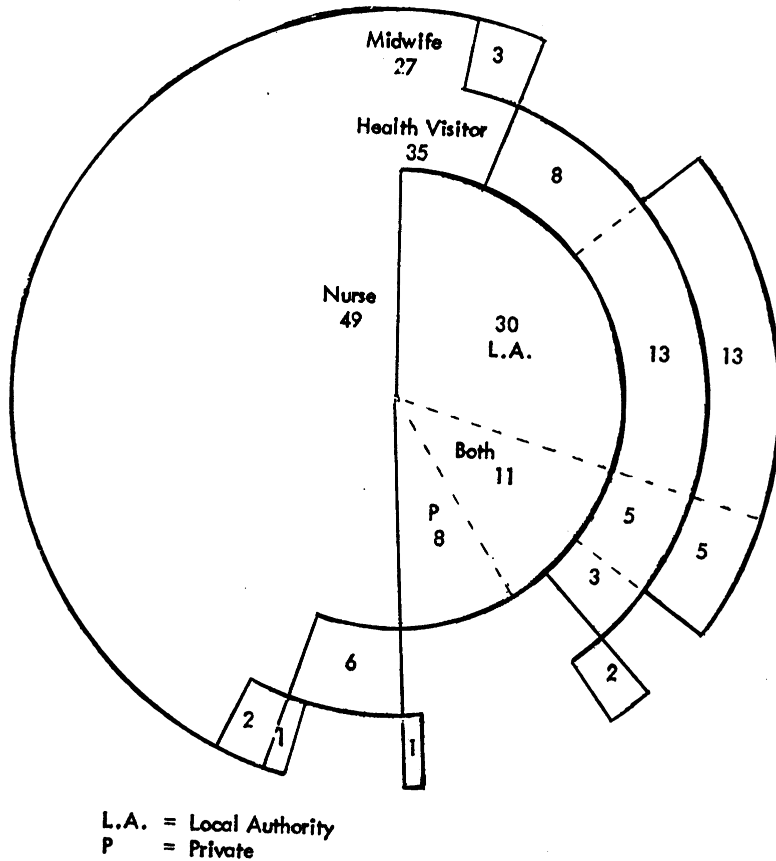

Figure 5
Percentage of practices having attached staff (each practice has the staff represented in a small segment cutting across the three bands. The numbers are percentages).

Discussion

In this paper we have seen how the work is being carried out by the paramedical staff in group practice. The work is generated on the one hand by the patients and on the other hand by the doctor and his team. For practice to work efficiently and provide the best service for the patient delegation of duties is important. We have examined some of the factors which might influence this. The range of work and hours of duty are wide and we have been unable to find factors to which this may be related, save perhaps for the fact that if sufficient clerical staff are employed then an appointment system will probably be in operation in the practice. The attached nurses in this survey seemed to be carrying out certain duties in the surgery to a less extent than perhaps they might be. Is this because they are unable to spend more time in the practice, or is it related to a dual loyalty? The doctor and each member of his team must be fully aware of the working potential of colleagues and use them in this capacity. If discussion of cases is a virtue then we have seen that attachment does seem to favour this.

One should not, he thought, be controlled or governed by an appointments system when trying to practice clinical medicine. He might finish an hour after the last appointment, at the rate of eight an hour. Some of his colleagues said he was slow but he tried to practise clinical medicine and he had fewer people coming back as a result of this. One could so easily be

governed and controlled by time and have a sense of hurry, which, if conveyed to the patient, tended to shut him up, so that he did not give the proper history in the necessary relaxed atmosphere.

With regard to premises, the architect did not always do the right thing *ab initio;* in their own case, the building was the wrong way round. This was terribly important. In the summer conditions were difficult. There were double-glazed windows, and there were four consulting rooms on the busy road aspect of the building, which was also the side which got the hot summer sunshine. If the windows were opened for ventilation a tremendous amount of noise was let in. The whole thing could have been obviated if the consulting rooms had been on the other side, away from the traffic and the sun.

With regard to the training of staff, this was an evolutionary process which was bound to develop. Most training could be done within the group practices by those who had developed their own experience.

