

# **“CO-OPERATION IN FAMILY CARE”**

**by**

**N.M. Bailey MB.ChB, BSc**

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*“To keep well is better than to be cured by the best doctor on earth”*

*Lord Snell, House of Lords, 1942*



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## INTRODUCTION

An individual can never be considered in isolation from the community of which he is a member. A person may at any one time be a member of several communities. He may have a recurring relationship with others in the home, at school, at play, at work or in a social organisation, to mention only a few of the possible place of contact. Of these, the relationship within the framework of the family is the the closest and most permanent, affecting as it des the individual from the moment of conception to that of death. Although the members of the family may change over a period of years, the influences of the family on the individual are permanent and inescapable.

This interaction between the individual and the family of which he is a part is being increasingly recognised as being of great importance by those who have responsibility for medical and social welfare. The expression 'family doctor' has become more generally used by general medical practitioners in recent years, to indicate the concept of 'family health care' which they consider to be their brief.

The 'family' is not only the unit of medical care, but it is also the unit on which the social services in Great Britain and many other 'Western' types of culture are based. Because of this, an increasing body of workers is becoming interested in the well-being of the family and its members. It has been recently calculated that, apart from doctors and nurses, as many as thirty-three different classes of people can now enter the home and advise on social matters.

It is an awareness of the increasing variety of advice that may be offered the family that has aroused my interest in this subject. The advice is, at the present time, largely uncoordinated, tending at best to confuse and at the worst, to be ignored, or even lead to frank antagonism. Any degree of co-operation between those concerned with family care cannot fail to be of benefit, not only in avoiding duplication of effort, but also in bringing to the family all the advantages of modern medicine and social progress.

It would be quite impossible to detail all the possible relationships as they are obviously very numerous. I will, however, consider the more profitable lines of co-operation, and instance schemes of liaison between the various workers which have proved to be of value.



## **FAMILY CARE WORKERS**

From time immemorial there have been those who have concerned themselves with the health and welfare of others. At first the family accepted responsibility for its own care and welfare, but in time there arose individuals having a highly developed community responsibility. Among these, all civilisations have recorded instances of people who have devoted their time and energy to the care of the sick.

Following the spread of Christianity throughout Europe, and with the foundations of the religious orders, the care of the sick and handicapped was taken over by these bodies, out of a sense of devotion and charity. A similar trend has been recorded in respect of the other 'great' religions of the world. Under the religious orders, many 'hospitals' were founded where the sick were housed and cared for and several of these hospitals survived the upheaval in this country at the time of the Reformation.

From early times there has been a division of responsibility in the care of the sick. There have been those who have concerned themselves with cause and treatment of disease (doctors) and those whose duty it has been to attend to the sick (nurses).

More recently, prompted in large part by the appalling conditions of life and work which followed the Industrial Revolution, many people have become interested in the social care of the individual and of the family of which he is a part.

## **FAMILY DOCTORS**

In England, a body of doctors developed who were concerned with the general treatment of the sick, as opposed to the special treatment of serious medical and surgical conditions. The influence of these 'apothecaries' grew until, by the end of the eighteenth century, they were caring in London for twenty times as many patients as were the physicians. The Apothecaries Act of 1815 established the apothecaries as independent qualified practitioners, and the Medical Act of 1858 "*completed the metamorphosis of the apothecary into the general practitioner*" (Townsend E. 1962)

Between 1850 and 1900 the population of Great Britain almost doubled, the increase being largely among the working classes whose wages were low even by the standards of those

days. A considerable amount of contract practice grew up, largely organised by the 'friendly societies'. *It has been calculated that by 1910 over six million employed persons were provided for by contract medical practice, at a fee of five shillings per person, including the cost of drugs and dressings (Plowright O. 1963)* Many more were looked after by doctors under contract to the Boards of Guardians.

In 1911, Lloyd George introduced the National Insurance Bill to Parliament, which then provided for free medical care by 'panel doctors' of all employed persons earning less than three pounds a week. The National Insurance Act was administered through the 'Friendly Societies' and it is important to realise that there was no provision in the Act for the care of the dependants of employed persons. As a consequence of this Act the "*notion that a private doctor should be the outpost of a system of preventative medicine arose*", but was "*novel and disturbing.*" Even so "*the personal relations between doctor and patient were changing as the State and the Municipality intruded further into the sphere of family practice*" (Horner N.G. 1922)

This interest of the State in family practice was the subject of much detailed discussion in the years between the wars, and culminated in the establishment of the National Health Service Act of 1946 which provided for the free provision of medical care for every member of the community. The keystone of medical care was to be the general practitioner, and he was to be, and still is, the only doctor to whom any patient has unrestricted access at any time.

The Sub-Committee of the Standing Medical Advisory Committee of the Central Health Services Council in their report "*The Field of Work of The Family Doctor*" 1963 (*The Gillie Report*) considered that the work of the family doctor has three aspects:

*"1. He is the patient's first line of defence in times of illness, disability and distress from birth to death. In most of these episodes he is the only doctor who is needed. His work in the surgery and the patient's home includes diagnosis, advice and treatment in acute illness, chronic illness and the enfeeblement of age, and in apparently trivial ailments.*

*2. He acts as the essential intermediary in the transmission of specialist skills to the individual. Without this function of the personal doctor the hospital service can be used wastefully, even damagingly, to the patient. This involves assessment of a patient's requirements and selection of the appropriate consultant and department. The family doctor*

*must interpret the patient, his problems and circumstances to the consultant, explain the need for hospital services and its possibilities to the patient and ensure the necessary communication with all concerned including the relatives. It is he who secures the essential after-care in the training of the patient in recovery or adjustment to handicap and co-ordinates the available resources to this end.*

*3. The family doctor is the one member of the profession who can best mobilise and co-ordinate the health and welfare services of the individual in the community, and of the community in relation to the individual”*

## **HOME NURSES**

When, in the middle of the nineteenth century, Miss Florence Nightingale returned from the Crimea, a breath of fresh air, or rather ‘a wind of change’ blew through the hospitals of England. The nursing services were dramatically and radically reorganised, and nursing became an occupation fit for ‘young ladies’.

At the same time, the conscience of Victorian England became aware of the atrocious living conditions of the poor, and of the terrible plight of those poor who had the additional misfortune to become sick. They could not afford to pay for medical attention, and consequently were being neglected, and left to die, cared for at best by an unskilled friend or relative.

In 1859, William Rathbone of Liverpool employed a Mrs Robinson for three months “*to nurse poor patients in their homes in a Liverpool district, with sufficient appliances, drugs and invalid food provided by himself, to make her ministrations effective.*” (Stocks M. 1960)

In spite of several set-backs, William Rathbone was successful in his efforts, and he formed a Liverpool District Nursing Association. In 1874 a district nursing association was formed in London and quickly gained the support of Florence Nightingale. The experiments in home nursing having proved successful, similar schemes were rapidly organised in other parts of the country.

Right from the start, the district nurses were encouraged to work under the direction of the patient’s own physician. In many of the poorer districts, and it was in these districts that nursing associations were first formed, patients could not, however afford the services of a

doctor. In such circumstances the district nurse was completely independent of any medical supervision. Senior nurses, and physicians were usually appointed to boards of supervision of nursing associations and standards of nursing care were maintained at a very high level.

Most of the country was soon provided with a series of district nursing associations, devoted to the home care of the sick. Those who could afford, paid according to their means, and the poor were treated free of charge. There was little change until the National Health Service Act of 1946, which in Section 25, required Local Health Authorities to provide a home nursing service, either independently, or through the medium of an existing district nursing association. It was only then that any sick person became entitled to free home nursing care.

To become qualified as a home nurse, the candidate is required to have completed a full course of hospital training, and to be a State Registered Nurse. In addition, six months of approved, supervised, home nursing must have been undertaken.

## **HOME MIDWIVES**

The art of midwifery has been, until recently, largely in the hands of unskilled women. It was as recently as 1739 that the first school for midwives was established at St. James's Hospital in London. Over a century later, in 1869, the Obstetric Society of London, having carried out a survey over the previous two years, found that in 75% of the confinements they investigated an attendant was present during labour. No attendant however had any formal training.

In 1902, the first Midwives Act was passed, establishing a Central Midwives Board and a Roll of Midwives, and after 1st April 1905 it became an offence for unqualified persons to call themselves 'midwives'.

Hospital trained midwives, being nurses first and midwives second, liked to work under the clinical direction of a doctor. However, it was not until 1918 that it became obligatory for a midwife to call in a doctor if an emergency arose. With many midwives it became a matter of honour not to call in a doctor, particularly as this would increase the cost to a patient.

Until 1936, home midwives were almost exclusively the agents of numerous voluntary organisations. In that year the Midwives Act empowered Local Authorities to establish domiciliary midwifery services, although it was not until the National Health Service Act of 1946 came into force that, under Section 23, Local Health Authorities became obliged to

organise a home midwifery service. In some Authorities this is still delegated through the medium of a voluntary organisation. With the passing of the National Health Service Act, home midwifery services became a free service, and at the same time the State made provision for the payment of a doctor called in an emergency by the midwife. This removed the one remaining physical barrier between the home midwife and the family doctor.

To become qualified as a home midwife, a general nursing training leading to State Registration must be followed by both the Hospital (Part 1) and the Home (Part 2) of the Central Midwives Board Training and Examinations.

### **HEALTH VISITORS**

In 1862 the 'Ladies Sanitary Reform Association of Manchester and Salford' employed "*paid visiting staff who were enjoined to visit all and sundry in their district, concentrating on cleanliness, good management and good living, helping the sick and advising mothers on the care of their children.*" (*An Inquiry into Health Visitors, 1956*) *The Report of a Working Party (Jameson Report)*

In 1892, Miss Florence Nightingale inspired a training scheme which she hoped would lead to "*a new work and a new profession.*" Whole time staff were being employed by many Local Authorities - led by Buckinghamshire. The field of the 'lady sanitary inspectors' or 'health visitors' at first was confined to physical and environmental health, but they soon also interested themselves in the care of mothers and young children. This latter aspect of their work has been largely influenced by the Maternity and Child Welfare Act of 1918, and in many places it is their primary interest.

The National Health Services Act of 1946 made it obligatory under Section 24 for a Local Health Authority to provide a service of health visitors.

To become qualified as a health visitor, a candidate must have completed a full course of hospital training, leading to State Registration, and must also have completed Part 1 of the Central Midwives Board training in hospital midwifery. This must be followed by a period of six months of approved social training at a University or approved training centre.

An increasing number of nurses are now becoming 'doubly' qualified as both home nurses and home midwives. Such nurses are obviously of the greater value in the care of patients in

rural areas. Also some are qualified in all three aspect of home care. These latter are being employed by some rural Authorities to provide a comprehensive home care programme.

## **SOCIAL WORKERS**

In addition to those already mentioned, who are qualified in medicine or in nursing, there are a large number of individuals and groups who are concerned in the social aspects of the individual and the family. *“What exactly is implied by ‘social work’ is difficult to say. There are twenty seven (or is it thirty-three?) different classes of people who can enter the home and advise on social matters.” (Editorial, Journal of the College of General Practitioners August 1963)*

The following list makes no attempt at being exhaustive, but gives some indication of the variety of interests covered by social work, as well as the obvious overlap of their fields of work:

**General Social Workers** - often employed by a Local Authority to deal with the general social problems of the population.

**Almoners** - initially a hospital worker, but being employed by Local Authorities to an increasing extent to deal with the re-settlement at home and work of patients discharged, or about to be discharged from hospital.

**Mental Welfare Officers**

**Psychiatric Social Workers**

**Social Workers for the Blind**

**Social Workers for the Handicapped**

**The Children’s Officer**

**Moral Welfare Officers**

**Probation Officers**

**Social Workers for the Local Housing Department**

**Social Workers for the Ministry of Pensions and National Insurance**

**Disablement Resettlement Officers of the Ministry of Labour**

**Social Workers of the various Voluntary or Charitable Organisations**

## **HOME HELPS**

The National Health Service Act of 1946 provided in Section 29 for the provision of domestic help in the home in those cases where the housewife was ill, or incapacitated by reason of

disease or old age. These workers are now called 'home helps' and play a very important part in the maintenance of family care during sickness or incapacity.

