# The working relationship between the general practitioner and the health visitor

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SUMMARY. The views of 40 health visitors from the Cambridge health district on their working relationship with general practitioners are presented. Patterns of attachment and facilities at the work base are described. The health visitors gave ratings for the frequency and facility of their contact with the general practitioners, the types of patients referred to them and their overall relationship with the doctors. The health visitors' own suggestions for improvement in the relationship are discussed.

## Introduction

THE primary health care team has been a reality since the 1960s. With the coming together of general practitioners, district nurses, midwives, health visitors and other medical and paramedical workers, professionals have realized that, in order to provide an efficient service which meets the needs of patients, they must liaise and communicate with each other.

This article describes part of a study of health visiting practice concerned with the working relationship between health visitors and general practitioners. The aim was to seek health visitors' views on attachment, their accommodation, their relationship and contact with general practitioners and systems of referral of patients. The health visitors were invited to make suggestions for improving the relationship.

## Method

A qualified health visitor was appointed as research assistant to the Early Parenthood Project to recruit and interview the health visitors. The survey was carried out between February and July 1982. In drawing the sample, care was taken to encompass as wide a range of working arrangements as possible. The numbers of health visitors working part-time or full-time in urban or rural areas reflected the proportions present in the health district. Variations in the number of health visitors working with general practitioners were accommodated within the selection. Where choice existed between health visitors in a similar situation, selection was random. A letter was sent to each recruit which was followed up by a telephone call inviting her to take part in the study. Forty-four health visitors, approximately half the total number working in the district, were approached and 40 agreed to take part.

The interviews lasted an average of one hour. Thirty-three out of the 40 health visitors agreed to have the interviews taped and these were later transcribed. The questionnaire administered during the interviews contained both fixed choice and open-ended questions covering the main areas of health visiting practice. It became clear from preliminary analysis of the data that discussions with senior nursing management would be beneficial. Three nursing officers and two senior nursing officers responsible for the health visitor participants were approached to take part in less formal interviews. They all agreed to take part and for their interviews to be taped.

## Results

### *Attachment to general practitioners and the working base*

Thirty-seven of the 40 health visitors described themselves as fully attached to a general practice and three as working in a defined geographical area. These three nurses worked in rural areas and cooperated with a variable number of doctors from several different practices. Twenty-five of the 37 practice-attached health visitors gave a clear picture of dividing the practice geographically with their colleagues; this was particularly true for those working in rural areas compared with city or urban areas.

Most health visitors in the study agreed that a close working relationship with the general practitioner was important for patient care and that communication with one practice rather than several practices was easier and more fruitful. However, of the 15 health visitors who had experienced both types of working arrangements with general practitioners only five preferred practice attachment unreservedly. The most frequently mentioned disadvantages of practice attachment were the

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**Table 1.** Health visitors' ratings of their working relationship with general practitioners.

| Rating | Response ($n=40$ health visitors) |
|---|---|
| Very good/good | 28 |
| Fair | 7 |
| Poor | 1 |
| Mixed response | 4 |
| Total | 40 |

increased travelling time that results from covering a wide area and the difficulty of getting to know local health needs and the local services available.

The number of general practitioners with whom health visitors worked ranged from one to 27. Three quarters of the sample worked with between one and four doctors and one quarter with five or more doctors.

Nineteen of the practice-attached visitors were based in the same premises as their general practitioners (10 in surgeries and nine in health centres) and two were based with some of their general practitioners. Seventeen health visitors, however (two of whom were geographically attached), were based in other premises, for example a child health clinic, school, hospital or another health centre. This last figure gives cause for concern.

One quarter of the sample rated their working base as 'good' or 'very good'; five of these health visitors worked in surgeries, five in health centres and one in other accommodation. One quarter gave a qualified response. Half the sample thought that their accommodation was 'poor' and although many of these health visitors were based in schools or clinics, it was disappointing to find that five of them worked in surgeries and three in health centres. The main complaints concerned lack of space and office equipment and having to share accommodation with other primary health care staff. However, one health visitor said how pleased she was that her practice had recently extended their premises for attached nurses.

