Common ground in general-practitioner and health-visitor training—an experimental course

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SUMMARY. A residential course for 21 general-practitioner vocational trainees and student health visitors is described. The aim was to introduce the two groups of trainee professionals to each other in an attempt to modify attitudes, increase knowledge of each other's work, and induce a more positive approach towards teamwork in their ultimate careers. Both groups achieved an improvement by the end, and over half said they understood the others' role better

Introduction

Interprofessional training

In 1972 a Joint Working Party was established in the Oxford region to discuss overlapping areas of training for general practice, health visiting, and community nursing. Membership consisted of the directors of nursing services from the local health authorities, health visitor tutors from the three training courses in the region, general-practitioner teachers from the General Practice Subcommittee of the Regional Committee for Postgraduate Medical Education and Training, and the Thames Valley Faculty of the Royal College of General Practitioners. One of the most important topics that needed attention was communication problems that often existed between general practitioners and health visitors.

Relationship difficulties

There seem to be several reasons why these two professions have communication difficulties. First, considerable ignorance exists on the part of the general practitioners about the role of the health visitor. She is the only member of the primary health care team who does not appear in the teaching hospital where most medical undergraduate training takes place. This ignorance often persists into the doctor's professional career and although attachment of nursing staff should have corrected this, there is often effective lack of communication. Gilmore *et al.* writing as late as 1974 describing an intensive survey of three centres with a random selection of a further 36 say that in most teams there exists a *laissez-faire* approach about having contact with each other. More of the doctors and district nurses were satisfied with this approach than were the health visitors. Most teams seemed to be composed of peer groups with little communication between one group and another.

This problem of ignorance of the role of health visitors is further complicated by different approaches that the two professions may adopt. In the past doctors have been little trained in prevention and in psychological and social factors of disease, and spend most of their time in an individual and illness-oriented approach to their work. They may fail to comprehend the importance of a team member concerned primarily with prevention. Indeed when the workload is temporarily heavy, as in an influenza epidemic, the fact that the health visitors appear to be outside the rush of the doctors and nurses may create resentment.

The health visitors for their part are concerned that doctors spend so little time in prevention and early detection. Difference in approach is one of the root causes of breakdown in relationships between doctors and social workers, but unlike social workers, health visitors have been trained originally as nurses in a setting where the doctor was very much the team leader. These

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attitudes on the part of both nurses and doctors die hard, and health visitors may accept an unsatisfactory place in the primary care team hierarchy, instead of questioning the status of the doctor.

Training

It is logical that many of these difficulties could be solved during the training period. Postgraduate training for general practice is developing rapidly and there are now 43 post-registration health visitor training centres in the United Kingdom. Yet there are disturbing stories of teaching practices both for the general-practitioner trainees and for the health visitor students' fieldwork where no effective team work or communication appear to exist.

The Oxford Region Joint Working Party has felt that it would be logical to develop the concept of multidisciplinary teaching practices with general-practice teachers and health visitor-fieldwork teachers working alongside each other. It was also felt that experimentation with a short joint training course would be worthwhile.

The pilot course

Organisation

A pilot course was initiated in 1974 and sponsored jointly by the Milton Keynes College of Education and the Thames Valley Faculty of the Royal College of General Practitioners. The main problem was that of imbalance between participants: all the health visitor students from the Milton Keynes course volunteered to attend, but hardly any of the general-practitioner trainees from the Oxford region. This seemed to bear out the findings quoted earlier from the study by Gilmore *et al.* (1974) In the end, there were 17 health visitor students, and four general-practitioner trainees. The majority was resident and the course lasted for four days. In addition two health visitor fieldwork teachers and one general-practitioner trainer attended.

Content

Most of the first three days was spent in group work discussing the care of young families, the middle aged, and the elderly. To help the groups, three descriptive profiles of imaginary practices were supplied. On the fourth day there were plenary sessions and in general there were many ideas. Three guest speakers contributed.

Results

The participants developed warm relationships quickly and contributed enthusiastically. They felt they had been helped to understand each other's role and problems, even if these were not always clearly defined. It was felt therefore that the course should be repeated in 1975 with an attempt to set clear educational aims and objectives and to achieve a more balanced representation of the two professions.

