The role of the visiting doctor in primary care clinics

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Abstract

The concept of doctors visiting clinics to support primary health care is well established but the role that these doctors should play is not clear, and varies from area to area.

As an approach to understanding the possible roles of visiting doctors in order to assist District Management Teams to produce job descriptions for such doctors, groups of clinic nurses in 2 districts in North West Province (Odi and Brits) were interviewed in focus groups. The question posed was, "What do you think about the role of the visiting doctor at your clinic?"

From the analysis, which was validated by participants from the groups, a number of key themes emerged. Many BENEFITS were identified which indicate that the role of the visiting doctor is a valuable one; benefits were attributed to patients, clinic staff, the clinic as a whole, the hospital and the service. However, there are also NEGATIVE EFFECTS, which arose as side effects of doctors' visits, mainly centred around issues of relationship with staff and patients, and sub-standard medical practice, which serve as a warning to all those involved. RELATIONSHIPS were identified as a central issue, which determines whether the visiting doctor's role is a negative or positive one. A number of CONSTRAINTS AND CHALLENGES emerged which need to be addressed, by doctors, nurses and, especially, District Management Teams, as these are thought to be critical for the development of the service.

Across all the themes there emerged a series of CONTRASTS which on the one hand highlight the potential for improved health care where the visiting doctor's role is clearly understood and the doctor is functioning optimally, but on the other hand show the potential for harm and discouragement where the doctors' visits do not serve their purpose.

Recommendations to optimise the role of the visiting doctor, which emerged from the groups, included the involvement of administrators to address some of the constraints, orientation and training of doctors, developing respect as a basis for teamwork, and ensuring networking and co-ordination. *(SA Fam Pract 2003;45(6):11-16)*

INTRODUCTION

Since the District Health System has been implemented as the vehicle for Primary Health Care in South Africa, the role of primary care clinics has become more significant. They are clearly seen to be at the forefront of the delivery of health care.

Professional nurses with varying degrees of training in primary health care run these clinics. Often they are supported by visiting doctors, employed by the district hospital or by the district itself. These doctors visit the clinic on a schedule that varies from monthly to daily, depending on the situation and the need. They usually review patients referred to them by the primary care nurses.

There has been debate in medical circles about the exact role that visiting doctors should play in such situations. The suggested tasks for these visits range from a consulting or teaching role to a broad involvement in the support of the clinic's primary health care function.

The issue of the role of the visiting doctor was discussed extensively in 1999 and 2000 on the Doctors' Dialo-

gue e-mail discussion list (known as Mailadoc) and on the District Health System e-mail discussion list (dhs-l), both hosted by Healthlink. The question of whether doctors should play a supervisory role, or should visit the clinics at all, was raised. As far as we could ascertain, none of the contributors were clinic nurses.

Health Systems Trust has published an issue of HST Update on the changing role of the clinic nurse, but this did not address the role of the visiting doctor[1]. No other published literature relevant to a South African context, nor articles on the issue of what clinic nurses want from visiting doctors could be found. It is to deal with this gap that the current research was conceptualised.

A BMJ editorial noted that there are few studies looking at the interactions, conflicts and collaborations between nurses and doctors, and called for more research so that interventions aimed at improving doctor-nurse collaboration can be developed[2].

While nurses and doctors usually value their collaboration with each other, their inter-professional relationship is often characterised by conflict, and is in most cases dominated by medicine[3]. Working together in collaboration, rather than simply working alongside, can energise both doctors and nurses and lead to new ways of facing problems and developing solutions[4]. We are not aware of any formal attempt to address this in the South African context. At the primary care clinic level, a first step in this process may be for doctors to understand what nurses expect from them.

The aim of this research was to understand how clinic nurses perceive the role of visiting doctors in order to make recommendations to District Health Management Teams and doctors visiting district clinics.

The context for this study was the Odi and Brits Districts, in the North West Province, which have 21 and 9 clinics respectively.

METHODS

Study design:

A qualitative study, using focus group interviews for data collection.

Having obtained agreement from the District Management Teams, representatives of each of the clinics in the Brits and Odi districts were invited to participate at central points. They were requested to discuss the issue of the role of the visiting doctor at their respective clinics prior to attending the meetings. Data was then collected during three focus group sessions, which consisted of 12 (Brits), 11 and 5 (Odi) professional nurses.

