The attitude of general practitioners towards practice nurses: a pilot study

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SUMMARY. Questionnaires surveying the attitudes of general practitioners towards the role of the practice nurse and its potential extension were distributed to a random 12% sample of Hampshire general practitioners. The response rate was 85%. It was found that practice nurses were performing more tasks of greater complexity than had been previously reported. The general practitioners expressed satisfaction with the role of the practice nurse, but had reservations about the evolution of that role towards that of a nurse practitioner. Inadequate resources were the most commonly cited factors limiting the development of practice nursing. In conclusion, it appears that Hampshire general practitioners wish to retain control of the evolution and extension of the role of the practice nurse.

Introduction

THE role of nurses in primary care has developed rapidly, and the best use is not always made of their skills and experience.[1] The majority of practice nurses are employed by general practitioners, who decide their work pattern, while community nurses and health visitors are employed by district health authorities. As a consequence the roles of these health care workers have diverged. The role of the practice nurse has expanded rapidly owing to the flexibility of general practitioner employers but the same is not true of the nurse's independence. In 1981 Bowling wrote 'The challenge for the future appears to be how to develop an expanded clinical role for nurses in general practice while minimizing role conflict and overlap with doctors, and without conflicting with the professional interests of either group'.[2]

The concept of a nurse practitioner initially arose in North America, and the difference between this role and that of the practice nurse is now less distinct. Key tasks that have been described[3] for nurse practitioners include: interviewing patients and diagnosing and treating specific conditions to an agreed medical protocol; referring patients whose medical condition lies outside agreed protocols to the general practitioner; conducting screening programmes; and referring patients for further nursing services.

There is evidence that an independent nurse practitioner could enhance care in the community, particularly in the areas of preventive and anticipatory care. A comparison of the work of a nurse practitioner with that of a general practitioner has shown that nurse practitioners could be a valuable extra resource for the development of new areas of care, rather than a cheap substitute for general practitioners.[4] The report of the Community Nursing Review recommended introducing the nurse practitioner into primary care, as part of a neighbourhood nursing service[3] but general practitioners have rejected this recommendation,[5] fearful of losing control over the role of the practice nurse.

Many nurses would like to extend their role with appropriate support.[6] Practice nurses employed by general practitioners have enjoyed certain advantages because of the flexibility of their relationship,[7] but general practitioners as employers may not have the knowledge, training and vision to extend the role of the nurse in the community.[5] In addition, there may be a conflict between the general practitioners' desires to control the role of practice nurses and the development of the nurse's professional position in primary care.

In order to develop the role of the practice nurse, resources for training, salaries, working space and time are required. So far practice nurse training has been on an ad hoc basis.[8,9] This has allowed rapid and flexible development, but more formal training is now required. Establishment of more courses recognized by the English Nursing Board will help[10] but the imposition of the new contract for general practitioners has aggravated uncertainty about resources.[11] The new contract will also increase the workload of general practitioners, especially in proactive care. Despite the anticipated shortfall in the number of nurses required to staff the National Health Service, some of this proactive work will be delegated to practice nurses, stimulating an expansion in their numbers and role.[12]

In 1987 Greenfield and colleagues surveyed the attitudes of practice nurses to their work.[6] When asked for the most important factor which stopped them from extending their role, 45% responded that it was the general practitioner's attitude. Before proceeding to a nationwide study, a pilot study was carried out to assess the attitudes of general practitioners toward practice nurses.

Method

In July 1989 a four part questionnaire devised by the authors was posted to a sample of 104 general practitioners on the Hampshire family practitioner committee list. The doctors were chosen using random number tables with further random selection procedures to ensure only one respondent from each practice. The final sample comprised 12% of the general practitioners on the Hampshire family practitioner committee list. After one reminder 88 questionnaires were returned, a response rate of 84.6%. Some of the respondents failed to answer all of the questions.

