Delegation to nurses in general practice

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SUMMARY. A random sample of general practitioners and their nursing staff was interviewed to examine the extent to which the doctors delegated medical tasks to the nurses and to analyse attitudes towards delegation. A significant minority of both doctors and nurses were reluctant to have minor clinical tasks delegated and a majority did not think that nurses should carry out delegated diagnostic procedures. Doctors and nurses who had completed their training since 1960 were more likely to favour delegation than those who had completed their training before 1960. This suggests that delegation may become more common. However, the finding that there is considerable opposition to delegation and that this opposition is often based on feelings of professional threat suggests that many doctors may not be ready to experiment with ways of expanding the nurse's role in general practice.

Introduction

STUDIES of nurse practitioners and physicians' assistants in the United States and Canada suggest that non-doctors can assess safely whether patients need to see a doctor and that they can also do many things traditionally performed by the doctor (Spitzer *et al.*, 1974). Little research has been carried out in Britain on the extent of delegation in general practice or on the scope for its expansion. We know from the study by Reedy and colleagues (1976) that attaching nurses to general practice is now common and that such nurses spend some time carrying out procedures in doctors' surgeries. Doctors are also increasingly employing their own nurses to work in treatment rooms. According to the same study there were 3,100 such nurses in 1974. However, in relation to the total number of general practitioners this figure is small. Moreover, Reedy and colleagues (1980) later found that nurses employed in general practice work only approximately 23 hours a week and that most of this time is spent in the surgery. Although the attached nurses employed by the area health authorities to work in the community were found to work 39 hours a week, only 18 per cent spent more than two hours a week in the practice premises. This is too short a time to make delegating tasks from doctors to nurses likely.

Most delegation studies have been based on individual practices, with the result that little is known about the prevalence or regularity of delegation. The recent national study of nursing activities in primary care (Reedy *et al.* 1980) showed that general practitioner-employed nurses scored higher than attached area health authority-employed nurses in carrying out technical procedures such as venepuncture, ear syringing and incision of boils. All nurses in the above study were asked whether they had ever performed such tasks during their present employment or attachment and during the previous month. In the case of each procedure listed fewer, sometimes considerably fewer, of the nurses had done them in the last month. Unfortunately, the frequency or regularity with which nurses performed the tasks was not measured.

Even less is known about doctors' and nurses' attitudes towards delegation. A recent postal survey of 533 randomly selected general practitioners (Miller and Backett, 1980) found that 45 per cent of doctors saw a permanent place for treatment room nurses undertaking an expanded role. Unfortunately the authors asked doctors about delegating groups of tasks rather than individual tasks. For example, they asked about history-taking, examination, diagnosis and advice on treatment all in the same question. Thus no data exist on doctors' (or nurses') opinions about delegating specific tasks in general practice.

Aims

This study was designed with the following objectives:

1. To document the extent of delegation in general practice in four urban areas of England and Wales.
2. To analyse general practitioners' and primary health care nurses' attitudes towards the delegation of medical tasks in those four areas.

Method

Four urban areas of England and Wales were selected

Table 1. Proportions of 68 survey doctors who delegated tasks in surgery.

	Frequency procedure delegated (per cent)		
	Regularly	Occasionally	Never
Injections, dressings, suture removal*	38	31	31
Immunizations and vaccinations	32	16	52
Ear syringing	43	19	38
Venepuncture	19	15	66
Cervical cytology	4	4	92
Minor surgical tasks, e.g. incision of boils	—	—	100

*These three activities were grouped after conducting a pilot study which showed that, if one was delegated, the remaining two inevitably were.

for study. For reasons of convenience these were Kingston-upon-Thames, Croydon, Swansea and Newport. In each area a random sample of 20 doctors was selected from the lists of the local family practitioner committees. Sixty-eight (85 per cent) of the 80 doctors sampled in this way were interviewed successfully. Their personal characteristics were representative of all general practitioners. The district nursing sisters and treatment room nurses with whom they worked were also contacted. Seventy-five (99 per cent) of the 76 nurses sampled were interviewed successfully; these comprised 30 treatment room nurses and 45 district nursing sisters. All were state registered nurses. Treatment room nurses may be defined as those who work predominantly in treatment rooms; they are usually privately employed by doctors but, in the case of health centres, may be attached to practices by area health authorities. District nursing sisters are nurses employed by area health authorities to work predominantly in patients' homes and who are attached to practices. These two groups are not necessarily mutually exclusive: district nursing sisters often perform procedures in the surgery and treatment room nurses may visit patients at home.

The results were analysed by computer using the Statistical Package for the Social Sciences. Chi-square tests, Fisher's exact test and tests of proportions were used to test the results presented and they satisfied a critical region of 0.05.

