Middle Articles

The Evolution of a Health Team: A Successful General Practitioner-Health Visitor Association

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Brit. med. J., 1965, 1, 181-182

We present this paper for two reasons; first, to describe the effects of an attachment of a health visitor to a London suburban practice, and, second, to enumerate for others what we feel should be the necessary steps for success.

The Practice

The practice is sited in a south-east London suburb in a middle-class residential area. Its size (in June 1964) was 7,250, and there were 550 children under the age of 5. Some patients live as far as 3 miles (4.8 km.) away, but the majority live within 1 mile (1.6 km.).

Following a preliminary secondment of health visitors for two weekly child-welfare sessions, arrangements were made in 1963 for a total attachment to the practice. The health visitor's work was to be concerned entirely with the persons in the practice and she was to have no regular outside commitments.

Present Routine.—Since the start of our association we have worked out a routine which works smoothly and efficiently. Briefly, a typical day consists of a meeting of health visitor, doctors, and clerical staff before morning surgery to discuss referral of patients by the doctors and a report by the health visitor on any problems found during the previous day. The health visitor then goes on her visits by car, while the doctors carry out the morning's consultations. There is an afternoon session every weekday and a further meeting of doctors and health visitor takes place. On one afternoon there is an antenatal clinic, on another the doctor has his child-welfare clinic at which the health visitor is present, and on one afternoon the health visitor carries out her own child-welfare clinic with no doctor in attendance. As a rule the health visitor finishes her work by the time the evening consulting session starts, at 5 p.m. She usually takes her records home for completion and analysis.

Year's Work by the Health Visitor

The Table shows an analysis of one year's work by the health visitor attached to the practice (June 1963 to May 1964). It gives the volume of work done by the health visitor but it gives no indications of the time taken for each special problem or situation. A few comments therefore are necessary to elaborate on the work carried out.

The care of *children* still accounts for three-quarters of the work, and much of this is routine. The numbers of children seen at the health visitor's own clinic has rapidly increased and

the health visitor is now seeing 25-35 children per session. Advice, weighing, and administration of poliomyelitis oral vaccine are the chief duties.

In this practice *antenatal care* is given to all expectant mothers, including those to be delivered in hospital. The reason is that it enables the establishment of close doctor-patient-health-visitor relations and provides excellent opportunities for health education and preparation for future child care. The health visitor gives mothercraft classes to all primiparae and she visits all mothers delivered in hospital during their stay in hospital and arranges for follow-up and care after discharge. A sound continuity of care is established and maintained, and mothers receive the health visitor as an old friend on return home or after the midwife has left.

The number of *elderly* persons seen by the health visitor accounted for 12% of all visits. Many of these were for social problems which required co-ordination of the available services—that is, home help, district nurse, recuperative holidays, nursing-aids and appliances, sitters-in, etc. From our age-sex register a start has been made for the health visitor to visit all patients over 70 who have not been seen by the doctors during the preceding year to ascertain if they require any assistance, social as well as medical.

Although *mental problems* accounted for only 1% of the work they were often very time-consuming.

Health education in a specific sense has involved 10% of surgery attendances. Mothercraft classes require little explanation, but a mention must be made of an anti-smoking clinic that has been organized in co-operation with Dr. C. H. Wood. This resulted in 5 out of 20 original starters giving up smoking completely.

The health visitor has established good relations with *local hospitals* by visiting patients while in the wards preparatory to discharge and so meeting and becoming acquainted with ward-sisters and almoners.

Among other roles peculiar to the practice have been teaching of medical students and R.A.M.C. officers, lecturing at medical schools and meetings, research projects on medico-social problems associated with children and the elderly, and participation at postgraduate meetings of local G.P.s.

Our Views on the Attachment

None of us had had any previous experience of working closely together in each of our fields. All of us had to start without any preconceived ideas, and we approached the whole project as an experiment in learning.

We are all of the opinion that it has been a success and none of us ever wants to return to our old way of working separately.

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Views of the Health Visitor

"Before becoming associated with the practice I worked in a localized geographical area which included patients of some 12 general practitioners and contact with about three to five further doctors at the local-authority child-welfare and school

*Visits and Consultations Carried Out by Health Visitor in One Year
(June 1963–May 1964)*

	No.	%
<i>Home Visits</i>		
Children :		
Routine visits to children under 5	1,141	76
Child-protection visits	22	1
Infectious diseases (0–16 years)	43	3
Schoolchildren (non-infectious)	16	1
Mental health	16	1
Adults :		
Elderly	175	12
Expectant mothers	10	—(1)
Physically handicapped	27	2
Adult sick	22	1
Marital and personal problems	15*	1
Others { Hospital visits	28*	2
{ Old people's home	5*	—(1)
	1,520	100
<i>Seen in Surgery</i>		
Children under 5 years	1,198	78
Antenatal	172	11
Mothercraft teaching	61*	4
Anti-smoking clinic	90	6
Special appointment	23	1
	1,544	100

