Attitudes towards practice nurses — survey of a sample of general practitioners in England and Wales

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SUMMARY. Practice nursing has expanded rapidly since the 1990 contract for general practitioners. In 1990, a national survey was undertaken of the attitudes of a random sample of general practitioners towards practice nurses. Responses to the postal questionnaire were received from 41.9% of the 4800 general practitioners sampled. Of the responding general practitioners, 90.0% were satisfied with the role of the practice nurse within their practice. To fulfil the requirements of the 1990 contract for general practitioners 50.7% had created a new nursing post, and 83.1% had expanded the role of nurses already employed; 89.7% wished to see further expansion of the practice nurse's role. However, lack of space was the factor most frequently reported as limiting the expansion of the practice nurse's role, mentioned by 76.0% of general practitioners. Only 43.7% of general practitioners recognized lack of opportunities for practice nurse training as a hindrance to role expansion.

The key to managing the expansion of the role of the practice nurse lies in the provision of resources and in training. A pressing need exists for a national training scheme based in general practice.

Keywords: practice nurse; nurse's role; doctor–nurse relationship; doctor's attitude; doctor's satisfaction.

Introduction

THE role of nurses in primary care has developed rapidly, but the best use is not always made of their skills and experience.[1] The practice nurse role has evolved in response to the perceived needs of the general practitioner employers. In 1981, Bowling wrote that 'the challenge for the future appears to be how to develop and expand the 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 an independent nurse practitioner was developed in the United States of America, and is now being considered in the United Kingdom. There is evidence that an independent nurse practitioner could enhance care in the community, particularly preventive and anticipatory care.[3] The report of the Community Nursing Review recommended introducing the nurse practitioner into primary care as part of a neighbourhood nursing service,[4] but general practitioners have rejected this recommendation,[3] fearful of losing control of the practice nurse. Greenfield and colleagues found that practice nurses felt that doctors' attitudes were the most important limiting factor in the expansion of the nurse's role.[5]

Many nurses would like to expand their role with appropriate support.[5] In order to do that, resources for training, salaries, working space and time are required. Until recently practice nurse training has been on an *ad hoc* basis.[6,7] This has allowed rapid and flexible development, but more formal training is now required. Practice nurse training is starting to become more organized, with input from the Royal College of Nursing and family health services authorities, but there remain wide variations in different areas.[8,9]

In 1989, prior to the new contract for general practitioners, a pilot study of Hampshire general practitioners was undertaken to survey their attitudes towards practice nurses.[10] It was found that practice nurses were performing more tasks of greater complexity than before. The general practitioners expressed satisfaction with the role of the practice nurse, but had reservations about the evolution of the role towards that of a nurse practitioner. Inadequate resources were the most commonly cited factors limiting the expansion of practice nursing. It appeared that Hampshire general practitioners wished to retain control of the evolution and expansion of the role of the practice nurse.[10]

General practitioners are not an homogeneous group. In 1986 Bosanquet found that innovation in primary care is not determined by attitude alone, but also by factors such as age of the general practitioner, and location and size of the practice.[11] The concept of an independent nurse practitioner may find most support among those general practitioners who have characteristics associated with innovation.

To investigate the findings of the pilot study[10] in more depth and the impact of the introduction of the new contract for general practitioners a national survey was conducted of a random sample of general practitioners in England and Wales to examine their attitudes to the role of practice nurses.

Method

Questionnaire

A six part questionnaire was designed by the authors. The first part elicited demographic data of respondents and the characteristics of their practices. Using closed questions, the second part assessed the range of tasks that the general practitioners employed practice nurses to undertake. Using a series of statements, the third part of the questionnaire addressed the way general practitioners perceived the role of the practice nurse. The fourth section, of closed questions, examined general practitioners' perceived barriers to the extension of the nurse's role. The fifth section, of closed questions, assessed changes to the practice nurse's role following the 1990 contract for general practitioners,[12] and the final section of the questionnaire assessed the use of job descriptions and protocols.

