A course for practice nurses

N. K. LEIPER, M.A., M.B., B.Chir., D.C.H., D.Obst.R.C.O.G.
Senior Lecturer in Primary Medical Care, Southampton University

During the past ten years there has been an upsurge of interest in the working relationship between general practitioners and nurses. The widespread attachment of local authority nurses to general practice has not prevented an increase in the number of nurses employed directly by family doctors. The only source of information on these nurses is derived from the returns made by general practitioners for the purposes of claiming reimbursement for the salaries of their employees. Where a nurse is employed in a practice, she may have a secretarial or other function in addition to her nursing duties; it is therefore difficult to be quite sure how much of her time is spent in nursing. However, there has been a rapid increase in the number of hours worked by these nurses, expressed in the table below in whole-time equivalents.

TABLE 1

PERCENTAGE INCREASE IN THE NUMBER OF HOURS WORKED BY NURSES DIRECTLY EMPLOYED BY GENERAL PRACTITIONERS IN ENGLAND AND WALES

Year	*Number (w.t.e.)*	*Increase (w.t.e.)*	*Percent annual increase*
1968	244	—	—
1969	316	72	*29·5*
1970	362	46	*14·6*
1971	447	85	*23·5*
1972	500	53	*11·9*
1973	567	67	*13·4*

In addition to these potential sources of error, the statistics are only available in whole-time equivalent units and therefore, it is difficult to know exactly how many nurses make up these equivalents. There are other women working in general practices who, although qualified as nurses, are employed mainly or wholly as practice administrators.

Figures are available for the hours worked by nurses employed by local health authorities. These show an annual increase, but the rate of increase is lower than that quoted above for directly-employed nurses. For example, the increase in the hours worked by local health authority employed nurses in England in 1972 was only 5·1 per cent above the previous year (Department of Health and Social Security, 1973).

Practice nurses may become professionally isolated, especially where they do not work as members of a nursing team. This isolation may be a factor in making the practice nurses feel that they are out of touch with modern trends in nursing and medicine. It may also be the cause of the views occasionally expressed by members of the nursing hierarchy, that practice nursing is not ' real ' nursing at all.

Planning a programme

One practice which employs a relatively large number of nurses and other ancillary staff tried to arrange brief introductory courses for new members of the practice staff. These were a qualified success and it was decided to increase the scope of the venture. A local technical college, which has been interested for several years in the education of medical secretaries and other paramedical personnel was then approached. The college authorities expressed interest in providing facilities and help in mounting a practice nurses' course. A member of the staff of the Social and Home Sciences Department was appointed as course tutor and a sub-committee was formed to plan the course. The committee consisted of the Head of the Social and Home Sciences Department, three members of her staff (all state registered nurses) and one family doctor. Proposals for the course were shown to nurses working in two group practices and their comments on the content of the course were taken into consideration in the final draft of the programme.

The meetings

It was found most convenient to hold evening meetings at weekly intervals in one technical college term. Meetings began at 1900 hours and ended at 2100 hours with a break for coffee and informal discussion. The meeting usually took the form of a lecture and discussions with the use of slides, films and on one occasion a tape recording from the Medical Recording Service Foundation of the Royal College of General Practitioners.

The course was advertised by the clerks of the local executive councils in the course of their usual correspondence with general practitioners. The response was encouraging and at the start of the course 35 women enrolled. Some came from a considerable distance, one travelling 51 km (32 miles) each week. In spite of difficulties caused by a petrol shortage and Christmas, 26 nurses were attending each week during the last few weeks of the course.

The nurses

Nurses attending were asked to complete a questionnaire and 26 completed forms were received (table 1). One local health authority nurse attended and one nurse was not currently working in general practice. Two were working as practice managers with limited nursing duties. Only one nurse had worked in more than one general practice. The duration of work in practice nursing was usually brief; in no case was the experience more than five years in length, the average being about 2½ years. In some cases two or more nurses attended from the same practice. About two thirds worked as members of a group of practice nurses, while the other third worked alone without any nursing colleagues. A third said that they did not belong to any professional body, for example, the Royal College of Nursing (table 1).

TABLE 1
PRACTICE NURSES ATTENDING THE COURSE

		Number	*Percent*	
1. *Age*	*Less than* 25 years	0	—	
	25–35	3	*11*	
	35–45	16	*61*	
	more than 45 years	7	*27*	
2. *Marital status*	single	5	*19*	
	married	17	*65*	21 of whom 19 (*90%*) had children
	divorced	2	*8*	
	widowed	2	*8*	
3. *Qualifications*	S.R.N.	19		
	S.E.N.	0		
	S.R.N. + S.C.M.	7		
	Other nursing qualifications	5		
	Non-nursing qualifications	3		
4. *Previous work*	Hospital Nursing	22		
	Private nursing	10		
	Industrial nursing	10		
	Other nursing	7		
	Non-nursing work	6		
5. *Membership of professional bodies*	Royal College of Nursing	13	*49*	
	Royal College Midwives	4	*15*	
	Both R.C.N. and R.C.M	1	*4*	
	None	8	*30*	

Nurses were asked about the work of the practice nurse in their practice and results are shown in table 2.

