THE HEALTH VISITOR AND THE FAMILY DOCTOR*

BY

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When I started collecting my thoughts for this paper I rather naturally began by considering the health visitor, but I was inevitably led to the realization that health-visiting work was only an aspect of the increasing service that is now expected from the general practitioner. No doctor who has been in practice over the last twenty-five years can have failed to realize that the conception of general practice has been, and is, changing; it will depend to a large extent upon the attitude of mind of the general practitioner himself if it is to be for the better. The medical profession, with the service it provides, is becoming increasingly important as a prop to the general weal of the nation; it must also be remembered that over the years we, as doctors, have been largely allowed to keep our own house in order. The number of Acts of Parliament regulating the profession of medicine has been very small. The first Acts I know of occurred in the time of Henry VIII† and simply said who could be allowed to practise medicine under certain conditions. The next Act was in 1858‡ and tightened up the controls, made more formal arrangements for entry into the profession, and provided, through the General Medical Council, for doctors who misbehaved to be taken off the list. Then we had the National Health Insurance Act of 1911, and the scope of this Act was much widened by the National Health Service Act of 1946. This last Act not only laid certain duties upon the doctor but by the comprehensive nature of the Act, and the associated obligations laid on the local authorities, increased the scope of the doctor's responsibilities.

There are, of course, other Acts which have affected doctors, and Parliament, through the Midwives Acts and the Nurses Acts, has provided assistants for him and arranged that they are adequately trained.

Although up to a century ago nurses were often disreputable, there has been little difficulty in their relationship with doctors: Florence Nightingale was more than a match for any man, even a doctor, and her influence remains.

It took a long time for the midwives and the doctors to settle down together; in the eighteenth century there were some very acrimonious discussions with midwives proper and the so-called "men midwives," who were beginning to make their presence felt. I cannot refrain from quoting William Smellie, about 1750, regarding the conduct proper to a midwife, for it is surely applicable,

*Read in opening a discussion in the Section of Preventive Medicine at the Annual Meeting of the British Medical Association, Cardiff, 1953.

†(a) The Physicians Act, 1540 (32, Hen. 8, C. 40).—The Act exempted members of the Fellowship of Physicians from having to undertake the duty of constable, and allowed physicians to practise medicine in all its branches. (b) The Herbalists Act, 1542.—In order to avoid "Sorceryes, witchecraftes and other inconveniencies, it was enacted that no p'son within the Citie of London, nor within seven myles of the same, shoulde take upon himself to exercyse and occupie as physician or surgeon, except he be first examyned approved and admitted by the Bisshopp of London."

‡The Medical Act, 1858 (21 and 22 Vict. Cap. 90).

with obvious modifications, to the relationships between doctors and their other handmaidens:

"She ought to be a decent, sensible woman of a middle age, able to bear fatigue and well instructed in the elements of practical midwifery.

"She ought to live in friendship with other women of the same profession, contending with them in nothing but in knowledge, sobriety, diligence and patience; she ought to avoid all reflections upon men practitioners; and when she finds herself at a loss, candidly have recourse to their assistance—this confidence should be encouraged by the man who ought to rectify what is amiss without exposing her mistakes.

"These gentle methods will prevent that mutual calumny and abuse which too often prevails among the male and female practitioners, and will redound to the advantage of both, for no accoucheur is so perfect but that he may err sometimes."

One is now led to wonder why the health visitors—the other assistants—have been introduced into the medical scheme of things. As I have pointed out, the scope of medical practice has widened—almost entirely owing to the work of the profession. The family doctor now appreciates that the full therapeutics of a sick person includes the welfare of the patient's family. The cure of the actual ailment and the full economic and medical recovery of the patient are often associated with such matters as the patient's occupation, his housing, his financial position, his relationship with other members of his family, and other medico-social aspects of the case. If the general practitioner loses sight of these facts he is in danger of ceasing to be the family doctor.

General practice as I knew it thirty years ago was largely a matter of medicine and personality. A country practitioner for whom I worked was an outstanding man, and combined a good knowledge of medicine with the means of meeting many of the social responsibilities of ill-health in his patients. I am quite certain he would not be able to do it now. Personality and integrity are still as important, but medicine is not merely a matter of medical therapeutics—it must include social therapeutics.