* These figures apply to February–May 1964 only.

clinics. It was quite impossible to get to know many of these doctors. The main change, then, has been that now I am working together with two doctors who are seen at least once every day, and excellent understanding and mutual confidence and respect are built up. There are no problems of communication. Immediate referral and exchange of problems is possible. Joint discussions lead to a better understanding of the patients' difficulties. Experience is built up of the potential of the local social and medical services. The doctor's background knowledge of the families is invaluable. There is access to the medical records and reports. Continuity of care is now a reality, as has been illustrated by maternity care. Patients accept me now as a member of the practice team and there is no difficulty of access even to the problem families. The most exciting outcome has been the much greater satisfaction in working in practice as a member of a team caring for a complete population of all ages composed of individuals and families."

Views of the Doctors

Our chief experience has been that of learning and discovering the great scope and potential of working together with a health visitor. Her achievements in the medico-social work of the practice have been a great revelation. Far from being a "blessed nuisance" we now look on her as an essential part of our practice. The scope of her work has been referred to, but all the time we are discovering ways of increasing her usefulness to our patients and of course to us. Has it reduced our own work? We think that it has, although this is difficult to measure over a period of one year. As examples, the health visitor now gives oral polio vaccine, she is able to prevent problems by organizing for the co-ordination of social services, and she has certainly prevented many infant-care problems by her close contact with young and inexperienced mothers. The quality and effectiveness of our work have greatly improved.

Views of Our Patients

All patients who have had contact with the health visitor have been most appreciative of the "nice kind lady" who has helped them with their problems and who has made routine calls on

them. Within no time she was accepted as part of our team and we were asked why this association had not happened before.

Factors for Success

Our own experience leads us to make the following suggestions for a successful association.

1. There must be a strong desire from general practitioners, the medical officers of health, the superintendent of health visitors, and the health visitor for such an association. There must be no question of having to force the scheme upon any of those concerned.
2. It is important to look upon the whole project as an experiment which will inevitably have to be modified to fit the practice in the course of time. Rigid preconceived ideas are disastrous if adhered to.
3. The health visitor remains an employee of the local authority. The general practitioners provide the accommodation, for which they should receive an honorarium and expenses for phone calls, etc.
4. The selection of the health visitor to be attached must be the responsibility of the superintendent of health visitors, who should have continuing contact with the general practitioners and meet and discuss the scheme with them regularly.
5. Ideally the attachment must be a full-time and total one. This will naturally be possible only with a practice that is large enough to warrant such an attachment. In view of the fact that there are approximately four G.P.s to one health visitor, there must be a practice population of 6,000–10,000 for a full-time total attachment. However, local factors such as the age distribution, social problems, and geography will all influence decisions. It should be possible for two practices to share one health visitor, but this will inevitably create problems.
6. The health visitor should be provided with a car.
7. She should have a room of her own in the practice where she can keep her records and interview patients.
8. She must have complete and free access to the medical records.
9. Details of the work-routine which we consider important are regular daily contacts and discussions, no limitation of case material (at least to start with), and separate clinics to be carried out by the health visitor alone.
10. The duties of the health visitor should be primarily concerned with health promotion, preventive care, medico-social problems, and mental health in any of the patients in the practice.
11. The health visitor should *not* be regarded as an extra pair of hands whose function is to reduce the work load of the doctors. She should not act as the practice's nurse or receptionist, nor as a clinical diagnostician and be sent on first visits to act as a clinical screener.
12. The essence of success is that there should be mutual respect and a clear understanding of each other's roles, with the appreciation that the health visitor has duties to her employers (the local authority) as well as to the general practitioners. Above all else there must be flexibility of interpretations, of outlooks, and of personalities of all concerned.

The Future

We believe that this concept of G.P.–H.V. attachment will spread so quickly that within 10 years it will be accepted as the normal pattern of work for both doctor and health visitor, as has been demonstrated by Swift and MacDougall (1964).

At this stage, however, it is important to look upon the scheme as an experiment and to collect as much information and opinions upon it as possible so that the essential bases for success might be defined.

Because of the stimulus and encouragement that we have achieved by our successful association we have given thought to the wider concept of a "health team" based on general-practice units. Why, in view of the success of G.P.–H.V. co-operation, should not district nurses and midwives also be attached to general practices?