### **NIGHT WATCHERS**

A very small number of Local Authorities are now prepared, in special circumstances, to provide specially selected persons, having some nursing experience, for the attendance at night on the seriously ill. Many authorities have great difficulty in obtaining suitable persons, and many even maintain that the home is no place for those whose illness necessitates constant attendance. If the proposals set out in the Hospital Ten Year Plan are to be implemented, there will be an increased need for these workers.

### **THE MEDICAL OFFICER OF HEALTH**

The Medical Officer of Health is responsible for administering those services which it is obligatory for the Local Authority to provide, and for the supervision of any discretionary services that may be provided. He is also responsible for the supervision of Local Authority Maternity and Child Welfare Services, and in particular for the supervision of Local Authority Clinics.

Many Medical Officers of Health are, in addition, School Medical Officers, and are responsible to the Local Education Department for the medical care of children of school age. It is obviously of great importance that any physical or mental handicap should be recognised, and if possible corrected, at an early stage in a child's education.



## OFFICIAL REPORTS AND ACTS OF PARLIAMENT

At this stage it is of advantage to consider briefly the Official Reports and the Acts of Parliament which have a bearing on this subject of Co-operation in Family Care. It will be seen that the legislation concerned is purely 'permissive' The values of an increased degree of co-operation are clearly seen by all the official bodies which have studied the subject.

### THE DAWSON OF PENN REPORT

In 1920 a report was published which had far-reaching effects on the planning of medical services in Great Britain. This was the '*Interim Report of the Consultative Council of Medical and Allied Services to the newly created Minister of Health*, and it is often referred to as the "Dawson of Penn Report.' This report is of great interest because it anticipates by over two decades much of what was included in the National Health Service Act of 1946. In particular it anticipates the need for co-operation between the proposed medical services, and also makes proposals for the Health Centres which were brought into being by the National Health Service Act. Certain paragraphs of the Report show great foresight, as the following extracts show.

6. *"Preventive and curative medicine cannot be separated on any sound principle, and in any scheme of medical services must be brought together in close co-ordination. They must likewise be both brought within the sphere of the general practitioner whose duties should embrace the work of the communal as well as individual medicine."*

The Report then goes on to define a '*Health Centre*' as "*an institution in which various medical services, both preventive and curative, are brought together so as to form one organisation.*" The proposed 'Health Centres' were to be of two types, Primary and Secondary.

"10. The domiciliary services of a given district would be based on a '*Primary Health Centre*' - *an institution equipped for services of curative and preventive medicine to be conducted by the general practitioners of that district, in conjunction with an efficient nursing service...*"

**'Secondary Health Centres'** would be reserved for "*cases of difficulty, or cases requiring special treatment*" and were to be situated "*in towns, where an efficient consultant service and adequate equipment could be expected.*"

Section 11 of the Report deals with the *proposed service to be provided by "doctor, dentist, pharmacist, nurse, midwife and health visitor."*

Section 111 gives details of the proposed **'Primary Health Centres'** which would be staffed by general practitioners and from which the domiciliary medical services would be organised. Accommodation was to be provided for doctors' clinics, operating rooms, radiography, laboratories for simple investigations, a dispensary, a doctors' common room, facilities for pre-natal care, child welfare and medical inspection and treatment of school children. There were also to be "*wards of varying sizes, and for varying purposes, including provision of midwifery.*"

**"A new type of Health Authority to bring about unity of local control for all health services, curative and preventive"** is then proposed.

'94. As regards the nature of this new Health Authority, there are some who favour *a Statutory Committee of an existing Local Authority*, whereas there are others who *favour the establishment of an ad hoc independent body for the purpose of administering health services alone.....*"

**"95. Whatever may be the nature of the future Health Authority, it will be necessary to devise machinery for securing the complete intercommunication and co-ordination above referred to, and what we desire to emphasise is that such inter-communication is vital to an efficient health service."**

The provision of domiciliary maternity care is outlined in paragraph 130. "*This should include:-*

- a) *advice and treatment for pregnant women unable to attend a Health Centre*
  
- b) *Provision for the conduct of labour and its after attendance at the women's home. A doctor and a midwife should be available for every labour, and, if occasion requires, an anaesthetist should be available also. Attendance by midwives trained to know when a doctor*

*is needed but prepared to wait on natural labour is of importance. Additional assistance might be obtained from a service of home helps exercising carefully defined functions and working under proper supervision.”*

### **THE MEDICAL PLANNING COMMISSION**

In 1942, ‘The Medical Planning Commission’ of the British Medical Association recommended that a health service should:

*“a) Provide a system of medical service directed towards the achievement of positive health, of the prevention of disease and the relief of sickness.*

*b) Render available to every individual all necessary medical services, both general and specialist, and both domiciliary and institutional.”*

*“Each family or individual should be under the care of a medical practitioner who shall be concerned not only with diagnosis and treatment but also the prevention of disease. It involves integration of the preventive and personal health services; it also involves radical changes in the country’s administrative machinery and in the training of medical students. It assumes that fusion of public health and other forms of practice will result in practitioners in every field working in close contact and accord, not only with each other but also with dentists, nurses, midwives and other auxiliaries”*

### **THE BEVERIDGE REPORT**

In the war-ravaged month of November 1942, a report was published which looked ahead to the days of peace, which had to be ‘planned for.’ This was the “Report on Social Insurance and Allied Service” (Beveridge W.H. 1942) The Beveridge Plan for social security is based on three assumptions:

- a) Assumption of children’s allowance
- b) Assumption of comprehensive health and rehabilitation services
- c) Assumption of maintenance of employment.

Assumption ‘b’ envisages a comprehensive National Health Service, which would ensure amongst other things, a domiciliary medical service and home nurses and midwives. The

Report identifies itself with the aims of the ‘Medical Planning Commission’ of the British Medical Association.

The Report expresses no opinion as to how a National Health Service is to be financed, and makes no recommendations regarding the relative merits of group or individual practice.

## **THE NATIONAL HEALTH SERVICE ACT**

The National Health Service Act of 1946 lays down in Section 21:

1) *“ It shall be the duty of every local health authority to provide, equip and maintain to the satisfaction of the Minister, premises which shall be called “health centres” at which facilities shall be available for all or any of the following purposes:*

*(a) for the provision of general medical services under part IV of the act by medical practitioners*

*(b) for the provision or organisation of any of the services which the local health authority are required or empowered to provide...*

*(2) A local health authority shall, to the satisfaction of the Minister, provide staff for any health centre provided by them; provided that a local health authority shall not employ medical or dental practitioners at health centres for the purpose of providing general medical services or general dental services under Part IV of this Act.”*

Other sections deal with the following domiciliary services:

Section 22	Care of Mothers and Young Children
Section 23	Midwifery
Section 24	Health Visiting
Section 25	Home Nursing
Section 29	Domestic Help

## **REPORT OF THE COMMITTEE ON GENERAL PRACTICE WITHIN THE NATIONAL HEALTH SERVICE (1954) (COHEN REPORT)**

*“It is becoming more widely recognised that if general medical practice is to be organised effectively, ancillary help is essential. A doctor should not himself undertake what can be properly delegated to a non-medical assistant. Provision of such help is easier to achieve in partnership and within groups of doctors ...the Committee concludes that many single-handed practitioners also need effective ancillary help.”*

*“The home nurse, midwife, health visitor, home help and social workers, provide services which need to be properly co-ordinated with the general practitioner’s own work, and here, the Committee believes, there is room for experiment and for further improvement.”*

*“The Committee believes that there should be further experiments in how best to link the work of the general practitioner and health visitor, so as to reproduce the successful co-operation which has for a long time now attended the work of general practitioner and home nurse.”*

*“The full use of health visitor, home nurse and midwife, and the recognition of the need for a home help, may all, in different ways, form part of the general practitioner’s work, and may, if properly used together, lessen the burden on the hospital.”*

*“There is need for experiments in different forms of association between groups of doctors and local health authorities, and a number of different solutions, suitable in particular local conditions, may gradually emerge. It should be possible, for instance, for local health authorities to associate their child welfare and other appropriate clinics with a group practice which occupies premises suitable for such clinics, and which was prepared to staff clinics in local health authority premises”.*

*“The most general need is for co-operation between the general practitioner and the medical officer of health, and in this field it is to be hoped that the medical officer of health will take the initiative whenever possible.”*

*“In the past, there has, for example, been insufficient co-operation between general practitioner and health visitors. There were indeed, at an early stage, antagonisms because of possible, and sometimes actual conflicts of influence, between the health visitor and the*

*family doctor.... The Committee hopes that there may be some re-orientation of the work of the health visitors which will make it easier for them to co-operate effectively with general practitioners.”*

*“Another way in which co-operation between the general practitioner and officers of the local health authority may be improved would be by an increase in experiments in which home nurses arrange to help doctors at their surgeries. In principle there should be no objection to this where the staff is available.”*

### **THE HOSPITAL PLAN**

‘A Hospital Plan for England and Wales’ was published in 1962 and revised to 1973, in 1963. This plans for a future hospital service in which there is an increased provision for the care of the chronic sick in their own homes, under the care of the family doctor, and local authority health and welfare services.’

### **THE PORRITT REPORT**

In 1958, a Medical Services Review Committee was appointed under the Chairmanship of Sir Arthur Porritt. This Committee produced in 1963 a Report, *“A Review of the Medical Services in Great Britain”* which considers in detail proposals for the future provision of Medical Services. Two important points arise: the first considers the unification of the National Health Service.

*“We have concluded that in future one administrative unit should become the focal point for all the medical services of an appropriate area, and that doctors and other personnel in all branches of the Service should be under contract with this one authority.”*

*“The efficiency of the family doctor service clearly depends upon the facilities available to the general practitioner - including those provided by the hospital and local health authority health service. The only administrative system that can really succeed is one in which the work of all three is planned in unison. We believe that this can be achieved only if the administration of all branches of the Service in an area is placed under one authority.*

*We therefore recommend that the responsibility for administering and co-ordinating all the medical and ancillary staff in an area should be in the hands of one authority only. This*

authority we suggest should be called, "The Area Health Board". The Committee then go on to consider the concept of the 'Health Team'

*"In domiciliary care the family doctor can no longer be entirely independent and more and more help is being provided by teams of skilled ancillary or paramedical workers or by medical auxiliaries. These teams include health visitors, home nurses, psychiatric social workers, family case workers, mental welfare officers, probation officers, children's officers, hospital almoners, disablement and resettlement officers of the Ministry of Labour and National Insurance, and members of various voluntary bodies, such as the W.V.S and the British Red Cross Society. With the increasing complexity of preventive medicine and medico-social work it is important to recognise where the family doctor stands today in relation to community medicine and, what the Editor of 'The Lancet' has called, 'the greater medical profession'*

***In our view the general practitioner should be the clinical leader of the domiciliary team, keeping in close contact with its members and guiding their work on his own patients in the way which he considers to be in their best interest."***

## **HEALTH AND WELFARE**

***"Health and Welfare, the Development of Community Care"*** was published in April, 1963. These are the ten-year plans for the Health and Welfare Services of the Local Authorities of England and Wales.

*"The first aim of the health and welfare services is to promote health and well-being, and to forestall illness and disability by preventive measures. Where illness or disability nevertheless occurs, their aim is to provide care in the community, at home, at centres, or where necessary, in residential accommodation, for all who do not require the type of treatment and care that can be given only in hospitals. Care in the community provided through the health and welfare supports and is supported by the medical care given by the general practitioner. The development of these services is, therefore, bound up with the future of the general practitioner services: the one will interact with then other and both in future must be considered together."*

The Report then considers ways of increasing co-operation between the family doctor and the health and welfare services.

