Middle Articles

GENERAL PRACTICE OBSERVED

Community Nurses' View of General Practice Attachment

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Summary: An analysis of 98 health visitors and district nurses attached and non-attached to general practitioners in three local authority areas showed that most of them were aged over 40 and that many had entered domiciliary work because of the convenient hours or because of its intangible attractions. Adequate preparation for attachment was considered important, particularly a clear definition of the roles of the attached staff and their relationships to other workers in the practice.

Attached staff were found to be much more satisfied with the information given by the general practitioner about their patients than were unattached staff, and the former usually had access to the patients' medical records. The principal advantages of attachment were listed as access to family history; improved co-ordination within the practice and co-operation with the social services; favourable patient response; and increased personal satisfaction. The principal disadvantages were increased mileage and work-load; the impossibility of crossing local authority boundaries; and having to deal with families registered with more than one doctor.

Though the concept of community health teams is gaining increased support, only 11% of local authority nursing staff are as yet attached to general practitioners (Anderson *et al.*, 1968a). In discussing the future of community medicine the importance of delegating appropriate duties to health visitors and district nurses is repeatedly stressed. This can be effective only when the team approach is endorsed, and is unlikely to be successful in the absence of formal attachment.

While proposals for integration of the three branches of the National Health Service might reduce the administrative barriers between general practitioners and their nursing colleagues, the success of the team depends essentially on personal understanding and good will. To assess the value of local authority nursing staff attachment to general practice, particularly from the point of view of the nurses and health visitors concerned, a survey of attached and unattached staff in three local authority areas has been made. The local authority areas chosen consisted of two predominantly rural counties and one large county borough. The proportion of staff attached to practices in the three study areas varied from 20 to 98%. With the co-operation of the M.O.H. and chief nursing officers, a sample of both attached and unattached health visitors and district nurses was interviewed by means of a standardized questionary. The main areas of inquiry were: the personal and professional characteristics of community nurses, attachment and its effects, and communication and contact with general practitioners.

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An initial sample of 100 persons was taken; of these, only two nurses found it impossible to co-operate. The categories of staff interviewed are shown in Table I.

TABLE I.—*Number of Study Population Working in Traditional and Attachment Methods*

	District Nurses (No. = 47)		Health Visitors (No. = 51)	
	No.	%	No.	%
Attached ..	27	57	31	61
Unattached ..	20	43	20	39

The use of an individual interview technique enabled the formal questionary to be completed and also provided a substantial amount of subjective information.

Personal and Professional Characteristics

Most of the nursing staff interviewed were not young, newly qualified people. Table II summarizes the age, marital status, and family patterns of district nurses and health visitors in the sample. It will be seen that 62% of nurses and 74% of health visitors were over 40; in fact, a quarter of the total were over 50 years of age. This pattern is a reflection of the age at which these nurses entered domiciliary work, which in turn seemed to be largely determined by family commitments. Seventy-seven per cent. of district nurses were married and 57% had children of school age. A slightly lower proportion (51%) of health visitors were married and only 24% were mothers of young families. Probably these domestic factors play a substantial part in the choice of a career.

TABLE II.—*Age, Marital Status, and Family Patterns of Attached and Unattached Staff*

	District Nurses (No. = 47)				Health Visitors (No. = 51)			
	Present		At Entering		Present		At Entering	
	No.	%	No.	%	No.	%	No.	%
Age:								
20–30	3	6	18	38	2	4	15	30
30–40	15	32	22	47	11	22	30	59
40–50	17	36	7	15	24	47	6	12
50–65	12	26	—	—	14	27	—	—
Marital status:								
Married	36	77			26	51		
Single	9	19			24	47		
Widowed	2	4			1	2		
Children at home:								
Yes	27	57			12	24		
No	20	43			39	76		

The reasons given by the study population for entering domiciliary nursing work are summarized in Table III. Because health visitors and district nurses are likely to be married women with young families, we had expected that convenient hours would be an important attraction to community nursing; in fact, 36% of district nurses and 37% of health visitors

specified this factor. Working independently was mentioned as a major attraction by 13% of district nurses but by none of the health visitors.