TABLE 2

WORK OF PRACTICE NURSES (n=26)

Is it normal for the practice nurse in your practice to:	*Yes*	*No*
Listen to patients' problems	26	0
Take request for repeat prescriptions on the telephone	26	0
Order dressings and other stock	26	0
Give advice on simple treatment on the telephone	26	0
Test routine urine sample	25	1
Dress varicose ulcers	25	1
Remove sutures	24	2
Syringe ears	23	3
Take a simple path specimen e.g. throat swab	21	5
Take 'phoned requests for visits	18	8
Take blood sample	17	9
File records	16	10
Help in antenatal clinic	16	10
Insert sutures	16	10
Receive patients	15	11
Set up ECG	12	14
Record ECG	10	16
Run appointment system	9	17
Perform other clerical duties	8	—
Take cervical smears	8	18
Change vaginal ring	7	19
Perform other nursing duties	7	—
Perform tonometry for glaucoma	0	26

The nurses were asked whether there were any jobs that they were asked to do that they felt were beyond them or, alternatively, whether there were any things that they would like to do that were normally done by the doctors (table 3).

TABLE 3

NURSES' OPINIONS

Did not like doing	*Would like to do*	
Suturing wounds (1)	Suturing wounds	(5)
	Remove foreign body in eye	(2)
	Follow-up visits	(2)
	Removing sutures	(1)
	Dressings	(1)
	Blood pressure readings	(1)
Cervical smears (1)	Cervical smears	(1)
	Venepunctures	(1)

Two nurses commented that they were not fully used as nurses. One said that one of the partners in her practice allowed her to syringe patient's ears, but that the other partners preferred to do this themselves. The impression gained was that some nurses were keen to be used more in a clinical capacity. Doctors seemed to be reluctant to allow them to perform some duties usually considered to be within the capacity of the state registered and the state-enrolled nurse.

The questionnaire included a question on the reasons why these nurses chose to work in general practice. They were asked to score from one to six certain possibilities. The scores were added for each possibility, so that a low total indicates a high degree of preference. The results are shown in table 4.

TABLE 4

REASONS FOR WORKING IN GENERAL PRACTICE

Reason	*Total score*
(1) Using acquired nursing skills	53
(2) Variety and interest of work	73
(3) Meeting many and varied people	85
(4) Hours suitable for home and family commitments	85
(5) Working as a member of a team	91
(6) Financial rewards	138

Additional comments in some cases indicated the nurses' appreciation of opportunities to learn while working in general practice, and of dissatisfaction with hospital nursing since recent

TABLE 5

THE PRACTICES FROM WHICH THE NURSES CAME

		Numbers	*%*
(1) *Type of practice*	Single handed	Nil	—
	2 doctors	2	*8*
	3 doctors	7	*28*
	4 doctors	10	*40*
	5 doctors	2	*8*
	6 doctors	1	*4*
	7 doctors	1	*4*
	8 doctors	1	*4*
	Health centre (6 doctors)	1	*4*
(2) *Staff employed in practice*	Practice manager	15	*60*
	Medical secretary	16	*64*
	Typist	17	*68*
	Telephonist	18	*72*
	Receptionist	25	*100*
	Other clerical staff	2	*8*
	Other non-clerical staff	4	*15*
(3) *Local Health Authority staff attached to practice*	Midwives	24	*96*
	District nurses	24	*96*
	Male nurses	6	*24*
	Health visitors	25	*100*
	Social workers	8	*32*

N.B. These figures are only approximate as some practices sent more than one nurse to the course.

changes have taken place. Only one nurse put ' financial rewards ' as her first choice, but 20 put it as their lowest choice of all. One commented wryly that she was paid about as much as a practice nurse as she would be paid as a home help.

During the course it became apparent that there were very considerable discrepancies in pay between practices where the practice nurses were performing duties of a comparable nature.

The practices

No nurse was employed by a single-handed general practitioner and the most came from groups of between three and five doctors. A high proportion of the practices employed managerial, clerical, and receptionist staff (table 5).

The numbers of part-time receptionists are high, and on average about four receptionists would be employed for each practice nurse. In spite of this, a considerable proportion of practice nurses performed some reception and clerical duties.