The first part of the questionnaire elicited demographic data characterizing the respondents and their practices. The second part assessed the range of tasks that the general practitioners employed practice nurses to undertake. A list of tasks was derived from the results of a survey by Greenfield and colleagues[6] where practice nurses described a range of tasks that they actually performed. The third part aimed to assess the attitudes of general practitioners to factors which might limit the extension of the nurse's role. Many of these factors had been volunteered by nurses in Greenfield and colleagues' survey. The final part of the questionnaire dealt with the way that general practitioners perceive the role of the practice nurse, ranging from a task oriented assistant to an independent nurse practitioner.

S Beaton, BSc, MRCGP, general practitioner, Stubbington; D Campbell, MRCGP, general practitioner, Blackfield; J O'Sullivan, BA, MRCGP, general practitioner, Twyford; G Robinson, MRCGP, general practitioner, Portsmouth; J Sedgwick, MA, MRCGP, general practitioner, Liss; S Tanner, MRCGP, general practitioner, Alresford; E Williams, BA, MRCP, MRCGP, general practitioner, Basingstoke; and P White, BSc, MRCGP, general practitioner, Romsey, Hampshire.
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In order to validate the questionnaire it was completed by 21 general practitioners and six practice nurses. The questionnaire was revised to overcome areas of ambiguity highlighted by these respondents prior to the postal survey. Questions requiring similar responses were included to test the consistency of individual respondents.

Completed questionnaires were analysed using SPSS statistical software. Group frequencies and means were calculated. The chi-squared test was used to compare sub-groups after cross-tabluation.

Results

Demographic data

Of 87 respondents answering the question 8.0% described their practices as rural, 43.7% as urban, 37.9% as mixed and 10.3% as inner city. Practice list sizes ranged from 2000 to 24 000 (mean 8693) and individual list sizes from 889 to 2667 (mean 1911) (mean for England and Wales 1924). Partnership sizes ranged from one to nine or more partners (mean 4.4).

Comparison of these results with the data for all general practitioners on the Hampshire family practitioner committee list and with Department of Health figures for England and Wales showed fewer single-handed practitioners among the respondents to this study (4.5% versus 14.2% in Hampshire and 11.3% in England and Wales) and rather more practices with six or more partners (25.0% versus 19.6% in Hampshire and 20.7% in England and Wales). It is therefore not surprising that only six of the study practices did not employ a practice nurse and only one did not have access to a treatment room. Comparability with all Hampshire general practitioners was indicated by the proportion of female respondents (22.7% versus 23.7% in Hampshire as a whole) and of dispensing doctors (12.1% (7/58) versuses 10.4% in Hampshire).

The respondents had been qualified for between five and 40 years (mean 19.4 years) and 63.7% had additional postgraduate qualifications: 43.2% the MRCGP, 48.9% the DRCOG, 14.8% DCH, 9.1% MRCP, 8.0% FFA or DA, 3.4% FRCS and 11.4% other qualifications.

Use of practice nurses

Table 1 lists the tasks that the general practitioners employed practice nurses to undertake. The total number of surveyed tasks performed in each practice ranged from nine to 19 (mean 14.0). Among the 76 general practitioners responding to the question 77.6% were satisfied with the present role of the practice nurse. However out of 81 respondents 97.5% wanted to expand the role of the nurse in their practice.

Sub-group analysis was performed to see if the type of practice influenced the total number and type of tasks undertaken by the practice nurses. It was found that inner city practices were less likely to have a practice nurse than practices in other areas (6/9, 66.7% versus 73/76, 96.1%; $P<0.01$). A larger proportion of nurses in inner city practices performed fewer tasks (mean 88.3% tasks versus 38.7%; $P<0.05$). For example, electrocardiogram recording was less commonly performed in inner city practices (33.3% of practices versus 91.9%; $P<0.01$) but it was more commonly performed in practices with over 6000 patients than in smaller practices (60/65, 92.3% versus 11/16, 68.8%; $P<0.05$).

Analysis of the data failed to show any correlation between those nurses performing an extended role (for example bimanual examination and direct referral to social services) and the type of practice in which they worked.

