Middle Articles

GENERAL PRACTICE OBSERVED

Use of General Practitioners in the School Health Service

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In recent years there has been increasing discussion on the use of general practitioners in the school health service. This has been motivated undoubtedly by the desire to secure better integration of the curative and preventive services, and to provide a more effective service for the schoolchild. Attempts to bring general practitioners into the school health service, however, raise administrative and organizational problems which are almost insurmountable, and so local education authorities have tended to employ selected general practitioners on a sessional basis in the neighbourhood of their practices but not solely on their practice patients (Chief Medical Officer, 1966a).

For some this is not acceptable, and a recent editorial in the *Practitioner* (1967) asks: "Has not the time come—indeed, been long overdue—when the care of our children be placed fairly and squarely upon the shoulders of family doctors. This would involve, among other things, routine medical examination of every child on first going to school. If any condition be found that should require special consideration, then the school authorities should be informed. The function of what would then be a much depleted school medical service would be the supervision of handicapped children—for example, the hard of hearing, the partially blind, the epileptic, the crippled. In this capacity they would act as paediatricians in conjunction with the local children's hospital."

In Somerset an attempt has been made to employ general practitioners in this more radical manner, and it is hoped that our experiences with a pilot scheme may be of interest.

Early in 1966 a full-time school medical officer retired unexpectedly. He had been solely responsible for the schools in a thinly populated and rural part of the county. The only towns in his area had populations of 3,000 to 4,000, and all of these were some miles apart. In the main, the general practitioners practised in groups from these towns, and each practice tended to have a distinct and local sphere of influence. Thus the majority of schoolchildren in each primary school in the area were patients of the local practice. Even in the secondary schools, which had wider catchment areas, circumstances were such that general practitioners could be employed to carry out school medical work on their own practice patients without causing chaos in the schools.

The Scheme

The scheme was confined to the Wincanton Rural District and covered 1,253 children at 15 primary schools and 821 children at three secondary schools, one of which had boarding facilities.

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Eleven general practitioners in the selected area were approached and all agreed to participate. They were asked to undertake all the duties (as under) carried out by full-time school medical officers, with the following exceptions: examinations under S.34 of the Education Act, 1944 (to "ascertain" which children require special educational treatment); examinations under S.57 of the Mental Health Act, 1959 (to find those children thought to be unsuitable for education at school); and Heaf testing and B.C.G. vaccination for schoolchildren registered on their National Health Service list or that of the practice. For children from other practices different arrangements were made (see Results, below).

Duties Required of Practitioners.—(1) Basic routine medical inspections at school entry. (2) Selective examinations at school-leaving age and at an intermediate stage. (3) Special examinations as necessary after referral by heads of schools, educational psychologists, parents, etc. (4) Re-examination of children previously found to have defects. (5) Accident cover. (6) Completion of immunization and vaccination programmes (Modified Schedule P). (7) Annual hygiene inspection of school and report.

Routine screening tests were continued as for other parts of the county, as were the services of the school nurses, educational psychologists, peripatetic teachers of the partially hearing, and speech therapists.

Full-time county school medical officers were expected to deal with the ascertainment of physically and mentally handicapped children, problems associated with special educational treatment, B.C.G. vaccination, and with the children of those general practitioners outside the area who were not in the scheme.

Initially both parties had misgivings. The schools and our committee appreciated the value of having the services of family doctors who were on the spot, but had doubts about whether they would have sufficient time to devote to their new duties. Some felt that a full-time school medical officer wholly in county employ offered a second line of defence in the detection of defects in schoolchildren, and that a new pair of eyes could discover defects that previously had been missed.