The 1975 course

Educational aims and objectives

The main aim was to introduce a group of general-practitioner trainees to a group of health visitor students in an attempt to modify attitudes, increase knowledge of each other's work, and induce a more positive approach towards teamwork in their ultimate professional careers.

The educational objectives were:

(1) The health-visitor student should improve her awareness of the conditions of work and traditional orientation of a general practitioner,

(2) The general-practitioner trainee should improve his awareness of the role, skills, and work of the health visitor,

(3) Both groups should be aware of methods of communication and potential problems, and the use of records and registers,

(4) The general-practitioner trainee should begin to identify problems to which the health visitor could contribute,

(5) The general-practitioner trainee should be more aware of the possibilities of preventive medicine in the primary health care team.

(6) The health-visitor student should improve her case-finding skills in relation to the work of the general practitioner and the primary health care team.

Background information from participants

Before the course, some information was collected from the participants' teaching practices (12 health-visitor fieldwork teaching practices, 11 teaching general practices and one non-teaching general practice—one of the practitioner participants was a junior principal).

The range of list size was from 3,000—20,000 with an average for both types of teaching practice of about 9,000. The average ratio of general practitioners to health visitors was 2:1 in both types of teaching practice although in one health-visitor fieldwork teaching practice there was only one health visitor to five general practitioners for a population of 10,000. Table 1 shows the frequency of informal contact between general practitioners and health visitors and and it will be noted that in eight of 24 practices this informal contact was only weekly.

TABLE 1

FREQUENCY OF INFORMAL CONTACT BETWEEN GENERAL PRACTITIONERS AND HEALTH VISITORS IN THE TEACHING PRACTICES

Frequency	*General-practitioner training practices*	*Health-visitor practices*
Daily or more	7	2
2–3 per week	3	4
Once per week	2*	6

(* includes the one non-teaching practice)

Table 2 shows the number of practices with the health visitors' accommodation on the premises and the number with regular clinics with general practitioners and health visitors functioning together. Only a third of the health-visitor fieldwork practices had the fieldwork teacher's office in the practice building.

TABLE 2

NUMBER OF TEACHING PRACTICES WITH HEALTH VISITORS' OFFICE ON PREMISES AND WITH REGULAR CLINICS INVOLVING BOTH GENERAL PRACTITIONERS AND HEALTH VISITORS

	General-practitioner training practices	*Health-visitor practices*
Health-visitor accommodation on premises	10*	4
Regular joint clinics	11*	3

(* includes the one non-teaching practice)
TOTAL: 12 of each type of practice

Table 3 shows the frequency of formal meetings and in only one of the 12 health-visitor fieldwork practices were formal meetings for practice planning and organisation held. These figures, although small in number, suggest that contact between the two professions should be improved especially when it is remembered these practices are approved for teaching.

Course organisation

As in the pilot course, the course was held in a residential College for Adult Education at Maryland, Woburn. We consider the residential and social aspects were important features. The right environment had to be created, and the physical surroundings of Maryland contributed to this.

TABLE 3

NUMBER OF TEACHING PRACTICES HOLDING REGULAR FORMAL JOINT MEETINGS

Purpose	*General-practitioner training practices*	*Health-visitor practices*
Practice planning and organisation	7*	1
Individual patient management	11*	10
Other	3	4

(* includes the one non-teaching practice)
TOTAL: 12 of each type of practice

The educational objectives involved not only an increase in knowledge, but changes of attitude and because of this, most of the work was done in small or large groups. Groups were set tasks relating to implications of role and training, areas of overlapping care and re-organisation of a team which was not functioning properly.