*“Meanwhile the increase in partnerships and group practices has been ending the old isolation of the general practitioner which the health centres were designed to remedy, and other forms of association between general practitioners and the local authority health services have arisen, such as the siting of group practices adjacent to clinics, the attendance of midwives at general practitioners’ surgeries for ante-natal sessions, the attachment of health visitors to practices for the whole or part of their time, and the growing use by general practitioners of the services of social workers, especially mental welfare workers. These developments are characteristic of the increasing part which the general practitioner, working first with the midwives and then with the health visitor, is taking in the supervision of health from birth onwards. A growing number of general practitioners arrange regular examinations for the babies and young children on their lists, often in the home or at their surgeries (individually or in group sessions) but sometimes at the clinic. In some areas general practitioners undertake child welfare sessions on behalf of the local authority, and see, not only their own patients, but all mothers and children who attend; and rota systems are sometimes arranged so that general practitioners have the opportunity of participating.”*

## **THE GILLIE REPORT**

*‘The Field of Work of the Family Doctor’ was published in 1963 by a committee under the chairmanship of Dr Annis Gillie, which had been set up to “advise on the field of work which it would be reasonable to expect the family doctor to undertake in the foreseeable future, having regard to the probable developments during the next ten to fifteen years both in general practice itself, including its organisation, and in the supporting facilities provided by the hospital and specialist and local authority services.”*

In considering the relationships between the family doctor and the public health service, the report considers that *“in all departures from health, social and environmental issues impinge on the medical problems. Co-ordination of the findings and advice of social workers with those of the doctor is essential if work in caring for the community is to be fully effective and not conflict or overlap. The statement that the family doctor should be ‘the leader of the domiciliary team’ has become a platitude, but he has rarely been the leader, and the reason for this needs to be investigated. He must have direct access to those who are dealing with his patients, and be able to consult with them and share in the control of their activities.*

*Full co-operation can be secured best by the attachment of field workers (for example, the nurse, midwife and health visitor) to individual practices. This is already occurring in some*

*areas and must become general. With determination to make the best use of scarce resources we believe difficulties can be overcome even in sparsely populated areas. The family doctor can extend the range of his professional activities by developing the capacity for consulting with various welfare agencies about his patients' particular problems. He may be the only professional person who is aware of some vulnerable families. The changing pattern of disease and of the population structure call for the joint activity which makes a continuing demand on the family doctor's leadership. This secures a two-way flow of valuable information. The needs of the very young and the very old, the handicapped and those with chronic disease and problems of mental health, can then be met by the joint actions of family doctor, local authority and other staff."*



## CO-OPERATION BETWEEN THE WORKERS

*“Government and co-operation are in all things the laws of life; anarchy and competition the laws of death” (John Ruskin)*

When there is a complete lack of understanding, there will be no useful communication of any sort between the various workers. Each will be working in complete isolation from, and in complete ignorance of, the others aims. The first stage of co-operation is reached when a worker, aware of the existence and interest of a fellow-worker, communicates with a view to passing on information. In the second stage, the communication asks for assistance. When awareness and communication exist between doctors and nurses, both information and requests for assistance are usually forthcoming.

Communications can be of varying degrees of usefulness: there is the ‘message’, the telephone conversation and the personal meeting. The ‘message’ can be either written or by word of mouth, and usually requires either action or a reply via the same medium. If passed on by mouth of mouth, a friend or relative of the patient is usually chosen to convey the message and any reply has to go back through the same messenger. This can be very unsatisfactory, and it is not surprising that messages get distorted and are often incomprehensible, when passed in this way. How often have I had a patient tell me, “Nurse says will you...” or “Nurse says she...” and not been quite sure what the nurse really wanted of me. It is not difficult to imagine how how distorted my reply will have become when the nurse eventually has received it. Unfortunately it is not easy for me to contact the nurse herself when I receive such a message, as she has not set hours for being at home, and as most of her working day is spent on the district, it is not possible for me to contact her, except perhaps late in the evening.

*“It is important that nurses should either visit the doctors’ surgeries, or receive written instructions. In order to do their work well they should know the diagnosis and details of the treatment advised by the doctor” (Miss E.J. Merry at a Symposium on December 2nd 1956 ‘Co-operation between the nursing profession and the general practitioner’)*

There are many advantages in the use of the telephone for communication between colleagues. Any confusion and misunderstanding can be eliminated by direct conversation. Much more information can be fitted into a telephone conversation than can ever be packed

into a 'message' and one has the great advantage of being able to get speedy implementation of any recommendation.'

There can, however, be no really satisfactory substitute for personal contact between the doctor and the nurse, or indeed any other members of the health team.

*"Personal contacts with the nurse were far more valuable than the exchange of cryptic messages written on official forms" (Anderson, 1957) The following verses, written half humorously, by the Assistant Superintendent of the Kensington District Nurse Association must nevertheless echo the heartache of many a home nurse.*

*"Dear Doctor, Please would you supply some more - ?  
(How often you have seen these words before  
On message papers, usually asking you  
For gauze or dressing, or for something new)*

*Now I would ask for something else from you:  
For your co-operation through and through,  
For backing when I'm not sure where I stand,  
For explanation of the case in hand.*

*A personal appearance now and then  
At surgery, or a patient's home, or when  
You happen to be passing by my place  
Would make my work much easier to face.  
So may I say a very big "Thank-you"  
For all the things that you already do" (Wright-Warren 1963)*

These varieties of communication between the various health care workers, although not universal, are very common. The next stage of co-operation consists of the coming together of the workers to form a 'team' in which each members identifies himself with the aims and objects of each other member. It is the various degrees of this type of relationship that I propose to discuss in more detail.

We have considered the relative values of the three main types of communication that may exist between workers. It has been shown that where communication is developed to a high degree, some form of co-operation is an inevitable consequence. This unofficial co-operation may develop into a very close relationship between the workers.

In isolated rural areas, it is usual for the family doctor, the home nurse and the home midwife to work in very close co-operation, and yet have no official backing for such an association.

In urban and suburban areas, close unofficial co-operation is far less common and many administrative difficulties are liable to arise. Therefore, although unofficial co-operation is encouraged, the close working together of the various workers is not possible without official sanction. It is with this in mind that I propose to outline the results of various official schemes of co-operation and attachment that have been in operation in recent years in various parts of the country

The official attitude, which considers the effects of attachment on the efficiency of the whole health service, was made clear in a speech by the, then, Minister of Health to the Annual Conference of Local Executive Councils in 1963, when he said: *“The ‘Hospital Plan’ and ‘Health and Welfare’ are themselves integral parts of a plan for the future of general practice. Perhaps the most striking outward and visible proof of this interaction is the rapid spread of attachments of local authority staff to individuals general practices. I myself am much struck, as I go about, by the growing prevalence of this, and I find, wherever it exists, unhesitating affirmation of its value on the part both of the doctors, and of the health staff of the local authority.”*

In June 1960, a Joint Liaison Committee set up by the Royal College of Nursing, The Institute of Almoners, and the Association of Psychiatric Social Workers, in a statement: *“Working Together for Family Health”* said that:

*“Individual workers must ensure that they know each other and be readily accessible for discussion so that they can work together in an atmosphere of trust and develop means of co-operation which are flexible enough to meet the needs of different families with their particular problems. Direct communication is essential. If personal discussions are replaced by the written word through a third party, be it Medical Office of Health, Superintendent Health Visitor, or Head Almoner, details vital to the best handling of a situation are likely to*

*be lost and misunderstandings may arise. Co-operation is closest and best when the different workers have a respect for their colleagues and an intimate knowledge of each others function.”*

## ATTACHMENT SCHEMES

### ATTACHMENT OF HEALTH VISITORS

In 1953 a group of five general practitioners had a Health Visitor attached for five sessions each week. She was responsible for all patients irrespective of area, and even though her own district was smaller than the area covered by the practice. She attended a baby clinic at the surgery and was able to attain almost 100% immunisation of infants in the practice. Domiciliary visits, broken down by age, amounted to:

New births	2 or 3 weekly
0 - 1 year	12 to 15 weekly
1 - 2 years	12 to 15 weekly
2 - 5 years	5 to 10 weekly

The health visitor was also able to visit aged patients. A weekly meeting was held with the doctors and the practice nurse-secretary. An ante-natal clinic at the surgery was attended by a local authority midwife.

The authors report that, *“The scheme would have been simplified if the health visitor had been attached full-time to the practice.” They found, however, that all concerned were able to give a more comprehensive service, and that there was no longer any tendency to give a patient conflicting advice. Also the scheme “has allowed more emphasis to be placed on preventive medicine and the promotion of health than would otherwise have been possible.” (Chalke & Fisher,1957)*

*Dr A.I. Riss in his Annual Report for 1962 as Medical Officer of Health to the County Borough of Bolton records that, “during the year there have been important developments in improved co-operation between general practitioners and health visitors. In June, one health visitor was attached to a group practice of three general practitioners. This resulted in the establishment of a well-baby clinic held at the surgery on one afternoon each week. In addition, the health visitor attended at the surgery for consultation with patients and doctors. A car was found to be essential to enable her to cover the extensive practice.*

*In addition, the doctors in eight practices requested the weekly attendance at their surgeries of a health visitor. The position at the end of the year was that health visitors were now visiting regularly each week a total of twenty-five doctors.”*

Dr W.G. Harding (in a personal communication) states that in his capacity as Divisional Medical Officer to the London County Council, he has attached a health visitor full-time to a four-doctor practice in Holloway. The experiment has been in operation for several months, and is working to the satisfaction of all concerned.

In the experimental integration of a health visitor into a practice of three doctors and 8,500 patients, the health visitor was found to be of the greatest value in diseases of the following groups:

- a) Nervous system
- b) Neuroses
- c) Pregnancies
- d) Diseases of the musculoskeletal system
- e) Senility

Repeat visits were required more by the elderly of both sexes, particularly if there area also diseases of the nervous, circulatory, or locomotor systems. The care of the aged often involved sharing the case-load with the district nurse, and this was particularly the case if there were respiratory diseases present. *“There seemed to be a clear indication here for the co-ordination of the activities of both these workers by the general practitioner.” (Pinsent, R.J.F.H. et al 1961)*

In the practice just referred to, a survey was made of a group of elderly male patients in order to try to assess the need and the value of routine health visiting in the aged, as a contrast with its established value in the young. The health visitor visited fifty-seven male patients over the age of seventy years, selected at random from the practice population. Forty-three of these were interviewed. Of these, only eighteen (forty per cent) provided) no problem relevant to the work of the health visitor. In ten cases a problem was foreseen and in a further fifteen immediate benefit followed her action. These figures suggest a need for health visitor care amongst old people which many not be sufficiently appreciated at present.

## **ATTACHMENT OF HOME NURSES**

Dr. G.S. Wigley, County Medical Officer of Health for Middlesex records in his Annual Report for 1962 that during the year there were "*two experimental schemes in which a home nurse has worked with a group of practitioners*".

In Willesden, after a preliminary meeting in January, a nurse began to work in this area, using a "moped" scooter. She continued for seven months, after which her place was taken by another nurse who had a car.

In eleven months 110 cases were paid a total of 2,898 visits. The experiment was considered to be successful by the nurse, the general practitioner, and by the area medical officer.

The types of patient visited were similar to those of other home nurses, with a large proportion of patients requiring general nursing care. The mileage and travelling time compared favourable with other nurses in the area, if the relief duties of those working in a group are taken into account. The chief advantage of the scheme is that there is a much closer link between the practitioners and the nurse. She meets the doctors at their surgery to receive instructions and to discuss the work, in this way bringing about a better understanding of each patient. The experiment has shown that there should be a closer liaison between all home nurses and general practitioners and the present group wish the scheme to continue. In the area concerned, extension of the scheme would be limited by the small number of group practices.

There has been a similar experimental scheme in operation in a group practice in Ashford since the end of April, 1962. The group practice is centred on one building. The home nurse who works with these five doctors attends morning surgeries, assists at minor operations and does dressings and treatments in the surgery. She also attends immunisation sessions, and the remainder of her time is spent nursing patients on the doctors' lists in their homes. The arrangement works very well and the nurse has established good professional relationships with the practitioners. It has been found however that one nurse is unable to cover the home nursing duties entirely and a proportion of visits have to be covered by other nurses. In future this scheme will need additional staff. A full review will be made when it has been running for a year.

In two other areas, an arrangement to second a home nurse to a group of general practitioners has been under consideration; in one case it was actually begun but had to be discontinued owing to the shortage of nurses.

