Middle Articles

GENERAL PRACTICE OBSERVED

General Practitioners and Nursing Staff: a Complete Attachment Scheme in Retrospect and Prospect

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The history of the Oxford general-practitioner/nursing-staff attachment scheme is briefly recorded from the first experimental full-time attachment of a health visitor to a partnership of three in November 1956 to the complete attachment of all nursing staff by 4 March 1965. For the past three years every practice, large and small, has had at least one health visitor, one district nurse, and one midwife, either full-time or part-time according to its need. The concept of the general practitioner as leader of the domiciliary team is working actively in practice throughout the whole city, to the advantage of patients, doctors, and nurses. It is believed that Oxford is still the only local health authority to have a complete attachment scheme, so that an account of our experience may be of interest to others.

Materials Available

Oxford, which is very much an industrial centre as well as a university city, had a population of 104,500 at the commencement of the scheme in 1956, and this has increased only slightly to 109,320 in 1965 when the scheme was completed. The city is divided longitudinally by the rivers Cherwell and Isis, and practices, on the whole, tend to concentrate on one side or the other. At the beginning of the scheme there were 32 practices, comprising 68 doctors, of whom 14 were in single-handed practice, seven had two partners, nine had three, two had four, and one had five partners. The nursing staff establishment, which remained static throughout the scheme, comprised 19 health visitors, 21 district nurses, and 10 midwives. This gives a ratio of one health visitor to 3.6 doctors, one district nurse to 3.4 doctors, and one midwife to 6.8 doctors. It also means that there is one health visitor to 5,700 population, one district nurse to 5,200 population, and one midwife to 10,900 population.

Methods

Concept

Membership of the health visitors working party emphasized the conclusion already reached by me that the future of health visitors lay in working in the closest possible relation with general practitioners. All the recognized means of achieving co-operation, including liaison schemes, had already been tried in Oxford, but in spite of great goodwill they were largely ineffective. General practitioners just did not understand the work of health visitors, and it was felt that they never would until both were responsible for the same patients and met

regularly for consultation. This gave rise to the idea of trying to find an opportunity for an experimental whole-time attachment to a practice. It was felt at the time that perhaps this might be more acceptable to the practitioners if the nurse combined the duties of health visiting and district nursing. Subscribing to the ideal of the general practitioner as a doctor responsible for his patients in health as well as in sickness, it seemed sensible to envisage the doctor's first assistant as a nurse also combining the duties of health teaching and sick nursing.

Combined Health Visitor and District Nurse Experiment

An opportunity occurred in 1955 to try out the concept of a combined health visitor and district nurse working in a geographically compact area of the city in which one partnership was responsible for the majority of the residents. The experiment was not a success. There were three occupants of the post in three years and each time recruitment was extremely difficult. It seemed that there were very few nurses who really wanted to combine the two functions of health teaching and sick nursing. Various sizes of population were tried, but time and again the variable day-to-day requirements of district nursing seemed to interfere with essential health-visiting work. It was decided to abandon the experiment in 1957; however, it is still considered that a combination of health visiting and district nursing has some merit. It is of interest that there has been a certain amount of discussion along these lines in more recent years.

First Health Visitor Attachment

In 1956 fortune presented the ideal opportunity for a full-time health visitor attachment scheme. A partnership of three doctors (later increased to four), already running their own practice antenatal clinic with a district midwife in attendance, politely informed me that they were planning to start a practice child welfare clinic. The help of a health visitor was offered, but this was at first considered to be unnecessary. However, the partnership was eventually persuaded to accept the health visitor at the practice child welfare clinic for a trial period of three months. This was so successful that the partnership then asked for the services of the health visitor in a full-time capacity. They felt that she had been so valuable to them, in connexion with the mothers and babies, that she would probably be equally helpful with their elderly patients, unmarried mothers, and in fact throughout the whole range of their practice. This was a wonderful opportunity, because here was a practice asking for the attachment of a particular health visitor,

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and the scheme was quickly agreed. Fortunately the main surgery premises were sufficiently commodious to allocate a room for the health visitor. She was therefore based permanently in the surgery premises with all her records, and she herself had access to all the general-practitioner records. From the start this was a tremendous success. The health visitor carried on with her normal health visitor's duties among the practice patients. She was usually in the surgery from 9 to 11 a.m., seeing her own clients as well as patients referred by the doctors. She had daily contact with all the partners, a familiar pattern being to discuss problems over morning coffee, after which doctors and health visitor all went out visiting according to agreed programmes.