A pilot study involving 104 Hampshire general practitioners was used to validate the first four parts of the questionnaire.[10] The last two sections, devised in the light of the pilot study and following the introduction of the 1990 contract for general prac-

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titioners, were validated by 121 general practitioners and six practice nurses.

Sample

A computer generated random sample of 4800 out of the 26 921 unrestricted principals in general practice in England and Wales was obtained from the 1988 database at the Department of Health. The sample was forwarded to the General Medical Council, who provided the registered addresses; 70 addresses were found to be unusable. The sample had been stratified according to the number of principals in the practice, and this sample size of 4800 was chosen to produce statistically significant results.

Survey

The questionnaire was addressed to a named principal, and was sent to only general practitioner in a practice. The questionnaires were first posted in June 1990, followed by a second posting in September 1990 to 1200 non-respondents chosen at random. A third questionnaire was posted to 150 overall non-respondents, stratified to include 90 single handed practitioners and 60 from practices of two or more partners.

Analysis

Completed questionnaires were analysed using the *SPSS* statistical package for the social sciences. Group frequencies and means were calculated. The chi square test was used to compare subgroups after cross tabulation.

Results

The three mailings of the questionnaire resulted in a response rate of 41.9% (2013/4800). Not all questionnaires were completed fully by all respondents.

General practitioners

Of the 2013 respondents, 99.6% were general practitioner principals; 78.8% were men. The general practitioners had been qualified for between two and 54 years, with 49.2% qualified for 20 years or less and 10.9% for 10 years or less. The most frequently held postgraduate qualifications included MRCGP 42.7%, MRCP 6.7% and FRCS 2.5%.

Practices

The respondents' practice list sizes varied from 211 to 22 000 with a mean of 7679 (standard deviation (SD) 4070). Further analysis showed that 48.0% of respondents practised in training practices with 18.9% of respondents being approved vocational trainers. Of 1303 respondents, 26.4% worked in dispensing practices. The location of practices and number of doctors working in the practice is shown in Table 1. Most respondents described themselves as working in urban or semi-rural practices. The number of practice partners was evenly distributed.

Between 1933 and 2002 respondents replied to the questions on practice arrangements. Their replies revealed that 95.0% of respondents had a treatment room, 88.4% had meetings with practice partners, 76.5% had meetings with other staff, 74.8% had a practice manager, 72.2% had a computer, 68.6% owned the practice premises, and 21.6% described themselves as a potential budget holder. Practices fulfilling all of the first five of these criteria were considered to be innovative practices and 877 out of 2013 respondents (43.6%) were identified as from innovative practices.

Practice nurses

The number of nurses directly employed by practices is shown in Table 1. When asked to calculate the number of hours worked by all practice nurses in total, respondents estimated that they employed nurses for a mean of 43.8 hours a week (SD 29.9 hours).

Practice nurses' role. Tasks that the general practitioners expected the practice nurses to undertake are shown in Table 2. More than 90% of respondents expected nurses to measure blood pressure, sterilize and maintain equipment, run health promotion clinics and give travel immunizations.

Table 1. Location of practices, number of doctors in the practice and number of nurses directly employed by the practices.

	% of respondents
Location of practices (n = 1775)	
Semi-rural	*38.1*
Urban	*37.9*
Rural	*12.1*
Inner city	*11.9*
Number of doctors in practice (n = 2013)	
1	*12.2*
2	*14.4*
3	*17.5*
4	*17.3*
5	*19.9*
6+	*18.7*
Number of nurses directly employed by practice (n = 1998)	
0	*7.8*
1	*28.9*
2	*31.4*
3	*18.4*
4	*9.1*
5+	*4.6*

n = number of respondents to question.

Table 2. Tasks that the general practitioners expected the practice nurses to undertake.

