THE HEALTH VISITOR AND THE FAMILY DOCTOR*

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BY COMPARISON with the warmth with which schemes for the closer working of domiciliary nurses and midwives with general practitioners have been greeted, the health visitor's welcome by doctors has been, to say the least, cool; so often is she praised with faint damns! Health visitors, in self-defence, are sometimes very critical of doctors but, on the whole, I think their feelings are of sadness rather than of anger.

I believe that there are two main reasons for the doctors' attitude. First, most of them still think primarily in terms of the therapeutic aspects of medicine, and find it difficult to accept the need for someone whose entire work lies in the field of preventive medicine. Secondly, the health visitor has traditionally worked apart from the practitioner, and the advice she has given has sometimes conflicted, or seemed to conflict, with his. A third might be personality differences. These occur in all groups of professional colleagues and cannot alone account for much of the ill-feeling. There are, of course, poor health visitors, as there are poor doctors, but their numbers are small. Unfortunately, bad news travels fast: widespread misunderstanding of the role of the health visitor may have its origin in the inadequacies of a few individuals.

A fully-qualified health visitor is a state-registered nurse who has undergone at least three months' training in obstetrics (many are state-certified midwives) and has taken a further course of full-time study lasting an academic year to obtain the health visitor's certificate. The syllabus includes a detailed study of the history, organization and administration of the social services, of the social aspects of health and disease, of the intellectual, emotional and physical development of the individual, and of the role of the individual within the group, particularly within the family. A thorough training

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is also given in the principles and practice of health education. The total length of the training is therefore at least four years. Most health visitors have worked for several years as nurses or midwives before taking the course. With their training and experience, they could be an asset to any practice; it is surely quite wrong to describe them, as they so often are described, as 'interfering busybodies'.

In urban areas, the general policy of local authorities is to employ full-time health visitors. In rural areas it would be uneconomic to do so; travelling would occupy too much of their time. It is more usual to find in rural communities a health visitor who is also district nurse and midwife. This 'triple-purpose' worker is often more acceptable to both patients and doctors than the full-time health visitor; she is regarded primarily as 'the nurse', whose work can be seen and appreciated. A familiar figure, assured of an entry to patients' homes and doctors' surgeries alike, she can carry out her health visiting work without criticism. Being in closer touch with her practitioner colleagues, her advice is more likely to be in accord with theirs. By contrast, the work of the full-time health visitor gives far less tangible results; neither doctor nor community can readily assess its worth.

The health visitor is primarily a family adviser and educator. But she is also a privileged observer: regularly visiting families with young children she is in a unique position to observe a child's physical, intellectual and social development and to detect deviations from normal. As a 'professional persuader' her influence on, for instance, the immunization rate for her area can be considerable. When new techniques such as routine screening of infants for phenylketonuria or hearing defects or congenital dislocation of the hip were introduced, she was the obvious person to use them. A growing area of work includes persuading women to attend screening clinics for cervical cytology and the early detection of breast cancer, diabetes mellitus and anaemia. Health visitors have also done much of the field work in connection with surveys such as the National Survey of Health and Development and the Oxford Survey of Childhood Cancers.

Let me give some examples from my own experience of the value of a health visitor's vigilance. A few years ago I was able to recognize early cretinism in two infants because the health visitors who brought them to my attention had noticed delayed physical development and failure to respond to a screening test of hearing. (The cause of the failure to respond was delayed maturation, not a hearing loss.) One of these infants was at the time being treated for an iron deficiency anaemia by the family doctor: she was certainly anaemic, but the cause was not iron deficiency. On another occasion I was told of a child with a congenital dislocation of the hip which was

first diagnosed at the age of 27 months, a year after he began to walk. When I looked up the health visitor's records I discovered that she had noticed shortening on the affected side at the age of six months and had drawn this to the attention first of the general practitioner and, later, of the clinic medical officer, both of whom failed at the time to appreciate the significance of the observation.

Sooner or later general practitioners will take over the greater part of the clinical work of the school health and infant welfare services from local authority medical officers. A system which was evolved to meet the needs of a population among whom malnutrition was rife and infectious disease largely uncontrolled, a population without access to free medical care, is no longer appropriate for present-day needs. But if the quality of the work is to be maintained, and indeed improved, and its volume controlled, the work must be organized on a much more selective basis than at present. Although a systematic physical examination of every new-born child is highly desirable, it is doubtful if this is necessary for the older infant, still less for the school child. Wider use of screening techniques, including questionnaires, for the early detection of physical and metabolic anomalies, together with social screening of children with inadequate parents, will obviate the need for routine examination of large numbers of healthy children. The health visitor is the key person in the application of these techniques: she is the only worker who can make it possible for the general practitioner to take over the work of the local authority child health services.

I am convinced that the health visitor, unseen and unappreciated, is even now making a substantial contribution to reducing the doctor's work-load. Advising on feeding problems and minor ailments, alleviating anxiety over children's development or behaviour, introducing other social agencies, she is treating problems which, had they continued, might well have led to a consultation at the doctor's surgery. How much more could be achieved if she and the doctor worked together in harmony.