Further Health Visitor Attachments

It was three years before further requests from doctors were received. By this time the obvious success of the original attachment was becoming known to both general practitioners and health visitors. A partnership of four and another of three asked for the attachment of particular health visitors whom they had come to know. In both instances the surgery premises were short of space and therefore the two health visitors concerned were based at new clinic premises situated not far from each surgery. After the attachment one practice quickly started their own child welfare clinic in the neighbouring local authority clinic premises, and more recently the other practice started a similar clinic in the same premises.

A single-handed practitioner with a full list was next allocated a health visitor half-time, and two two-man partnerships in the same district shared a health visitor equally between them. By now many of the remaining practitioners were showing increasing interest and further applications came in quickly. All these requests from general practitioners were very welcome, particularly if for a named health visitor. There is all the difference in the world between a medical officer of health trying to persuade a rather reluctant general practitioner to have an unknown health visitor and a practitioner requesting a particular health visitor who is known to him. By mid-year 1963 a 75% attachment scheme was operating. The remaining geographical areas, served by a few health visitors, were now so bizarre in shape that it was decided the attachment scheme should be completed as quickly as possible. All the remaining doctors, most of them single-handed practitioners, were approached and agreed to take part, and the scheme was completed in November 1963.

District Nurses

The initial experiment of the attachment of a district nurse to a partnership of three was started in May 1963. The previous use of the district nursing service by this partnership seemed to indicate that a nurse would be required on a half-time basis, but it was soon clear that this was inadequate. The attachment scheme had uncovered a hidden need and the nurse was therefore allocated to the partnership on a full-time basis. It was very soon apparent that this first attachment of a district nurse was most successful and it was quickly decided to try to organize a complete district nurse attachment scheme. At this time we were below our establishment, but a campaign aimed at recruiting married women on a part-time basis was most successful, particularly as some of the smaller practices required only part-time help. The district nurse attachment scheme was completed by March 1965 and has been welcomed by all concerned. Most of the work has continued to be carried out in the homes of patients, but wherever the size of the practice was sufficient to provide a worth-while number of ambulant patients the nurse was encouraged to undertake a short daily session at the surgery premises.

Midwives

The attachment scheme for midwives was carried out as a set exercise. It was decided to attach the midwives in pairs rather than singly, and the scheme was based on the amount of domiciliary midwifery undertaken by individual practices, so as to get an even distribution of cases among the five pairs of midwives involved. As from 1 October 1964 all new bookings were made on the basis of the attachment scheme. There were no difficulties; all the midwives were well known to the general practitioners, and many had assisted at general-practitioner antenatal clinics for several years. The attachment scheme was a particular advantage when a new G.P. maternity unit opened at the Churchill Hospital in August 1966, the responsibility for patients being shared by the general practitioners and their attached midwives.

Comment

Procedure

The essential ingredients for the start of an attachment scheme are a reasonably enthusiastic medical officer of health and superintendent nursing staff and a willing practice. A superintendent nursing officer can have a critical influence on the attitude of her nursing staff in this matter. An attachment scheme should be allowed to start quietly and to mature gradually. At every stage there must be full discussion with all concerned. Personalities are involved in addition to a new scheme of working, and it was therefore agreed that each attachment should initially be regarded as an experiment for six months.

It takes several months before most general practitioners even begin to appreciate the work of a health visitor. They learn best by example in connexion with their own patients. There has been no attempt whatsoever to misuse health visitors by asking them to undertake duties which do not come within their accepted sphere of work. There has been no loss of control, the superintendent nursing officer being able to maintain all necessary contact with the attached staff. Whenever a vacancy has occurred the general practitioners concerned have been consulted about the new appointment. Most of the recruitment of health visitors has been by way of the student scheme, and as soon as they complete their training course they act as relief workers to cover periods of sickness and also holidays, and in this way they become known to most of the practitioners, thus facilitating eventual attachment.