Task	% of GPs expecting practice nurses to undertake task (*n* = 1748–1797)
Measuring blood pressure	*99.2*
Sterilizing and maintaining equipment	*95.5*
Running health promotion clinics	*92.7*
Advising on and giving travel immunization	*92.4*
Carrying out venepuncture for blood sampling	*89.5*
Measuring blood glucose level	*85.5*
Performing cervical smears	*84.1*
Performing childhood immunization	*82.1*
Helping with minor surgery clinics	*76.0*
Measuring peak expiratory flow rate	*75.4*
Examining for breast lumps	*64.5*
Performing electrocardiograph recording	*61.1*
Carrying out home visiting of over 75 year olds	*55.2*
Recognizing anxiety and depression	*53.6*
Observing skin for signs of disease	*38.4*
Carrying out home visits for other reasons	*32.4*
Making referrals directly to social services	*31.3*
Summarizing medical notes	*27.5*
Performing stethoscopic examination of heart/chest	*8.2*
Making referrals directly to hospital departments	*7.0*

n = range of number of respondents replying to questions.

General practitioners were asked to choose which statement most closely represented their perceptions of nurses' working practices. Of 1963 respondents, 39.6% agreed with the statement that practice nurses are able to diagnose and initiate treatment for certain conditions independently; 30.9% with the statement that practice nurses are able to work only within agreed protocols, to make a diagnosis and to treat; 19.4% that practice nurses are able to work only within agreed protocols, to make a diagnosis but not to treat; 9.6% that practice nurses are employed to do given tasks and not to diagnose; and 0.5% that practice nurses are able to diagnose and initiate treatment for any condition independently.

Between 1911 and 1951 respondents replied to the question showing which statement agreed most closely with their own views on the role of practice nurses. Ninety seven per cent of respondents agreed with the statement that the practice nurses' role should be a matter for negotiation between the individual nurses and general practitioners; 93.7% of respondents agreed that patients should be able to refer themselves directly to practice nurses; 93.0% agreed that practice nurses should extend their role from basic nursing tasks to counselling and advice roles; 72.9% agreed that practice nurses should be legally responsible for their own actions; 49.5% agreed that general practitioners should be medicolegally responsible for all professional actions undertaken by their practice nurses; 29.7% that practice nurses should be independent practitioners; 27.0% that practice nurses should never prescribe; and 14.2% of respondents that practice nurses should only perform their duties after referral by the general practitioners in their practice.

Barriers to role extension. Respondents were asked to identify perceived barriers to the extension of the practice nurse's role (Table 3). Of the respondents, 1499 (89.7%) wished to see the role of the practice nurse extended. Of the 21 barriers cited, lack of space in the practice premises was cited most frequently, by 76.0% of respondents.

Table 3. Respondents' perceived barriers to the extension of the practice nurse's role.

Perceived barrier	% of respondents identifying perceived barrier (n = 1465–1519)
Lack of space in practice premises	76.0
Uncertainty over salary reimbursement	63.1
Legal implications of extended role	53.4
Nurses' family commitments	48.7
Nurses' inability to drive car	48.5
Views of Royal College of Nursing	48.4
Nurses' attitudes	46.2
Nurses' lack of time	45.1
Difficulties with pay grading	44.7
GPs' attitude to practice nurses	44.3
Lack of opportunities for further training	43.7
Nurses inability to prescribe	41.5
Nurses' lack of self confidence	41.2
Views of family health services authority	41.1
District nursing managers' attitudes	40.6
Lack of availability of equipment	40.4
Lack of proper job definition	38.5
Lack of opportunity to extend role	32.6
Nurse has no desire or need to extend role	31.3
Confusion between role of nurse and doctor	26.4
Patients' perceptions of practice nurses	24.9

n = range of number of respondents replying to the questions.

Changes following the 1990 contract. To meet the increased workload of the 1990 contract, 50.7% of respondents had created a new nursing post, 83.1% had expanded the role of existing nurses, and 22.3% of respondents were considering buying time from their district health authority.

Changes to the practice nurse's role following the 1990 contract were surveyed (Table 4). The percentage of doctors considering whether the employment of a nurse to carry out the tasks was justified is also shown in Table 4. Employing practice nurses to run health promotion clinics was cited most frequently by respondents, and child health surveillance clinics least frequently.