NM, a professional nurse, facilitated the groups using the exploratory question, "What do you think about the role of the visiting doctor at your clinics?" Each group session was video- and audiotaped, and lasted 60-90 minutes. Verbatim transcriptions were analysed by the research team using content analysis, through cut-and-paste and integration, to understand the themes.

The results were validated by taking the draft analysis back to at least two of the participants of each group for comment and feedback.

RESULTS:

(See Table 1)

1. Benefits of visiting doctors

The respondents were of the opinion that doctors play a significant role at the clinics and their visits benefit the personnel in a number of ways. Doctors provide clinical support and backup to the nurses. *"As a primary health care nurse I benefit from the doctor because if I assess a patient and not knowing what to do, the abnormality that I find on the patient, when the doctor comes to the clinic I am able to present the patient to the doctor we can make a diagnosis and that is what I am gaining from the doctor."* This interaction is an important source of knowledge. *"I am gaining from the doctor unlike when a patient goes to hospital."* This is particularly so when the doctor is a good teacher: *"And then he is also teaching us a lot and we are sort of not doing unnecessary referrals to the hospital."* The doctors also help in reducing the workload.

Patients experience a direct benefit from visiting doctors. The visits to the clinics by doctors help in reducing the travelling cost. Doctors are seen to provide comprehensive care at the

Table 1: Themes identified

Benefits of visiting doctors
1. To patients 2. To staff 3. To the clinic 4. To the hospital 5. To the service
Negative effects of doctors' visits
1. Blaming nurses 2. Poor relationships 3. Patients being sent away 4. Poor feedback 5. Doctors not known to patients and staff 6. Lack of knowledge of procedures/ protocols 7. Discontinuity 8. Not examining patients
Constraints and challenges
1. Lack of management support 2. Lack of skills 3. No orientation 4. Lack of equipment 5. Divergence in ways of working 6. Language problems 7. Inadequate time with patients 8. Community preferences
Relationship issues
1. Respect 2. Attitude 3. Teamwork 4. Continuity of relationship 5. Support
Contrasts *(apparent across all themes – see table 2)*
1. Quality of visit 2. Satisfaction 3. Respect 4. Quality of the doctor 5. Continuity of care 6. Commitment 7. Support 8. Attitude
Optimising the role of the visiting doctor (recommendations)
1. Involvement of administrators 2. Orientation of doctors 3. Instilling specific skills 4. Appropriate allocation 5. Respect 6. Teamwork 7. Networking 8. Co-ordination

clinics and address a multiplicity of problems presented by the patients, also helping in resolving undifferentiated problems for the patient. The doctors' visits to the clinics can be a source of trust for the patient. *"If you take a patient to the doctor she feels proud, she feels she is wanted you know she is accepted and then easily takes up the instructions."* Patients enjoy the comfort of being managed near their homes in a familiar environment. "C*ulturally however they really do not want to be referred to hospital so they normally stay at home with whatever condition they are having... now we need a doctor at the clinic I should think a lot of diseases will be prevented."* Patients benefit from being managed by a team. *"The patient is also stress free because once we are not sure of other things we refer the patient to the doctor."* Doctors may admit patients directly to a hospital ward, which improves patient satisfaction. *"I think it is very much important that when the doctor sees the very aged clients he admits that he will write the admission form and then he admit them to the particular ward he wants them to go to and he will also take blood, take the patient to the hospital he is attended to immediately. There is no need of saying go to OPD, x-ray so that is very much preferred for him"*

The clinic as a whole also benefits. Medication that is not on the essential drug list and which nurses are not allowed to prescribe is supplied to the clinics, which are visited by doctors. *"We are concentrating on the EDL of which some of the medication for emergencies is not met. So we order it for the visiting doctor."* An example of a benefit cited at one clinic was a relationship with the doctor that included him being available telephonically at all hours. *"We have also build a relationship with [the doctor] even if when he is off-duty we can phone him."* The visiting doctors are important members of the health care team; their presence enhances the functions of the team and gives confidence to other team members *"With combined ideas you are able to reach the goal." "He has confidence in us, that means good teamwork and good team spirit."*

Doctors' visits to clinics are also seen to bring benefits to the hospital, in that they reduce referral of patients to the hospital, and they follow up patients who are discharged post-operatively. Also doctors are instrumental in the promotion of preventative activities, in the management of chronic diseases and in the implementation of new programmes, benefiting the service as a whole.