Need

The number of patients on the list is some guide towards the need of that practice for attached nursing staff; but other factors also require consideration—for example, the relative proportion of young children, elderly persons, and immigrants. For instance, it has been found that a practice of 5,000 on a new housing estate with many young children requires two health visitors, whereas a practice of 9,000, including many students, in the university area of the city is adequately staffed by one health visitor. A practice that ordinarily would need only one health visitor may require two because of the high number of immigrants on its list. A practice having a high proportion of elderly persons requires extra district nursing and health-visiting help.

An attachment scheme works better for the larger partnerships; if more than one health visitor or district nurse is attached to a practice, then the management of staff sickness and of holidays is made easier. For the smaller partnerships where staff are shared no nurse should have to visit regularly more than two surgery centres. A single-handed practice in a compact area is relatively easy to deal with; it is the small

practice with central surgery premises and with patients in many areas of the city which is the most difficult to manage from the point of view of an attachment scheme.

Siting and Transport

The ideal arrangement is to have attached nursing staff working at and from the same practice premises as the doctors, but in only a very few instances have existing surgery premises been large enough to make this possible. The second best arrangement is to site health visitors at the clinic premises nearest to their attached doctors. Such a policy has involved a gradual process of decentralization which has now reached the stage where only the superintendent nursing officer and the deputy superintendent health visitor are housed centrally.

All attached nursing staff need the use of a car, but this is something that most of them should have anyway. A little more time may be spent on travelling, but the visits made are much more purposeful. Where comparisons have been possible the mileage covered has risen slightly in most cases but in no instance by more than 10%.

Other Duties of Health Visitors

A complete attachment scheme for health visitors means that not quite the whole of their time can be given to the practice, because there are a few local authority duties that must be performed. Most of the school health work can be undertaken satisfactorily by school nurses and by clerical staff, but there are a few duties which require the special training skills of health visitors, such as health education and the responsibility for nursery and infant schools. So far as possible the school work is arranged so that the attached health visitors are responsible for the schools attended by the greatest number of practice children. There are also some child health clinics which have to be manned each week.

Hospital liaison duties involve about half a dozen health visitors, each of whom attends a weekly session at different hospitals. Although these duties take them away from their practice, they do, nevertheless, utilize this opportunity of visiting practice patients in hospital.

Discussion and Assessment

An attachment scheme is not an end in itself, but rather an essential step towards creating the best conditions for the optimum functioning of the community health services. After a complete attachment scheme has been achieved a number of important questions arise.

Composition and Organization of Team

The question must be asked whether doctor, health visitor, district nurse, and midwife constitute a complete team. It has been suggested that the team should also include a general-purpose social worker, and this possibility has been considered in some detail. Up to the present time health visitors have undertaken most of the necessary general-purpose social work and have called in more specialized social workers such as child-care officers, welfare officers, and mental health officers when necessary. It would be true to say that as a result of her familiarity with all the various local authority and voluntary services the health visitor is well placed to arrange for any help required for practice patients.

Though a general-purpose social worker would undoubtedly be an asset in any practice, and particularly in a large partner-

ship, nevertheless there are at least two cogent arguments against such an arrangement. Firstly, there is a very real danger in making the team too large. It is already difficult enough, in a large practice, for the various members of the team to keep in daily touch with one another. One of the main advantages of the attachment scheme is the opportunity it provides for frequent personal discussion about patients; the larger the team the more difficult this becomes. Secondly, recruitment would be difficult because most of the social workers practising in the community services are working under a specialist umbrella. Trained medico-social workers would be ideal, but are generally to be found only in hospitals and are in increasingly short supply. It could be argued, with justification, that these hospital-based medico-social workers would be more effectively deployed in the community, and if attached to general practitioners would be ideally placed to follow up their patients when they are admitted into hospital.

If there were to be a social worker member of the domiciliary team it would certainly allow the health visitor to give more of her time to the medical and health aspects of her work. This in turn would mean that there would be a greater similarity between the work of the district nurse and that of the health visitor, which might justifiably raise, once again, the concept of a "family nurse" combining the functions of health visiting and district nursing.

