Training district nurses

THE composition of the primary health care team is still a subject for discussion: whether it should or should not include social workers, remedialists, or counsellors remains in doubt. The advantages of including multidisciplinary skills in the team are obvious, but the consequential losses and difficulties in communication which arise with each increase in the size of the team make each new extension harder to decide.

What, however, has never been in doubt is the absolute insistence by virtually all general practitioners that the district nurse is an essential member of the primary health care team. Indeed the relationship between general practitioners and district nurses has traditionally been rather happier than that between practitioners and health visitors; it has been one of the undoubted successes of British general practice during the last decade.

However, throughout the years of attachment there has been a great imbalance between the training of future general practitioners and the training of future district nurses. Since the closure in 1967 of the long established Queen's Institute of District Nursing, which for many years provided excellent training for some district nurses, the need for a new look at district nurse training has been apparent. General practice has been heavily preoccupied, at least since 1965, with introducing an entirely new and much publicized system of training, whilst much less has been done by its sister profession. District nurses have been left out in the cold.

To some extent the educational fate of district nurses was bound to hinge on the recommendations of the Briggs Committee (1972), and on the response by the nursing profession itself and the government. The prolonged delay in that response occurred at least partly because of the considerable disagreements within the nursing profession, and eventually between its different branches.

For many in other caring professions, the Briggs concept of unification of the differing branches of the nursing profession, with further specialization superimposed after a general basic training, had much to commend it. In the event, the nurses have chosen to go for separate statutory committees.

This leaves the position, status, and training of the district nurse a matter of acute concern, not only for the district nurses themselves but for their colleagues in the community. Given that separate and specific training is being agreed for midwives, it becomes essential to develop appropriate training courses for future district nurses.

It is therefore a relief to hear that the four Health Ministers in the United Kingdom have recently agreed proposals to introduce a new six-month course for district nurse training, which will start in the autumn of 1981. This has been fully approved by the Panel of Assessors for District Nurse Training. However, there is regret that the Ministers have not seen their way to accepting the need for an obligatory period of three months' supervised practice for newly trained staff which the assessors had strongly recommended. What is of great importance, however, is that district nurse training is to become mandatory for employment as a district nurse in the future. No longer will district nurses be dropped in at the deep end of nursing care and be left to sink or swim alone.

These important changes in the training for nurses working in the community have come surprisingly late. They should now do much to help prepare the district nurses of the future for the extremely important tasks they will perform. Government after government has emphasized the importance of improving standards of care in the community (DHSS, 1977) and the combination of early discharge after surgery, day care surgery, and a reduced admission policy in mental health means that the primary health care team is now bearing increased responsibilities. Many patients who would in the past have been nursed in hospital may in future be nursed at home. The possibilities for practical preventive work are immense.

The need for specific training for home nurses thus parallels exactly the need for specific postgraduate training for domiciliary doctors. Many vocationally trained general practitioners now enter practice with three years' experience of small-group behaviour and decision making behind them. In most vocational training schemes today doctors training for general practice have remarkably little contact with district nurses and almost no joint training sessions with them. If doctor and nurse are to work closely together in partnership in the future, joint training is surely advisable and would seem feasible already within existing arrangements.

We publish today four articles with different implications for further nurse training. Elliott and colleagues (p. 69) describe the history and future training of district nurses, while Mourin describes the content of a practice nurses' course, from which he derives a syllabus

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of practical skills (p. 75) and evaluates the course (p. 78) and Barley (p. 101) asks "Why not a nurses' formulary?" Finally Tough (p. 85) examines the role of five surgery-attached psychiatric nurses.

We welcome the nursing profession's growing emphasis on its professional independence and the role its members should play in interdisciplinary discussions about the care of patients, and we especially welcome the new developments in post-qualification training for nurses and wish them every success in the future.

Reference

Committee on Nursing (1972). Briggs Report. London: HMSO.
Department of Health and Social Security (1977). *The Way Forward.* London: HMSO.

Doubt and caution about the D and C

DILATATION and curettage (D and C) is one of the most common operations and is performed even more frequently than the removal of tonsils and adenoids.

About 24,000 D and C operations were performed in the single year of 1974 in Scotland alone, the patients taking up more than 71,000 bed days.

Some reasons for doing a D and C can probably never be eliminated; it is often essential in controlling the bleeding associated with retained products of conception, in some cases of infertility, or in diagnosing endometrial cancer. However, it is clear from subsequent follow-up, and indeed from hospital records, that the more common indications nowadays are minor disorders of menstruation, cervicitis, or cervical erosion. For these reasons and particularly for patients under the age of 35, this procedure must be critically questioned.

Vessey, Clarke, and MacKenzie (1979) from the University of Oxford have now carried out a valuable study of the Scottish hospital inpatient statistics for 1974 using the summaries of all patients discharged from hospitals other than psychiatric and maternity units. The clinical data included up to three diagnoses coded according to the eighth revision of the *International Classification of Diseases* and up to two surgical procedures.

In women under the age of 35, almost 10,000 operations were undertaken, of which more than half were associated with a principal diagnosis of menstrual disorder or benign disease of the cervix. Three cases of endometrial cancer were found in this age group, and a further nine women had a diagnosis on discharge of genito-urinary tuberculosis. The mean time of stay was 2·9 days for women recorded as undergoing D and C.

Vessey and his colleagues point out the dangers. These include the small risk from general anaesthesia, and the specific hazards associated with a D and C, such as perforation of the uterus about once in every thousand operations, and the longer term complications of cervical incompetence, which may have important implications for future pregnancy.

In addition to these physical problems, general practitioners will be aware that an unnecessary D and C may arouse considerable anxiety, especially in young unmarried women, and cause needless and unhealthy doubts in their minds about themselves and their bodies.

Cervical erosion is an extremely common and possibly physiological condition. General practitioners who carry out numerous pelvic examinations, for example in routine examinations for cervical smears, often see cervical erosions quite unassociated with any symptoms. The clinical dilemma for the primary physician, however, is the management of abnormal menstrual bleeding and a policy of 'wait and see' cannot be justified if there is any significant risk of serious progressive pathology. New medical options, such as 'medical curettage' using a high dose of progestogen such as norethisterone may offer alternative opportunities for treatment at home and there are also alternative methods, for example aspiration curettage on a day care basis (Bjerre *et al.*, 1971; Mathews *et al.*, 1973) which can often, if not always, avoid admission to hospital.

The article by Vessey and colleagues suggests that the D and C is not now a cost effective investigation for women under the age of 35 with minor gynaecological conditions. The authors calculate that three or four thousand operations would have to be performed at the current rate to discover, on average, only two endometrial cancers and the risks for this group of women as a whole may now exceed the gain.

General practitioners play a special role in balancing the risks of intervention against the gains. Operations which are particularly common need particularly critical evaluation. Routine tonsillectomy is already under a cloud; there is now good reason for doubt and caution about the D and C.

References

Bjerre, B. A., Gardmark, S. A. & Sjoberg, N. O. (1971). Aspiration curettage—a new diagnostic method. *Journal of Reproductive Medicine,* **7**, 221-223.
Mathews, D. D., Kakani, A. & Bhattacharya, A. (1973). A comparison of vacuum aspiration of the uterus and conventional curettage in the management of abnormal uterine bleeding. *Journal of Obstetrics and Gynaecology of the British Commonwealth,* **80**, 176-180.
Vessey, M. P., Clarke, J. A. & Mackenzie, I. Z. (1979). Dilatation and curettage in young women. *Health Bulletin,* **39**, 59-62.