In preliminary discussions all the general practitioners stated their preference for payment on a sessional basis, but were persuaded to accept an annual capitation fee despite longstanding antipathy towards this form of payment. However, it was thought likely that the general practitioners would not wish to devote a full two and a half hours one or more times a week to school work, but would develop a pattern of short though frequent visits to schools, thus providing closer linkage than could be given in this rural area by the existing full-time school health service. Remuneration by capitation fee obviated

the need for the general practitioners to keep records of the time that they worked, and it did away with the need to impose definitions of sessions and norms of work—for example, 15, 18, or 20 children per session. Though the doctors had reservations about "open-ended contracts" they agreed to accept them and to keep careful records of the time and effort involved for the duration of the trial.

Finally, it was agreed that fees from the local authority for vaccination and immunization record cards would continue until April 1967, and thereafter the practitioners would claim the revised fees for each procedure from the Somerset Executive Council.

Results

The scheme started in January 1967, and Table I gives the number of pupils on the register of each school and the number inspected during the spring and summer terms. Some 572 children were found to be on the lists of practitioners outside the prescribed area and for whom separate arrangements were made.

TABLE I.—*Number of Pupils on the Registers of the Maintained Primary and Secondary Schools in the Selected Area and the Number of Pupils Inspected by Practitioners*

School	No. of Pupils on Register	No. of Pupils Covered by G.P.s in Scheme	No. of Pupils Inspected by G.P.s		
			Arrears of Inspections	Current Inspections	Total
15 Primary schools . .	1,495	1,253	219	422	641
3 Secondary schools	1,151	821	231	44	275
Total	2,646	2,074	450	466	916

The spring term was devoted mainly to the examination of those children who had missed routine school inspections and re-examinations at the appropriate age owing to the illness of the now retired medical officer. In all, some 916 children were examined during the two terms, 608 of whom were seen for periodic inspections.

The number of pupils inspected at periodic inspections, together with the numbers found to require treatment (excluding dental disease and infestation with vermin), are given in Table II. Of the 159 pupils found to require treatment 50 were recorded as having visual defects.

TABLE II.—*Number of Pupils Medically Inspected at Periodic Medical Inspections, Together with the Number Found to Require Treatment (Excluding Dental Disease and Infestation with Vermin), During the Spring and Summer Terms 1967*

Age Group	No. of Pupils Inspected	Individual Pupils Found to Require Treatment	
		No.	%
5	53	16	30.2
6	162	35	21.6
7	91	39	42.9
8	39	7	18.0
9	25	7	28.0
10	23	9	39.1
11	85	14	16.5
12	34	7	20.6
13	20	3	15.0
14	12	5	41.7
15 and over	64	17	26.6
Total	608	159	26.2

The rate of defect finding (26.2% of children examined) compared favourably with that for the whole county, which averaged 18.3% over the previous five years, and the 15.8% for England and Wales (Chief Medical Officer, 1964, 1966b) over the four years 1962–5.

Seventy-one per cent. of the examinations carried out by general practitioners were attended by parents, compared with 64% for the remainder of the county area. The increase was

noticeable in the secondary school age group, where over a third of the children were accompanied by a parent.

Some 42 children were referred to appropriate specialists for further advice or treatment as follows:

Referred to orthopaedic clinic	20
Referred for ascertainment under S.34 of Education Act 1944	9
Referred to audiology clinic	6
Referred to child guidance clinic	4
Referred for speech therapy	3

The remaining 67 pupils were treated by the general practitioners. These defects fell broadly into three groups—namely, respiratory tract infections, skin disease, and minor emotional and behavioural disorders. By dealing satisfactorily with the behavioural disturbances, our impression is that the practitioners substantially reduced the number of referrals to the child guidance clinic.

These preliminary statistics appear to offer no support to the contention that general practitioners would find fewer defects than full-time school medical officers, and the system had the undoubted advantage that the doctor who found the defect was also responsible for its continuing treatment.

At the end of the summer term all the doctors and the schools were visited by one of us (A.R.B.) in order to assess the reactions of the participants. In general, the schools thought that the scheme offered considerable advantages to the children (and to the schools) over the traditional school health service, mainly because of closer contact with the doctor and ease of reference of problems at local level. The schools were also impressed that the new system had been well received by the parents concerned.