With regard to organization, there have been recent suggestions that the domiciliary nursing team should be constructed on a hierarchical system like a hospital ward, with a sister in charge. The members of the team would have received varying degrees of training and would be deployed according to their skills. The employment of such a team would be feasible only in very large practices and would probably not be very effective, except perhaps in health centres. The concept of a senior nurse in charge of the team, who would presumably be the normal channel of communication with the general practitioners, would, in my view, be disadvantageous, in that she would in many cases only be passing on information gathered by other members of the team, whereas what is really needed is direct consultation between the doctor and the nurse who has visited the home.

Housing of Team

There is no doubt at all that in order to function at its optimum the domiciliary team should be housed in the same premises. Very few practice premises are large enough for this purpose, and health centres must surely be the right answer for the future. The completion of our own nursing-staff attachment scheme has possibly been an important factor in the rapid growth of interest in health centres in Oxford. Three health centres are now functioning and already nearly half the practitioners are practising, wholly or partially, either from health centres or from clinic premises in the city.

Participation of General Practitioners in Preventive Work

The attachment scheme has certainly encouraged general practitioners to participate in various aspects of preventive work. Nearly half the child health clinics in Oxford are now taken by general practitioners, such clinics being restricted to the individual practice patients and the doctor being paid the recognized sessional fee. The last remaining local authority antenatal clinics closed in 1965, since when all antenatal work has been undertaken by general practitioners with the assistance of the attached domiciliary midwives. A number of general practitioners are taking part in the local health authority cervical cytology scheme, in which they undertake sessions for their own practice patients with the help of their attached nursing staff. Some practices have organized their own practice parentcraft teaching course, both doctors and nursing staff

taking part in these programmes. There is ample scope for further expansion along these lines, perhaps particularly in the direction of presymptomatic diagnosis by concentrating on high-risk practice patients. For instance, the elderly men in a practice might be persuaded to have a chest x-ray examination, and the diabetic "at risk" groups to undergo appropriate investigation. The domiciliary team should also be well placed to undertake family planning advice and treatment.

Co-operation between Hospital and Community Services

The domiciliary team is well equipped to deal with the early discharge of patients from hospital. The necessary detailed consultation concerning an early-discharge patient is in this way made much easier, because the hospital need contact only one focal point—namely, the general practice centre, where the relevant member of the team can make all the necessary arrangements. Problems of rehabilitation and the return home of seriously handicapped patients are similarly more easily dealt with. The vital liaison between hospital geriatric departments, the domiciliary services for the elderly and infirm, and the patient's home is facilitated by an attachment scheme. There must be many other opportunities for co-operation that have yet to be explored; for instance, could the heavy load on a hospital diabetic clinic be lightened by the return of some patients to the care of their general practitioners, in the knowledge that the practice health visitor would visit them regularly?

Effect of Attachment on Work-load

An attached district nurse can lighten the doctor's load by undertaking specific visits and, where the practice is sufficiently large and concentrated, by undertaking regular nursing sessions at the surgery. She can also give material assistance to the doctor at special surgery sessions for such purposes as prophylactic injections, cervical cytology, etc. It has been found, however, that one or two large practices require more nursing help at the surgery than the district nurse has time to give if she is to continue to undertake her traditional role of nursing in the home. Such large practices also require the services of a part-time surgery nurse who would undertake all the practical nursing work at the surgery, leaving the attached district nurse to concentrate on home visiting.

Health visitors have been able to help by undertaking regular visits to elderly patients and by follow-up visits in connexion with the common infectious diseases. When social problems are uncovered the health visitor is able to save the doctor a great deal of time either by dealing with them herself or by getting in touch with the appropriate statutory or voluntary organizations. The health visitor, with her knowledge and experience, should be able to obtain whatever help is required for any practice patient.

The midwives have developed an even closer working relation with their medical colleagues than that which they previously enjoyed, and the majority of practices that are undertaking domiciliary midwifery now hold practice antenatal clinics with an attached midwife in attendance. The attachment scheme has been particularly helpful in connexion with the recently opened G.P. maternity unit. All the domiciliary midwives have been given honorary contracts by the United Oxford Hospitals to enable them to undertake duties in this maternity unit.