Results

Doctors

Frequency of delegation (Table 1)

Many of the doctors occasionally delegated minor clinical procedures to nurses. However, far fewer delegated them regularly. For example, in no case did the proportion of doctors regularly delegating a particular procedure exceed 43 per cent.

Doctors who delegated on a regular basis three or more of the six groups of clinical tasks listed in Table 1 were classified as practising a high degree of delegation, and doctors delegating tasks less frequently, or delegating fewer tasks, were classified as practising a low degree of delegation. Altogether, 31 per cent practised a high degree of delegation and 44 per cent a low degree. A quarter practised no delegation in the surgery at all.

Who were the delegating doctors? (Table 2)

Doctors practising a high degree of delegation were more likely to practise with a group of doctors, to be more recent medical graduates and to undertake a wider range of procedures and activities. They were also more likely to have a higher degree of practice organization, measured by the possession of a treatment room nurse and an appointment system.

Doctors' attitudes towards delegation

A proportion of doctors who did not delegate particular clinical procedures regularly were nevertheless in favour of doing so. For example, 62 per cent were in favour of delegating injections, dressings and stitch removal, 54 per cent favoured delegating immunizations and vaccinations and 49 per cent ear syringing. For venepuncture, cervical cytology and minor surgical tasks the proportions were 58 per cent, 49 per cent and 62 per cent respectively. Yet approximately a tenth to a quarter of all these doctors would not actually delegate the task regularly themselves. In no instance would more than half of those doctors who never delegated particular tasks be willing to delegate them regularly in the future. Doctors with favourable attitudes towards delegation were similar in their characteristics to those already practising a high degree of delegation (Bowling, in press).

When asked more fully about their views on delegation, doctors mentioned three main types of advantages and four main disadvantages. Almost half, 49 per cent, said that delegation saves the doctor's time. One young doctor said:

> "Younger doctors are beginning to realize that there's so much more you can do with general practice given the time. I didn't do biochemistry to spend my life syringing ears."

Fewer (16 per cent) mentioned that delegation results in a better distribution of skills, or that delegation increases the doctor's satisfaction with work (18 per cent).

The opposition to delegation among those with unfavourable views often appeared formidable. For example, 35 per cent felt that delegation threatens the independence of the doctor. These tended to be doctors graduating before 1960. For example, one of these doctors said:

> "I don't want anyone interfering in my practice. I prefer to work completely on my own. You're more independent this way. I don't even like working with other doctors. I can see younger doctors may be more willing to look at this delegation more seriously, but general practitioners of my age-group are too insular.

Table 2. The extent of delegation and characteristics of delegating and non-delegating doctors.

	Percentage of doctors practising		
	A high degree of delegation in surgery (21 doctors)	A low degree of delegation in surgery (30 doctors)	No delegation in surgery (17 doctors)
Practices with three or more doctors	*90*	*57*	*18*
Graduated 1960 or later	*48*	*23*	*23*
Technical procedures are performed in the practice (cervical cytology, electrocardiographs, haemoglobin levels, erythrocyte sedimentation rate)	*81*	*40*	*12*
Holds special clinics	*71*	*50*	*24*
Has part-time hospital appointment	*48*	*10*	*24*
Has special medical interest (excluding psychiatry)	*48*	*43*	*12*
Has a full appointment system	*90*	*70*	*24*
Has a treatment room nurse	*100*	*7*	—

> The thing is, general practice was the first career choice for many doctors in my day because it meant you really were an independent practitioner. We tend to equate independence and clinical freedom with the freedom to do exactly what we want with no interference."

Twenty-six per cent of doctors felt that delegation does not save the doctor's time but simply creates more work because of the general incompetence of ancillary staff. One elderly doctor practising from a partnership of two said:

> "I do all the ear syringing, everything in fact. If you ask someone else to do things they will invariably be cocked up."

These doctors felt that ancillary staff merely "get under your feet" and create more work by "consulting you all the time".

Twenty-two per cent of doctors were reluctant to delegate minor clinical tasks because they believed them to be properly within the role of the doctor. These doctors tended to feel threatened by the concept of delegation. For instance, one doctor asked:

> "But what would I do instead if I delegated all this? I really think, after all, that these procedures should remain in the doctor's province."

Sixteen per cent also mentioned the doctor-patient relationship as a legitimate reason for not wanting to delegate tasks. It was felt that the introduction of a third person would form a barrier between doctor and patient. The concept of personal doctoring was taken literally:

> "You know, relationships between people don't happen instantaneously. They're the result of a collection of small events. A minor procedure such as ear syringing can seal that relationship. It's the doctor-patient relationship that's so important."