2. Negative effects of the doctors visiting the clinics

The respondents described negative issues arising from the doctor's visits. Doctors blame nurses for the way they treat the patients and other shortfalls in the system. *"The doctor would say that the nurse who referred you doesn't even know the work. If the doctor feels that the nurse doesn't know her work why doesn't the doctor do it in writing and not through the patient? Because the doctor saying this to the patient, the patient is losing trust." "When the clinic doctor arrive he will be blaming the sisters that they receive the client and refer the client to him. That it was not necessary for the nurse to refer the client."* Some doctors lack respect for nurses and this filters down to the care of the patient. The nurse feels undermined and degraded by this behaviour. *"If the very doctor talks nasty to a patient and he is your visiting doctor, how are you going to work with that doctor? That very doctor says too many things to the patient, that stupid nurse who is abusing the money and the patient said this to me. So I did not even know the structure of this doctor but I felt like I was going to strangle that doctor."*

Patients get tossed between the nurse and the doctor and between the clinic and the hospital. Due to lack of understanding of the clinic situation doctors in the hospital chase patients away to the clinics, while the doctor in the clinic is unable to cope with some patients and also has time constraints, so he sends the patients away. *"You refer the child to the hospital seeing that it is urgent and the baby needs to be attended immediately and the doctor at the hospital throw back the child." "We referred a pregnant woman with hypertension to the hospital and then the doctors at the hospital just referred her back. We have a visiting doctor only once a week so the woman had to wait for a whole week."* Poor feedback from doctors, mainly those based at the hospital, was discussed. *" We receive many clients from the hospital with referral letters that are not clearly written, others don't have venues and then the others having small signatures. So for us to send patients back to the hospital for the correction of these things needs money." "You had wanted to know about the outcome but you find that you get nothing."*

Some doctors are not even known to the clinic staff and patients. They do not introduce themselves and so patients at times would not recognise them as doctors. *"You know there is the joke of one patient ... She was not aware that this was the doctor so she went back to the queue and queued again."* There is no effort by these doctors to create rapport and join the team. There is a lack of continuity in the care of patients because the doctors in the clinic either do not come or are changed too frequently and there is no time to create rapport.

The nurses in the clinics feel they do not know the rules that guide the work of the doctors. Of concern is the number and type of patients the doctors are supposed to see. Because of this lack of knowledge there is no co-ordination of activities. Some of the doctors visiting clinics do not examine patients. *"You will find that the doctor sees the patient in the clinic and sometimes he is negative to all patients or he does not even examine the patient and again the treatment is not good and so he decide to refer the patient."*

3. Constraints and challenges

There were a number of constraints and challenges noted, which need to be addressed in order to improve the system.

Lack of support by the management was identified as a major constraint in the functioning of the visiting doctor. The nurses identified lack of transport and medicines as having serious implications.

Some of the doctors visiting clinics lack skills that are essential for primary health care, such as in the management

of psychiatric illnesses, the Integrated Management of Childhood Illnesses (IMCI) and prescribing skills.

The nurses identified that the doctors sent to the clinics never get an orientation about the system and their role. They just appear at the clinic without knowing what is expected of them.

All the groups mentioned the problem of lack of equipment. *"Because sometimes we don't have enough equipment at the clinics ... then if the doctor doesn't come with the equipment now she is going to run this way and that way by borrowing, using the same equipment."*

The respondents illustrated the divergence between nurses and the doctors in their ways of working. These differences were at times a cause of conflict. There is particular divergence in prescribing behaviour. *"They ignore the EDL whereas EDL is part of what they should be doing in the hospital". " Sometimes you see the doctor over prescribed a medication and then to us we are thinking about the side effect."* There are differences in the management of illnesses in children, particularly where nurses are trained in IMCI.

The nurses felt that language was a major constraint, as many of the doctors needed the services of the nurses as interpreters. This wastes time. The time doctors spend with the patients at the clinics is seen to be very inadequate. The doctor is always in a hurry due to other commitments, in the hospital or other clinics. The nurses viewed this as a cause of mistrust by the community. *"This created hatred between nursing staff and the community."* As a result, certain communities have a preference for the hospital.