An attachment scheme can be brought into effect irrespective of nursing staff shortages; the same population has to be cared for whether it is divided on a geographical basis or by practice patients. Nevertheless, our own attachment scheme has effectively shown the need for, and the advantage to the general practitioner of having, a good deal more nursing help than has

been the custom in the past. In other words, a successful attachment scheme has revealed the need for an increase in the establishment of both health visitors and district nurses.

Job Satisfaction

There is no doubt at all about "job satisfaction" in working in an attachment scheme. Practically all the doctors and also their nursing staff prefer such an arrangement. There are, of course, varying degrees of satisfaction from the very enthusiastic to the rather lukewarm. Views are bound to be affected to some degree by the personalities involved; one or two doctors have certainly coveted their neighbour's health visitor, and it is realistic to assume that one or two members of nursing staff might have preferred to work with some other practice, even if they have been too diplomatic to say so.

A Few Disadvantages

The present local health authority boundaries are a real nuisance. Adjoining counties can probably make mutually satisfactory reciprocal arrangements for attached nursing staff to visit practice patients in each other's territory. The same will also probably apply over the borders of two neighbouring county boroughs. The difficulty arises when a county borough adjoins one or more counties. Oxford is surrounded by the Counties of Oxfordshire and Berkshire, and city practitioners extend their services quite widely into the neighbouring county areas. Realizing the benefits of the attachment scheme to their city patients, the doctors have many times asked if their attached nursing staff could also give service to the very considerable number of their patients over the Oxford boundary. The respective medical officers of health would have been very willing to have made reciprocal arrangements, but as there are very few county doctors with patients in the city the traffic would be virtually all one way. Any agreement between the city and the two adjoining counties would thus involve considerable payment by these counties to the city for services rendered. Because of this aspect it has been impossible to make any progress at a time when the Royal Commission on Local Government is sitting, and when local authorities are very conscious of their boundaries.

About half the weekly child health clinics are not connected with particular practices and are taken by local authority doctors with the assistance of one of the attached health visitors. Such health visitors do not know the patients attending these clinics or their homes nearly as intimately as a health visitor who is working in the surrounding geographical area. This same criticism also applies, though to a lesser extent, in connexion with the school health service, where an attached health visitor does not have the same detailed knowledge of all children attending those nursery and infant schools for which she is responsible as did the health visitor working in the same geographical district as that in which the local schools are situated.

Summary

The various steps leading to the completion of a general-practitioner/nursing-staff attachment scheme are outlined. An experimental full-time attachment of a health visitor to a partnership of three doctors in 1956 was so successful that other general practitioners were stimulated to make similar requests, leading eventually to a complete health visitor attachment scheme by November, 1963. The immediate and obvious success of an experimental attachment of a district nurse to another partnership of three doctors in May 1963 resulted in a complete district-nurse attachment scheme by March 1965.

The attachment of domiciliary midwives was undertaken as a set exercise as from the beginning of October 1964.

Comment is made on some aspects requiring consideration as an attachment scheme develops.

For the last three years every practice in Oxford has had its own team of health visitor, district nurse, and midwife, and this experience is discussed and evaluated with particular reference to the composition, organization, and housing of the team. Examples are given of the increasing participation of general practitioners in preventive work and the greater co-operation between hospitals and the community services as a result of the attachment scheme. The effect of attachment

on work load and job satisfaction is discussed. A few disadvantages are outlined.

The scheme described is a practical outcome of the excellent co-operation that has existed in Oxford for very many years between the general practitioners and the health department. Grateful thanks are due to all the practitioners and nursing staff concerned, but perhaps particularly to Drs. R. G. Seaver, D. H. Richards, and W. G. R. M. Laurie and Miss K. J. Hayes (recently appointed deputy nursing officer, Cumberland County Council), who were the pioneers. The success of the scheme has also owed much to the help and co-operation of Miss M. G. Atkinson, superintendent nursing officer (now principal nursing officer, West Riding County Council), and Miss P. Millar, supervisor of midwives.

CONFERENCES AND MEETINGS

British Association of Physical Medicine

[BY A SPECIAL CORRESPONDENT]

The Annual Meeting of the British Association of Physical Medicine for 1968 was held at King's College Hospital, London, on 9 March, under the presidency of Dr. F. S. COOKSEY (King's College Hospital).