Guest speakers provided additional material and helped as resource men in the groups Dr B. L. E. C. Reedy, Senior Lecturer in the Medical Care Research Unit at the University of Newcastle-upon-Tyne, spoke on ' Communication and Status Problems.' Mrs June Clark, a health visitor and member of Berkshire Area Health Authority emphasised the problem of selection of priorities for the health visitor, in an environment mainly organised for therapeutic care. Dr D. H. H. Metcalfe, Senior Lecturer in the Department of Community Health at the University of Nottingham, dealt with recording systems in primary care. A team from Haddenham described a transition from a single-handed practice to a new health centre. Miss G. Flack, Professional Adviser to the Council for the Education and Training for Health Visitors was present for part of the course and summed up at one stage on communication problems. Two general practitioners and three fieldwork teachers were also present for all or part of the course, and we both acted as course tutors.

The 1975 course was much improved compared with the pilot course by the fact that there were roughly equal numbers of health-visitor students (11) and general practitioners (nine trainees and one junior principal). The health-visitor students came from Milton Keynes College of Education and their costs were paid for by their sponsoring area health authorities. The general-practitioner trainees came from various parts of the Oxford region and the course was approved under Section 63 to enable them to claim their expenses.

Group work

On the first day the groups were asked to discuss the ways in which general practitioners and health visitors differ in their training, and what implications this had for working with each other and other professionals, especially nurses and social workers. The groups settled down quickly and felt that in many ways there were similarities in their postgraduate training with a change in emphasis from disease-orientated approach to more awareness of social and emotional factors.

The status of the doctor was underlined and the difficulty that many doctors see the nursing profession in a subordinate role, thereby making it more difficult to accept the health visitor as a case finder and professional equal. Mention was made of the apparent attempt by doctors to remain outside the integrated health service with their independent contractor status, whilst the health visitors, like other attached nurses, had dual loyalties to the doctors and the employing area health authorities. The doctors' ignorance of the health visitor's role was emphasised and the need for more joint training programmes was felt.

On the second day the groups were asked to list the main areas in which general practitioners and health visitors overlapped, and where the main problems seemed to lie. Later the discussions centred around specific case histories which the general-practitioner trainees had brought from

the following problem areas; bereavement, mental and physical handicap, child behaviour, termination of pregnancy, and contraception. It was felt that the health visitor should have a place in all aspects of preventive medicine carried out by primary care team members. Wasteful overlap of work should be avoided particularly in the field of developmental paediatrics. Confidentiality and personalities might pose problems and most difficulties could be overcome by establishment of clear policies and mutual respect within the team.

On the third day the groups considered the hypothetical situation of joining a new practice and finding that the general practitioners and health visitors had hardly any contact. They were asked what changes they would try to initiate to improve matters. Participants (realising the situation could become real for some of them in the future) emphasised that careful exploration and assessment was needed first, with minimal aggression. An attempt would have to be made to establish a meeting for some initial planning with consideration of subsequent methods of contact and frequency of regular meetings. Health visitors should accept they may need to " sell " themselves, and if possible find some means of establishing an office on the premises if not already there. Records systems would require special study and some long term plan should be devised.

Miss Flack, who had contributed to the Gilmore study, in her summing up on communication problems emphasised that delivery of a message was only part of the problem, and that change should be effected to complement this. Many people feared change and preferred conflict. It was important to recognise that receptionists need to understand the health visitor's role. There was fundamental responsibility of training bodies to promote advances with field work and administrative staff in interprofessional fields.

Assessment

In order to attempt to measure the effectiveness of the course all participants completed questionnaires and a modified essay question at the beginning and the end of the course. It should be borne in mind that the numbers of participants was small and therefore the figures should be interpreted with caution.

Modified essay question

The modified essay question concerned a professional man with a physically handicapped wife and three children who were new to the district and whose circumstances were discovered by accident at a social function. The participants were asked what action they would take, and what important topics needed exploring. Subsequently the husband died suddenly and they were asked to describe their initial plan of action. The questions were arranged in two forms—one for the general practitioner and one for the health visitor. Each group did their own paper first and then that of the other group. At the end of the course each group only answered the other group's questions to attempt to see if they had a better understanding of the other's duties in a case which involved both professions.

A marking schedule was devised by the course tutors with the help of several general-practitioner trainers and fieldwork teachers who completed the paper before the course. The average marks are shown in tables 4 and 5. It will be noted first that both groups achieved an improvement. The general-practitioner trainees appeared to have a better idea of the health visitor functions at the beginning and end than the health-visitor students did of the general practitioners' functions. But it must be pointed out that the general-practitioner trainees were a self-selected group and had more practical experience of working in the field than the health-visitor students. The latter had to produce positive reasons for opting out of attending the course and their fieldwork was limited in the main to one day a week.