TABLE III.—*Reasons for Entering Domiciliary Work*

	District Nurses (No. = 47)		Health Visitors (No. = 51)	
	No.	%	No.	%
Convenient hours	17	36	19	37
Intangible attraction	16	34	19	37
Interest in preventive medicine	5	11	26	51
Negative feelings toward hospital work	10	21	4	8
Independence	6	13	—	—
Higher pay	—	—	3	6

Sum of percentages are not always 100 where multiple answers are possible.

Because of the age pattern most of the nurses and health visitors had had wide professional experience before entering domiciliary practice. Of the district nurses 77% (36) possessed the District Nursing Certificate, 12% (6) the State Registered Mental Nurse Certificate, and 4% (2) the Registered Fever Nurse Certificate. Within two of the study areas dual-purpose nurses were employed, so that 40% (20) of the district nursing sample were also qualified midwives. It was interesting to discover that two district nurses possessed Health Visitors Certificates, one of whom had found the role of district nurse less emotionally demanding. Two of the health visitors were trained district nurses, and 16% (8) had a background of district nursing before entering health visiting. In addition to hospital practice as staff nurse and sister, many entrants to community nursing had additional experience in a variety of fields, which included private nursing, industrial and occupational nursing, and psychiatry.

Type of Attachment

A variety of definitions of "attachment" have been offered, the most workable being that of Anderson *et al.* (1968b), in which the health visitor or nurse is exclusively responsible for the patients on the list of specified general practitioners. "Liaison" is defined as this type of responsibility combined with that for a traditional geographical district. Recently the scope of attached local authority nursing staff has been widened under the Health Service and Public Health Act 1968 (Chapter 46), and we now regard "full" attachment as that in which the health visitor or nurse works in the patient's home and in addition is developing a function within the practice itself.

In our study this definition of full attachment applied to a third (8) of attached district nurses. A further 19% (5) were attached to one practice but had no surgery responsibilities while 22% (6) had loyalties to two or more practices, and 30% (8) retained responsibility for a geographical area in addition to their practice commitment. In total 52% (14) of district nurses in attachment or liaison schemes held sessions in the practice premises.

It is not possible to apply the same strict criteria of attachment to health visitors because of the nature of their work and the variation of general practitioners' attitudes to routine child welfare. Thirty-nine per cent. (12) of health visitors were in liaison schemes in which they carried responsibility for a geographical area as well as practice commitments, while 61% (19) worked only with defined practices. All were still involved in some way with local authority clinics or school health services.

Preparation for Attachment

Though there has been a steady increase in the number of attachment schemes since 1960 the greater part of our sample personnel had not been attached for more than three years. Eighty-seven per cent. (27) of health visitors and 81% (22) district nurses had been approached initially about attachment by their chief nursing officer or medical officer of health, but it seemed significant that in 19% (5) of nurse and 13% (4) of health visitor attachments the general practitioner made the initial contact. In these attachments it could be assumed that a satisfactory relation between community nursing staff and doctor already existed or was expected. Among the remainder, however, a preliminary meeting appeared to be essential, and in 85% (23) of nurse and 61% (19) of health visitor attachments such a meeting was arranged to discuss definition of function, working arrangements, and methods of communication. Apart from the general practitioners and nursing staff concerned, the chief nursing officer of the authority was present at over 80% (37) and the medical officer of health at half (21) of these meetings. On over half of these occasions both a nurse and a health visitor were being attached to the same practice.

An attempt was made to assess the value of these meetings. Eighty-seven per cent. (20) of attached nurses were convinced of the importance of the meetings, but 42% (9) of the health visitors thought that these preliminary preparations were inadequate. The health visitors in particular suggested that meetings of this type should define more clearly the roles of attached staff, since a failure on the part of the general practitioners to appreciate fully the training background and potential of nursing and health visiting staff could be a major cause of difficulty. One other point suggested by most attached staff was the importance of clarifying relations between themselves and other workers in the practice.