The scheme at Ashford has flourished and Dr Wiley tells me (in a personal communication) *that an almoner and a mental welfare officer (part-time) are now being added to the practice. One of the Council medical officers and a health visitor do an infant welfare session at the group practice. Even closer collaboration is looked for in the future.*

### **ATTACHMENT OF HOME MIDWIVES**

*In a survey of the obstetric work undertaken in a general practice of some 5,30 patients run by two partners, it was found that 70% of the cases were confined at home. This was only possible because of the closest possible co-operation between the doctors and the midwife. An ante-natal clinic was held weekly and run jointly by one doctor and the domiciliary midwife. Patients booked for home confinement were seen throughout the pregnancies. Patients booked for a hospital confinement attended the ante-natal clinic until the 32nd week, when they visited the hospital clinic. Thereafter they attended the hospital and the surgery alternately, at weekly intervals, until confined.*

*It was only found possible to attain such a high domiciliary to hospital ratio because of the liaison between midwife and doctor and the willingness to transfer to a hospital booking any patients who developed any warning signs of a possible danger (Bury & Gaston, 1963)*

My own practice in Peterborough is divided geographically into two distinct parts. The larger area is centred on my main surgery in the town, and patients in this area are also served by many other doctors, and a number of midwives. The smaller part is centred on a village some three miles from my main surgery and here I am fortunate in being the only doctor to have a surgery in the village, and also to have the services and co-operation of a most efficient home midwife. It has always been our custom to work in the closest liaison, and since October 1962 we have been running a joint ante-natal clinic at my branch surgery. This is attended not only by those patients who hope to be delivered at home, but also, with the blessing of the two consultant obstetricians, by certain of those patients who are booked for a hospital confinement and who find it more convenient to attend my clinic than to travel four to five miles to the local maternity unit.

I do not consider that there has been any improvement in the standard of care that is offered the patients who attend the clinic as opposed to those who visit my main surgery, but the overall improvement in efficiency and convenience to the patients, the midwife and myself has been most marked. No longer do the patients have to attend both a doctor's and midwife's clinic, thereby overcoming any impression that they are being cared for by a divided service. The possibility for a patient being offered conflicting advice is almost completely eliminated; in fact, the midwife and I are so attuned to each others ideas and attitudes that the patient is inevitably impressed by an obviously united service.

Because of this treatment of the 'whole' patient by the 'whole' service, not only has co-operation been increased between doctor and midwife, but also to a most marked degree between the patient and the service which is caring for her. Any advice offered is usually accepted and acted upon and consequently the confidence which one is able to place in the home care service is greatly increased.

### **COMPREHENSIVE ATTACHMENT SCHEMES**

In Brighton, there are some 100 general practitioners, 35 home nurses, 10 midwives and 35 health visitors. *The Medical Officer of Health, Dr W.H. Parker, told the Symposium on 'Changes in General Medical Practice' organised in 1959 by the South-East England Faculty of the College of General Practitioners, "I believe that the best way in which I can help the general practitioner is to lend them these trained workers and thus save them much unnecessary work."*

Dr Parker felt that one of his chief functions was to provide the general practitioners with adequate ancillary help, and that it was not any part of his duties to try to set up in opposition to the family doctor.

### **THE HAMPSHIRE SCHEME**

The County of Hampshire illustrates what a progressive Authority can achieve in arranging the attachment of of personnel to general practitioners. *Dr I. MacDougall, the County Medical Officer of Health, described the aims of the scheme at the Symposium on "Social Medicine and the Family Doctor" in November 1963.* He considers that it is the duty of the Medical Officer of Health to assist the family doctor to achieve home care. In this way the Hospital Ten Year Plan for the treatment of suitable patients at home can be implemented. It is felt that this can be most readily be done by the attachment of staff exclusively to family

doctors. At the present time about 100 family doctors in Hampshire have health department staff attached to them.

District Nurses and Midwives are readily accepted by most family doctors, though it was felt that health visitors would not be so readily accepted. To overcome this anticipated difficulty, a scheme for the attachment of health visitors was started first. Now all the members of the public health nursing service are equally accepted.

There has been no administrative difficulty in arranging attachments, and the increased cost of the service is very much less than was anticipated. There has been no difficulty in persuading committees of the desirability of allowing attachment. Attached staff are happy staff, and do not leave the authority service as frequently as previously.

In rural areas, a triple qualified nurse has been found to be the ideal, in the ratio of one such nurse to each single-handed doctor. A two-doctor partnership should ideally have two triple-qualified nurses attached, but this has not so far been attained in many cases.

In urban areas, a doubly-qualified district nurse-midwife is the person of choice, in proportion of one nurse to each 3,000 patients in the practice. In addition, if the practice is large enough, (from 5 to 6,000 patients), to justify this, a health visitor is also attached.

Discussion between the general practitioners and the Medical Officer of Health prior to attachment of staff has prevented any misuse of the service. Attached staff are encouraged to use the practice premises, and to run joint clinics with the general practitioners. Attached staff should not be used in place of a practice nurse or receptionist, but may do dressings and inoculations that she would otherwise do in the home.

In small rural areas, the family doctor is encouraged to co-operate with the health visitor in the care of children at the local school. In general however it is not possible for attached health visitors to work in the school health service.

In very few instances it has been found necessary to attach one nurse to more than one practice, and then only with the free consent of all the parties concerned. No difficulties have arisen where the area covered by the practice extends beyond the boundaries of Hampshire.

By mutual agreement with the neighbouring health authorities, the attached personnel follow the doctor in all the ramifications of his practice.

Dr J. Happel told the Symposium that he is a member of a two-doctor practice. The partnership has 3,500 patients scattered over a radius of some ten miles from a village which is the natural centre of the practice. Most of the maternity work is carried out by the partners. About 70% of the deliveries take place in the general practitioner maternity unit in the neighbouring Hampshire town of Alton.

Until recently, five health visitors and nine district nurses worked in the area covered by the practice. There was very little contact possible between the doctors and the other health workers. Dr Happel had never met some of the health visitors.

Some months ago, following discussions with the County Medical Officer of Health, a triple qualified nurse, Mrs J Cooper, was attached to the practice. She identified herself with the patients and with the area of the practice. Because of her triple qualification she combines the duties of of district nurse, midwife and health visitor. The nurse visits the practice every day after morning surgery to discuss cases with the doctors. This daily conference is found to be of invaluable mutual help. As a result of this close personal relationship, many conditions are seen, and consequently treated, much earlier than previously by avoiding unnecessary overlap of visiting. Dr Happle finds that his monthly visiting list has been reduced whilst at the same time his patients have a more comprehensive service than before.

Mrs Cooper previously worked in an area of some five miles radius, which included four villages. Thirteen doctors had patients in this area and it was found to be quite impossible to know the particular likes and dislikes of each doctor or even to discuss the cases with him. She enjoys the present opportunity of discussing cases with the doctors and finds that discussion may sometimes lead to controversy. Opinions having been aired, a course of action is agreed upon, and no longer is the patient able to 'play the nurse against the doctor, or vice versa'. Mrs Cooper frequently finds that a patient will ask her to act as an intermediary with the doctor, and so conditions may come to light at an early stage.

Mrs Cooper feels that she is a better nurse because she is also a health visitor, but regrets that she no longer has the time to do any school health work. She feels that this is a loss to her work as a health visitor. Very few clinics are attended, but there is an increased opportunity for teaching in the home.

The nurse has access to the surgery premises at any time, and in particular, is encouraged to consult the patients' medical records and hospital letters, so that she has first hand knowledge of any specialist's recommendations.

In addition to her other duties, the nurse is able to give many prophylactic inoculations in the home to those patients who would otherwise find it difficult to visit the surgery.

Both Dr Happel and the nurse are very satisfied with the present arrangements and are conscious of the improved service that the present arrangement enables them to give the patients under their care. It is felt, however, that one triple qualified nurse is overworked in this two-partner practice, and it is hoped that it may soon be found possible for a second nurse to be attached to the practice.

Miss P.M. Gillett is a health visitor attached full time to a group of seven doctors who practise in the City of Winchester. Before attachment, she was working in the area of many more doctors, but now finds that, through personal contact, she is able to know the personal likes and dislikes of each doctor.. Uniformity of both advice and treatment is thus possible. The doctors, in turn, are able to take advantage of all the services to which she has access. Miss Gillett visits the surgery each day for consultations with the doctors. Child welfare clinics are held in the surgery, and one of the doctors attends, so that immediate treatment is possible for any abnormal conditions found. Health visitor records are kept at the surgery, so that all records are equally available to both the doctors and the health visitors.

Miss Gillett finds that the scope of her work has increased considerably, and that all the members of the family now come under her care. She now knows many more old people. She has great satisfaction in her work and likes to feel that her usefulness is in large part derived from her having a 'foot in both camps' - those of the general practitioner and the local authority.

Mrs G.G. Morgan is a combined district nurse and midwife, who is attached to a partnership of three doctors, together with a similarly doubly qualified nurse and a health visitor. Before attachment, she worked in an area covered by 25 different doctors. The present arrangement is found to be very satisfactory. In particular, the greater personal contact has broken down any barriers that may have existed between herself as a midwife, and the health visitor. This

has led to improved co-operation between these two members of the health team. In particular, the health visitor takes part in the relaxation classes of both the domiciliary and the hospital booked maternity patients. She thus becomes a friend of the mothers before the problems of infancy arrive.



## ANCILLARY STAFF EMPLOYED BY DOCTORS

### THE SURGERY NURSE

Many doctors, and more particularly groups of doctors, employ a surgery nurse. Her main function is to carry out those examinations, tests and treatments that her nursing training have equipped her for. In this way, the many doctors who employ a full time or part time nurse in their practice, find that they acquire additional time to spend with the patient. In addition many surgery nurses are responsible for inoculations, and occasionally may visit patients in the home to give injections or carry out dressings.

*“The main effects of a nurse working in general practice are, first, to extend the care given to patients; secondly by relieving the doctor of arduous and time-consuming tasks, to ease his sense of frustration; and thirdly to reduce the amount of use made of other parts of the Health Service, and in particular the hospitals, district nurse, health visitor, and possibly the pharmaceutical service”*

*“In various ways the nurse helps to co-ordinate many different services. She does not replace the health visitor or district nurse, but helps to ensure efficient collaboration between them and the general practitioner.” (Cartwright & Scott 1961)*

Commenting on the increased economy and efficiency experienced during the employment of a surgery nurse in his practice (Townsend E. 1962) also found that: *“It was not until a fully trained state registered nurse was employed in the surgery that we (four partners) found ourselves to be able to cope adequately with the work we wished to do. The saving in doctor time is not confined to the avoidance of routine dressings and injections but in the making and keeping of immunisation records, the care of instruments and equipment, the sterilisation of syringes etc.”*

A practice of five doctors which has had a full-time practice nurse for ten years has published useful data. She has dealt with an average of 9,988 attendances at the surgery each year, comprising:

Immunisation	32%	Ear Treatment	2%
Dressings	34%	Minor Operations	1%

Injections	18%	Miscellaneous	6%
Ear Syringing	5%		

Her aim is to immunise and vaccinate every infant born into the practice and to keep appropriate records. She does no domiciliary work except in an emergency.

*“I believe that full nursing cover in the surgery is a ‘sine qua non’ for the good general practice of the future. Two things happened when a nurse came into our practice, firstly she saved us much time, and secondly the standard of nursing procedures improved out of all recognition.” (Forman J.A.S 1962)*

## **SOCIAL WORKERS**

The Younghusband Report on ‘Social Workers’ considers that, *“General practitioners’ surgeries are key points at which a trained social worker can identify social problems related to sickness and ill-health, sometimes at a relatively early stage, that is at the point at which they arise in the home, and before a further crisis may be precipitated by a breakdown in family care or admission to hospital..... In addition, this setting provides an opportunity for effective team work between general practitioners, almoners and health visitors in particular and between general practitioners and other local authority workers, such as mental welfare or child care officers or welfare officers for the handicapped.”*

A trained social worker who has been working with four doctors at Darbyshire House since 1955 published a most interesting report. Darbyshire House is the University of Manchester general practice teaching unit, and about 12,000 patients are under her care. After three years experience of her work there, the social worker was able to list her six main advantages of working with general practitioners.