TABLE 4

MODIFIED ESSAY QUESTION AVERAGE MARKS ON THE GENERAL-PRACTITIONER PAPER

General-practitioner trainees before	*Health-visitor students before*	*Health-visitor students after*
43%	*27%*	*35%*

TABLE 5

MODIFIED ESSAY QUESTION AVERAGE MARKS ON THE HEALTH-VISITOR PAPER

Health-visitor students before	*General-practitioner trainees before*	*General-practitioner trainees after*
43%	*37%*	*49%*

The average marks hide individual performances. Two health-visitor students had significantly lower marks at the start from the rest of the group (both ten per cent); both improved significantly by the end (34 per cent and 32 per cent). Three-health visitor students had lower marks at the end than the beginning (47, 37 and 32 per cent falling to 46, 32 and 25 per cent respectively).

Four general-practitioner trainees had marks below the average at the start, although none of these was proportionately as low as the two low scoring health-visitor students. These trainees all improved significantly (35, 28 and 25 per cent and 24 per cent before increasing to 57, 55, 49 and 33 per cent respectively).

No general-practitioner trainee obtained lower marks at the end than the beginning.

Mutual areas of concern and prevention

Two questions in the questionnaire asked the participants to identify six topics where the health visitor could help the general practitioner and to identify six aspects of preventive activity which were thought to be important. The marks are shown in table 6. The general level of marks is high and both groups improved on both questions except for the health-visitor students in aspects of prevention. This was surprising at first sight. On further examination it appeared that some of the health visitors had not answered the questions as carefully or as relevantly the second time. Mixing two professional groups of differing academic standards even with experienced workers where the oral level of communication is good can present difficulties. It may be that the health-visitor students needed more time for consolidation and it is possible that the course should have been aimed slightly lower to allow for this.

TABLE 6

AVERAGE MARKS FOR TOPICS OF HEALTH-VISITOR CONTRIBUTION AND ASPECTS OF PREVENTION (PERCENTAGES)

	General-practitioner trainees		*Health-visitor students*	
	Before	*After*	*Before*	*After*
Health-visitor contribution	*85*	*90*	*77*	*80*
Prevention	*72*	*82*	*82*	*71*

The topics identified where the health visitor can help the general practitioner are shown in table 7. Several possibilities including retirement, the menopause, and unmarried mothers did not feature at all. The traditional area of maternal support and advice (including feeding problems) featured much more prominently at the start than the end when there was a more even spread of suggestions.

Table 8 identified the topics they thought important in prevention. This was the question that the health visitor students answered less well at the end than the beginning. It is interesting that here they appeared to revert to the traditional field of antenatal, mothercraft and child care at the expense of health education, bereavement, retirement, and the menopause.

TABLE 7

TOPICS OF HEALTH-VISITOR CONTRIBUTION EXPRESSED AS PERCENTAGE OF TOTAL ANSWERS IN EACH SECTION

Topic	*General-practitioner trainees*		*Health-visitor students*	
	Before	*After*	*Before*	*After*
Maternal support and advice	*43*	*35*	*30*	*16*
Supporting handicapped and elderly	*25*	*21*	*13*	*27*
Emotional and psychological	*22*	*26*	*9*	*23*
Educational	*6*	*12*	*6*	*9*
Assessment	*4*	*2*	*22*	*13*
Contraception/abortion	*0*	*4*	*5*	*9*
Liaison with other agencies	*0*	*0*	*13*	*3*
Immigrants	*0*	*0*	*2*	*0*
TOTAL SUGGESTIONS	51=*100%*	57=*100%*	54=*100%*	56=*100%*