Delegating tasks involving decision-making skills

Doctors were asked whether they ever delegated initial home visits which require nurses to make a diagnostic decision about whether a doctor's visit is necessary. Twenty-three per cent of doctors delegated such visits occasionally, 44 per cent were in favour of delegating them regularly and 90 per cent of these would delegate them themselves. They were also asked about initial screening by a non-doctor in the surgery, about delegating history-taking and preparing patients to see the doctor. Only 26 per cent of doctors were in favour of initial diagnoses being made by a non-doctor in the surgery and fewer, 15 per cent of all doctors, would actually have been willing to delegate this themselves. Fifteen per cent were in favour of a non-doctor simply preparing each patient for the doctor and taking a brief medical history; 12 per cent of doctors would have been willing to delegate this themselves. These figures suggest that it is mainly in the surgery that doctors are unwilling to forgo being the professional who makes the first contact.

Doctors mentioned five main disadvantages of delegating initial screening in the surgery. Fifty-one per cent said that they should remain the professional of first contact because only fully qualified doctors could or should diagnose. A further 10 per cent said this was because initial screening by a non-doctor would make them redundant. For example, one doctor said:

> "Of course, one of the problems of this . . . is that I'd be done out of a job then. General practitioners are no more than physicians' assistants these days. The work is very repetitive and untechnical. After a few years in practice you forget any skills you once had."

Nineteen per cent felt that the doctor should remain the first contact because only they could recognize emotional problems, which may be camouflaged by trivial complaints. This source of opposition stemmed not solely from concern for patients, but also from professional considerations, as the following statement reveals:

Table 3. Type of nurse performing clinical tasks in the surgery.

	Percentage of district nurses performing task (45 nurses)			Percentage of treatment room nurses performing task (30 nurses)		
	Regularly	Occasionally	Never	Regularly	Occasionally	Never
Injections, dressings, suture removal	2	49	49	80	20	—
Immunizations and vaccinations	—	16	84	57	43	—
Ear syringing	9	31	60	80	17	3
Venepuncture	—	13	87	37	23	40
Cervical cytology	—	—	100	17	7	76
Minor surgical tasks, e.g. incision of boils	—	—	100	—	13	87

> "I'm one of the newer schools of thought who are trying to make general practice a specialty in its own right . . . I think the future of general practice lies in concentration upon patients' emotional problems, and the successful treatment of such problems depends on the establishment of a good doctor–patient relationship. The use of intermediaries to initially screen patients would lead to more barriers between doctors and patients. This would be to the detriment, not only of the patient, but also of general practice. General practice would become just clinical medicine with no distinctive features of its own."

Thirteen per cent of doctors argued that using intermediate health care personnel to screen patients initially would lower the standard of care. Finally, 28 per cent said that such a system should not be introduced because patients would not like it. Doctors tended to feel that patients expected to see the most highly trained personnel available: "They come to see the doctor, no-one else."

Nurses

Attitudes towards delegation

What about nurses' views? Table 3 shows the distribution of clinical tasks performed in the surgery by treatment room nurses and district nursing sisters.

Their attitudes towards carrying out their delegated clinical tasks were similar to those of doctors towards delegating them. For example, 70 per cent of those nurses not performing injections, dressings and stitch removal regularly in the surgery and 67 per cent of those not performing immunizations and vaccinations regularly were in favour of doing so; 57 per cent of nurses not performing ear syringing regularly, 61 per cent of those not performing venepuncture regularly, and 54 per cent of those not performing cervical cytology regularly were in favour of carrying out these procedures. Fifty-five per cent of all nurses were in favour of performing minor surgical procedures regularly. Again, a small number of nurses with favourable attitudes would not actually perform the tasks themselves.

Treatment room nurses were more likely to favour delegation than district nurses. Fifty-eight per cent of treatment room nurses were in favour of performing at least four of the six listed clinical tasks, in comparison with four per cent of the district nursing sisters. The prospects for expanding at least the role of the treatment room nurse in the surgery are therefore encouraging. Not unexpectedly, district nurses prefer to concentrate on caring for patients in their homes rather than assisting the doctor in the surgery.

When asked for their views in more detail, nurses mentioned a number of advantages and disadvantages. Seventy per cent said that carrying out delegated medical tasks increases their job satisfaction; 21 per cent disagreed, saying that expanded roles in the surgery are not satisfying. Eight per cent felt that performing delegated medical tasks raises the status of their profession; 15 per cent argued that it lowered it. One nurse said:

> "Delegation may save the doctor's time but by implication the nurse's time is seen as less valuable. I think all this business of delegation is really pure pig headedness on the part of the doctor, with only his time being saved. There's no way we are going to be treated as equal health professionals with that attitude."

