New roles for nurses in general practice—a lesson from America

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SUMMARY. In North America attempts have been made to counteract the shortage of doctors by training ancillaries: the physician's assistant (P.A.) and the family nurse practitioner (FNP). Though physician assistants may give rise to interpersonal difficulties within practices the concept of the family nurse practitioner has much application in Britain. The possibility of employing family nurse practitioners in British general practice is discussed particularly with regard to the help they might give in diagnosis, in psycho-social counselling and follow-up.

Introduction

In large areas of the United States there are no general practitioners or their equivalent. This paucity of doctors and their poor distribution has contributed largely to the so-called health care crisis which exists in the USA. Canada with its widely scattered population has similar problems. The universities have responded to this dearth of doctors by increasing production and by attempting to produce doctor substitutes. Since production of doctors is a slow business and their delivery to under-doctored areas by no means certain, increasing attention has focused on doctor substitutes. Two such substitutes have emerged: the physician's assistant and the nurse practitioner.

Physician's assistant

The idea of the physician's assistant (P.A.) was conceived when the attendance at a particularly good course for American general practitioners was inadequately attended. Investigation of this revealed that doctors did not attend because they were unable to leave their practices. It was decided that it should be possible to train para-medical personnel to act as part time locums for the doctors attending postgraduate courses. There were available partly trained paramedical staff in the military corpsmen (the equivalent of Army Medical Corps non-commissioned officers) who were returning from Vietnam.

These corpsmen were put through a two-year abbreviated medical curriculum (Duke University, 1971) and emerged as extremely efficient paramedical technicians. Since their arrival coincided with the sudden decrease in primary care physicians they served not just as locums as originally planned but as a new source of medical manpower. Physicians' assistants from the University of Florida (Henry, 1972) and Duke University, North Carolina have shown themselves efficient pleasant people to work with who have quickly been accepted by their patients. The problem, however, is that they start as second class doctors but through experience of general practice they may well become as good at their job as the first class doctors. Since they get a smaller share of practice profits such a state of affairs may become explosive in the future.

Nurses

As doctors retired from rural communities nurses have taken over some of their role. At first such a takeover was due to expediency; there was nobody to cope so the nurse assumed more of the doctor's simpler tasks. With the realisation of what was happening the universities, through their schools of nursing and departments of community medicine, formalised the training of the family nurse practitioner (FNP) and the paediatric nurse practitioner (PNP) to fill the ever increasing gap in primary medical care.

By 1971 there were many university programmes designed for training FNPs or PNPs and in that year the Secretary of the Department of Health, Education and Welfare received the report of the commission set up to examine extended roles for nurses (HEW, 1971). This report reviewed the whole field of nursing but focused particularly on the position of the nurse

in primary care. In addition to the more usual work of the nurse it laid down nursing tasks in the following fields hitherto considered the provinces of the physician:

Eliciting and recording the history,

Physical and psycho-social assessment,

Arranging for the interpretation of laboratory data,

Making diagnoses,

Prescribing therapy,

Assessing community resources,

Providing emergency therapy (e.g. treating for shock, or cardiac arrest),

Supplying appropriate information to patient and relatives about disease.

To cope with these new tasks the nurse, be she a registered nurse trained traditionally through a hospital nursing school or a baccalaureate nurse holding a B.S. in nursing from a university nursing school, was given a further six month course. This course was spent learning physical diagnosis, examination techniques and the use of the laboratory to equip her with the necessary new skills.

Here then was a nurse assuming the physician's mantle in the field of history taking, examining, diagnosing, treating and in making a prognosis. What had started in expediency had ended in what some physicians see as a threat and the boundaries between the roles of doctors and FNP are difficult to define (*Journal of the American Medical Association*, Editorial, 1971). This state of affairs has not arisen without opposition from nursing as well as medicine. Rogers (1972) strongly opposes this tendency for nurses to encroach on the field of the physician holding that while such a departure from nursing may or may not strengthen medicine, it certainly weakens nursing.