4. Relationship issues

Issues around relationships between doctors and nurses and doctors and patients were commonly raised, both negatively and positively. Respondents indicated a need for respect – towards the nurse and the patient. *"It is appropriate that doctors respect their colleagues they work with."* Lack of respect was however quite common. *"Now I need to say doctors need to change their attitude."*

Lack of respect mitigates against teamwork. *"We need to respect one another whatever rank, we are the team."* One particular example of this attitude involved a staff member at a clinic, who *"was very ill and she was a patient from another institution but we felt the way the condition was she cannot be at home and she cannot wait for an appointment date to come to that institution. Since she is our personnel we need to give her as much care as possible... To our surprise she was cursed so much, the doctor said you are not our patient, why did you come here, wait for your appointment ... she went back home in that condition and we were depressed."* Where the attitude is good, the team is built up. "B*eing attended to by the health team as opposed to an individual who is a nurse but equally proficient makes this whole thing of caring more effective."*

An important aspect of a good relationship was clearly stated to be continuity, i.e. that there is a continuing relationship developing with the visiting doctor. This applies both for the clinic nurse and for the patient. *"The doctors they come and go and this one say this and that one say that and you find there is discontinuity of services and eventually the patients don't trust enough." "We have one or two doctors that are really known to us who would be coming to visit our patients ... so you create that rapport with the doctor."*

Nurses appreciate a relationship in which there is encouragement. *"He is interacting with us, and he doesn't say I am a doctor, he has confidence in us that means a good teamwork and good team spirit."* One respondent gave a practical example of this supportive relationship, where a doctor told her, "*sister I honour you now, so you should always have confidence, you should always know your findings are your findings and I am your colleague, and if I am wrong you shouldn't take it that I am right ... so we are working hand in hand."*

Nurses demonstrated an understanding of the pressures on doctors, in terms of their workloads, though this was not free of criticism. *"We understand the workload that doctors have got especially in the hospital but we expect that they treat our patients with respect."* As mentioned above, particularly aggrieving is the practice of some doctors to blame nurses for what goes wrong or to criticise the nurse in front of her patient. Poor feedback generally was seen to be a problem. *"It's appropriate that doctors respect their colleagues they work with and give feedback in an appropriate way, not through the patient... it makes patients to lose trust in the service" "Patients they say that those nurses know nothing and that was confirmed by the doctor, its unpleasant to people who are holding the fort all the time."* Fortunately this is not true of everyone. *"We don't have the same problem of getting feedback from the doctor."*

5. Integration

(See Figure 1)

The doctor plays an important role in terms of interaction with the nurses, other professionals, the clinic and the hospital, with relationships being a key factor. His/her visits do have significant positive effects, as intended, in the form of benefits to the patients, nurses, the clinics, the hospital and the system. Overcoming the constraints that exist leads to the overall goal of having better services and better patients. However, there are negative effects which may arise from unhelpful doctors' visits, which together with the constraints not being overcome, result in poor outcomes for patients.

Most of the issues came out in terms of major contrasts. The contrasts show how much difference can be made by an appropriate visit from the doctor as well as how much damage can be done by a dysfunctional doctor's visit. ***(See table 2).***

DISCUSSION

The positive role of visiting doctors to clinics cannot be over emphasised. The benefits of this service are best summed up by their relevance to the principles of Family Medicine, elucidated by McWhinney[5]. The visits enhance the principles of comprehensive care, continuity of care, preventative attitude, appropriate management of resources, promotion of teamwork and networks,

