Is the practice nurse a good idea?

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THE CONCEPT of the practice nurse has generated two opposing points of view. Is it possible to reach a compromise position? First, it is important to clarify the term 'practice nurse'. Some Health Authorities (or Boards) employ nurses for work on general practice premises; they are practice nurses although not employed by the general practitioners. In this article, the term 'practice nurse' indicates a nurse who is employed by general practitioners, which is the usual arrangement.

The doctors' viewpoint

Why has the practice nurse become a popular figure? It seems to me that the main benefit of the practice nurse is her 'pliability' within the framework of the practice, undertaking whatever tasks her employers identify for her. This must make the practice nurse an asset as far as the doctor is concerned, especially if she can save time and money. To have a qualified nurse working the hours one chooses to ask of her and carrying out the tasks one requires, without having to negotiate the whole business through complex and time-consuming committees should please any general practitioner. However, there are many who do not see why they should have to contribute financially to the nursing service provided within their NHS practice. Their medical colleagues in hospital do not have to pay for the support of nursing staff in the care of their patients, so why should general practitioners be penalized?

Many general practitioners see their nursing colleagues as collaborators rather than employees and subordinates. They recognize that suitably qualified and experienced nurses, working as health visitors or district nursing sisters, can add a dimension to general medical practice which complements their own. They enjoy a collegiate rather than an employer/employee relationship. Moreover, they recognize that nursing colleagues need to have their careers safeguarded, that they, too, need ongoing education and refresher courses, to keep up to date. These are facilities which cannot easily be provided by general practitioners.

The nurses' viewpoint

The alternatives of employment by the general practitioner or by the Health Authority have both supporters and opponents within the nursing profession. There are many practice nurses who enjoy their working conditions and would not readily change them. They have a loyalty to their medical employers and readily undertake delegated duties. Practice nurses who value their professionalism will be able to indicate their competence to comply with the employer's wishes. Moreover, profession-conscious nurses are likely to be members of the Royal College of Nursing, which can defend their interests. (The RCN is developing a section for practice nurses.)

There are, however, many practice nurses who remain employees of the Health Authority: they appreciate their affiliation with general practices within this management structure; they see their contribution to general practice as more effective in this type of organizational framework; they see disadvantages in a system that might not allow them to function as responsible professional colleagues.

General practitioners may react to such objections by employing their own nurses. This, in turn, creates problems. The practice nurse may be less qualified than the Health Authority employed nurse and yet may undertake functions not permitted for their own nurses by the Health Authority. She is therefore favoured by the general practitioner as the more useful colleague. Understandably, the Health Authority employed nurse does not relish such a situation, and even the practice nurse is not always content in a dual employment system: she sees in the Health Authority employed nurse a 'protected' worker, a worker whose educational and welfare interests, such as holidays, pensions and so on, are safeguarded; her Health Authority employed colleague has study days, has contact with other nursing colleagues and learns more about career opportunities; she can ask for transfer of employment, can change off-duty with a colleague and has more scope in arranging holidays. Of course, there is not always jealousy or animosity between practice nurses and Health Authority employed nurses who work together; and there are many general practices where all members of the team are content.

Compromise

Is it possible to reach a compromise which is more acceptable than either of the present methods of employment? In my view, all nursing staff should have the

© *Journal of the Royal College of General Practitioners*, 1984, **34**, 102-103.

same employer, and this employer should be the Health Authority and not the general practitioner. I believe that nurses and doctors should work together in a collegiate rather than an employee/employer relationship. For such a system to operate effectively, the nursing staff must be competent and be allowed to work as professional people, judging for themselves under what conditions they can and should undertake particular professional nursing functions. Only nurses who can be trusted to act independently in a professionally responsible manner should be employed as health visitors, district nurses or practice nurses.

The senior nurse's role

There is a role for a senior nurse who could have the support of less experienced nurses and students for whom she would take responsibility. In this way, the senior nursing sister, like her hospital counterpart, the ward sister, would also gain experience in teaching other nurses and in managing a complex organization. She would be able to assess whether procedures which the general practitioner wished to delegate should be accepted or not. She would have to provide convincing reasons for her decisions. She would be the person who would make the appropriate decisions in relation to the nursing component of patient care. She would also be the person who would negotiate with the general practitioner (in consultation with the nursing hierarchy) if, and when, changes in policies concerning nursing seemed desirable.

Delegation of duties

The compromise lies in neither the general practitioners nor the nursing hierarchy's increasing their influence but in increasing the status and independence of the individual registered professional nurse, functioning as a responsible senior member of the primary care team.

Would this compromise be hard on the general practitioner? I do not think so. If he has a good case for the delegation of suitable duties, his nursing colleague will help if she can do so without neglecting the nursing work within the practice. If the general practitioner merely wishes to save time or increase his income, maybe his case is not fully justifiable.

Is this compromise hard on the nursing hierarchy, particularly the nursing officer (community)? Is she facing redundancy? I do not think so. There is much of interest and value for such a person to do. For example, the identification and initiation of suitable nursing research spanning more than one practice setting; the collection and dissemination of relevant information; the counselling and development of individual members of the nursing team; the adequate cover of a group of practices; the channelling of appropriate information up and down the hierarchy; the matching of nursing staff with practices; support for individual nurses who may feel 'trapped' by their medical colleagues and, equally, support for practices 'trapped' by seemingly obstructive or otherwise difficult senior nurses.

Conclusion

Is the practice nurse really a good idea? I believe that we need nursing staff to undertake some procedures on the practice premises, but would like such nurses to be fully integrated members of the nursing team. Some procedures require complex nursing knowledge and skills irrespective of where they are undertaken. It is neither the venue nor the task which determines the level of knowledge and skill needed for it; it is the patient and the situation in which he finds himself. It is the senior nursing sister who, as leader of the nursing team, should have the responsibility of ascribing nursing functions within general medical practice.

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Note

The author would like to make it known that she is still a nurse—having been a district nurse, midwife and health visitor.

Cardiac arrhythmias in squash players

Ambulatory electrocardiography was carried out in 21 healthy, fit, male squash players (aged 23–43 years) before, during, and after match play. Resulting electrocardiograms were analysed with respect to heart rate and changes in rhythm. The results indicate that sqaush increases the heart rate to 80 per cent of an individual's predicted maximum heart rate for the duration of the game. Ventricular arrhythmias were detected in seven of the subjects during play and in seven in the immediate postexercise period, an incidence which was not reproduced on subsequent maximal treadmill exercise testing.

This study indicates that squash is a physiologically demanding sport which places a severe strain on the myocardium for considerable periods of time and is capable of generating cardiac arrhythmias. These findings are particularly important for an individual already at risk of sudden death from coronary artery disease or structural cardiovascular abnormalities. Medical advice before participation in the game will identify those at high risk of cardiovascular disease. Subjects in this study who developed arrhythmias were not, however, identified by history, examination, or exercise electrocardiography. Thus, it seems unwise to begin playing squash after the age of 40 years. Whether subjects in this age group already participating in the game should continue to play remains a matter for individual judgement.

Source: Northcote RJ, MacFarlane P, Ballantyne D. Ambulatory electrocardiography in squash players. *Br Heart J* 1983; **50**: 372-377.