Dr. G. H. DOBNEY (Whittington Hospital, London) reported the use of an apparatus to record pressures below the ischial tuberosities and hamstring muscles of car and tractor drivers. There was an increased pressure on the right side in the majority of right-handed people, but this was far less in left-handed drivers.

Dr. P. HUME KENDALL (Guy's Hospital, London) reported a double-blind controlled trial of physiotherapy exercises for patients suffering from chronic backache. A comparison was made of three groups of patients undergoing either back extension exercises, general flexion-mobilizing exercises, or lumbar isometric flexion exercises. The only statistically significant differences found were that the exercises in the last category were the most successful, and that spinal extension exercises made 50% of the patients' backache worse during the period of treatment.

Presenting a follow-up study of 38 patients for six to 20 months after fractures of the leg, Dr. P. H. MERRY (Bridge of Earn Hospital, Perthshire) showed that progress after reduction of the fracture was related to the severity of the original injury and that active leg, foot, and ankle exercises resulted in a better rate of improvement than that found in patients who were given passive movements in addition. The most rapid rate of improvement occurred in patients who returned to work early, provided that this did not involve long periods of standing and walking.

Care of the Disabled

Dr. G. M. COCHRANE (Derbyshire Royal Infirmary, Derby) stated that the number of

physically disabled patients in the United Kingdom was not known exactly, but it was estimated to be about 6% of the adult population. He emphasized that the rehabilitation of these patients depended on an accurate estimation of the degree of the disability, and whether or not this was stable or likely to deteriorate. Other factors that were also of importance were racial variation in stoicism towards a known disability and the individual drive to overcome it. Dr. Cochrane suggested that, where possible, the final stages of rehabilitation should be carried out within industry, and that there was a great need for sheltered workshops.

Dr. E. A. BENNET (Maudsley Hospital, London) described the problems of the severely mentally disabled in their hospital and social backgrounds. He emphasized the importance of deciding whether or not a disability was stable before planning rehabilitation. Family relationships were of great importance and contributed considerably to progress. A policy of to-and-fro rehabilitation was inevitable owing to the fluctuation in the patients' state, and close observation was the duty of the psychiatrist.

Dr. J. C. BROCKLEHURST (Orpington Hospital, Kent) discussed the difficult problem of the elderly disabled—a group of patients, he pointed out, in whom physical and mental disease was compounded with social malaise. About 12% of the total population of the country were old-age pensioners; of these, 95% lived independently in the community and were a potential source of breakdown. A comprehensive geriatric service should have three essential features: assessment wards; rehabilitation wards; and accommodation for long-stay patients. From either of the first two the patients might return to their own homes or residential centres and subsequently attend a day hospital for routine management.

A follow-up study of 200 consecutive discharges from his hospital wards had shown

that the need for subsequent readmission was considerable—a finding which made the surveillance of patients after discharge of prime importance. Such after-care was best conducted by close contact with the general practitioner, district nurse, and health visitors.

Dr. CICELY SAUNDERS (St. Christopher's Hospice, London) defined terminal care as care of "the state that commences when somebody else said that there was nothing further to be done." She described the work of St. Christopher's Hospice, which opened in July 1967 for the terminal care of patients with malignant disease, and had found that one of its main functions was to help relatives in nursing patients at home. She considered that the hospital was needed as a focus in both advising on care and helping the attitude to individual patients. She felt that it was not only important that patients should die peacefully but that until this time they should live fully.

Annual General Meeting

The Annual General Meeting was presided over by the retiring President, Dr. F. S. Cooksey. In his report he announced that the training programmes for specialists in physical medicine and rheumatology, issued by the Royal College of Physicians, had been integrated. He pointed out that the specialty was now clearly identified and that the amalgamation of physical medicine and rheumatology would be of outstanding benefit to both specialties. The major part of the practising physical medicine consultants' work was rheumatology, but there would be an important place for highly specialized rheumatism research units and intensive rehabilitation centres. Dr. Cooksey noted that most of the great advances in rehabilitation had come from practising clinicians.

Dr. R. M. MASON (London Hospital) was elected as the new President.