Effect of Attachment on Work Content

We had expected to find substantial alteration in work patterns after attachment. In our study both health visitors and nurses reported an increase in work-load (Table IV). The district nurses had also noted a substantial change in actual work content, and this was assessed by a study of currently unattached staff.

TABLE IV.—*Effect of Attachment on Work-load*

	Attached District Nurses (No. = 27)		Attached Health Visitors (No. = 31)	
	No.	%	No.	%
Volume of work increased:				
Yes	19	70	24	77
No	4	15	6	19
Always attached	4	15	1	3
Area of increase:				
General nursing care	10	37	—	—
Supervision of elderly	5	19	19	61
Surgery sessions	6	22	—	—
Social problems	3	11	8	26
Follow-up of children	4	15	12	39

Sum of percentages are not always 100, as multiple answers are possible.

A comparison of the work of attached and unattached nurses showed that any change was due almost entirely to the introduction of surgery sessions with their related diagnostic and technical procedures (Table V). In addition the scope of the

TABLE V.—*Comparison of Proportion of Attached and Unattached Staff Involved in Particular Duties*

	Att. D.N. (No. = 27)		Unatt. D.N. (No. = 20)		Att. H.Vis. (No. = 31)		Unatt. H.Vis. (No. = 20)	
	No.	%	No.	%	No.	%	No.	%
General nursing care	27	100	20	100	—	—	—	—
Exercises and rehabilitation	19	70	10	50	2	6	—	—
School nursing	—	—	—	—	13	40	12	60
Group teaching	5	19	—	—	21	68	19	95
Venepunctures	13	48	3	15	10	32	8	40
Blood pressure	17	63	7	35	11	35	7	35
Diagnostic tests	12	44	5	25	22	70	11	55
Surgery sessions	14	52	—	—	7	23	—	—
Supervision of elderly	18	67	13	65	29	93	17	85
Clinics	10	37	5	25	27	87	19	95
Social problems	16	59	6	30	26	84	13	65
Follow-up of children	9	33	2	10	31	100	10	100

Sum of percentages are not always 100, as multiple answers are possible.

attached nurses' work tends to overlap that of the health visitors, particularly in the management of social problems and in the follow-up of childhood illnesses. There was no substantial contrast, however, in work content between unattached and attached health visitors, though 23% (7) of the latter were now conducting some clinics in general practitioners' premises.

Preparation for these new duties was necessary, particularly for the nurses, of whom 30% (8) as opposed to 16% (5) of health visitors suggested a short term of special training before attachment. Subjects suggested included psychiatry, recent advances in therapy, nursing of sick children, and the carrying out of certain technical clinical procedures—for example, blood pressures, venepunctures, and E.C.G.s. The social aspects of community nursing were also mentioned, and suggestions included help with management and behaviour disorders, psychology of the adolescent, and availability of legal and counselling aid for marital problems. A period of observing a smoothly functioning attachment scheme was suggested as the best means of preparing both local authority staff and general practitioners for attachment.

Liaison with General Practitioner

The most obvious consequence of attachment is increased contact between general practitioner and the community nurse (Table VI). All of the attached district nurses and 97% of the attached health visitors met their general practitioner at least weekly, many in fact daily. Even without a formal attachment 70% of unattached district nurses reported weekly contact with one or more general practitioners, whereas only 20% of unattached health visitors consulted with the family doctor as often as this—the majority less than once a month, one never.

TABLE VI.—*Frequency of Contact with the General Practitioner*

	Attached D.N. (No. = 27)		Unattached D.N. (No. = 20)		Attached H.Vis. (No. = 31)		Unattached H.Vis. (No. = 20)	
	No.	%	No.	%	No.	%	No.	%
Weekly and regular	27	100	2	10	28	90	2	10
Weekly but irregular	—	—	12	60	2	6	2	10
Occasionally (per month)	—	—	4	20	1	3	9	45
Rarely (2–3 times a year)	—	—	2	10	—	—	6	30
Never	—	—	—	—	—	—	1	5

As well as improving contact between doctors and community nurses, attachment schemes led to closer working relations between nurses and health visitors themselves. Almost 90% of the attachments we studied involved both a nurse and a health visitor, and in 45% (26) this had produced increased contact between them. In 70% (19) of district nursing attachments and 61% (19) of health visiting attachments regular team conferences on at least a weekly basis were arranged. In 20% (11) of both health visitor and district nursing schemes, however, no conferences of this type were ever held.