Dr Struthers (*chairman*) said that the scope of ancillary or para-medical help was probably the most important part of the whole programme. The whole problem of general practice or community care was in a transitional phase. It has taken a long time but it was still in transition. The preceeding survey had clearly demonstrated that the job of the various members of the team had not yet been properly defined. The health visitor was still looking for a rôle, and he believed that she was going to be a social worker of a slightly different kind.

"We are looking", he said, "at the best way of delivering medical care. The doctor alone cannot deliver it. The patient still wants an individual working near his home—but with x-ray apparatus, cardiac transplants, the lot—all for him! How do we provide the best medical care and get the patient to accept that what is being done is the best for him?".

A plea was made for a psychiatric social worker in addition to the social worker in view of the prevalence of psychiatric problems in general practice.

Dr T. H. H. Green (*Wallasey*) who had taken part in the work connected with Dr Michael's survey expressed surprise at the large number of group practices which existed in a relatively small area. It was not surprising that 81 per cent of those consisted of only three or four doctors. He had been impressed by the fact that in 12 per cent of those group practices having a local authority nurse attached, and in 20 per cent of those with a local authority and private nurse, the nurse sometimes made the first home visit. This was very important. In 60 per cent of the practices the nurse sometimes made a follow-up visit. Was this the beginning of the kind of scheme which existed in Russian medicine?

The point was raised by the chairman that according to the Royal College of Nursing, it was against the rules for nurses to be taught primary diagnosis.

Dr J. Weston-Smith referred to a quotation from Dr Michael's paper: "Delegation by the doctor may be easier to his own employee than to a nurse who must answer to another authority as well." In his own case they had seen quite dramatic results from having a nurse incorporated into the centre. She was given full responsibility and felt herself to be one of the team. She was used for primary screening, with special regard to primary visiting. She went out and assessed whether a visit by one of the partners was necessary. This system had been started with trepidation but so far in three years there had been no difficulties or complaints, though care had to be taken. The effect had been quite dramatic. There was now about the same demand for visiting but it was not for the doctors to visit. The primary demand was for the nurse—"Will the nurse come and see the child". Over the years there had been built up this sense of responsibility and the patients realized that the nurse was an extension of the practice. This was a development of ancillary help which should be encouraged. It was not the thin end of the wedge of the Feldsher scheme. The results show that there was something worth-while.

Dr K. S. Dawes said that people were very loath to look objectively at what they were doing. If it were looked at objectively and not emotionally, not in terms of "my patients", "my practice", but what the patient was requiring, it was surprising how much of it could be done by someone else.

The ancillary was in direct professional partnership with the doctor. The nurse, the health visitor, the social welfare worker could do a great deal in the way of primary care a lot better than the doctor. It was easy to delegate to nurses because traditionally one knew what they were doing.

Mrs E. H. Simmonds (*chairman, Health Visitors Association*) said that the health visitor had to keep a certain record which went on for the child's school life and on into the education department, so that at the moment she had to keep a separate record; but one doctor had the inspiration to use a continuation card which went into the family folder. While the health visitors were under the local health authority the records were a difficult problem. They had been trying to get the authorities to have a standard record for 20 years and had got nowhere yet, despite countless resolutions: everyone thought his own card was best!

In Brent, with more than 260 doctors in a six square mile radius it was difficult to arrange health visitor attachments. If there were zoning it could be done.

With regard to legal indemnity, Mrs Simmonds asked who was responsible for anything that went wrong with the local authority or local health authority nurse or visitor in the general practitioner's surgery. She had understood until recently that it was not the general practitioner, but the Health Visitors Association had had a case of the local authority saying, "It is not our responsibility", so this was an area in which some ruling must be given. Her own authority had accepted this responsibility but as more and more as staff were delegated to general practitioners this difficulty would arise.

Dr K. S. Dawes said that the insurance which went with the membership of the Royal College of Nursing would cover any actions of nurses who were members of the College. The Medical Defence Union would cover the actions or omissions and commissions of any deputy of a general practitioner provided they were carrying out duties that the doctor thought them capable of. Unfortunately, this was a problem of what was considered "capable", and the Medical Defence Union felt that until such a case came before the courts it was not really possible to say exactly what a nurse or health visitor was capable of doing on the instructions of the general practitioner.

The chairman said that, for example, they could take blood but could not give an intravenous injection unless so taught as midwives.

