LETTERS

Is the Practice Nurse a Good Idea?

Sir,

In response to Lisbeth Hockey's article (February *Journal*, p. 102) let me clarify definitions. The practice nurse is directly employed by the general practitioner, the treatment room nurse by the district health authority.

For two years there has been a joint committee of doctors and nurses considering the training needs of the practice nurse. It is hoped that its findings will be used to help draw up a recognized course. In the meantime, study days, updating sessions and conferences are arranged by various bodies outside the NHS. The practice nurse herself provides some of these through local interest groups that involve general practitioners, proving that both general practitioner and nurse are fully aware of their professional responsibility to nurse education. Ideal opportunities in the primary health care team exist for inservice training by the head of the team (the general practitioner). This qualifies the practice nurse, in the eyes of her employer, to perform her duties—many of which the treatment room nurse is forbidden to carry out by some district health authorities.

The practice nurse, in the employer/employee situation, has excellent communications with her general practitioner as shown in the DHSS Survey, 1980 (nurses working in the community). Flexible working hours complement the doctor's surgery hours, and with responsibility to her doctor alone, the practice nurse does not have the conflicting dual responsibility of the treatment room nurse to both doctor and health authority nursing hierarchy. This creates a good working relationship for the practice nurse within the primary health care team.

Practice nurses can be relied upon to act with independence, carrying out continuity of patient care in a professional manner and so becoming recognized members of the primary health care team, as are district nurses and health visitors.

Some of these advantages explain why the practice nurse prefers to be directly employed by the general practitioner, who, being an independent contractor of the NHS, has the right to choose his own nursing staff best suited for the practice workload. The increase in numbers of practice nurses shows that general practitioners also favour this method of obtaining nursing skills within their practice.[1]

Practice nurses are often decried for their lack of recognized training. Practice nurses are willing to be trained and want recognition. It is those that have the authority to negotiate training who have been dragging their feet.

These opinions are not necessarily the views of the RCN.

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Reference

1. Mackichan ND. *The general practitioner and the primary health care team.* London: Pitman Medical, 1976.

Sir,

Ms Hockey's article (February *Journal*, p. 102) misses out several important issues and misrepresents others.

She omits to point out that the practice nurse employed by the general practitioner can give continuity that attached staff do not always provide. Attached staff, by being promoted, are removed from both the primary care team and direct patient contact. They can be transferred at the instigation of nurse managers, and owing to financial stringency are not being replaced.

Delegation of responsibilities such as screening provides an interesting and challenging area for nurses and such work must be continuous. Restrictions of duties of health authority nurses and health visitors imposed by the nursing hierarchy for example to venepuncture and immunization are demeaning and make their jobs less interesting.

To say that general practitioners cannot provide educational courses is untrue. Most postgraduate centres run educational meetings which are open to all members of the primary care team.

Perhaps the fact that many general practitioners feel it necessary to finance their own practice nurses is an indication that the nursing hierarchy has failed in some ways to understand the needs of general practice.

MAIRI G. B. SCOTT
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Royal Medical Benevolent Fund

Sir,

There has been some confusion over the Fund's role.

It is a non-contributory charity which has been operating since 1836, almost one hundred and fifty years. From its early days the Fund assisted, in time of need, any medical doctor or dependant, as it does today. Contributions by donation or legacy from the profession, including past and present general practitioners, have helped to create the resources from which awards are made, but these contributions do not give a prior right to consideration. In 1983 almost £400,000 was allocated for actual payment during 1983/84. This considerable sum is distributed to doctors, their divorced or separated wives, their widows and children.

There is no discrimination by the Fund between speciality, religion, colour or sex. Restrictions do however exist which may limit the amount of aid available, namely to supplementary benefit claimants and those above a certain level of income or capital.

The Fund owns neither nursing nor residential accommodation, preferring to supplement an applicant's income to enable fees to be paid in the accommodation of the beneficiary's choice. Helping with fees, however, is only one of the many forms of financial aid awarded and I will give further information to those interested.

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Effectiveness of General Practitioner Advice to Smokers

Sir,

During examinations to give a second opinion on capacity for work, 500 claimants in NW England, who were being certified as incapable of work by their general practitioner, were asked about their smoking habits and whether they had received advice to stop from the family doctor.

72 per cent of those with smoking related illness had been counselled,