In accordance with health service policy, local health authority staff were associated with a high proportion of the practices. Midwives, district nurses, and health visitors were almost universal. Male nurses were attached to a quarter of practices and social workers to a third. One nurse was employed partly by a practice and partly by the local authority; she worked in the surgery in the morning, some patients from the district being brought to the surgery for dressings and other nursing procedures. In the afternoon she fulfilled the role of a district nurse.

The content of the course

The following topics were discussed:

(1) The evolution of general practice,
(2) Community medicine,
(3) The future of nursing in general practice,
(4) The role of the nurse in the general-practice team,
(5) Legal aspects of general practice,
(6) Cardiac emergencies in general practice,
(7) Surgical emergencies and early discharge of surgical cases,
(8) Psychiatric emergencies,
(9) Aspects of antenatal care,
(10) Cervical cytology,
(11) Geriatrics and family medicine,
(12) The re-organisation of the National Health Service.

The final session took the form of a discussion evening. The discussion indicated that the main aims of the course—instruction, stimulation, and social contact—had to some extent been achieved. The general form of the meeting—that of lecture/discussion—was felt to be too formal and a desire to have more demonstrations, for instance of dressing techniques, venepuncture, and electrocardiography became apparent. There was also a desire to visit practices to see the practice nurse ' in action ', but this had proved impossible to arrange. Further discussion of the legal status of the practice nurse was suggested. The possibilities of drawing up a ' job description ' of the practice nurses' role, and the provision of a specimen contract of employment were discussed.

It was felt that the practice nurse was definitely in need of representation by a professional body, and it was suggested that the Royal College of Nursing might form a practice nurses section to promote the interests of nurses employed by family doctors. The need for refresher courses was unanimously endorsed, and several suggestions were made for another course to be arranged at a later date. It was suggested that an informal body should be formed to plan and arrange this course and to consider the basic needs of practice nurses in this area. A Wessex Practice Nurses' Guild was therefore formed and a committee elected. Subsequently, further meetings have taken place.

Discussion

Twenty years ago, Taylor (1954) found that some practices had for years been " built around " a nurse and listed a number of tasks that a nurse might then perform. The Royal College of

General Practitioners (1968) has been instrumental in exploring the potential of nurses in general practice. A considerable amount has been written about the work of the practice nurse, notably in the series of articles by Reedy (1972).

In the past 20 years the hospital nurse has emerged from her former role as the doctor's handmaid and has become a full professional in her own right. Practice nursing has not shared in this increase in status. It lacks a career structure. Conditions and terms of service vary from the very good to the very bad. The nurses in our course could think of no organisation that cared for their particular interests. Indeed the educational needs of the practice nurse are currently the responsibility of no one professional body, although the Royal College of Nursing (1959) has organised courses for practice nurses in the past.

The courses of instruction provided by the Queen's Nursing Institute (1974) have been attended in the past by practice nurses, but although the district nurse and the practice nurse overlap in their sphere of duties, their jobs are not identical. It has been found that local health authority nurses perform more varied work after attachment to general practitioners.

Hasler *et al.* (1972) has taken the initiative in organising a course of formal in-service training for a group comprising both local health authority nurses and practice nurses. Our course differs in that it was almost entirely composed of practice nurses. The planning of future courses should arise from the ' shop-floor ' level so that they will meet the needs of nurses actually working in general practice. The responsibility for the nurses' continuing education should primarily be the concern of the nursing organisations, although the medical profession would almost certainly have a part to play in providing instruction and advice. It is to be hoped that this course has provided a further stimulus toward educational self-help.

A Joint Board of Clinical Nursing Studies has been formed by the Secretary of State for Social Services and the Secretary of State for Wales, to consider the future educational needs of the qualified nurse. It is likely that the Board will make recommendations for the provision of suitable postgraduate training for nurses employed in general practice.

Those responsible for the general training of nurses have in the past paid scant attention to the needs of the community and have done little to prepare nurses for work outside hospital. Perhaps, if the current increase in interest in practice nursing is maintained, a part of the nurse's basic course will in the future take place in the community.

Recent trends in secondary education have made the technical colleges more aware of their responsibility to meet the educational needs of diverse groups in the community. It is suggested that it is the duty of technical colleges to assist in the planning and organisation of courses such as the one described in this article. The colleges are widely scattered over the country and their position and facilities should make them ideal centres for the provision of further education for practice nurses.

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The acting secretary of the Wessex Practice Nurses' Guild is: Miss Anne Balshaw, S.R.N., The Surgery, Bell Meadow Road, Hook, Hants.

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