### *Health visitors' ratings of their working relationships and their frequency of contact*

Health visitors were asked to rate their working relationship with their general practitioners as 'very good', 'good', 'fair' or 'poor'. Four were unable to give a one-word answer as the quality of the relationship varied with different doctors. The results are shown in Table 1.

Almost three quarters of the respondents rated the relationship as 'good' or 'very good'. This is similar to the figure quoted by Dunnell and Dobbs in their national study of over 1,000 health visitors.[1] The proportion of health visitors in this sample who reported a 'fair' or 'poor' relationship with their general practitioners was too small to explore the relationship between the ratings and other parameters, for example, whether the health visitors were based with their general practitioners, conducted a child health clinic with the doctors or had access to medical notes.

Health visitors in this study were also asked to rate their relationships with other primary health care professionals. The results showed that in general they rated their relationships with district nurses, practice receptionists, other health visitors and clinical medical officers as better than those with their general practitioners. However, relationships with community midwives were not as good as those with general practitioners.[2]

### *Frequency of contact*

Health visitors were asked how often they met with their general practitioners. From Table 2 it can be seen that there was a wide variation in the frequency of contact. Half the sample met their general practitioners at least once every week. Nineteen of the 21 health visitors based with their general practitioners met them at least once a week, one health visitor met her general practitioners once every month or two, and the other had no regular meeting. Nine out of 19 health visitors not based with their general practitioners met regularly at least once a week.

There was a wide variation in the type, frequency and expressed need for communication between health visitors and general practitioners. Where the relationship was described as 'good', the contact was frequent and flexible, each professional contacting the other whenever the need arose, either meeting face-to-face, using the telephone or writing messages to each other. Some health visitors experienced considerable difficulty in communicating with general practitioners: for example, three said that they had to wait in the surgery until a convenient moment arose when they would try to 'catch' the doctor between seeing patients. Some general practitioners were described as being unwilling to set aside time for discussion about clients and a few as

**Table 2.** Frequency of contact with general practitioners.

| Contact | Response ($n=40$ health visitors) |
|---|---|
| Daily | 10 |
| Two to five times a week | 4 |
| Once a week | 6 |
| Once a fortnight | 2 |
| Between once a fortnight and once a month | 4 |
| 'As often as necessary' or 'When the need arises' | 7 |
| No regular meetings | 2 |
| Mixed response | 3 |
| Never | 1 |
| Not known | 1 |
| Total | 40 |

showing very little interest in the health visitor's role in the practice. One health visitor expressed the fear that frequent meetings with her general practitioner might generate both too much work and the type of work which might be more properly referred to the district nurse.

### The nature of the working relationship

The respondents were asked whether their general practitioners referred clients to them, what type of clients, and whether they felt that they were acting as independent practitioners. Thirty-five health visitors said that their general practitioners referred clients to them. Four gave qualified answers and one health visitor said that patients were never referred to her. The types of clients referred to health visitors are shown in Table 3.

As expected, children and babies with minor health problems were referred to nearly all the health visitors, and more than three quarters received referrals concerning the elderly needing help and support. It was perhaps surprising that not more handicapped children and children at risk were referred, although some practices may have very few of these types of patients registered with them. One health visitor said that she did not have as many children with behavioural problems referred to her as she would like and implied that there may have been more children in her practice needing help. Thirty-eight out of 39 health visitors whose general practitioners referred patients to them said that the doctors left them to act according to their discretion, and one gave a qualified answer.

Respondents were asked whether they had access to the medical records of their clients. Thirty-one health visitors had full access and two were allowed to look at records but they had to be retrieved by the receptionist. Three health visitors were not allowed to see the records of any of the general practitioners to whom they were attached; one of these doctors had had a bad experience in the past with confidentiality of notes and was not prepared to let his attached health visitor see them. Four health visitors did not have access to any of their clients' records: one was refused access, two were geographically attached and had not made enquiries about access, and one worked with a doctor with a 'lock-up' surgery that made access difficult.

The advantages of full access were well described by one health visitor, who said that she was able to check the medical condition and treatment of each client from the notes. She found that in this situation there was less likelihood of giving conflicting advice. Another health visitor commented how important it was to discuss individual clients with their general practitioners, rather than merely to read clients' notes.