Figure 1: Overall schema

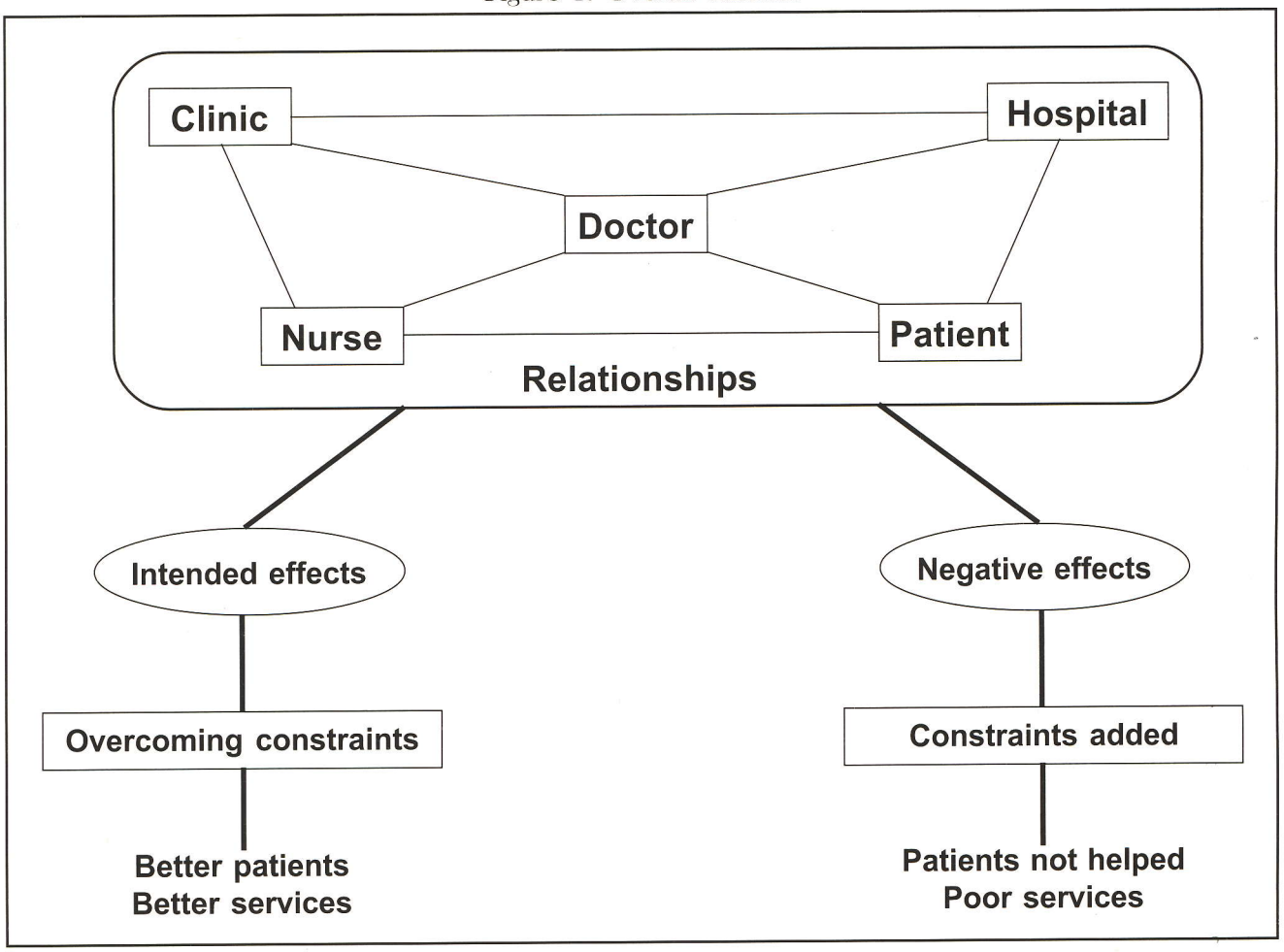

Table 2: Examples of contrasts identified.		
Good visit Good doctor	VS	Bad visit by the doctor Bad doctor
Patients very satisfied with the doctor's care because he greets them, examines them and makes follow up.	VS	Patients very dissatisfied because the doctors do not come, do not examine them or do not respect them.
Nurses very satisfied with the doctor	VS	Nurses very dissatisfied with the doctor
Good relationship between doctor and the clinic staff	VS	Poor relationship between doctor and the clinic staff.
Doctor respects and is committed to patients and nurses	VS	Doctor shows no respect for or commitment to staff and patients
Continuity of care with good patient care	VS	No continuity of care with negative influence on patient care
Doctor provides lots of support to staff and the clinic	VS	Doctor not supportive of staff and clinic.
Doctor has a good attitude toward patients and staff.	VS	Doctor has a poor attitude to patients and staff.
Doctor promotes teamwork	VS	Doctor does not work with the team
Supportive management	VS	No support by management

interest in the person of the patient, interest in the context and the provision of holistic care. It is a system with subsystems, which if functioning in harmony can have positive outcomes as was expressed by the respondents.