Despite this the family nurse practitioner flourishes; many are working well in the States (Schulman and Wood, 1972) and in Canada (Joyce, 1971) and physicians working with them are impressed not only by their efficiency but also by their realisation of their limitations. In all cases they function under the close supervision of a physician. Such a practitioner working at a clinic some distance from her backup doctor will have a precisely defined field of operation, departure from which indicates mandatory referral to the doctor. Such referral should ideally be in person but often will be by telephone. Frequently a single doctor will run a busy clinic with one or more family nurse practitioners who manage many patients especially the followup of such conditions as hypertension, heart disease, arthritis, psychiatric disease, obesity and diabetes.

Of such cases the family nurse practitioner may manage some 75 per cent without referral to her doctor (Schulman and Wood, 1972). One task that is increasingly falling to her is the collection of historical, examination and laboratory data which contributes to the data base of Weed's problem-oriented record (Weed, 1969; Bjorn and Cross, 1970).

United Kingdom

In the United Kingdom the scene is different; the general practitioner may be overworked but is not such a rare creature as his American counterpart. The high pattern of demand in British general practice makes time the doctor's limiting factor. Demand is not likely to reduce and the pressure on time made by the need for psychosocial counselling is increasing. Though modification of diagnostic patterns is continually debated, time is critical and time shortage has a bearing on what American critics call the poor quality of diagnosis in British practice.

The general practitioners in the NHS could well take a leaf out of the American book and train their nurses to save them time. The nurse is assuming more responsibility for therapy, screening of requests for visits, chronic visits and for carrying out simple diagnostic tests such as urinalysis, weighing and blood pressure estimation. These roles are simply an extension of the tasks they were trained for and do not really show imaginative use of their skills.

Certainly the nurse's therapeutic role could be extended to include some of the time consuming psychosocial counselling and follow-up of certain long term problems such as diabetes and hypertension and this field is much stressed in America. However, in Britain it is in diagnosis that the nursing profession have a major contribution to make. In a survey into diagnostic

methods in six general practices in England (Hull, 1972) it was shown that the nurse contributed to diagnosis in less than one per cent of cases (though Moore *et al.* (1973) have reported a comparison between nurses and doctors in decision-making in general practice which showed that the nurse was as good at decision-making as the doctor in the majority of cases). The same six-practice survey showed that about 65 per cent of new patients were seen only once by the doctor, suggesting that many of them had diagnostically simple conditions.

It is of course right that patients who are worried by a symptom whose significance they cannot be expected to appreciate should present for evaluation, but a patient told by a tired harassed doctor that she is wasting his time may later fail to report symptoms indicating major disease. Thus there is a need for screening of symptoms before the doctor is involved. This immediately raises the problem of the nurse acting as a barrier between patient and doctor and this must be guarded against. Firstly there must be a fail-safe system so that in any doubt, or at patient demand, the case should be referred to the doctor. Secondly the nurses must be adequately trained and must have standing orders which precisely define their fields of responsibility.

A fail-safe system has been used traditionally by the doctor usually as " if you don't get better come back." Such a technique should be widely used by the nurses and return for an unresolved problem would become a mandatory reason for referral.

Standing orders should lay down precisely those conditions which the nurse may treat without referral to the doctor. These orders should define the illnesses the nurse might deal with, give notes on aetiology, clinical features, laboratory tests, differential diagnosis, treatment, complications, reasons for referral to the doctor and a guideline for follow-up. Excellent examples of such standing orders are available (University of North Carolina, 1973).

Probably, at first, the subject of therapy would give rise to problems. The first cases that nurses undertake to diagnose and treat should be those requiring the simplest symptomatic therapy but with increasing experience and increasing confidence it is likely that the physician would increase the list of permissible therapy. This will probably give rise to organisational problems with regard to the signing of prescriptions but these should not be insoluble.

In the six-general-practice survey it was shown that about 20–30 per cent of patients were asked to return for review of diagnosis though in fact only about two per cent had the initial diagnosis altered. This large area of followup is one where the nurse could greatly assist the physician's diagnosis so allowing him increased time to deal with new patients.

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