Miss N. C. Daniells (*London Boroughs Training Committee*) said that at the request of the Royal College of General Practitioners and some of the London Boroughs a series of regional conferences had been held encouraging local authorities and doctors to have both health visitors and district nurses attached. In the working party and in the meetings the whole question of the legal position of the nurse had been investigated. They had consulted the Royal College of Nursing, the British Medical Association and the Medical Defence Union. The nurse was in a peculiar position. The General Nursing Council acted for nurses in the same way as the General Medical Council for doctors. A nurse could be struck off the register. A nurse was responsible in law for her own actions. Whatever the employer might say or whoever he might be, she was responsible as to whether she felt competent and felt herself to be up to date in practice. Therefore, whether a nurse was employed by a local authority or by a doctor as a practice nurse, she should be insured in her own right as well as by the employer taking out an insurance to cover him or her.

It was singularly difficult to get over to doctors that a nurse was responsible in law for her own actions. Until recently she had been Chairman of the Public Health Section of the Royal College of Nursing, and one of the reasons why the Royal College had had such lengthy discussions with the B.M.A. was that there were about five cases a week of nurses being sued in their own right, whether they were in hospital or local authority service. This sort of litigation had increased over the years.

The growth of attachment had increased the number of patients and the number of responsibilities that a health visitor must cover; so much so that whereas a few years ago some district nurses were under-employed, they were now stretched to the maximum, and in the next two years would have to increase their total complement by ten per cent to meet the needs of

attachment alone. There was not only the growth in the demand for their services from attached doctors but also from the others.

With regard to primary visiting, the quality and ability of nurses and health visitors varied, just as much as that of general practitioners, and before long there might be cases in which an inadequate general practitioner was using an inadequate nurse, and some ghastly catastrophe would arise.

Dr W. Dodd said that as a practitioner from rural Scotland he has found the discussion about the rôle of the health visitor and the nurse difficult to understand. Their district nurse was a qualified health visitor and also was the local midwife. This produced remarkably good results, with complete continuity of care. She could also move from the advisory capacity of health visitor into a clinically active rôle as the district nurse. He understood that in one or two areas in England there was enlightenment and efforts were being made to introduce a community nurse on somewhat similar lines. This might be the mechanism whereby the difficulty in understanding the position of the health visitor might be overcome.

Dr E. V. Kuenssberg was concerned to slaughter the 'sacred cow' that the nurse was not trained to diagnose. All of them had worked in hospital at one stage or another and knew perfectly well who it was that told them, in the early stage of their career, which patient suffered from what. 'Who was it at night who kept a watchful eye on the appearances of patients, the first signs of anything untoward? Who could say, therefore, that nurses could not or did not diagnose? The nurse diagnosed throughout her life. She was trained to recognize the abnormal and the normal and to differentiate. This constituted diagnosis.

One thing the survey of ancillary staff had shown was that doctors had not yet learned what each of these other professions could do. They realized what the private nurse could do, up to a point, and made her do it. The local authority nurse was the same creature in a different uniform, paid by a different person. She could do exactly the same things. Why not let her? Doctors had not yet learned to use these people, who were wrongly called "ancilliaries" instead of members of the team. "The minute we regard them as members of our team we begin to use them properly". "They work for us but not with us" declared Dr Kuenssberg, "and I have no doubt the latter is the way in which we have to work". In his own practice they had experimented with this for years and found that it could be done. The safeguards were extremely important. Admittedly they must all be insured, doctors and nurses. "But what is much more important", he said, "is that we use nurses and doctors alike in the capacity in which they have been trained. They have either done it or they have not, and if they have not done it they must learn it. Once they have been trained to do a particular thing there is no further problem, as this then defines their capabilities in the legal sense. The same applies to all other procedures, and this is again where we go wrong as general practitioners. We do not ask people who know about this. The people who can give us the greatest help in assessing the nurses attached or employed are the nursing supervisors or the health visitor supervisors of the local authority. They can tell us precisely what their girls have been trained for and trained in. Let us get together with them and work as a team".

Various speakers made the points summarized here:

"The different figures obtained in the survey must surely be an incentive to experiment with delegation and attachment, and it would be a tragedy if we thought of the team working as 'mould' into which we all require to fit—we know far too little about it yet, and must all keep a flexible outlook on this. However we have not yet even managed to adapt the hospital nursing and technical staff procedures and responsibilities for the work of the community care."