Doctors are certainly in need of a job description for clinic visits. However, beyond a job description, there is a need for guidelines for clinic doctors regarding their roles and the expectations on them, with an emphasis on communication and teamwork. Of course there is only a limited amount that guidelines can achieve, and perhaps orientation programmes, which include interpersonal skills, would achieve more. It is crucial that doctors appreciate the role played by other team members in the overall goal of good patient care. It is speculated that the problem starts at medical school where doctors are taught in a mode of being in-charge, being superior, etc, and not taught about relationships with colleagues, teamwork, etc. This is an

doctors, the staff from labour ward, the professional nurses from the district, the matrons of the hospital and the tutors from the Nursing College.

The purpose of the meeting was to reconsider the hospital policy on 'Indications for episiotomy'. The information from the literature review and the records review was presented. After an open discussion it was agreed to do a formal quality improvement project.

Topic

The topic was identified as "Indications for episiotomy".

The team

The team consisted of:

1. Tutors from the College who are responsible for Midwifery teaching.
2. Staff from labour ward.
3. The doctor in charge of the Maternity ward.
4. The doctor involved in training the Professional Nurses in primary health care.
5. The doctor in charge of the Gynaecology ward.

Standard

The standard in the literature was set at 'no routine episiotomies' and the rate of less than 30 % episiotomies per total deliveries.[6] There was clearly room for improvement. However, we did not set a specific standard for the hospital. There were some differences in opinion about a restrictive policy, though everybody agreed to keep in mind what had been discussed.

Present practice

Advanced midwives and professional nurses run the Labour ward. The doctor conducts only complicated deliveries. The policy and teaching by the professional nurses had been to perform a routine episiotomy on:

- All primigravidae.
- Patients with previous caesarean section who did not have a previous vaginal delivery.
- Gravida 2 patients where difficulty with the delivery is expected; and
- All patients with other indications for episiotomy, namely breech presentation, vacuum delivery, big baby, etc.

This resulted in 66,2% episiotomy rate (493 episiotomies performed over 745 deliveries) between the May and the November 1998.

Plan

The implementation plan was:

- To keep in mind all we discussed and learned at the meeting;
- To assess each primigravida delivery and see if a routine episiotomy could be avoided;
- To consider the other indications for episiotomy stated above still valid.

We decided to put it like this in order not to force change on this long established practice.

The atmosphere in the meeting was good. Everybody appreciated the purpose and the outcome of the meeting.

Measurement of implementation plan

From the 1st December 1998 till the 31st March 1999 there were 423 deliveries. According to the routine episiotomy policy 205 women would have had a routine episiotomy. Instead, only 107 episiotomies were performed on specific indications, e.g. big baby, vacuum extraction, breech presentation and tight perineum. There were no complications for the babies and some minor complications for the mothers ***(See Table I)***.

Evaluation of plan implementation

The episiotomy rate was reduced from 66,2% before the intervention to 25,3% after the intervention ***(see Figure 1)***. The episiotomy dehiscence rate was reduced from 2,28% to 0,7 %.

There had been a dramatic improvement in practice and outcomes. The team was of the opinion that this new practice was consolidated. From the records it appeared that the more experienced midwives were the first to have changed practice. Once all the other midwives had seen the positive results, they also had changed their practice.

Other gains were:

- Reduced workload for midwives to suture episiotomies;
- Saving on suturing and other material;
- Reduced admissions in the Gynaecology ward due to reduction of episiotomy dehiscence.

The Team was surprised that even though no strict standards had been set and no one had been forced to change, the results were good. A spirit of enthusiasm and achievement was evident amongst the team and the staff.

Patients were amazed for not getting an episiotomy and were very satisfied to go home after delivery without an episiotomy. This made them more comfortable and able to care for their babies.

Table I : Episiotomies performed on primigravidae

PRIMIGRAVIDAE DELIVERIES								
WITH EPISIOTOMY			WITHOUT EPISIOTOMY					
Month	**Done**	**Gaping at 5 day post-natal clinic**	**Not done**	**Skin nicks**	**1st degree**	**2nd degree**	**3rd degree**	**Vaginal tears**
DEC	39	1	19	1	3	0	0	4
JAN	18	2	32	0	0	0	0	0
FEB	16	0	23	1	0	2	0	2
MAR	34	0	24	4	1	1	0	5
Total	**107**	**3**	**98**	**6**	**4**	**3**	**0**	**11**