Table 4. Percentage of respondents directly employing a nurse to help fulfil contractual obligations, and percentage considering that using a nurse for the tasks was justified.

	% of respondents	
Task	Directly employing nurse (n = 1878–1905)	Considering employing nurse justified (n = 1819–1883)
Running health promotion clinics	87.3	87.4
Carrying out three yearly patient health checks	77.0	71.1
Carrying out new patient registration checks	75.8	76.4
Making annual home visits to over 75 year olds	51.0	63.3
Running child health surveillance clinics	26.7	48.8

n = range of number of respondents replying to the questions.

Use of job descriptions and protocols. When asked if practice nurses had a job description, 87.4% of respondents replied that they did. No written protocols were used in 20.8% of cases and 62.0% reported that written protocols were used for a few specified conditions; 28.0% of respondents reported that they were used for a wide range of conditions (some respondents chose more than one option).

When asked if they were satisfied overall with the role of the practice nurse within their practice, 90.0% of general practitioners replied that they were. Approval of the changes in practice nursing which have resulted from the 1990 contract was expressed by 69.1% of respondents.

Cross tabulation of associated factors

Cross tabulation of various factors was undertaken. Approving of independent nurse practitioner status was found to be associated with general practitioners qualified for less than 10 years (56/139 versus 505/1753, $\chi^2=8.14$, $P<0.05$); membership of the Royal College of General Practitioners (257/698 versus 243/949, $\chi^2=21.61$, $P<0.001$); being a vocational trainer (120/322 versus 384/1373, $\chi^2=10.79$, $P<0.001$); and innovator status, that is those practices having a treatment room, a computer, employing a practice manager, and holding regular staff meetings (291/866 versus 229/862, $\chi^2=10.17$, $P<0.001$).

Restrictive behaviours for role development of the practice nurse (not providing job descriptions or protocols from which to work) was associated with non-membership of the RCGP (49/762 versus 13/615, $\chi^2=14.75$, $P<0.001$); being a single-handed general practitioner (16/121 versus 59/1436, $\chi^2=20.2$, $P<0.001$); not being a trainer (65/1112 versus 3/276, $\chi^2=10.75$, $P<0.001$); urban location (38/570 versus 37/971, $\chi^2=6.33$, $P<0.05$) and viewing practice nurses as employed to do given tasks only (11/117 versus 63/1412, $\chi^2=5.73$, $P<0.05$).

Discussion

The imposition of the 1990 contract for general practitioners[12] with its increased demands has led to a rapid expansion in practice nursing. While this survey shows that practice nurses are performing many valuable tasks, attention must focus on how they may develop their full potential.

Of the general practitioners surveyed 90% wished to see further expansion of the practice nurse's role, 94% felt that patients should be able to refer themselves directly to a nurse, 93% felt that practice nurses should extend their role from basic nursing tasks to counselling and advice roles, and 30% felt that practice nurses should be independent practitioners. Only 10% felt that practice nurses were employed to do only given tasks and not to diagnose. It would seem that the majority of general practitioners wish the role of the practice nurse to evolve from that of a task oriented assistant, and their enlightened views are encouraging.

Since the new contract 50% of respondents had taken on new nurses to cope with the extra workload and 83% had expanded the role of their existing nurses. These nurses are breaking new ground, undertaking new patient registration checks, running health promotion clinics and visiting the homes of those aged over 75 years. This expansion draws attention to the adequacy and standard of training received by these practice nurses for their new role.

Resources are needed to expand the role of the practice nurse; 76% of general practitioners felt that lack of space was a factor preventing role expansion, 63% felt some uncertainty over salary reimbursement, 45% noted nurse's lack of time and 44% felt that lack of opportunities for further training might limit role expansion. This contrasts with the practice nurses in the study by Greenfield and colleagues who considered lack of training to be the most important hindrance to role extension.[5]

Increased responsibility will go hand in hand with an expanded role. This study found that 73% of general practitioners felt that practice nurses should be legally responsible for their own actions. The view that practice nurses are able to work only within agreed protocols, to make a diagnosis and to treat was shared by 31% of general practitioners; 40% took a less restrictive view, that practice nurses are able to diagnose and initiate treatment for certain conditions independently. These views most strongly correlated with general practitioners' acceptance of nurse prescribing, only 27% of general practitioners considering that practice nurses should never prescribe.