1. *Accessibility*
2. *Participation in group discussions*
3. *Interpretation of the aims and limitations of social work. The doctors and social worker must pool their resources.*
4. *Exploration of the role of the social worker as a colleague of the doctor. The patient must not be too hastily referred to the social worker, or this may be interpreted as a rejection. The patient must feel that the doctor has taken his*

*trouble seriously and that the social worker is a colleague “supplementing and not supplanting the aid he offers”*

5. *Discovering unmet needs in general practice*
6. *Opportunity for preventive work*

*(Dongray M. 1958)*

In another report of work with social workers it is said that, every morning, except at the weekend, the County Council social worker visits Stafford General Infirmary, and attends each ward, taking details of every admission. She also visits the outpatients department if requested by the staff. The report is ready next day, and domiciliary visits are recommended to be carried out by the social worker or a health visitor if required. The patient’s general practitioners are informed of all discharges by telephone, and of any need for local authority services. The scheme has been received with widespread enthusiasm. The vast majority of discharges require:

1.	District nurse	145	out of 3185 admissions		
2.	Home help	42	“	“	“
3.	Health visitor	37	“	“	“
4.	District nurse and health visitor	16	“	“	“
5.	Social worker	8	“	“	“

*(McFarland W.D.H. & Ramage G. 1963)*

*In the Messer Committee Report it is recorded that, “There is no almoner on the staff of the Mexborough Hospital Management Committee’s Hospitals. By agreement with the West Riding County Council, the Hospital Management Committee and the general practitioners of the district, a health visitor on the staff of the local health authority, working under the direction of the divisional medical officer of health, is attached to the hospital as care and after-care liaison officer. She attends the hospital on three half-days a week and obtains particulars of any cases discharged to their own homes requiring after-care. With the consent of the general practitioners concerned, she visits the homes of the patients and makes arrangements for the care to be provided, e.g. home nursing, domestic help, care of premature infants, etc. Where a knowledge of the social background of a patient newly admitted to hospital is needed she obtains this and passes it to the registrar of the hospital for attachment to the patient’s clinical record.”*



## **FORMS OF MEDICAL PRACTICE**

### **PARTNERSHIPS AND GROUP PRACTICES**

The tendency in general medical practice today is toward the formation of partnerships and group practices, and as a consequence the number of single-handed practitioners in the country as a whole is falling. In 1962, there were 5,000 single handed doctors, compared with the 15,000 who work in partnerships of two or more.

Partnerships and groups practices are formed with the idea that by working together and by pooling expenses, a better service will be provided for the patients and better conditions of service for the doctors. Not only will the doctors be able to ensure the necessary provision of cover for off-duty time, holidays and sickness, but ancillary staff will be more easily provided: secretary, receptionist and surgery nurse. Also by working together from one building, the group practice is able to provide a central point at which the doctors can meet, and work with, the members of the local authority nursing services.

### **HEALTH CENTRES**

In 1922, the Dawson of Penn Report introduced the concept of 'Health Centres' and this was subject to a great deal of discussion within the medical profession. Right from the start these were envisaged as centres at which members of the general practitioner, hospital and local authority services could meet in the common service of the patients. It has been this concept which has largely been responsible for their failure. However, discussion waxed and waned until in 1946, the National Health Service Act laid down in Section 21: 1

*"It shall be the duty of every local health authority to provide, equip and maintain to the satisfaction of the Minister, practises which shall be called 'Health Centres'"*

There was a great deal of speculation at the time as to whether this section of the Act would be implemented.

*"In spite of the mandatory opening of this section: 'It shall be the duty of every local health authority to provide 'health centres' the duty is apparently only enforceable by the Minister insisting on such provision under Section 20. It remains to be seen whether the Minister will*

*insist on early implementation of this section, or whether in many areas - possibly on grounds of building and other difficulties - it will not be enforced” (Speller S.R.1948)*

The Central Health Service Council ‘Committee on Health Centres’ reported in 1950:

*“We have concluded that one of the most valuable functions the health centre would be that of providing a natural meeting place for all those working in the health services of the neighbourhood by bringing surgeries, clinics, and offices of the curative and preventive services into one building to which doctors, dentists, midwives, health visitors, nurses and others would be obliged to go in the course of their daily work.”*

A series of articles was published in “The Lancet” in 1947 under the general title ‘*Health Centres Tomorrow*’. In these the advantages of ‘health centre’ practice were considered largely in the light of a breaking down of the administrative barrier that existed between the curative and the preventative health services, and the possibility of the ‘health auxiliaries’ working from the same centre as the general practitioner. It was also thought that the local authority would be prepared for nurses to work within the health centre, and to act as surgery nurses.

*“The greatest need (apart from clerical assistance) will be for nurses. The nurse can assist in the examination of female patients, do minor dressings, take charge of minor operation rooms, sterilise instruments and dressings, and assist in a hundred ways.”*

In fact, very few health centres have been built since 1948. The first to be planned was that on a new housing estate at Woodbury Down in North London, at a total capital cost of £198,000. The Centre was opened in 1952, and six doctors began working from the Centre in 1953. The doctors are reputed to have easy communication with health visitors and midwives, but there are no common meeting rooms in the Centre for the various workers. None of the eight doctors who now work from the Centre do any local authority work. The local authority provide the following services: maternity, child welfare, school health service, physiotherapy, chiropody, dental, speech therapy, health visiting, psychiatric social work, home nursing, child guidance, children’s officer, smoking advisory clinic, auditory training and tutorial class. Although eight doctors work from the Centre, there are five partnerships and the doctors have resisted any attempt to form a group practice.

The Harlow Development Corporation have built several health centres in the New Town, of which Nuffield House is typical. This was completed in 1955, and now houses four doctors, all of whom do local authority work at the centre, and who have formed themselves into a group practice. The local authority services provided are maternity and child welfare, dental, and health visiting. These centres are unusual in that none of the doctors have other surgeries.

The Health Centre at Oxhey is an unusual combination of health centre and group surgery, the local authority having been responsible for the health centre and the doctors for the practice part of the premises. This Centre has been open since 1958 and five doctors work in partnership from the Centre. None of the doctors do any local authority work, although the local authority provide many of the services including maternity and child welfare, school health, dental, speech therapy, health visiting, psychiatric social worker, and home help.

Writing in 1961, J. Slugget says, *“In 1944 a British Medical Association questionnaire showed that 60% of the participating doctors were in favour of Health Centres as described by the Medical Planning Committee and undoubtedly many of us were induced to join in the National Health Service in 1948 because of the promise embodied in the Act. Yet despite all this official encouragement, the number built since the appointed day is very small.”*

The concept of the health centre, as seen by Dawson of Penn, and as embodied in the 1946 Act is now being gradually being abandoned in the light of experience. It is considered to be fundamentally unsound as it attempts to bring together parts of the service which have little in common. It is in particular now considered unsound to attempt to bring the hospital consultant into the same buildings as the family doctor.

*“A modified idea is now generally accepted of group practice centres with health visitors attached to the practice.”* (Warren M.D 1962) This would appear to be a very much sounder arrangement.

*M.D. Warren goes on further to suggest that ‘Medical Centres’ should be built to provide in-patient care for aged people, and also rehabilitation facilities. The Medical Centres could also accommodate general practitioner maternity units and provide X-ray and minor laboratory facilities. It might also be possible to provide minor surgery facilities at which the surgeon does the operation and the general practitioner provides the aftercare.*

## **DIAGNOSTIC AND TREATMENT CENTRES**

Another recent development is the 'diagnostic centre'. The one at Corby New Town provides diagnostic, laboratory and X-ray facilities for the local doctors, together with outpatient sessions for local consultants. Treatments and dressings can be arranged at the centre. The facilities are obviously of great value in a new town built at some distance from the nearest hospital.

A similar project is the South East London General Practitioner Centre' at Peckham, in the building which previously held the Peckham Health Centre. This was opened in 1961 and is greatly appreciated by the local family doctors and their patients. *"The unit was primarily designed to provide diagnostic facilities for family doctors to enable them to investigate fully any of their patients who do not need a specialist opinion. For this purpose the regional board established and maintains an X-ray department and pathological laboratory and provides an electro-cardiograph. The secondary aim was to provide treatment and minor operative facilities; so a theatre, recovery room and treatment cubicles were combined in a self-contained nursing unit."* (Jenkins, M. 1962)

The services of a health visitor are also available and she attends the centre on four mornings each week.

The centre also provides meeting facilities for the family doctors who use the centre, and gatherings are often attended by as many as sixty family doctors.

Altogether some 115 doctors use the facilities at the centre, and in the first year of running, some 6,000 patients were treated or investigated.

## THE CARE OF SPECIAL GROUPS

### INFANTS AND CHILDREN

It will now be of value to consider the care of certain groups within the family in greater detail.

Infants and children up to school age are the responsibility of both the family doctor, and the local authority through the medium of infant and child welfare clinics which are run by health visitors under the direction of local authority medical staff.

In many areas there is an increased co-operation between family doctor and health visitor. The need for this was highlighted in the Report of the Cohen Committee. *“In the past, there has, for example, been insufficient co-operation between general practitioners and health visitors. There were indeed, at an early stage, antagonisms because of possible, and sometimes actual, conflicts of interest and of advice between the health visitor and the family doctor .... The Committee hopes that there may perhaps be some re-orientation of the work of the health visitors which will make it easier for them to co-operate effectively with general practitioners.”* - And, also from the same Report - *“There is need for experiments in different forms of association between groups of doctors and local health authorities, and a number of different solutions suitable in particular local conditions may gradually emerge. It should be possible, for instance, for local health authorities to associate their child welfare and other appropriate clinics with a group practice which occupied premises suitable for such clinics or which was prepared to staff clinics in local health authority premises”.*

### ANTE-NATAL AND POST-NATAL CARE

D.N. Hughes referred in ‘The Fourth James Mackenzie Lecture to conditions that he experienced in the maternity service twenty-five years ago. *“In those days, midwifery dominated one’s life....There were few district nurses in those days, and I was obliged to attend all the confinements looked after by handy women. As one might expect since there was so little ante-natal care, severe toxæmia of pregnancy was commoner than today. It is astonishing how ill an expectant mother would allow herself to become before calling in her doctor.....Though regular ante-natal work has made a difference, there is much still to do.”*

Regular ante-natal examinations, with a view to discovering those cases which require hospital care are the key to good midwifery. This, however, is not enough. As RDC Handfield-Jones (1963) says "*Unforeseen complications must be planned for.*" He goes on to describe the midwifery done in the preceding two and a half years in his practice at Haddenham Bucks " *130 babies were born. 68 at home and 13 in a nursing home under my care. In addition, 14 were transferred to hospital on medical grounds, and of the remainder, 35 were booked for hospital confinement from the start on medical or social grounds. There were no maternal or foetal deaths in the 95 cases booked for home confinement. It is important to obtain the cooperation and trust of the district midwife, who can attend the doctor's weekly ante-natal clinic and keep him informed of progress as labour proceeds.*"

In the Report of the Working Party on Midwives (1949) under the chairmanship of Mrs M.D. Stocks is recorded the opinion: "*It seems to us that the assets and liabilities of doctor and midwife are complementary, and that the arrangement under the new health service with the two working in partnership may prove to be a good one. It will only be successful, however, if both parties recognise their partnership.*"

In those circumstances where it is not possible for the doctor and midwife to attend the same ante-natal clinic, and where the patient is also possibly attending a hospital ante-natal clinic, there is a great need for a definite means of communicating information between the two or three persons concerned with the care of the expectant mother. To this end, a 'Co-operation Record Card' was introduced by the Minister some months ago. This has been found to be of invaluable help. It contains space for all relevant information and for records of each ante-natal attendance. By means of this card, the omission of any test or examination is readily brought to attention at any subsequent examination. The mother keeps this card in her possession and it is thus available to the family doctor, the midwife and the hospital.

As far as co-operation with the hospital is concerned, I myself am fortunate in having access to the local maternity hospital in the capacity of Honorary Clinical Assistant to the Consultant in Obstetrics and Gynaecology. I find it invaluable in extending my knowledge of the subject and of the patient, to be able to continue the care of the patient referred by me for hospital confinement.