Figure 1: Episiotomy rates before and after the intervention

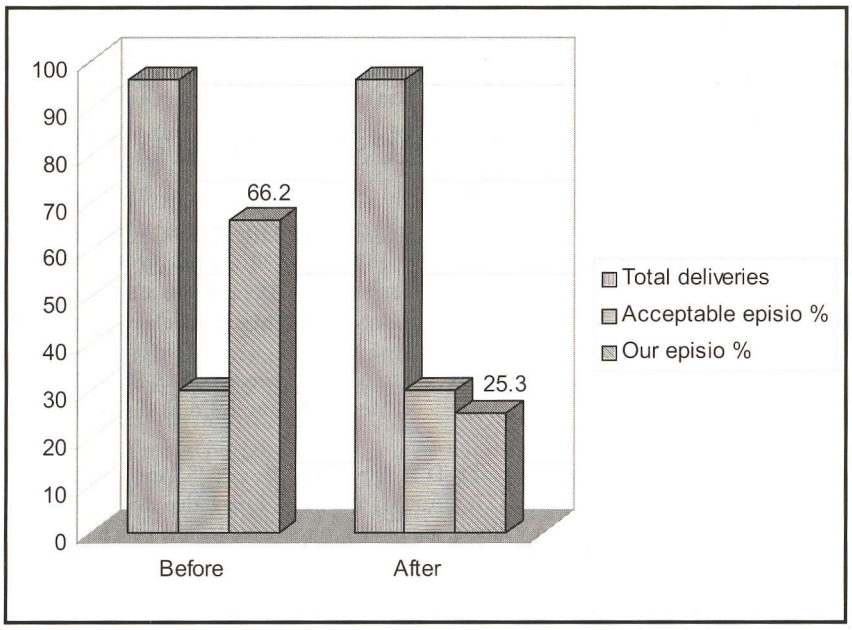

Table II: Principles of quality improvement
• Focus on the **Patient** Quality is improved by **Teamwork.**
• Understand and address **Processes Communication and relationships**.
• Use the best **Information Start Small Seek solutions Success.**

DISCUSSION

Reflecting on this project one can look at some principles of a quality improvement process ***(See Table II)***.

Focus on the patient

The wish to provide better care for a patient triggered the project. The process did not include patients as team members, which would have been better. Fortunately, the patients were very satisfied and the plan corresponded with their preference.

Quality is improved by Teamwork

The importance of teamwork is clearly demonstrated. Quality in primary care happens when a team is learning, changing and improving. A quality improvement project thrives on good teamwork and can enhance team functioning. The different roles in the team are not documented in this article. Aspects such as leadership, facilitation and management in teamwork are important and need attention.

Understand and address Processes

The process and history of a labour ward and the difficulty posed by a change was considered. That is why the strict standards and rules were avoided. An important aspect of the process was the fact that the most experienced team members took the lead. That inspired the rest of the team and led to positive changes.

Communication and relationships

The people in this team knew each other for a long time and this made it possible for the team members to participate in the process and trust each other. A specific focus in relationships makes quality improvement more effective and enjoyable.

Effective communication of the present practice, information from the literature and positive change in outcomes was communicated clearly and that encouraged the team.

Use the best Information

The team looked at the best available information in accessible Evidence Based Practice resources. They could act on this information, as it was both valid and relevant. The also used easily available and simple data to assess the present practice and monitor the change. This contributed to the understanding of the problem and encouraged change.

Start Small

This is a small and achievable project and its success made it possible for other quality improvement projects to be successful in the hospital and in the district.

Seek Solution

The initial discussion and the review of the literature provided a very simple solution. Not too much time was spent on analysing the problem. A lot of information could have been gathered about the type of organisms, the type of suturing material, the technique, the teaching, the feeding of mothers, the rising incidence of HIV and many other issues. Instead, the team found a solution and focused their efforts on that. Solution thinking is used in family therapy with the understanding that one cannot solve a problem with the same kind of thinking that created the problem[9]. It is helpful to consciously focus on the solution rather than the problem in quality improvement. It is creative and gives people hope.

Success

Success was a clear driver in the project. The initial success of the experienced midwives made a big difference. It is wise to work with things that can be successful and with people who can make it a success.

Improving quality is a journey. The family doctor plays a crucial role in making quality care possible. He/she has the responsibility to be an active agent for change and a structured quality improvement cycle is one way of achieving that.❐

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