The ultimate purpose of attachment schemes is to produce a more effective service to the patient by improving communication within the community team. In this area of inquiry a striking difference between attached and unattached staff emerged. Only half the unattached district nurses and a third of the unattached health visitors were satisfied with the information provided by the general practitioner about their mutual patients. Only one attached district nurse and two attached health visitors reported any dissatisfaction in this respect. Conversely, the flow of information from community nurse to the general practitioner was improved with attachment. One of the important functions of the community nurse is to recognize the need for specialized social help—for example, home helps, meals on wheels, chiropody, W.V.S. services, etc. Only 5% (1) of unattached district nurses and none of the unattached health visitors always reported referrals of this type to the general practitioner. Their attached colleagues showed a definite contrast, 56% (15) of district nurses and 42% (13) of health visitors always keeping the general practitioner informed.

Clinical information is readily available when attached staff have access to general practitioners' records, and this existed in 96% (26) of district nurse and 87% (27) of health visitor attachment schemes. The availability of records and frequency of general-practitioner contact are probably the two major factors which led 78% (21) of attached nurses and 65% (20) of health visitors to believe that their overall level of clinical knowledge had improved. While only two district nurses noted no improvement, 10 health visitors (32%) were in this category. The major factors are probably the differences in training, in function, and in general practitioners' attitudes to the two types of community nurse.

Methods of record-keeping vary widely. One quarter (14) of attached staff were expected to use the patient's National Health Service card for recording important clinical information and in addition 33% (9) of district nurses and 6% (2) of health visitors maintained a register of patients treated in the surgery. The majority of all staff surveyed were also required to maintain substantial records for local authority administrative purposes.

Attitudes Towards Attachment

Advantages and disadvantages of existing attachment schemes have been discussed at length (Akester and MacPhail, 1964; Anderson *et al.*, 1968a). Opportunity for this sample to take a critical look at their particular attachment was thought to be of value. The most common problems are listed in Table VII.

TABLE VII.—*Reaction to Attachment*

	Attached District Nurses (No. = 27)		Attached Health Visitors (No. = 31)	
	No.	%	No.	%
Disadvantages:				
Personality difficulties	1	4	7	23
Mileage increased	12	44	16	52
Work-load increase	12	44	10	32
Local authority boundaries	7	26	7	23
Time expenditure in G.P. consultation	2	7	2	6
Overlap of function	4	15	5	16
Unfamiliar with families	1	4	5	16
Multiple doctor families	3	11	7	23
Lack of contact with other G.P.s	3	11	3	10
Inadequate definition of role	5	19	5	16
Other organizational difficulties	4	15	15	48
No problems	2	7	4	13
Advantages:				
Access to family history	25	93	18	58
Improved co-ordination	19	70	17	55
Easy liaison with G.P.	14	52	15	48
Co-operation with social services	14	52	10	32
Leadership from G.P.	14	52	12	39
Improved management of urgent cases	15	56	12	39
Personal relationship with G.P.	17	63	19	61
Co-ordinated advice to patient	15	56	19	61
Favourable patient response	22	81	20	65
Mutually educational	19	70	19	61
Personal satisfaction	20	74	16	52
Other	4	15	7	23

Sum of percentages are not always 100, as multiple answers are possible.

Higher mileage, a heavier work-load, and local authority boundaries which could not be crossed were the major disadvantages. Health visitors experienced more clashes of personality within attachment schemes than did district nurses. In several cases the practice receptionist was involved. In urban areas the transition to attachment schemes caused problems due to overlap of attached or unattached staff and the phenomenon of several doctors for one family. The attached health visitor who retained school and clinic work felt this to be inefficient when the children did not belong to her particular practice.