In a Supplementary Memorandum on General Practitioner Maternity Services submitted to the Committee of Inquiry into the Maternity Services in England and Wales on 31st January, 1957 (College of General Practitioners Research Newsletter 1957 4. p.169) it is stated:

*“General practitioner maternity departments in hospitals or their annexes would be staffed by mid-wives seconded for regular periods from the main hospital obstetric service. Domiciliary midwives could, under some conditions, play their part in the work of these annexes, as well as in independent general practitioner obstetric units. Health visitors, also, could visit both. This co-operation between family doctors, midwives and health visitors would be developed still further by meetings in the main hospital, in doctors’ surgeries, and in patients’ homes. In this way, family doctors, midwives and health visitors could contribute much to each others work. Distance must necessarily limit opportunities for this relationship, but to an ever lessening extent as suitable premises and an integrated organisation develops.”*

## **SCHOOL CHILDREN**

There is a wish on the part of family doctors to take an increasing interest in the health and welfare of the school child. There is no desire to take over the specialised function of the school doctor in respect of visual and audiometric surveys, or intelligence testing and grading of the sub-normal.

The Cohen Committee (1954) in Appendix 1 reports an interesting experiment. In Lincolnshire (Lindsey) the school health service refer to the general practitioner all cases involving :

1. Minor ailments and injuries
2. Specialist examination or treatment
3. Hospital treatment, (out-patient or in-patient)
4. Handicapped children requiring medical treatment

In all other cases, the general practitioner is informed of any action proposed or taken. A similar scheme has been in operation in all infant welfare clinics during the previous twelve months.

*“Medical practitioners have been anxious to make the scheme work. The Authority’s Assistant Medical Officers objected at first to losing responsibility for treatment, but have now accepted the position.”*

*“With the approval of the Local Medical Committee, the services of the midwives have been made available to practitioners when carrying out ante and post-natal examinations. A few are now holding ante-natal sessions at which the midwife attends.”*

*“The health visitors have been instructed to enlist the co-operation of practitioners when the opportunity arises, and they are doing what they can in this connection. They are no longer regarded as ‘nosey parkers’ whose main object is to get patients to attend Local Authority clinics.”*

## **THE AGED**

The care of the aged has been given a great deal of thought in recent years. A Joint Working Party of the Scottish Council of the College of General Practitioners and the Scottish Branch of the Society of Medical Officers of Health was convened to discuss methods of promoting closer relationships in the care of the elderly. After friendly and helpful discussions, it was decided to recommend to the two parent bodies that *“There was need for experimentation in the field of collaboration between general practitioners and health visitors, and that this collaboration should not be confined to the problems connected with the care of the aged, but should cover all age groups.”* (Eleventh Annual Report of the College of General Practitioners.London 1963 p.48)

The relationship between home nurses and family doctors in the care of the aged has also to be considered. *“Where full liaison existed between the doctor and the nurse, the latter was often particularly helpful in giving advice on accident prevention and health education to the elderly patient. By her more practical contact with the patient, she often heard of conditions which had been troubling the patient, but which had been thought to be too unimportant to mention at the more formal consultation with the doctor.”* (Anderson, 1957)

J Fry (1957) found that in spite of adequate facilities, help from the various ancillary public health services in his practice at Beckenham, Kent, was necessary for only 20 of the 315 patients in the practice aged 70 or over. This he considered was due to the lack of an appreciation of the availability of these services, rather than the small demand for them. In

caring for the aged the family doctor must *“Practise preventive medicine to the full....Ideally the family doctor should be able to call in his local Medical Officer of Health on a domiciliary consultation to arrange for the extra care of his old patients.”*

Another approach to this problem, is that of R. Gibson (1957) in the Butterworth Prize Essay - *“The Care of the Elderly in General Practice”*..... *“There are clinics for children and young people. Is it not of equal importance that there should be a similar service for the elderly, though it may be forbidden that they should ever be called clinics. This service could well be run by general practitioners under the protective umbrella of the Local Health Authority, and with the approval of the Minister of Health. It is obviously unfair that elderly patients should be at the mercy of a haphazard organisation depending on the enthusiasm and ability of a few general practitioners. The service for them should be as efficiently organised and as much a part of the National Health Service as that provided for babies and expectant mothers”*.....*“Unless there is a general awareness amongst general practitioners of the elderly patient’s need for care and protection at an early stage, the strain on the hospital as well as on the Local Health Authority’s services is bound to increase from year to year as the proportion of elderly in the population increases until a general breakdown seems inevitable.”*

The Younghusband Report records that there is a consultative Health Centre at Rutherglen where a consultant and local health authority service is provided for the elderly in co-operation with general practitioners. *“Members of the voluntary old people’s welfare committee attend the centre regularly, thereby meeting elderly people of whose existence they may have been previously unaware. They co-operate with health visitors and undertake home visiting in addition to organising social and other activities at the Centre.’*

The value of voluntary help in the care of the aged is stressed in the Porritt Committee Report (1963) *“but it is essential that it should be co-ordinated.”*

## **THE HANDICAPPED & THOSE SUFFERING FROM CHRONIC ILLNESS**

The care of the handicapped, and those suffering from chronic illness must also be considered in the light of the improved care that will be available with increased co-operation. Very few specific projects for the co-operative care of these patients have been recorded. It is in this very group that the ‘Hospital Plan’ proposes increased domiciliary care. Only by offering the

family all the available services will this plan be implemented without any increased hardship, and only improved liaison between the services will this be possible.

*The Montefiore Hospital 'Home Care Program' is an interesting example of what can be achieved in the home care of suitable cases. (Bluestone E.M. 1954)*

## **PATIENTS SUFFERING FROM A TERMINAL ILLNESS**

The needs of the patient suffering from a terminal illness are discussed in the Research Newsletter of the College of General Practitioners (No 16 1960)

*“Facilities Available: In most cases of cancer, the hospital treatment is only a small part of the control and care of the patient. Because the illness occupies a great length of time, the family and pecuniary considerations become tremendously important. Hospital almoners help greatly when the patient is in hospital, but there is need for more adequate liaison between them, the health visitor, the patient's doctor and the Assistance Board.*

*Health Visitors give advice about the care of all patients ill at home, but they do not always appear very enthusiastic in liaison with cases of cancer.*

*The District Nursing Service is invaluable, and terminal care would be impossible without it. It is the most appreciated organisation by the patient and relatives. To function properly however, it requires to be supplemented by a Night Nursing Service and proper laundry facilities for bed-linen of incontinent patients, and those with evil-smelling sores. The National Assistance Board will help with night-sitters but rightly maintain that if a patient requires a night sitter, the proper place is hospital.”*

## **MENTAL HEALTH**

Providing there is the closest possible co-operation between hospital, local authority and general practitioners, an adequate alternative care to in-patient treatment can be provided in many cases of mental illness.

*“In order to play his vital part in this service, the general practitioner must co-ordinate his work in this sphere with psychiatrist, psychiatric social workers, mental health workers, health visitors and voluntary agencies. The health visitor, having to some extent mastered her task of advising on physical problems, and with ready access to young mothers, children and*

*the aged, is increasingly turning her professional curiosity towards this new field. In various centres she is already receiving training in psychiatric measures.” (Crawford Little J. 1961)*

In this country there is an average stay in mental hospitals of 6 to 8 weeks, with 90% of patients returned home.

*“This is only made possible through careful hospital follow-up treatment and improving standards of after-care by general practitioners and local authority mental health staff....As yet the numbers of trained personnel in local authority mental health services is small, but this is likely to improve as the benefits of this new approach become more widely apparent.” (Crawford Little J. 1961)*

## **HOME ACCIDENTS AND HEALTH EDUCATION**

The Health Department of the London County Council discovered 7,795 cases of home accidents during 1957. The number in the country as a whole, who never reach hospital, but who are treated by a district nurse, first aider, or family doctor, must be enormous.

In respect of injuries to young children: *“The education of the mother by the family doctor must be reinforced by help from the health visitor and district nurse. He alone is able to walk freely into any part of the house.....teamwork, however, can reap the greatest rewards in this field. The family doctor can help the domiciliary nursing services, keep them aware of the problem, and add, when need be, the weight of his authority.”*

*“Every accident should be the subject of an enquiry by the team, and the lessons learnt applied not only in the home of the victim, but in all other homes where it may be profitably taught.” (Editorial. Journal of the College of General Practitioner. 1958 Vol 1. No 1)*

*Health teaching is conceived as supplementary to medical care. Health teaching should be given with the consent of the physician and considered to supplement medical care, that is, the health nurse teaches what the doctor has not time to teach.” (Emory F.H.M. 1953)*

## **LOCAL AUTHORITY CLINICS**

The local authority services for the care of vulnerable groups, infants and young children, the school child and the pregnant woman, date from the time when these were the only free service available. The clinics on which these services are based have brought incalculable

benefits to these groups of the population. Following the introduction of the National Health Service of 1946, a free medical service became available to all members of the community. Subsequently, family doctors have been interesting themselves in all groups of the population, and not least in the care of these vulnerable groups.

Many authorities are now considering their future policies regarding the provision of clinic facilities, and it will be worth while to consider a few of the more interesting alternatives to the standard clinic.

In Luton, the Medical Officer of Health has persuaded the local Health Authority to build four 'Health Centres' purely for Local Authority work in various parts of the town. In all, about twelve such centres are planned, and they will each occupy a strategic position in the town. Local Authority clinics will be held at these centres. The family doctors are encouraged to attend the centres and to be available for consultation, with health visitors and midwives, about their own patients.

The Medical Officer of Health hopes that, in the near future, all his clinics will be staffed by family doctors, and that he will no longer require Assistant Medical officers for this work.

In 1959, Bradford City Council and the Health Committee approved a five-year development plan for the provision of new clinic premises throughout the city. *"Attention had been given to the desirability of close co-operation between the local health authority services and the general practitioners in those premises. In September 1959, a meeting had been convened by the Clerk of the Bedford Executive Council to discuss the provision of surgery accommodation on a new housing estate which, when fully developed, would house approximately 10,000 people. It was agreed that there was an urgent need for surgery premises and that the local authority should be requested to consider providing them in association with the local authority clinic to be erected on that estate. At a subsequent meeting, to which all general practitioners in the City had been invited, some sixteen doctors indicated their interest and subsequently the City Council had approved premises comprising three surgery suites on the estate. The interested doctors had been kept fully informed at all stages of the development, and frequent meetings had been held to discuss the layout of the surgery accommodation. Decisions had been reached only after close consultation. Eventually a rent of seven shillings a session of one hour was agreed, since in all cases the accommodation was only for branch*

*surgeries. The clinic and practice centre had been opened in March of this year (1963) and was proving extremely successful. (Douglas J. 1963)*

It must be emphasised that these premises were not a Health Centre and did not come within the scope of the National Health Service Act, 1946.

*“The real purpose was to encourage an even closer understanding and working relationship between the different members of the local health authority team and the family doctors.”*

In 1952, an annotation in ‘The Lancet’ (Vol 1 p.713) entitled “*The General Practitioner and the Health Visitor*” recorded that “*the City of Birmingham have seen an opportunity for closer co-operation between the health visitor and the general practitioner, and have sought to reaffirm the family as the unit of medical care. They regard the general practitioner as the medical officer of the family unit, and logically the health visitor should now become his aide instead of being based in a municipal clinic. To this end, no more traditional clinics were to be built. In new housing areas, the health visitors were to join forces with local general practitioners. Not only may the general practitioner use the health visitor in his surgery, but he is also free to hold ante-natal and post-natal clinics at the local authority maternity and child welfare centres.*”

A by-product of this proposal will be efficiency, economy and goodwill. On these foundations the hoped-for health centres of the future can be built.



## **THE ADEQUACY OF EXISTING CO-OPERATION**

*“A Postal Inquiry among General Practitioner Principals” (British Medical Journal Supplement, 1953 pp 105-131)* was carried out by a Committee under the chairmanship of Dr C.W. Walker. Among other factors, they recorded the opinion of the general practitioners on the degree of co-operation with the members of the public health nursing service. Also recorded was the opinion of the individual doctors as to whether the degree of co-operation had increased or decreased during the previous five years, that is, since the inception of the National Health Service.