Within primary care there exists a group of general practitioners who are receptive to the concept of an independent nurse practitioner. These general practitioners were more likely to have been qualified for less than 10 years, to be members of the RCGP, to be vocationally approved trainers, and to be in innovative practices. With their experience of training these doctors could be an asset to the future development of practice nursing.

If practice nurses are to be more autonomous they will need support. The danger exists of professional isolation and exploitation on the one hand and being caught in a struggle for the ownership of their role on the other. Cooperation between doctors and nurses, such as in the RCGP's practice nurse task force report, is essential.[13] Failure to respond to this challenge will result in practice nurses becoming disillusioned by a lack of guidance and a loss of professional integrity.

Teamwork in primary care nursing needs reappraisal. The present situation produces two groups of nurses: practice nurses employed by general practitioners, and community nurses, midwives and health visitors employed by the district health authority. This does not lend itself to an integrated team which shares common aims.[14] General practitioners may be reluctant to relinquish control over their practice nurses, as they fear their present flexibility will be lost to a more bureaucratic approach. One solution to this problem would be to explore more involvement by the family health services authority. If they were to hold the practice nurses' contracts through a nurse superviser employed by the family health services authority, then practice nurses could be more autonomous, but still share aims with general practitioners. In time, as the purchaser–provider system grows, family health services authorities may become integrated into district health authorities, producing a single authority involved in primary care, thus reducing the present problem of fragmented nursing services.

Parallels exist between the present professional development of practice nursing and the historical development of general practice into a separate discipline.[15] Is it possible to overcome the problems for practice nurses, namely their method of employment, their limited funds for training and their professional leaders, few of whom have been practice nurses?

The key to these problems must lie in training of both general practitioners and practice nurses. For general practitioners the training should include understanding and facilitation of the developing role of the independent nurse. Development of individual skills, confidence and professionalism are vital ingredients for practice nurse training. This should take place in the setting of general practice, to ensure speed of change and team involvement.

It is essential that training programmes for practice nurses fit within the statutory framework of post-basic registrable qualifications, and recognize the current debate and developments in post-registration nurse education.[8,9] The review by the English National Board for Nursing, Midwifery and Health Visiting proposes that students have a mentor, that they have an assessor of practice, that experienced practice nurses are involved as sessional teachers, and that there are learning contracts.[9] This parallels vocational training for general practitioners.

A national training scheme for practice nurses, adopting a multidisciplinary, practice based approach, building upwards from existing workers with experience of practice nursing, has much to recommend it. Desired standards for training could be defined and agreed by all the agencies involved. Nurse teaching practices could be established, based on mandatory criteria, and involving as teachers both general practitioners and practice nurses with suitable practical experience. This could provide a setting for the realization of the aims of the practice nurse training review.[9] Flexibility in training would be needed to offset the problems facing practice nurses with varying educational needs and who may have children and who may work part time.[5] With participation of the many agencies involved towards a common purpose, an atmosphere could be created allowing general practitioners to reduce their ownership of the role of the practice nurse, in the knowledge that practice nursing would evolve flexibly and responsively to the needs of patients, nurses and doctors.

Integration of the primary care team, and a national training scheme for practice nursing, built on coordinated planning and existing achievements, would be of enormous benefit to patients. This change is long overdue.

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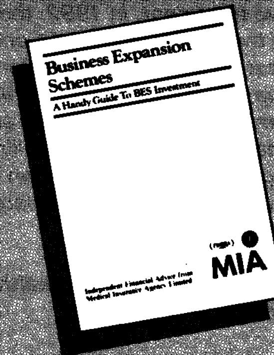

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