The widening outlook has been obvious in the field of hospital practice, where the hospital practitioner is buttressed by an increasing army of auxiliaries—almoners, physiotherapists, dietitians, occupational therapists, and others. The same has been happening in general practice—for have we not there the children's officer, the probation officer, the N.S.P.C.C. officers, and others?—but in the subject of our talk we also have a key worker, one who can assist the practitioner to deal rationally with these other useful auxiliaries, and one who can also help the practitioner himself.

How the Health Visitor can Help the Doctor

I would therefore like to introduce to you the health visitor and let you know how I feel she can help you in your work. First of all, it is not always realized what a well-qualified and well-trained person she is. She must (1) be a fully trained registered nurse; and (2) have taken at least the first part of the midwifery certificate (as a matter of fact most health visitors are fully trained midwives and have worked as such); and (3) have passed an examination following a nine-months course in social medicine, including a knowledge of infant and child care, welfare work in relation to the disabled and the aged, maternal care; personal, domestic, and community hygiene, including household management; together with knowledge of social, industrial, and economic conditions and of the means of teaching.

I have analysed the qualifications of about 370 health visitors in some of our largest cities. Apart from the qualifications mentioned above, which they all possess, a number of them have also been trained and had experience in fever nursing, orthopaedics, housekeeping, tropical diseases, nursery nursing, the care of the tuberculous and mental cases—a few hold a higher qualification such as a tutor in public health training, the diploma in nursing, or are Queen's nurses. Taking gross populations, there appears to be about one health visitor per 9,000 of the population in these big cities. There will therefore be in this 9,000 about 130 births per annum, and about 500 children under school age; there will also be about 900 persons over the age of 65, a number of whom require some constant supervision. Apart from these there will be disabled persons, both young and old, problem families, and tuberculous patients. It is no light task helping to keep this mixed family under observation and to provide for them, but the health visitor's training equips her to do much for them, although I know only too well the magnitude of the task and the severe shortage of health visitors that exists.

The general practitioner will obviously want to know what assistance he can get from the health visitor. In a talk such as this I can only indicate the various fields where she can assist the doctor through her intimate knowledge of the family, or by invoking the assistance of other voluntary or statutory organizations. In many towns the health visitor is already carrying out the work I shall mention. I would like her to do this in a closer association with the family doctor. Before proceeding, I may remind you that the health visitor trained as a nurse is fully aware of her ethical obligations towards any patient she visits.

1. Care of the Mother and Child

This has been the primary function of the health visitor for over a hundred years when society in general was little concerned regarding the health and happiness of women and children. Although uninvited, and with no statutory right of admission to a home, the health visitor has been instrumental by her knowledge and perseverance in promoting the welfare of mother and child, and surely the husband also. The health visitor can assist the doctor in seeing that his advice on infant feeding and the care of premature children is followed, and in dealing with minor ailments and maladjustments. The continuing oversight of problem families, who cause such expense to the nation and such trouble to society, has been safely entrusted to her, although she would welcome some guidance and encouragement from the doctor.

The anxious mother welcomes the opportunity of discussing her difficulties with a knowledgeable person. These mothers ask questions and seek advice. How much better it would be if the health visitor knew that she was reinforcing the opinion of the family doctor. When emergencies occur—a mother is ill at home or has to leave a family to go to hospital—the health visitor can be left to do all she can to provide assistance. Then there is the preparation of the family for the return of a patient from hospital, sometimes imperfectly cured, needing special attention, diet, or care. Health visitors are encouraged to make direct contact with the hospital almoners so that there is a continuity of care.

Sometimes the aid of specialist agencies must be invoked—the children's officer, the probation officer, the N.S.P.C.C., and the doctor's time can often be saved by requesting the health visitor to make the necessary arrangements with these persons.

