Paediatrics head-to-head, BJGP

Matthew J Ridd PhD FRCGP,[1] Matthew J Thompson MBChB, DPhil[2]

[1] Population Health Sciences, University of Bristol, UK

[2] Department of Family Medicine, University of Washington, Seattle, USA

Why did you become a general practitioner or family physician? Whatever we call ourselves, one of the attractions is being a generalist physician who cares for families, over time, rather than individuals or specific body systems in isolated encounters. Many GPs will have been particularly attracted by the opportunity to see children and their carers in the context of their community. The challenge of providing personal continuity is such that every household may not be known to us, but electronic records allow us to cross-check information with people registered with the same home address; and knowledge is shared between primary health care team members.

Around 11% of our consultations are for people under 15 years[1] and the idea of community-based paediatricians, rather than GPs, providing primary care to children is not new.[2 3] A mix of different types of providers is found in Europe, with paediatric primary care provided by GPs only in 12/29 (41%) countries;[4] and the United States, where a third of children are cared for by family physicians rather than paediatricians.[5] Yet, there are recurring calls for all paediatric primary are to be provided by paediatricians rather than GPs.

We don't have any evidence that primary care provided by paediatricians rather than GPs in the UK would improve the care of children.[4] Reports have advocated better training of GPs and communication between GPs and paediatricians, but not a sea-change to primary care paediatricians.[6] However, many GPs now work in systems that actively discourage referral and one-to-one discussion of patients with specialist colleagues (referral management systems, advice by email rather than by telephone).

Fragmenting primary care into paediatrics and adults would likely make things worse rather than better for children and their families and begs several questions. Who would train the new cadre of specialists – paediatricians, with limited experience of managing diagnostic uncertainty in the community? Or GPs, who are blamed for the poor care the new model is being introduced to address? Where would the age cut-off be between primary care paediatrics (infancy, adolescence, emerging adult?) and "adult only" GP. How would care be safely and effectively transitioned from one provider to another. And what about the practicalities of providing appointments? Would primary care paediatricians work from the same building and share the same support staff? If not, then how would services be provided close to patients' home and school, with a trusted group of clinicians? Who would provide out-of-hours care – GPs who are able to cope with the vast range of patient care issues in such settings but would become further deskilled from lack of in-hours contact with children? And finally, what about busy carers who previously would have a booked a double appointment, one for themselves and another for their child, possibly for the same illness, who must now see two doctors at different times? Finally, would paediatricians really want to take on these roles, having previously "extracted" themselves from this "no mans land"?[2]

With increasing sub-specialism, more than ever patients need a good GP to "hold the whole", to coordinate and make sense of care for them. Rather than gatekeepers, GPs are "gate openers" – facilitating and advocating for appropriate and timely care, while protecting our patients from over-diagnosis and over-treatment. In paediatric as in other patient groups, it is the work done by GPs

that means bad things do not happen: immunisation preventing serious disease; identification of and provision of support for carers struggling with parenthood or adverse social circumstance; avoiding unnecessary referrals of children with self-limiting acute or illnesses. And we don't yet fully appreciate the value of knowledge of the whole family in helping identify serious illness – the change in behaviour noted because "mum isn't normally a worrier", prompting an urgent referral and timely diagnosis.

We're not arguing that standards of paediatric care are adequate everywhere or that more shouldn't be done to improve them. But we caution against further increasing specialism and plurality of provision, in the absence of any evidence that this would be a more clinically and cost-effective way to improve outcomes. The burnout experienced by paediatricians and paediatric trainees mentioned by Dr Newton is highly unlikely to be solved by a shift to general practice; "from firepan to fire". Rather, we suggest the following goals.

First, evaluate (and potentially adopt) flexible models of primary care professionals trained in child health working closely together,[7] such "Child health GP hubs".[8] This may include other ways of supporting GPs to provide paediatric care – such as GPs with Extended Roles, the use of mid-level providers (Nurse Practitioners, Physician Assistants) who are a significant part of the primary care workforce in the USA for example, as well expanding GPs' access to real-life/virtual opinions from specialists as needed.[9]

Second, GP training should be longer and postgraduate training in paediatrics mandated. What is debateable however, is the setting and nature of this training. Traditional models of hospital or paediatric community clinic-based service-delivery are unlikely to improve future GPs' ability to diagnose and manage the spectrum of disease seen in general practice.

Third, give GPs the resource we need to do our jobs properly – appropriate time for consultations, access to diagnostics and specialist services, and technologies that facilitate (rather than add burden to) the efficient delivery and coordination of care.

By all means let's work together to provide better care for children outside of hospitals, but let's not "throw out the baby with the bath water" by eliminating one of the core purposes (and joys) of being a GP.

Word count: 913

References

1. NHS digital (2009). NHS Trends in consultation rates in general practice 1995 to 2009. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/trends-in-consultation-rates-in-general-practice [accessed 13.12.19]
2. Bhrolchain CM. Who should provide primary care for children? *Archives of Disease in Childhood* 2004; 89: 116-17
3. Peile E. The future of primary care paediatrics and child health Archives of Disease in Childhood 2004; 89: 113-115. *Archives of Disease in Childhood* 2004; 89: 113-15.
4. van Esso D, del Torso S, Hadjipanayis A, et al. Paediatric primary care in Europe: variation between countries. Archives of Disease in Childhood; 2010; 95(10): 791-95. doi: 10.1136/adc.2009.178459
5. Freed GL, Dunham KM, Gebremariam A, et al. Which Pediatricians Are Providing Care to America's Children? An Update on the Trends and Changes During the Past 26 Years. *The Journal of Pediatrics* 2010;157(1):148-52.e1. doi: 10.1016/j.jpeds.2010.01.003

6. Kossarova L, Devakumar D, Edwards N. The future of child health services: new models of care. London: Nuffield Trust, 2016
7. Wolfe I, Thompson M, Gill P, et al. Health services for children in western Europe. *The Lancet* 2013; 381(9873): 1224-34. doi: 10.1016/S0140-6736(12)62085-6
8. Montgomery-Taylor S, Watson M, Klaber R. Child Health General Practice Hubs: a service evaluation. Archives of Disease in Childhood 2016; 101(4):333-37. doi: 10.1136/archdischild-2015-308910
9. Saxena S, Francis N, Sharland M. Primary care of children: the unique role of GPs. BJGP 2012; 62(600): 340-41. doi: 10.3399/bjgp12X652166