Better communication, access to medical records, and increased work satisfaction were reported to be the major advantage of attachment schemes. Table VII also shows a generally

favourable response of staff to several aspects of attachment. The district nurses expressed more satisfaction in attachment schemes than did health visitors.

Discussion

There can now be little doubt that the majority of general practitioners favour local authority nurse and health visitor attachment schemes (Boddy, 1969). While administrative problems do exist, the fact that they can be overcome is clear in the reports of Leiper (1965–6) and Warin (1968). When full attachment is an established policy its ultimate success is a highly individual matter depending largely on the personalities and motives of those involved. Attachment is a partnership between doctors and nurses, each of whom will have well-established work patterns in an independent setting. Certainly nurses are likely to be aged over 40 and to have had a wide range of professional experience. The transition to the comparative intimacy of the team will make a variety of demands of all concerned.

The more we study this subject the more striking we find the similarities between nurse attachment to general practice and traditional concepts of courtship and marriage. There is good statistical evidence to support a suspicion of the durability and quality of "shotgun matches" (Registrar General, 1966). The same may be true of attachment schemes.

Many of the criticisms of attachment can be levelled at an inadequate period of preparation or "courtship," which is often notable by its absence. In many instances staff were attached without adequate definition of the part they were to play, and in the case of the health visitor often without sufficient understanding by the general practitioner of the importance she attached to her traditional work in preventive child care. The fact that only a minority of the health visitors we studied were involved in routine child welfare sessions in collaboration with the general practitioner to whom they were attached suggests that this particular work is still regarded by many general practitioners as outside the health visitor's province. When she still holds clinics of this type in local authority premises, this can only aggravate her sense of divided loyalties, particularly if she feels more competent in this field than the general practitioner to whom she is attached.

Preparation of the general practitioner for attachment must produce a doctor who appreciates the training, background, and functions of the staff attached, but because of the overriding importance of personality compatibility a trial period of informal association or "courtship" should precede attachment proper. The role of the medical officer of health or chief nursing officer as "matchmaker" at this stage is important in defining expectations. Equally important is follow-up by the medical officer of health or chief nursing officer when any difficulties can be identified and remedied, particularly if this takes place after the initial "honeymoon" period, when the novelty of attachment has subsided.

The concept of "the team" is still relatively new and there is a danger that success may be assumed too readily. Attachment when it works well appears to be infinitely preferable to independence. If the "community physician" of the future is to be an organizer and co-ordinator of community medical services the obvious place to begin is the "community team." It may be that the effort required has been underestimated by some medical officers of health. Changes in both medical and nursing education (Walker and Barnes, 1966 ; Wenborn, 1966 ; *Medical Officer,* 1969) will produce workers to whom the team approach is fundamental. The future of medical care in the community may depend on current medical officers of health creating the atmosphere in which this may develop.

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MEDICAL HISTORY

The Rev. Samuel Warneford, M.A., LL.D. (1763-1855)*

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Among the more notable past benefactors of medical institutions may be numbered the Rev. Samuel Warneford, an eccentric but highly practical philanthropist, who for 44 years was a country rector in the Cotswolds.

He came of an ancient but often impoverished north Wiltshire family, "distinguished for nothing in particular except its antiquity," said to date back to the twelfth century, whose country seat was named Warneford Place, near to the town of Highworth between Swindon and Lechlade. The house, once a stately Tudor mansion, had often been left empty and neglected. Both his father and grandfather were beneficed clergymen of York, of no substantial means, but his mother inherited wealth from her father, a drug merchant in the City of London, and he himself married the daughter of a wealthy cheese merchant in Berkshire. Though he was a second son, his mother left most of her fortune to him, and he thus became a very rich man. He was born in 1763, and died in 1855, aged 92. He was ordained in 1790, seven years after leaving Oxford, and took the degree of LL.D. about that time. He held, for the rest of his life two livings, of which Bourton-on-the-Hill, Gloucestershire, was the principal, where he spent 44 years and where he is buried.

The *Dictionary of National Biography* states: "He decided to distribute his superfluous means in his lifetime by gradual instalments so that, as time went on, he might rectify errors and re-direct his charity." This bears the stamp of a generous but

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