Doctors' attitudes to the role of the practice nurse

Table 2 shows the respondents' attitudes to factors which might limit the extension of the practice nurse's role. Sub-group analysis revealed that larger practices were more likely than smaller practices to feel that lack of space was a problem (82.8% versus 44.4%; $P<0.001$); that difficulties existed with pay grading (48.3% versus 22.2%; $P<0.05$) and that lack of opportunity for further training was also a problem (56.9% versus 26.9%; $P<0.05$). Doctors working in rural or mixed practices were less concerned about the legal implications of extending the nurses' role than were doctors in other areas (17/39, 43.6% versus 32/45, 71.1%; $P<0.05$).

The doctors were also asked to indicate whether they agreed with a number of statements describing the terms of service and the role of practice nurses (Table 3). Sub-group analysis revealed that more inner city practitioners were less receptive to the idea of practice nurse prescribing (77.8% versus 26.0%; $P<0.01$). The 25 doctors (30.9%) who felt that nurses should only perform given tasks or work within protocols for diagnosis, but not treat patients, were also more likely to feel that nurses should never prescribe than the 56 doctors (69.1%) who felt that nurses could treat patients (68.0% versus 14.3%; $P<0.01$). The concept of the independent nurse practitioner found less support among doctors who had been qualified for 21 or more years than among more recently qualified doctors (21/52, 40.4% versus 4/32, 12.5%; $P<0.05$). The 43 doctors who identified lack of time as a factor which might prevent expansion of the nurse's role were more likely to feel that they should be medico-legally responsible for the actions of their nurse than the 40 doctors who did not identify lack of time (64.3% versus 37.5%; $P<0.05$).

Further analysis was performed to see if there were differences between the 10 doctors who felt that the practice nurse is employed to do given tasks (the conventional role of a practice nurse) and the 30 doctors who felt the practice nurse is able to

Table 1. General practitioners reporting tasks currently performed by practice nurses.

Tasks currently performed by nurse	% of GPs responding positively
Suture removal ($n=82$)	98.8
Ear syringing ($n=82$)	98.8
Sterilization/equipment maintenance ($n=82$)	97.6
Measurement of blood pressure ($n=82$)	97.6
Provision of advice on/give travel immunization ($n=82$)	97.6
Measurement of blood glucose level ($n=82$)	92.7
Initiation of resuscitation until medical help obtained ($n=81$)	91.4
Complete item of service claim forms ($n=82$)	89.0
ECG recording ($n=81$)	87.6
Venepuncture for blood sampling ($n=80$)	86.3
Childhood immunization ($n=80$)	85.0
Peak flow measurement ($n=80$)	68.8
Cervical smears ($n=82$)	63.4
Recognition of anxiety and depression ($n=79$)	60.8
Observation of skin for signs of disease ($n=79$)	58.2
Examination for breast lumps ($n=82$)	57.3
Bimanual examination of uterus and adnexa ($n=81$)	19.8
Direct referral to social services and voluntary agencies ($n=80$)	18.8
Summarizing medical notes ($n=81$)	17.3
Intrauterine contraceptive device removal ($n=81$)	8.6
Stethoscopic examination of heart and chest ($n=81$)	6.2
Examination of testicles ($n=80$)	5.0
Other[a] ($n=82$)	12.2

n = total number of respondents. ECG = electrocardiogram.
[a] Includes domiciliary visits.

Table 2. General practitioners' attitudes to factors which might prevent extension of the role of practice nurses.

Factors preventing extension of nurse's role	% of GPs responding positively
Cash limits on staff salaries ($n=82$)	82.4
Lack of space in practice premises ($n=85$)	70.6
Legal implications of extended role ($n=85$)	57.7
Lack of time ($n=84$)	51.2
GPs' attitudes to practice nurses ($n=85$)	49.4
Views of the Royal College of Nursing ($n=81$)	49.4
District nursing manager's attitudes ($n=82$)	48.8
Lack of opportunities for further training ($n=84$)	47.6
Nurses' attitudes ($n=84$)	47.6
Availability of equipment ($n=85$)	47.1
Lack of proper job definition ($n=85$)	45.9
Inability of nurses to prescribe ($n=85$)	43.5
Nurses' family commitments ($n=85$)	43.5
Nurses' lack of self confidence ($n=85$)	41.2
Difficulties with pay grading ($n=85$)	40.0
Confusion between roles of nurse and doctor ($n=85$)	40.0
Nurses' inability to drive a car ($n=84$)	28.6
Lack of opportunity ($n=84$)	28.6
The desire or need to extend role ($n=85$)	25.9
Patients' perceptions of practice nurses ($n=85$)	22.4

n = total number of respondents.

