of appropriate training be required from doctors, be they GPs or child health doctors, who in future undertake work hitherto done by CMOs.¹⁴ The introduction of a combined GP/child health doctor vocational training,¹⁷ whittled into three years and without evidence on completion of more than six months having been spent in primary community paediatrics, is a recipe for inferior child health care.

We would be less critical of this vocational training if it aimed only to raise the level of expertise in developmental surveillance of infants and young children. Many of our colleagues believe that this is the objective but we are less sure, and if it were true the training would be a sinecure for child health doctors practising educational medicine and working with handicapped children and adolescents. We are convinced that it is just not possible to provide adequate basic training in primary community paediatrics in much less than two years. We appreciate the objective of this combined training in furthering integration but integration should not be sought at the expense of competence.

For this reason it is essential that: (1) on completion of three years' vocational training doctors wishing to specialise in primary

community paediatrics should have additional training and experience in the care of the health and development of children of school age, the assessment and management of children with hearing, speech, and language disorders, the diagnosis and management of children with learning and behaviour disorders, and in adolescent medicine and counselling; (2) there should be some form of certification after such training; and (3) district health authorities should not employ doctors for health work in clinics and schools who have not obtained this certificate.

There are still NHS regulations that prescribe the qualifications required of doctors who examine pupils who may have special educational needs. Several university departments of child health already have academic courses of nine months' duration set up for the purpose of these regulations¹⁸ and in anticipation of the eventual need for training in community paediatrics. These could provide the additional training referred to above, and obtaining the Diploma in Child Health (recently redesigned and taken over by the Royal College of Physicians) could be the evidence required of having satisfactorily completed such training.

The term "community paediatrics" is here to stay not only by common usage but also for want of a better one. Logically, doctors who practise community paediatrics should be called community paediatricians but this suggestion has not found favour among consultant paediatricians. "Child health practitioner" has recently been suggested, but this might be equally disliked by general practitioners. We prefer the term "child health doctor" because it is just as precise but less contentious, it matches that of family planning doctor, and it is compatible with the title community health doctor now used by the CCCM (but not, we notice, by its Community Health Doctors Subcommittee) when referring to CMOs. As a generic term community health doctor is sensible, but when it comes to employment the title of the doctor must identify his specialty. It is important for the true image of these doctors as clinicians that their title should not include the words "medical officer," which have inappropriate connotations with officialdom.

Consultants in community paediatrics

The Community Health Doctors Subcommittee has recommended that SCMOs become eligible for upgrading to consultant status on appointment to new posts in the community health services (principal CMO) after a fourth year's higher training in their chosen specialty. No job description for such posts is offered so we must assume that PCMOs would function as glorified SCMOs.

The function of SCMOs at present is clinical and administrative. Their principal clinical responsibilities relate to handicapped children, usually in special schools and district handicap teams. This is secondary clinical work and calls for knowledge and skills associated with consultant training and status; it is an historical anomaly that most SCMOs currently undertaking such work are not consultants. Their principal administrative responsibilities are concerned with the organisation and management of community health services, mainly for children. These call for the knowledge and skills of community physicians; it is an historical accident that SCMOs still have an administrative role.

In the short term some of today's SCMOs may need to continue their dual role in order to prevent the collapse of the child health services as these are handed over from area to district health authorities, just as area specialists (child health) performed a service-saving role in 1974. But such posts should be held on a personal basis, and only until such time as their administrative responsibilities can effectively be taken over by suitably experienced community physicians.¹⁹ Even if there was a need for a senior grade of clinician in the community child health services—which there is not—it would be quite wrong for promotion in the clinical sphere to require the assumption of non-clinical duties.

There is undoubtedly a need for paediatricians of consultant status who are trained and employed for part of their time in community paediatrics. As SCMOs relinquish their administrative responsibilities they should be considered for personal clinical consultant posts, and these should eventually be replaced by established consultant posts that require a specified

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duties would cause a profound change in consultants' ability and attitudes to undertake clinical work, much of which may be unpredictable and demanding immediate attention. If the intention of the DHSS is to cajole consultants into staggered clocking-on and clocking-off times they would eliminate the present professional nature of consultant work.

Resident cover

The question of resident cover is not specifically mentioned in the Abrams general medical team model but it is implied. The two medical SHOs in the posts that are to be disestablished are assessed to be working for 21 hours each during their on-call availability. These duties, which must mean living in the hospital, are to be equally distributed among the seven consultants. When this work is redistributed about half of the consultants' time on duty would be spent actively working in hospital. This would only be possible if they were expected to "kip down" and become resident. The whole of the Abrams calculation would be invalidated if the five SHO posts were in a one-in-five rota as there would not be this amount of work to be redistributed.

Nevertheless, the thought and the intention are quite clear. The "Abrams model" for the traumatic and orthopaedic surgery team not only perpetuates the same inaccuracies as the general medical model but envisages that most of the time that these consultants spent on call would be taken up by actual work in the hospital. Before the change in the mixture of grades, three orthopaedic consultants were on call for 38 hours and worked three of these in hospital. After the change the six consultants would each work 12 hours extra a week in hospitals during their notional 19 hours on call. As this work would be carried out in the evenings and weekends, "kipping down" in hospital would be essential. No consultant should be deceived into thinking otherwise.

The DHSS's initiative incorporated in the Government's response to the Short Report would mean consultants in the acute specialties doing more clinical work, even though their

numbers were increased. The DHSS's view seems to be that such changes would not require radical modification in the terms and conditions of service, and so far there has been no move by officials to initiate any discussions on their intentions before they are implemented.

The tragedy of the DHSS's approach to medical staffing is that it is based primarily on the highly arbitrary reversal of ratios in the mixture of grades and not on service to patients, which should, of course, be the main objective. The impact of the initiative is already being felt in many health districts. The Chief Medical Officer assured the CCHMS that no consultant would be compelled to change his pattern of work, but if the CMO's plans are to be fulfilled such a change is inevitable and neither he nor his successor would be able to stand by the promise. Such a change implies 9 am to 6.12 pm "shift" medicine, flexible rostering, and residence in hospital for the rest of many consultants' working lives. I find it hard to believe that the present junior doctors in training would relish the idea of becoming permanent residents. Existing consultants certainly do not, and if the DHSS is to maintain any credibility in their eyes this initiative must be halted and proper consultation take place with the profession.

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participation in the child health services outside the hospital. There is certainly no place in the community for pseudo-secondary services divorced from the hospital-based specialist services and staffed by PCMOs in posts that are "broadly equivalent to that of consultant within the community health service."¹¹

Specialisation within the community health clinical services is essential. We have outlined a career structure for community health doctors whose sole concern would be with the health of children because we are familiar with such work. It happens to be the major sphere of work of most community health doctors, but we are well aware that there are other important areas. While we have no personal experience of these we see no reason why the career structure that we have proposed should not be a model for other specialties.

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