Before proceeding further, however, it is necessary to consider the relative numbers involved. Taken as a whole there are in

the National Health Service 4 G.P.s to 1 health visitor, to 1 district midwife, and to 1.5 home nurses. These ratios vary from area to area, but they do suggest that units of population of 10,000 could be served by four G.P.s working together with one health visitor, one midwife, and one or two home nurses. Consideration should also be given to the place of an all-purpose nurse *cum* social worker in general practice.

What we are convinced of is that the time is surely past when general practitioners and health visitors worked independently out of sight and out of touch in mutual antagonism. They are endeavouring to provide medical care for the good of our

community, and this is, after all, best provided by a joint and co-operative team-approach.

We acknowledge the support given to us by Dr. A. Elliott, County Medical Officer of Health of Kent, and to Miss A. Clarke, the Superintendent of Health Visitors of Kent. We also wish to thank Miss P. Robinson and Mrs. G. Towey, the health visitors who worked in the practice at the start of the scheme.

REFERENCE

Swift, G., and MacDougall, I. A. (1964). *Brit. med. J.*, 1, 1697.

Co-operative Effort to Reduce a Waiting-list

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Brit. med. J., 1965, 1, 183–184

A significant proportion of a general surgical waiting-list is made up of cases of hernia repair awaiting operation; these are continually being displaced by more urgent or more desperate cases. Consequently the waiting-list tends to grow and the hernia cases are further delayed.

This report shows the favourable effect on a growing waiting-list of a well-organized co-operative scheme for the early discharge of hernia cases.

In 1961 I began a scheme for the early discharge of my herniorrhaphy cases; they were transferred to Blackwell Recovery Hospital, 14 miles (22.5 km.) from this hospital, by ambulance, on the second post-operative day. Although 140 were dealt with in this way, the waiting-list was still growing after 18 months and there were difficulties in persuading patients to accept transfer, mainly because of difficulty of transport for visiting.

I decided, therefore, to inaugurate a home-discharge scheme, and with the concurrence of general practitioners and the City Medical Officer of Health the plan outlined below was devised, and an explanatory letter was sent to all G.P.s in the district.

The New Scheme

I reserve two beds for hernia cases—admitting on Monday, operating on Tuesday, discharging home or to Blackwell on Thursday; admitting at once a successor to the bed for operation on Friday and discharge on Monday, and so on. This keeps the patient under my eye until I am fairly certain all is well. It also keeps the bed in continuous use and is a protection against temptation to put another case into the space left. This may be weak in theory, but is not so in practice, since we have approximately 60% of emergency admissions to wards to compete for beds.

A simple form has been devised by which to notify the M.O.H. and the G.P. when a patient has been sent for. The patient is notified about 14 days before admission, and at the same time a form is sent to the G.P. and also to the M.O.H. The M.O.H. arranges for a district nurse to visit the home and report on the conditions; if these are unfavourable arrangements are made for the patient to be admitted to Blackwell Recovery Hospital. There are other advantages from this visit. Some patients may have moved house and not let us know, or may have colds or domestic trouble and wish to defer their

operation. Experience shows that such patients are just as likely to ignore the bidding notice as to fail to inform us of their difficulties, and so a bed is wasted. With this scheme, however, the M.O.H. notifies us in time to send for another patient.

On the patient's discharge the supervisor of district nursing of the area is informed by telephone. She then arranges for post-operative visits and for removal of the sutures on the date given by us. An appointment is made for the patient to be reviewed in the out-patient department three weeks after discharge.

This scheme came into operation in 1963. The accompanying Table gives figures for the last six months of the old scheme and the first six months of the new one; 136 hernias were dealt with in the first six months of the new scheme compared with only 37 in the last six months of the old one. Indeed, in 18 months of the previous arrangement only 140 hernia cases were removed from the waiting-list as against 136 in the first six months of the present scheme.

One Year—Proportion of Total Admissions to Waiting-list

	Total Admissions to Ward	Total Waiting- list Admissions	Hernias Admitted	Total Waiting- list Additions	Balance of List
<i>Six months of old scheme</i>					
October 1962	74	22	8	40	+18
November 1962	68	19	6	24	+5
December 1962	72	28	7	36	+8
January 1963	70	18	4	29	+11
February 1963	68	20	5	25	+5
March 1963	70	24	7	26	+2
<i>Six months of new scheme</i>					
April 1963	102	36	12	26	–10
May 1963	106	50	20	23	–27
June 1963	85	45	24	20	–25
July 1963	98	58	30	41	–17
August 1963	108	58	30	28	–30
September 1963	70	40	20	24	–16

Operative Technique

The usual standard procedures are carried out. Nylon monofilament on an atraumatic needle is used for repairs of all types. Fascial grafts have not been done, but nylon darn and implants

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