Table 3. General practitioners' attitudes to the role of practice nurses.

	% of GPs responding positively
Agree/disagree with the following statements:	
Patients should be able to refer themselves directly to a nurse ($n=87$)	97.7
Practice nurses' role should be a matter of negotiation between the individual nurse and GP ($n=87$)	95.4
Practice nurses should extend their role from basic nursing tasks to the provision of counselling and advice ($n=88$)	93.2
Practice nurses should be legally responsible for their own actions ($n=85$)	76.5
General practitioners should be medico-legally responsible for all professional actions undertaken by their practice nurses ($n=87$)	50.6
Practice nurses should never prescribe drugs ($n=86$)	31.4
Practice nurses should be independent practitioners ($n=84$)	29.8
Practice nurses should only perform their duties after referral by a general practitioner ($n=87$)	10.3
Choose one of the following statements to reflect present views (n = 83)	
Practice nurses are able to diagnose and initiate treatment for certain conditions independently	37.7
Practice nurses are able to work within protocols to make a diagnosis and treat patients	32.5
Practice nurses are able within agreed protocols to make a diagnosis	18.1
Practice nurses are employed to do given tasks	12.0
Practice nurses are able to diagnose and initiate treatment for any condition independently	0.0

n = total number of respondents.

diagnose and initiate treatment for certain conditions independently (the conventional role of the nurse practitioner). The doctors favouring the practice nurse role were more likely to be in inner city practices than those favouring the nurse practitioner role (30.0% versus 0.0%; $P<0.01$). The doctors favouring the practice nurse role were less likely to feel that pay grading was a potential problem (11.1% versus 58.1%; $P<0.05$), but were more likely to feel that nurses' attitudes were preventing the expansion of the nurse's role (77.8% versus 29.0%; $P<0.05$).

In none of the analyses was the sex or postgraduate qualifications of the respondent or whether the respondent worked in a training practice a significant factor.

Discussion

The results of this pilot study need to be interpreted with caution, but they outline some interesting trends. Earlier reports that the majority of general practitioners are in favour of an extended role for nurses in general practice are confirmed.[13] Most nurses in this study appear to be carrying out more tasks of greater complexity than previously reported[6] and there was an indication that further extension is being considered.

The majority of general practitioners in this survey believe that the extension of the practice nurse's role is limited by lack of resources. Salary cash limits and lack of space were the most common reasons given by general practitioners for not increasing practice nurse services. However, fewer doctors felt that legal implications, lack of time, general practitioner's attitudes and the views of the Royal College of Nursing were factors. Only a few of the general practitioners felt that practice nurses lacked motivation. In contrast, Greenfield and colleagues found that the three main factors that practice nurses felt prevented the extension of their role were lack of further training, lack of time and general practitioner's attitudes.[6]

This study has shown that the majority of responding general practitioners were in favour of patients having direct access to the practice nurse, as did Salisbury and Tettersell in 1988.[4] Most general practitioners agreed that the nurse's terms of service should be a matter of negotiation between the individual nurse and general practitioner and they also favoured extension of the role into counselling. However, there was strong opposition to nurses acting independently to diagnose and treat, unless within agreed protocols. Only 30% of respondents agreed that nurses should be independent practitioners, suggesting that the general practitioners want to retain control of the practice nurse's role and its expansion. Doctors must ask themselves whether this control of the practice nurse's role is restricting the development of better quality nursing in primary care.

Since this initial pilot study the imposition of the new contract for general practice has set the stage for an increase in the number of practice nurses, and an extension of their role. The attitudes of general practitioners will be fundamental to the way practice nursing evolves. Debate focuses on who should control this evolution. This issue must be addressed and analysed if the extended role of practice nurses is to meet the challenge of the new decade. A national study of general practitioner's attitudes to practice nursing is now being conducted by the authors to investigate these findings further.

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Address for correspondence

Dr G Robinson, Lake Road Health Centre, Portsmouth PO1 4JT.