	<u><b>Public Health Nurses</b></u>	<u><b>Midwives</b></u>	<u><b>District Nurses</b></u>
Replied:	339	310	310
No change in co-operation	75%	63%	76%
Improvement	10%	8%	12%
Deterioration	10%	11%	6%

### **Health Visitors**

Satisfactory Relations:	56%
Unsatisfactory	20%
Little or no contact	24%
Total replied:	334

Most criticism related to the local authority maternity and child welfare clinics, and to school clinics. The Committee recommended as a result of this Inquiry that each general practitioner in an area should have a district nurse attached to his practice. Both the doctor and the nurse

would gain by the personal contact and common interest arising out of attachment. The patient would be happier with a district nurse whom he could identify with his doctor's practice.

A Questionnaire from the Postgraduate Education Committee of the Council of the College of General Practitioners produced the following information on the ancillary help used by the 1,664 doctors who replied:

Nursing:	a) district nurse	1,352
	b) nursing staff of local hospital	321
	c) a nurse in the surgery	204
	d) a private nurse	6
	Total	<hr/> 1,883 <hr/>

*“In addition, five male nurse receptionists were employed. A person employed in more than one capacity may have been shown more than once. Again staff shares by two ‘members’ may be mentioned by both, and so appear twice. The figures, therefore, give a measure of the number of doctors employing such help, rather than the actual number of helpers employed”. (Journal of the College of General Practitioners 1958 Vol. 1 pp. 36-41)*

In the *“Report on Co-operation between Hospital, Local Authority and General Practitioner Services”* to the Central Health Services Council, under the Chairmanship of Dr F. Messer, was recorded the opinion that: *“We must make it clear that we are not satisfied with the present degree of co-operation in the National Health Service.”*

*It was considered that the problems of co-operation were aggravated by: 1) The tripartite structure of the National Health Service, with “no advisory co-operation” and 2) The problems of numbers and geography.*

## THE FAMILY DOCTOR IN PREVENTIVE MEDICINE

*“The most important concept of the century in the field of medical care is the idea that preventive medicine is an integral and necessary part of the everyday practice of medicine.” (Smillie W.G. 1951)*

*“We begin to perceive the outline of a new physician scientist and social worker, prepared to co-operate in team work and in close touch with the people he serves: a friend and leader, he will direct all his effort towards the prevention of disease and become a therapist when prevention has broken down - the social physician protecting the people and guiding them to a healthier and happier life.” (Sigerist H.E (1941)*

In the General Medical Council interim - unpublished - report on health centres, recorded in the Report of the Council for the year ending December 1950 is the following statement: “The full use of the health visitor as well as the home nurse and the midwife and the recognition of the need for a home help, may all, in different ways form part of the preventive and curative aspects of the general practitioner’s work and may if properly used together lessen the burden on the hospitals. These resources may, if properly employed, enable a patient discharged from hospital to recuperate more rapidly at home. Experiments along these lines are being tried out for instance at Cambridge, with promising results.”

*“The major activities of the doctor in private practice are usually confined to curative medicine, while the public health team is engaged primarily in preventive and promotional health services. This distinction is admittedly artificial. It is not always easy to distinguish between the preventive and curative phases of medical care. Invariably, the interests of the public health team and the private practitioner will merge and overlap. Because of this coalescing of objectives and services, there is abundant opportunity for individual patients, families and community groups to receive better services when the doctor in private practice and the members of the public health team find ways of working together. This can be described as the synergistic relationship between the doctor and the public health nurse. “There is a great deal of evidence that the work of both doctor and nurse is made more effective through their co-operative activities.” (Coulter P.P. 1954)*

“New drugs and procedures, health visitors, district nurses, home helps and other ancillary workers enable him to treat at home or in his surgery many cases formerly sent to hospital. Preventive medicine can no longer be separated from curative and the general practitioner should ultimately be responsible for most, if not all, of the clinical work at present coming within the scope of the local health authority. He cannot do everything himself, but, as patients come to him first, he would be the co-ordinator of all those services and his would be the ultimate responsibility. His spheres of activity would increase rather than diminish and with the lessening incidence of many infectious diseases there will be more time to devote to the increasing problems of our day which are grouped very loosely as ‘psychosomatic’ diseases. All this is what I understand by good medical care.” (Slugett J. 1961)

## INTERNATIONAL TRENDS

The modern concept of family care is that in which the doctors, nurses and social workers, whose common interest is the maintenance of family health, work as members of a team. This concept, however must not be considered only in relation to the services needed in Great Britain. The progress that is being made in this country in family care is representative of a world-wide movement. One can here only mention brief examples.

For instance in the U.S.A a great deal of *interest is being shown in the 'Home Care Plan' organised from Montefiore Hospital in New York.* "Does the home care program give to the medical social worker the resource she needs when the hospital has made the decision that a given patient no longer requires a hospital bed? Does it bring physician and social worker together, at long last, and relegate their estrangement to the pages of history?" (Bluestone E.M. 1954)

Also arranged by the Montefiore Hospital is the '*Family Health Maintenance Demonstration*' in which a number of families are subject to regular examination by a team consisting of physician, public health nurse and psychiatric social worker. The social worker and the public health nurse "supplement and complement the medical and teaching aspects of the doctor's job." (Silver, G.A 1954)

In Canada, in 1946 '*The Manitoba Health Plan*' was announced. It was proposed to have a '*Medical Nursing Unit*' and '*Doctors' Workshop* in every town or village where a doctor practises, containing an office, examining room, emergency room, 6-12 beds (maternity and medical) labor room and nursery. (Jackson F.W. 1949)

In the Netherlands, the general practitioner and the medical officer of health work very closely together. The public health nurse is paid by the government, but works under the clinical direction of the general practitioner. She is concerned in country districts with the general nursing care of the community, domiciliary midwifery and immunisation. She meets the general practitioner at frequent intervals. The home care 'team' in the Netherlands consists of the doctor, district nurse, health visitor, midwife, school teacher and clergyman.

In Czechoslovakia *“The organisation of the Czechoslovak health service is based on the health district-borough system. About 4,000 citizens are under the care of a district doctor who, if necessary, visits his patients with the district nurse at their homes.” (Plojhar 1958)*

To come nearer home, the British Armed Forces are now beginning to care for the individual as a member of his family. *In 1963, J. Fry visited Germany to see the Royal Army Medical Corps family care units at work. It is significant that he called his article “General Practice in an Ideal Setting.” He found general practice taking place in good premises with adequate clinical and diagnostic equipment, with auxiliary staff, with good support from the hospital and public health services, and an organising authority which gave fullest help with least interference.*

## THE CHARACTERISTICS OF A TEAM

*“The workers who co-operate in their efforts to make health services optimal may constitute a team, or in some situations, a group of teams. A team may be thought of as a group of individuals who have found it expedient to work together than to work alone. Because of the symbiotic nature of the relationship, group activity is of mutual benefit to workers and to consumers of service”*

*“The group working together as a team has some distinguishing characteristics which may be listed as follows:*

*They establish common objectives*

*They recognise the essential role of each member*

*They accord each other status*

*They agree to subordinate personal interests to the welfare of the group*

*They recognise that all will succeed or fail together*

*They realise that the team is bigger than the sum of its component parts.”*

*(Coulter P.P 1954)*

*The World Health Organisation Report No 257 (1963) on “Training of the Physician for Family Practice” is of the opinion that: “At all stages in the training of the family doctor, increasing attention should be paid to the development of the skill of working with auxiliary and paramedical personnel. Well organised co-operation with properly trained paramedical and auxiliary personnel would multiply the effectiveness of the physician’s work.”*

Similarly, in the General Practice Teaching Unit of Edinburgh University, *“An attempt is made to bring together all the necessary skills and to integrate these in such a way that the whole person is treated.” (Scott, R 1950)*

*“The patient, however, must always be our first concern, and the patient will only get the best service if all the different types of nurses work closely together so that each knows what the others are doing and knows the services which each can render to the other. There is also a need to integrate more closely the work of the nurses with that of other social workers, many of whom are employed by local authorities, and to establish a closer link with the general medical practitioner.” “Ancillary help should be designed primarily to provide for the*

*doctor; trained persons to whom he can delegate duties and responsibilities, thus gaining for himself more time to devote to the care of the patient, and secondly, to give direct help to the patient.” (Journal of the College of General Practitioners 1958 Voll pp 36-41)*

## DISCUSSION

The family is generally considered to be the unit of our civilisation and it is on this family unit that most social and economic measures are based. Nevertheless, it has only in comparatively recent times been widely accepted that the family, rather than the individual, must become the unit of health care. It is only within the framework of the family that care can be effectively directed towards the individual.

The general practitioner of yesterday is re-orientating himself more and more to become the family doctor of today. Because of his sincere belief in the health and welfare of the family, he is in many cases leading the trend towards comprehensive family care. The good family doctor considers that his brief is the best possible care of the individual, within the family, 'from the cradle to the grave'.

It is an almost universal experience of family doctors that their time is being taken up to an every decreasing extent with the problems of curative medicine, due largely to the increased effectiveness of modern therapeutics. In its place are the problems of preventive medicine. The hopes of any future medical utopia are largely centred in the extension of the principles and practice of preventive medicine.

The Report of the Porritt Committee anticipates a future in which *"real co-ordination of preventive and curative medicine must be achieved by one doctor undertaking both, or by two people working very closely together."*

I have considered the very considerable army of medical, nursing and social workers who are all concerned with some aspect of the care of the individual and the family. The number of different workers who may at any one time be visiting the home to advise on medical and social problems may introduce its own problems. Conflicting advice may lead at best to none being heeded and at the worst to distrust and animosity. Yet as the *Younghusband Working Party* point out *"the real problem of 'multiple visiting' is the multiplicity of independent and uncoordinated visiting."*

I am firmly of the belief that the only effective answer to this problem is for there to be the greatest possible degree of co-operation between the various workers. I believe that a 'team' of health workers must be formed and that this team must have official backing and

encouragement. I have considered in detail a few of the many schemes in which Local Health Authority workers have been attached to general practitioners and I am impressed by many advantages that have been found to derive from such attachments. The enthusiasm of attached personnel is a striking indication of the stimulus to more effective care that follows an attachment. A desire to continue and extend schemes of attachment is almost universal amongst those who have been fortunate enough to have first hand experience of its value. Opposition to attachment is rarely found amongst those who have had the opportunity of working closely with other related workers.

In the Technical Report on the 'Training of the Physician for Family Practice' the World Health Organisation say that the family doctor *'has responsibility for creating an atmosphere of team work by balancing the delegation of responsibility with adequate supervision'* It is my contention that the family doctor has the additional peculiar and special responsibility of acting as a means of liaison between the patient and the other workers. *The family doctor is the only person who has a common interest, in the patient and the family, with each and every other worker.*

In any team there must be a leader, and I agree with *Dublin and Fraenkel* in *"The Family as a Unit of Health"* (1949) that *"The family or general physician must be the focal member of the medical team, the co-ordinator of all services."*

Because of his traditional close contact with the patient and the family, over a prolonged period of time, he occupies a unique position in family care. *"There can be no serious contender for his position as 'conductor of the orchestra' (Townsend E. 1962)*

The medical officer of health on the other hand only comes into contact with certain members of the family at vulnerable periods in their life, almost entirely through the medium of local authority clinics. He is rarely in a position to treat the whole person and even more rarely, the family. However, the medical officer of health has a unique experience in administration of medical services. He it is who must continue to be directly responsible for the organisation of local health authority workers and for ensuring that they are available to work at all times under the clinical direction of the family doctor.

It would seem to me that the future of the medical officer of health will be as a Consultant in Social Services, who may be called upon to advise the family doctor and the hospital service

in all aspects of social care. His unique knowledge of all the members of the health team, as well as of all the facilities available, would be invaluable in domiciliary consultation and as important as his function as administrator for the social services.

Unfortunately, the public health doctors at the present time (1963) are largely duplicating the work of family doctors and there seems to be a fear of losing authority and a distrust of innovation here. At times, and in places, there seems to be a 'cold war' between 'Town Hall medicine' and general practice, and the initiative in ending this must come from the medical officer of health. There should be regular meeting between the family doctors and medical offices of health to discuss common problems.

As far as the work of the family doctor is concerned, medical officers of health can only gain by raising the status of their work to consultative and administrative level, rather than competing with the general practitioner in the clinical care of individuals. Many medical officers of health now see their prime function to be that of providing support to the family doctors of their area. I hope that in the future many more will identify themselves with this aim.