TABLE 8

IMPORTANT TOPICS OF PREVENTION EXPRESSED AS PERCENTAGE OF TOTAL ANSWERS IN EACH SECTION

Topic	*General-practitioner trainees*		*Health-visitor students*	
	Before	*After*	*Before*	*After*
Antenatal, mothercraft and child care	*25*	*15*	*18*	*32*
Health education (including dental, smoking, diet, drugs)	*18*	*17*	*20*	*13*
Bereavement, retirement and menopause	*2*	*2*	*9*	*4*
Contraception and sex education	*11*	*15*	*14*	*13*
Immunisation	*7*	*10*	*13*	*13*
Emotional and social	*16*	*11*	*3*	*4*
Accident prevention	—	—	*2*	—
Screening for specific disease	*21*	*30*	*21*	*21*
TOTAL SUGGESTIONS	44=*100%*	47=*100%*	56=*100%*	47=*100%*

Records systems

Participants were asked the uses of an age-sex register and asked how they would define vulnerable groups in the community. The marks are shown in table 9. Although there was a general improvement, the second question was badly worded in that not all participants were clear that it was the mechanisms of identification of groups that was wanted. All participants gained the same marks or more except for one student health visitor on each question.

TABLE 9

AVERAGE MARKS FOR USE OF AGE-SEX REGISTERS AND MEANS OF IDENTIFYING VULNERABLE GROUPS (PERCENTAGES)

	General-practitioner trainees		*Health-visitor students*	
	Before	*After*	*Before*	*After*
Use of age-sex register	*36*	*48*	*25*	*29*
Identification of vulnerable groups	*14*	*32*	*25*	*33*

Failure of communication and ways of making contact

Participants were asked to list reasons for the two professions failing to communicate and indicate ways in which contact could be made on a daily basis in order of preference. Extra marks were given where some scheduled face-to-face contact was given as first preference. The marks are shown in table 10 and there is a significant increase in the health-visitor students' marks on the second question. In table 11 the reasons for non-communication are listed as a percentage of the total answers in each section. Table 12 shows a similar analysis for methods of day-to-day contact. The student health visitors appeared more conscious than the general-practitioner trainees of the general practitioner's ignorance and status problems, although the trainees seemed to be more aware of these difficulties by the end of the course. Although it appears in table 12 that scheduled face-to-face contact has declined in popularity, this was because the participants were identifying more alternative methods by the end and there was no decrease in the popularity of this method of contact—there was no significant increase either.

TABLE 10

AVERAGE MARKS ON THE REASONS FOR NON-COMMUNICATION BETWEEN GENERAL PRACTITIONER AND HEALTH VISITOR AND THE WAYS OF MAKING DAY-TO-DAY CONTACT (PERCENTAGES)

	General-practitioner trainees		*Health-visitor students*	
	Before	*After*	*Before*	*After*
Reasons for non-communication	*58*	*66*	*60*	*64*
Methods of day-to-day contact	*47*	*55*	*46*	*68*

TABLE 11

REASONS FOR FAILURE OF COMMUNICATION EXPRESSED AS PERCENTAGE OF TOTAL ANSWERS IN EACH SECTION

Reason	*General-practitioner trainees*		*Health visitor students*	
	Before	*After*	*Before*	*After*
Ignorance of health visitor's role, skills and training	*23*	*32*	*39*	*39*
Status, personality clashes, rivalry	*20*	*16*	*33*	*27*
Working from separate premises	*27*	*23*	*17*	*17*
Apathy. *Laissez-faire* approach	*10*	*10*	*5*	*10*
Poor organisation	*17*	*3*	—	*5*
Heavy workload. Fear of more work	*3*	*13*	*3*	*2*
Poor or inaccessible records	—	*3*	*3*	—
TOTAL SUGGESTIONS	30=*100*%	31=*100*%	36=*100*%	41=*100*%

TABLE 12

METHODS OF MAKING DAY-TO-DAY CONTACT EXPRESSED AS PERCENTAGE OF TOTAL ANSWERS IN EACH SECTION

Method	*General-practitioner trainees*		*Health-visitor students*	
	Before	*After*	*Before*	*After*
Scheduled face to face	*72*	*53*	*53*	*41*
Telephone	*7*	*31*	*18*	*30*
Written messages or records	—	*16*	*18*	*26*
Joint clinics	*21*	—	*11*	*3*
TOTAL SUGGESTIONS	14=*100*%	19=*100*%	17=*100*%	27=100%

Opinion of level of communication

Participants were asked to judge from their own experience what the level of communication was between the two professions. The rating scale was 0 (non existent) to 5 (good). One trainee at the beginning and a further three trainees at the end rated this at 2 or less. We hope the larger number at the end is explained by an increased awareness of problems. Six student health visitors scored their own experience at 2 or less at the start but by the end three of them had raised their score to 3. Only one participant (a general-practitioner trainee) rated his practice as 4, and the general rather average level is disappointing, but not unexpected.