2. The Aged

Every general practitioner has a quota of persons who are old and, as a consequence, more frail and subject to disabilities, and more in need of friendly assistance, care, succour, and comfort. We are encouraging our health

visitors to keep these elderly people under supervision, report to the general practitioner when a special need arises, and ask for his assistance when a question of the disposal of these old people, either to an old persons' home or to a hospital, arises. The health visitor will, with his permission, call in a district nurse or suggest the need of a domestic help. Very often, in cases of inattention, arrangements can be made for the old person to be bathed, for the home to be cleansed, and for laundering the linen. The health visitor also frequently arranges for relatives to be informed of the condition of one of the elderly members of their families.

During the period of shortage of beds, either for the chronic sick or for the old people's home, the health visitors are asked for an assessment of the patient's "social" needs in assessing priorities for accommodation. I would much prefer that this was done with the assistance, or at the request, of the general practitioner, and, in fact, in my city it is an invariable practice for the general practitioner to be informed of the opinion of the health visitor regarding the disposal of such a case. Very often the health visitor is able to provide assistance to the elderly people by making their needs known to the Assistance Board or the Ministry of National Insurance, to invoke the assistance of voluntary agencies such as the "meals on wheels" service, or to arrange for assistance in shopping.

3. The Disabled and Handicapped

I very much doubt if a large number of general practitioners are aware of all the agencies that are willing and anxious to help disabled persons. Knowledge of these agencies can often lead to the provision of necessary help and comfort; not only that, but the local authority itself has an obligation to promote the welfare of the disabled, who include many aged persons. Special arrangements are also in force for caring for the mentally handicapped, both psychiatric cases and mental defectives. There are special visitors to provide for the particular needs of blind persons. As time goes on it will be possible to provide training in new work, occupational therapy, arrangements for the sale of goods made, for recreational facilities, for clubs, and so on. One of our big difficulties at the moment is to know the number and needs of persons in the different categories, for special facilities are often necessary to deal with special disabilities. The local authority would welcome information from the general practitioner, and much of the investigation of the case can, to begin with, be undertaken by the health visitor, especially if she has the co-operation of the doctor. The family health visitor is the general social worker; she will call for the specialist social worker—the psychiatric social worker, the probation officer, the home teacher for the blind, etc.—when necessary. With one key worker the number of visitors can be reduced.

In some cities, particularly in Cardiff, there are specialist health visitors dealing with certain types of aftercare. Specially trained health visitors visit diabetic cases, cases of gastric ulcer, and so on, in order to ensure that the regime prescribed at the hospital or by the doctor is being followed; but practice varies in different areas.

4. Tuberculosis

As our therapeutic advances begin to show a result it is likely that we shall have more cases of chronic tuberculosis on our hands, and not all of them can be contained in hospitals. The health visitor, working either as a specialist tuberculosis visitor or as the family-care worker, can see that the instructions of the general practitioner, the chest physician, or the medical officer of health, in relation to prevention are followed. She will see to it that the child is segregated where necessary, that contacts are shepherded to the chest clinic for investigation, and that extras, whether from statutory or voluntary agencies, and any special allowances which are necessary for the tuberculous patient himself, are

obtained and properly used. Tuberculosis is a chronic disease presenting a great variety of problems taxing the resources of the doctor and the local authority. Non-medical problems of finance, housing, and employment are frequent, and opportunities for discussion of a case with a social worker such as a health visitor must be very useful.

5. Accidents

As infection and other disease of childhood are becoming less prevalent it is surprising how accidents have emerged as a major cause of death and injury. Accidents in the home are very numerous. We are arranging for our health visitors to obtain as full information as possible about these, and to advise the mother how best to prevent recurrences.

Obligations of the Local Authority

I have pointed out the social and economic repercussions of sickness and the many agencies that are available to assist. The obligations of the local authority are very important: it must provide midwives, district nurses, home helps, and an ambulance service, and is encouraged to provide "care and aftercare"—a territory insufficiently explored but full of possibilities, both for the patient and for the doctor. A social worker like the health visitor can, with the doctor's assistance, make the needs known to the local authority.