All respondents were asked whether they conducted a child health clinic with one or more of their general practitioners. Only 14 out of 40 health visitors did so. Two of these health visitors also had a clinical medical officer examining children at the clinic. A further two health visitors did a regular clinic with the general practitioner on the premises as a back-up.

### Suggestions for improvement

The health visitors were asked for suggestions for improvements in their relationships with all primary health care workers. The most concrete suggestion made by 11 health visitors was for more frequent and regular meetings with general practitioner colleagues.

The nursing officers interviewed in this study held strong opinions on problems in the working relationship between health visitors and general practitioners. One nursing officer commented that general practitioners were often independent, not wanting to work as a team, and some were adamant about not breaking confidentiality. She felt, however, that younger doctors with more commitment to the primary care team were influencing their older colleagues. Another said that in her experience it was common to find general practitioners who did not see the necessity to meet and discuss patient care and that health centres had not been the answer to the problem.

**Table 3.** Types of clients referred by general practitioners to health visitors.

| Referral category | Response ($n = 38$ health visitors*) |
|---|---|
| Babies and children with minor health problems | 37 |
| The elderly | 33 |
| School children | 26 |
| Handicapped children | 26 |
| Marital problems | 26 |
| Children at risk | 24 |
| Behaviour problems | 24 |
| Family problems | 24 |

*Information was not available for one health visitor about referrals, and one practice did not refer clients to the health visitor.

## Discussion

The results of this article suggest that there are problems in some of the working relationships between health visitors and general practitioners. In spite of the working arrangements of 'attachment' and the primary health care team approach, there is evidence that the role of the health visitor is not always valued and that some health visitors have little contact with their medical colleagues and no true working relationship with them.

Health visitors have a long tradition of independence. Their role has evolved from that of the sanitary missioner of the nineteenth century. Since the inception of the National Health Service in 1948, health visitors have been regarded as 'all purpose family visitors'.[3] In 1969 the Council for the Education and Training of Health

Visitors identified the main aspects of their work as: the prevention and detection of ill-health; the recognition and identification of need; and the mobilization of resources and provision of care where necessary. The health visitor's role of prevention and health education is unique. Robinson suggested that, when in 1919 general practitioners opposed the suggestion of employment by local health authorities, the opportunity to develop a community-based health service founded on preventative principles was lost.[4] It was not until the early 1960s that formal working arrangements between doctors and community nurses were encouraged.

The conditions of employment for health visitors and general practitioners differ. Health visitors are employed by the local health authority and are responsible to that authority and their senior nursing managers. They are placed with a practice and there may be no formal interview or discussion between doctors and prospective health visitors over the latter's appointment.

The accommodation provided for health visitors is dependent to some extent on the practice to which they are attached. Health visitors, like doctors, need adequate accommodation for administration, filing space and proper telephone facilities in addition to a private room to interview clients. However, there are problems for general practitioners in providing accommodation for their attached staff. Although grants or loans from Family Practitioner Committees are available for extension of premises, the surgery site may not be suitable. In 1975 the Department of Health and Social Security recommended that local health districts should pay for heating and telephone charges for attached staff but this money has not always been forthcoming. Improved accommodation for attached staff with their general practitioners does not necessarily facilitate good working relationships.[5]

Various government reports since the 1920s have recommended that community nurses and doctors should work more closely together. The Dawson Report suggested that primary care should be organized in health centres.[6] The Jameson Report strongly recommended that general practitioners work more closely with health visitors and in 1967 the then Minister of Health urged all local authorities to further the joint working of nurses with general practitioners.[7] In 1961 there were a few experimental attachment schemes in operation and by 1971 60 per cent of health visitors were working in such schemes.

