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.

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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,

with complete or partial success in 72 per cent. In illnesses not related to smoking, 37 per cent had been advised with some success in 23 per cent.

These findings are based on the patients' answers. They do confirm Russell's comment that face to face communication may be more persuasive, especially for the less well educated majority.[1]

Boulton and Williams have directly observed general practitioners giving advice. Their findings are based on one consultation per patient and in less than a fifth of the consultations for smoking related illness did the doctor exploit the opportunities available to discuss smoking habits. For illness not related to smoking in only 2 per cent of the consultations was the matter raised. The doctors in my series have seen their patients many times and the illnesses are sufficiently severe to need time off work. The increased opportunities have been exploited to a large extent, though 28 per cent of those with smoking related illness said they had not been advised. Advice to stop in illnesses not related to smoking is less effective but still worthwhile.

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References

1. Russell M A H, Wilson C, Taylor C, Baker C D. Effects of general practitioner's advice against smoking. *Br Med J* 1979; **2:** 231–235.
2. Boulton MJ, Williams A. Health education in the general practice consultation: doctors' advice on diet, alcohol and smoking. *Health Education Journal* 1983; **42** no 2: 57–63.

Home Nursing Service

Sir,
For the past twelve months our practice has been involved in providing a charitable nursing service to help relieve relatives looking after very sick or dying patients at home. I would be interested to hear from any other doctors who run similar schemes.

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Post-coital Contraception

Sir,
Let alone availability of post-coital contraception (March *Journal*, p. 175), who knows if this is actually effective? It is impossible to conduct a trial, as many women taking the 'morning after pill' will not become pregnant anyway.

I have used it successfully in 75 per cent of patients, but how do I know that it actually *worked* in these women?

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Design of General Practice Equipment

Sir,
The Research Division has been discussing methods of improving the design and quality of equipment used by the general practitioner. In particular, we are aware that with changes in the pattern of care patients who were previously referred to hospital are now being treated in general practice, and that this may require the design of new equipment or modifications to existing equipment.

May I, through your columns, invite general practitioners who have worked in this field or have views about the inadequacy of their existing tools to write to me?

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Zooneses and Veterinary/Medical Co-operation: A Missed Opportunity

Sir,
We were interested to read the article on veterinary/medical co-operation (December *Journal*, p.819) and whilst agreeing entirely with the need to improve liaison between our professions, we would wish to correct the erroneous impression that little liaison already occurs. In recent years positive steps have been taken to improve and extend inter-professional dialogue, both in Scotland[1] and elsewhere in the UK.

One of the most important developments has been the creation of local liaison groups, many of which, although not all, followed the introduction of the Zoonoses Order 1975. The background to the development of those in Scotland has previously been described.[2] These groups bring together colleagues from the medical and veterinary professions and environmental health officers who also have an important role to play in zoonoses control. Most of these groups discuss topics far wider than those covered by the Zoonoses Order. Membership of several groups includes general practitioners, but the continuing problem of persuading practitioners to attend such meetings has not been satisfactorily resolved. Perhaps one way of attracting greater interest would be for more local divisions of the British Veterinary Association and the British Medical Association to hold joint meetings.

The Zooneses Order has also directly contributed to improving liaison by the creation of the 'nominated officer' who has the responsibility to co-ordinate the investigation in animals and to communicate with his medical and environmental health colleagues. We would agree that the Zoonoses Order should not be confined to salmonellae and brucellae and there is scope for inclusion of other zoonotic organisms such as toxoplasma, campylobacter, leptospirae, chlamydiae and so on.

Another significant move has been the secondment in 1977 of a veterinary surgeon from the Department of Agriculture and Fisheries for Scotland to the Communicable Diseases (Scotland) Unit. A similar appointment was made in 1979 between the Ministry of Agriculture, Fisheries and Food and the Communicable Disease Surveillance Centre of the Public Health Laboratory Service. The remit of these posts, albeit part-time, included zoonoses surveillance and control as well as the improvement of liaison between the professions. The success of those posts is reflected in the many successful joint investigations carried out, for example cysticercosis surveillance, ornithosis in ducks, milkborne salmonellosis and so on.

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References

1. Reilly WJ, Sharp JCM and Collier PW. Interprofessional liaison in Scotland. Veterinary Record (1982), **111:** 384-385.
2. Sharp JCM. Medical-Veterinary liaison in Scotland. Veterinary Record (1977), **101:** 200-201.