Personal qualities

The health-visitor students were asked to describe briefly their ideal general practitioner. They listed a total of 45 qualities between them at the beginning and 28 at the end (table 13). It is interesting and perhaps not unexpected that the qualities most in demand were communicative skills rather than competence and sympathy and the difference is marked by the end of the course. Other qualities included enthusiasm, flexibility, and good looks!

TABLE 13

HEALTH VISITOR STUDENTS' VIEW OF THEIR IDEAL GENERAL PRACTITIONER EXPRESSED AS PERCENTAGES OF TOTAL SUGGESTIONS AT THE BEGINNING AND END

Qualities	*Before*	*After*
Capable, competent, resourceful congenial, sympathetic	*40*	*18*
Willing to communicate, listen, accept advice, shares records, appreciates teamwork	*56*	*71*
Other	*4*	*11*
TOTAL SUGGESTIONS	45=*100%*	28=*100%*

The general-practitioner trainees were asked to describe their ideal health visitors and their answers are analysed in table 14. By the end of the course the general-practitioner trainees were more concerned about the professional and communicative abilities of the health visitor (perhaps because now they appreciated they needed them) rather than just personal qualities. Other qualities included good driving, and maternal experience.

TABLE 14

GENERAL-PRACTITIONER VIEWS OF THEIR IDEAL HEALTH VISITOR EXPRESSED AS PERCENTAGES OF THE TOTAL SUGGESTIONS AT THE BEGINNING AND END

Qualities	*Before*	*After*
Capable, competent, resourceful, friendly, sympathetic	*40*	*32*
Willing to communicate, listen, interested in work, appreciates need for teamwork	*34*	*46*
Other	*26*	*22*
TOTAL SUGGESTIONS	38=*100%*	28=*100%*

Reactions of the participants

Finally at the end of the course each participant was asked what he or she had got out of it. Their replies are shown in table 15. It was pleasing to see, in relation to the educational objectives 1 and 2 set for the course, that over half from each discipline felt they understood the others' role better. There was an appreciable number from both disciplines who felt they had gained in ideas and a small number who felt something had happened to them personally increasing self-awareness or optimism. What is not recorded in analytical form is the general enthusiasm the course seemed to have produced in many of the trainees and students. Many said they enjoyed the chance to discuss their training and professional roles and problems with other people.

TABLE 15

WHAT THE PARTICIPANTS SAID THEY OBTAINED FROM THE COURSE SHOWING TOTAL NUMBERS FOR EACH STATEMENT AND EXPRESSED AS PERCENTAGES FOR TOTAL NUMBERS FOR EACH DISCIPLINE

	General-practitioner trainees		*Health-visitor students*	
	Number	%	*Number*	%
Understanding other's role	7	*48*	7	*42*
Understanding other's problems	2		3	
Understanding other's training	3		1	
Ideas for improving team performance	4	*40*	5	*46*
Motivation and ideas for better communications	4		5	
New ideas about records	1		1	
Opportunity for discussions in depth	1		1	
Awareness of own deficiencies	2	*12*	1	*12*
More optimism about future	1		1	
Inspiration to be more active			1	
TOTAL	25	*100*	26	*100*

Conclusion

Final plenary sessions

Similar comments were made on the final morning of both the pilot and 1975 course. All felt the experience was valuable and should be universally available for all general-practitioner trainees and student health visitors. There was discussion at length as to whether social workers should be involved in future courses, and there was a feeling that this would be a desirable development although careful arrangement of the groups and group work would be needed.

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