The development of attachment as a working arrangement has not been without problems. Its development has been reviewed by Hawthorne[8] and Clark[9] and the problems discussed in the Department of Health and Social Security's document *The way forward*[10] and in the evidence submitted by the Health Visitors Association to the Royal Commission on the National Health Service.[11] Most health visitors in this study were attempting to combine the best features of geographical and practice attachment. They also expressed strong commitment to the primary health care team approach. Reedy has said that eventually the time may come when the ideology of team work in primary care can develop without recourse to attachment.[12]

In this study of health visiting practice, one quarter of the sample were dissatisfied with their working relationship with general practitioners. More than 10 years ago, Brooks said that the best way to organize the primary health care team was unclear:[13] each team would need to struggle with the problems of role definition, leadership, communication, goals and priorities. Different styles of organization would emerge, some of which would be equally effective in providing primary care. She gave as examples six primary health care teams situated in the north of England who held meetings for all members. Their meetings varied considerably in frequency and formality. She pointed out that not all members regarded them as equally useful: nurses with well-defined roles—such as midwives and district nurses—found it irksome to have to sit through discussions of families they did not know. If regular meetings are to be a means of improving interprofessional relationships then their content and purpose needs to be clearly thought out.

For some time it has been suggested that shared training for different medical professionals might lead to better interprofessional awareness and teamwork. One way of achieving this has been tried in Crumpsall, north Manchester, with some success.[14] An annual study session is run for the trainee general practitioners, student district nurses and student health visitors, with the aim of promoting more knowledge of different professional medical roles and developing positive approaches to team work.

In order to encourage a good working relationship between the health visitor and the general practitioner, each must appreciate the other's role. Good accommodation, working under the same roof and devices such as attachment and the primary health care team may help, but it is the nature of the communication between the two professionals which is vital for the preservation and improvement of standards in community medical practice.

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## DOCTORS TALKING TO PATIENTS

*Doctors talking to patients,* by Professor P. S. Byrne, a distinguished past-President of the Royal College of General Practitioners, and Dr B. E. L. Long, an expert educationalist, was first published by HMSO in 1976.

This well known book has made a major contribution to the understanding of the consultation in general practice and illustrates the potential for using modern methods of recording for analysing the problems of doctor–patient communication.

With permission of HMSO, the Royal College of General Practitioners has now reprinted *Doctors talking to patients* and so made available this classic work to a new generation of trainees and general practitioner principals.

*Doctors talking to patients* can be obtained from the Publications Sales Office, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £10.50, including postage. Payment should be made with order.

## A HISTORY OF THE ROYAL COLLEGE OF GENERAL PRACTITIONERS
### The First 25 Years

This book records early attempts to form a College, the birth of the College itself, and the story of its growth through childhood to maturity. Edited by three distinguished founder members, John Fry, Lord Hunt of Fawley and R.J.F.H. Pinsent, it is a fascinating tribute to the enthusiasm, persistence and dedication of the men who made the College.

Written by those who were actually involved in its development, the chapters describe not only the story of the structure and organization of the College as a whole but of each of its component parts. Thus its involvement with medical education, standards, research and literature is described as well as relationships with other bodies at home and abroad—and a glimpse into the future.

Undoubtedly a success story, this account of the first 25 years of the College is recommended to those interested not only in the College but in the evolvement of general practice itself. Copies can be obtained from the Publications Sales Office, Royal College of General Practitioners, 8 Queen Street, Edinburgh EH2 1JE, price £10 to members, £12 to non-members, including postage. Payment should be made with order.



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## Long-term use of anxiolytics

Long-term use of anxiolytics has been a cause for concern because of the possibility of dependency and other adverse consequences. In a nationally representative probability survey of adults conducted in the USA in 1979, it was found that long-term use (defined as regular daily use for a year or longer) was relatively rare, occurring among 15 per cent of all anxiolytic users—a rate of 1.6 per cent of all adults between the ages of 18 and 79 years in the general population. The data indicate that long-term regular users tend to be older persons with high levels of emotional distress and chronic somatic health problems. They are preponderantly women, and many are sufficiently distressed to seek out other sources of help (mental health professionals and other psychotherapeutic medications) as well. The sizable majority of long-term users is being monitored by their physicians at reasonably frequent intervals. The data give little support to current stereotypes of long-term users and suggest, instead, that such use is associated with bona fide health problems that are being treated within the broader context of the health system.

Source: Mellinger GD, Balter MB, Uhlenhuth EH. Prevalence and correlates of the long-term regular use of anxiolytics. *JAMA* 1984; **251:** 375-379.