It is becoming more widely recognised that general medical practice, to be organised effectively, must make use of ancillary help. *"A doctor should not himself undertake what can be properly delegated to a non-medical assistant"* (Cohen H. 1954) To this end, and because he it is who has to work in close co-operation with the ancillary workers, the family doctor should himself select, as far a possible, the team members with whom he is going to work.

Lord Cohen also recommends that *"general practitioners should be co-opted to all statutory local health committees"* and that *this should be an obligation, not discretionary as at present. Only by full recognition of his experience and need, and only by acceptance of his advice on organisation and selection of personnel will the family doctor gather around himself the trained persons to whom he can "delegate duties and responsibility thereby gaining for himself more time to devote to the care of the patient, and secondly, to give direct help to the patient."* (Education Committee of Council of College of General Practitioners 1955)

When health personnel are attached to a family doctor, there is a great need for them to identify themselves completely with the practice, to the extent that they are no longer 'working from the County Hall' but rather 'working with the family doctor'. To assist this transition, artificial geographical limits should no longer be imposed on attached personnel, but they should be permitted and encouraged to identify themselves completely with the area of the practice.

It has been found as a matter of experience that independent motor transport is essential for all attached personnel who are responsible for care in the home. This should be provided as a matter of course.

The number of single handed family doctors in the country is continuing to fall as more partnership and group practices are formed, and this in itself must be an additional spur to the formation of health teams. It is relatively more difficult to attach personnel to a single handed doctor than to his colleagues practising in a group. In rural areas these difficulties can be overcome, and every effort should be made to provide single handed doctors with ancillary assistance. It must be realised though that this will not be as economic as providing the service to partnerships or groups.

"Health and Welfare" and "The Hospital Plan" both make provision for an increase in the domiciliary care of the seriously ill in the future. Coincident with this, the mental welfare service and services for other specific groups within the community will all make increasing demands on the domiciliary services. It is therefore of great importance that the domiciliary service should have adequate financial provision. The home care services can no longer be run on a financial 'shoe-string' as in the past. Coincident with an increase in domiciliary care will be a decrease in the need for institutional and hospital care. It may well be found that staff and finance are being diverted from 'hospital' to 'home care' programmes. It must not be forgotten, as Miss E. J. Merry has pointed out (*Symposium: 'Cooperation between the Nursing Profession and the General Practitioners 1956*) that "*Home treatment, even with full use of home helps and other ancillary services, costs less than half the expense of a hospital bed.*"

Unfortunately, the tripartite system of our health service means that the three branches are financed individually, and the incentive to make a saving in one branch such as hospital care, disappears when it means extra expenditure in another department. Similarly, there is little

incentive for the local health authority to spend money on providing extra nursing staff to help general practitioners when the saving in the doctor's time represents a profit to the doctor, and not a credit to put against the debit in the local authority's accounts.

The Porritt Committee (1963) have advocated the setting up of an 'Area Health Board' as a means of overcoming this: the first of.. *"three outstanding problems in medical care today. Firstly the integration of the three branches of the National Health Service... (Warren M.D 1962) for... "It was surely the greatest defect in the National Health Service that its administrative division of the medical services into three branches intensified and perpetuated existing divisions, gaps and overlapping which should not exist at all. (Townsend E. 1962)*

With the finance and central organisation of the health service under one Area Health Board, a proper appreciation of the needs of the family care programme should be possible.

There is a shortage of all family care workers, not least of family doctors, and this shortage will probably intensify in the years to come. The proper distribution of personnel within the area will be the responsibility of the Area Health Board.

The surgery nurse is a valuable member of the family doctor team. When properly employed, her duties are precisely those which could be carried out by local health authority workers, and yet she is paid entirely by the family doctor, in those cases where he can afford to employ her. Her main duties are those of doing dressings, assisting at minor operations, and giving injections and inoculations. *I therefore deplore the attitude of the Minister of Health, when in his Annual Report for 1953 he says:*

*"Good cooperation between the district nurse and the general practitioner was well established before the appointed day, and the introduction of the National Health Service has called for little in the way of special arrangement in this respect. In some areas, indeed, it has been necessary to resist the tendency on the part of some general practitioners to make extensive demand on the services of district nurses for attendance at their surgeries for the purpose of giving dressings and other nursing attentions."*

Rather do I identify myself with the *Report of the Cohen Committee 1954* who state: *"Another way in which co-operation between the general practitioner and officers of the*

*local health authority may be improved, would be by an increase in experiments in which home nurses arrange to help doctors at their surgeries, In principle, there should be no objection this where the staff is available.”*

In fact, I would go further, and I believe that every group practice should employ a surgery nurse who should quite properly be paid by the Area Health Board or other central body. In those practices which are too small to employ a full-time surgery nurse, the local health authority should allow a home nurse to attend the surgery on one or more occasions each week for the purpose of carrying out dressings, inoculations and injections and similar procedures.

The overall gain might benefit the doctor incidentally, but patients in the country as a whole could only gain from the increased efficiency.

Local health authority ante-natal clinics, infant and child welfare clinics and the school medical service, grew up at a time when most people could not afford adequate family doctor services. They have served a very useful purpose in promoting the health and welfare of vulnerable sections of the community. I believe that there is no longer any need for these services in their present form, and that they provide a re-duplication of service which can no longer be afforded, and which is no longer necessary. All these clinics should now be either organised by the family doctor at his surgery or group practice premises, or run under his clinical direction at local authority premises. The only exception I believe to this general rule should be in the case of specific specialist functions of the School Health Service.

*“If every general practice had adequate secretarial and nursing help, the partners would have ample time to give adequate service to all their patients.... The function of the Medical Officer of Health is not to take over the work of the family doctor; it is to provide him with the nurses, health visitors and home helps who will allow him to provide his patients with that continuing care which it is his duty - and ambition - to provide.” (Editorial, Medical News, November 1st 1963)*

Many volumes could be filled with all that has been said and written about the value of co-operation in family care. One is left with the question: Why is it that so little has been put into practice?

The incidence of co-operation is undoubtedly increasing, but much remains to be done. A lot of difficulty stems from a conservative attitude and distrust of innovation on the part of all the individuals concerned. Logically put, the case for co-operation seems unassailable, but how many of us can look logically at our own problems and take the necessary 'logical' action? It is easy for an on-looker to take an impartial view of the subject, but the majority of individuals in the service are too close to the problem to see it dispassionately. It is to be hoped that they will be given a lead by official action to implement the many official recommendations.



## CONCLUSIONS

1. A team of health workers should be organised under the leadership of the family doctor.
2. The Medical Officer of Health should become a consultant in social services and administrator of these services.
3. It should be obligatory for family doctors to be represented on all statutory local health committees.
4. The family doctor should be concerned in the selection of personnel with whom he is to work.
5. All attached personnel should identify themselves with the area of the practice in which they are working. Independent motor transport should be provided.
6. Increased finance should be made available for the greater provision of domiciliary care of the chronic sick and the handicapped as envisaged in the Ten Year Plan.
7. The tripartite system of administration of the health service should be replaced by Area Health Boards as envisaged in the Porritt Committee Report.
8. The importance of surgery nurses should be recognised and they should be paid, as are other ancillary workers, by the local health authority.
9. Group practice and health centre practice should be encouraged further.
10. Local authority clinics should be under the clinical direction of the family doctor, and where possible, should be run from shared premises. They should eventually be completely integrated with the family care programme.



## SUMMARY

**Introduction:** A brief outline of the scope of the dissertation

**Family Care Workers:** This is a short historical review of the various professions: medical, nursing and social who have developed a common interest in the care of the individual and his relationship to the family. The current responsibilities in the care of the family held by: family doctors, home nurses, home midwives, health visitors, social workers, home helps and night watchers, and Medical Officers of Health.

**Official Reports and Acts of Parliament:** The relevant parts of the following Reports and Acts of Parliament have been mentioned:

The Dawson of Penn Report	1920
The Medical Planning Commission	1942
The Beveridge Report	1942
The National Health Service Act	1946
The Cohen Report	1954
The Hospital Plan	1962
The Hospital Plan (as revised)	1963
The Porritt Report	1963
Health and Welfare	1963
The Gillie Report	1963

**Co-operation between the Workers:** A discussion of the various forms which communication and cooperation can take.

**Attachments Schemes:** Instances are given of schemes of attachment of individual local authority health staff to general practitioners. The comprehensive schemes involving the multiple attachments of local authority staff are described in more detail.

**Ancillary Staff employed by doctors:** The place of the surgery nurse and social workers in family care is described.

**Forms of Medical Practice:**

Partnerships and Group Practices  
Health Centres  
Diagnostic and Treatment Centres

**The Care of Special Groups:** Certain vulnerable groups in the population are recognised as requiring special care. The way in which the care of these groups is related to the care of the family as a whole is discussed.

**Local Authority Clinics:** Instances of a number of authorities that are developing their clinics in a rather revolutionary way, bringing the family doctor into the clinic as medical officer.

**The Adequacy of Existing Cooperation:** The results are given of some enquiries, including the postal enquiry among general practitioner principals in 1953 and an enquiry on ancillary help by the College of General Practitioners in 1958.

**The Family Doctor in Preventive Medicine:** A discussion of the increasing importance of the role of the family doctor in the field of preventive medicine.

**International Trends:** A few brief examples of the way that family care is developing in some other countries.

**The Characteristics of a Team:** Some reference, in general terms, to the features of a team and of the advantages of team work in the concept of family care.

**Discussion:** In the course of the discussion the following points are made, and some conclusions reached:

- 1: The concept of a 'family doctor' is discussed. Preventive medicine is forming an increasingly large part of the work of the family doctor.
2. The large number of workers concerned with family care is noted together with the problem of multiple visiting - which is essentially that of 'independent and uncoordinated visiting.

3. There is a need for the greatest possible degree of cooperation. The formation of teams of health workers, with official backing and encouragement, should take place. The role of the family doctor is that of leader of the health team.
4. The role of the Medical Officer of Health in the team should be that of consultant and administrator of social services.
5. There is an unnecessary duplication of services in local authority clinics and also a need for an increasing number of ancillary workers in medical practice.
6. It should be obligatory for family doctors to be represented on all statutory local health committees, and the family doctor should be concerned in the selection of personnel with whom he is to work.
7. Local health authority workers should identify themselves completely with the area of the practice and attached personnel should have independent motor transport.
8. There is relative difficulty in attachment of personnel to singlehanded practitioners. There are considerable benefits to group practice and health centre practice.
9. An increasing provision should be made for the domiciliary care of the chronic sick and handicapped as envisaged in the Ten Year Plan, and for this to be effective domiciliary services must be adequately financed.
10. The tripartite administration of the National Health Service should be replaced by Area Health Boards as envisaged in the Porritt Committee Reports.
11. The surgery nurse is very important to the efficient working of the family doctor. Her importance in preventive health care and her place in the health team tends to be overlooked. The surgery nurse should be financed by the Area Health Board.
12. Group practice and health centre practice should be encouraged further.

13. Local Authority clinics should be under the clinical direction of the family doctor, and where possible, should be run from shared practices. They should eventually be completely integrated with the family care programme.

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1858	Medical Act
1893	Education (Blind and Deaf Children) Act
1902	Midwives Act
1911	National Insurance Act
1918	Maternity and Child Welfare Act
1919	Nurses Registration Act
1920	Blind Persons Act
1926	Adoption of Children Act
1929	Local Government Act
1933	Children and Young Persons Act
1936	Midwives Act
1936	Public Health Act
1943	Nurses Act
1944	Education Act
1944	Disabled Persons (Employment) Act
1945	Family Allowances Act
1945	Nurses Act
1946	National Insurance (Industrial Injuries) Act
1946	National Insurance Act
1946	National Health Service Act
1948	Children's Act
1948	National Assistance Act
1948	Employment and Training Act
1948	Nurseries and Child Minders Regulation Act
1949	Nurses Act
1949	Adoption of Children Act
1949	National Health Service (Amendment) Act
1950	Medical Act

1950	Adoption Act
1951	Midwives Act
1956	Medical Act
1956	Dentists Act
1956	Family Allowances Act
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