From the point of view of the school the scheme involved co-operation with more than one doctor, and necessitated coping with different techniques, and, more important, an increase in the frequency of visits. Most schools found that there was an additional work load placed in the school secretary, but part of this burden was occasioned by the backlog of children not examined, and by the newness of the system. One or two of the larger secondary schools were served by two and occasionally three practices. As might be expected, clerical difficulties increased when more doctors were involved with the school. In our view, and in that of the head teachers, these disruptions in the life of the school were more than outweighed by the advantages in having general practitioners doing the work. All are agreed, however, that a further increase in the number of doctors visiting a school would be undesirable. In urban areas the children at each school may have up to 20 different general practitioners. If the school health service is to be carried out in a school setting the number of general practitioners serving each urban school would make the administrative burden intolerable. In towns general practitioners could undertake school health work either on a sessional basis with one practitioner to each school or by conducting the examinations in their own surgeries. The latter solution would break the ties with the schools and in our opinion would be unacceptable to most teachers.

The general practitioners were, on the whole, well satisfied, and all agreed to continue the scheme. Several general practitioners appreciated the opportunity of acting as school doctor, and mentioned that there was no longer any likelihood of anxious parents presenting problems, previously discussed with their family doctor, to an unsuspecting school medical officer. We were impressed by the enthusiasm with which they carried out the work, and felt, like Didsbury (1964), that selective medical examinations were better carried out by doctors who already had a detailed knowledge of the child and its background and family. Referral for specialist advice and treatment had been simplified, and subsequent follow-up with the school had been improved.

Summary and Conclusion

An account is given of a trial project in Somerset employing general practitioners to undertake school health service duties for schoolchildren registered on their National Health Service list or that of the practice.

After the trial had lasted two terms everyone concerned wished to continue the scheme. Undoubtedly both parents and teachers appreciated having their own family doctors acting as school medical officers, and this advantage clearly outweighed the increased clerical work for the school. From the outset we

thought that these arrangements could only have a chance of working in a rural area. This view has been confirmed.

REFERENCES

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MEDICAL HISTORY

A Letter from Sir Morell Mackenzie

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A few months ago Sir Terence Cawthorne was moving house and was in the usual dilemma of what to take with him and what to leave behind or give away. Among the gifts was a fine mounted, framed, and signed Spy cartoon of Sir Morell Mackenzie, of which I was the fortunate recipient. I wanted

to hang it in my room at the Institute of Laryngology and Otology and decided that it should be reframed to match the other pictures. When the frame was removed the apparent signature "Yours truly, Morell Mackenzie" was found to be the ending of a letter which had been folded behind the picture,

exposing the signature to give the impression of an autographed portrait. The letter must have been in this position for a good many years, forgotten or unknown. The ink of the signature is greatly faded compared with the rest of the letter. The paper was dry and split at the folded edges, but the script is easily legible. Through the kindness of Dr. Noel Poynter at the Wellcome Institute the letter was carefully restored and mounted and is now in our historical museum at the Institute (see Figure).

Mackenzie was writing from Potsdam, the palace of Emperor Frederick III at Charlottenburg, and had been in almost constant attendance on the Emperor for four months, enduring the emotional professional complications which have been so exhaustively described by Mackenzie himself and many others. In Mackenzie's book *Frederick the Noble* he has a note on 10 April 1888 of the Emperor's remark about the patients in England almost identical with that in this letter of six weeks later, but the letter is unrecorded. It is of some additional historical interest as it is an uninhibited *cri de cœur* from the writer in a private communication to a friend. Mackenzie reveals how keenly he felt the anomalous position he was in and how he found it impossible to extricate himself. However, the Emperor's condition rapidly worsened and he died just over two weeks later, on 15 June.

By all standards this was a difficult case, the management of which was made more difficult by the blaze of publicity in which it was conducted and the personalities and jealousies of the numerous doctors concerned. Lionel Colledge held strongly

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