A frequently heard complaint is that there are too many persons, representing well-intentioned and often necessary organizations, knocking at the door of the harassed housewife requiring information or offering assistance. I have counted over twenty such organizations in my own city. It is surely a waste of time for them to call indiscriminately. I would like to use the health visitor as a funnel, which, with the doctor's assistance, could be concerned with the economic deployment of these agencies. She could do this if she knew she was the accepted assistant of the doctor.

I have spoken of the health visitor in a city, but I know very well that in a country area, where the health visitor is also the district nurse and also the midwife, a close association has already evolved, and there is a good understanding between the doctor and her. It is not so easy in a town. The doctor may not know where to get hold of the health visitor, and hesitates to bother with officialdom in the town hall. We, as medical officers of health, are always ready to help, and would respond to any request from the doctor or the patient—and it often happens in this way—but I would much prefer that the contact was direct between general practitioner and health visitor. No general practitioner in Sheffield thinks of getting in touch with me when he wants the services of a district nurse or a midwife, and I am not particularly interested in supervising the day-to-day work of the health visitor.

It would save much trouble if the health visitor and doctor dealt direct with one another, either by telephone or in person, or that there was an arrangement for a regular transmission of information as required. No doctor thinks it necessary to provide his own midwife or district nurse; and, indeed, the State, appreciative of the value of these women, arranges to provide them and for the local authority to pay for them. The health visitor is in exactly the same position, and although the local authority engages her, supervises her, and deals with her terms of service, she is there for the good of the public, and in particular for the help that she can give to the general practitioner, who is primarily concerned with the care of the sick person and the welfare of his family.

Finally, although I have stressed the importance of the personal association between the doctor and the health visitor, I would like to say that this co-operation could be much better brought about if there was a closer association between the general practitioner and the medical officer of health and his medical staff. Both of us have our responsibilities to the patient, and we all have, I hope, the same desire to serve.

THE GENERAL PRACTITIONER AND THE HEALTH VISITOR*

BY

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During my 30 years in general practice I have had the advantage of a happy family partnership and the privilege of having practised medicine in an era which exemplified Mr. Churchill's dictum, given to a Royal College of Surgeons gathering, that the "longer we look back the further we can look forward," for we have seen more striking advances than could have been thought possible, among which must be counted the present liaison that is developing between those engaged in preventive medicine and general practitioners.

All my days the medical officer of health, owing allegiance to the local authority, has been respected as an administrator and regarded as an able colleague having specialized knowledge of infectious diseases, but whose duties in the main were no concern of ours. During my early years of practice, apart from social contacts, relationships between the work of the general practitioner and the medical officer of health were poor, and my then seniors in practice regarded welfare clinics as a form of subsidized competition which they disliked and mistrusted. In fact, in populous areas the work of the whole-time medical officer and that of the general practitioner were poles apart.

Let it be remembered, however, in arriving at a true conception of the picture, that the general practitioner was, in the main, a single-handed individualist, and obviously the time was not then ripe for the liaison we envisage to-day.

Nursing, the Keynote

The value of nursing has, to my mind, been paramount in the conduct of a practice, and I believe that nursing is the keynote to its success. I have had the advantage of having the same nursing sister with me for over a quarter of a century. At an early date I realized that her value was not just that of a nurse whose duties I understood and who officially carried out my treatment. The knowledge of the lives and habits of our patients which she gleaned and passed to me, and of the effect of their social problems on their illnesses, gave me an understanding which was invaluable in appreciating and treating their real difficulties—a knowledge which I had never encountered, or even considered, in my impersonal hospital life. It was she who revealed that a large proportion of patients who consulted us without physical signs, or who did not make progress, had financial, marital, or other family problems. It was she who comforted the pregnant single girl, and advised all patients, from the young mother to the aged sick, in those problems which were outside my clinical approach. She assisted in running our own infant clinic and became the confidant and friend of the parents, and, of course, of the children, who are now our second generation of patients. I suppose that, in the confines of one practice, this was the forerunner of social medicine and the liaison between doctor and health visitor as we are beginning to understand it to-day.

I am sure that all interested parties agree that the closest possible co-operation exists between the general practitioner and the nursing profession so far as the district nurse and the midwife are concerned. In my own area, with a popula-

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