A number of nurses were aware of the present debate about the nurse's role. Fifty-one per cent argued that performing delegated clinical tasks was not within the scope of their job; 84 per cent of these were district nurses. They tended to define nursing as caring rather than technical work. As one district nurse said:

> "Sometimes patients come home to an empty house, so we have to boil the kettle for them, look for some clean clothes, light the fire. If I didn't go in I don't know how patients would manage. If you're in the community it really is nursing. Nurses in hospital, just like those in the surgery, are just like technicians. They're getting away from nursing."

The nurses mentioned two other main advantages of expanding their clinical role. Thirty-four per cent said that delegation saves the doctor's time and 17 per cent said it saved the patient's waiting time. On the other hand, 19 per cent said they personally would not want the greater degree of responsibility delegation would bring. Seventy-nine per cent of these were district nurses. Nurses often seemed uncertain about whether they wanted to expand their role. For example, 73 per cent said they would like to expand their role in the surgery, but, as we have seen, 51 per cent, in reply to an

open question about delegation, argued that clinical tasks delegated by the doctor were not within their role.

Performing tasks involving decision-making

What did nurses think about doing things which require some degree of autonomy? They were asked about doing initial home visits, the initial preparation of patients in the surgery, including history-taking, and initial diagnostic screening in the surgery. Few, five per cent, said they prepared patients for the doctor and took medical histories. Sixteen per cent occasionally performed initial home visits for diagnostic reasons. No nurse undertook initial screening in the surgery. With the exception of initial home visiting, nurses' attitudes towards taking on decision-making tasks were more favourable than doctors' attitudes towards delegating them. Sixty-two per cent of nurses who were not preparing patients for the doctor and taking medical histories were in favour of doing this regularly. Thirty-nine per cent were in favour of nurses carrying out initial screening in the surgery. Fewer, 25 per cent, were in favour of regularly undertaking initial home visits. As before, a minority of nurses with favourable attitudes would not have been willing to undertake the tasks themselves. In the case of initial screening in the surgery, the proportion was as high as 31 per cent. In summary, while doctors appeared reluctant to give up being the professional of first contact in the surgery, and were more enthusiastic about delegating initial home visits, the reverse was found among nurses. They preferred to undertake initial screening in the surgery because they felt it involved less responsibility than such screening in the home. For example:

> "I wouldn't mind seeing patients first in the surgery, but I wouldn't do it in the home. In the surgery there's always the doctor there if you need any advice, but he's not there in the home."

Nurses in favour of initial screening in the surgery were more likely to have qualified in 1960 or later (68 per cent, in comparison with 49 per cent of other nurses). No differences were found between district nurses' and treatment room nurses' attitudes on this issue.

When questioned about the advantages of initial screening in the surgery, 29 per cent of nurses said it saved the doctor's time and 20 per cent said that if nurses did this they would obtain more satisfaction from their work. All these nurses were treatment room nurses.

A number of disadvantages were mentioned. Thirty-two per cent argued that initial screening was not within their role; these nurses tended to have qualified before 1960 and tended to emphasize the caring aspect of their role:

> "This is getting away from nursing. I wouldn't want to be a mini doctor."

Thirty-two per cent also felt that only a fully qualified doctor could diagnose safely. Nurses, as well as doctors, appear to need re-educating before such a system could be introduced on a wide scale. As one nurse said, they felt that:

> "It's dangerous to have someone who's undertrained."

Thirty-seven per cent said that patients would never accept nurses carrying out initial screening. For example:

> "I think there would be a punch-up out there in the waiting room if anyone said they weren't ill enough to see the doctor."

Twenty per cent of nurses also said that opposition from doctors would prevent any initial screening scheme being implemented. They believed that the doctors would feel dispensable and thus threatened.

Discussion

It is possible that, as more doctors practice from groups and take more interest in efficient methods of practice organization, delegation may become more common. These changes may occur as recent graduates replace older doctors. Older doctors possibly define independence more rigidly and regard teamwork as alien to this concept. It may be difficult to alter the attitudes and practices of earlier graduates who have had longer experiences of unaided practice. It appears from this research that doctors are particularly reluctant to delegate tasks which are clearly within their role, such as diagnosis. At present one of the few clearly defined aspects of the general practitioner's role is that of professional of first contact. Until definitions of the general practitioners' role go beyond such superficial descriptions, they are unlikely to wish to delegate this aspect of it. As doctors may also feel that the element of decision-making involved in being the professional of first contact is central to the autonomy of their profession, it is not unexpected that they may be anxious to preserve this contact. The suggestion that someone other than the doctor sees patients first introduces an element of dependence on assistants which may be seen to conflict with their professional autonomy.

A significant minority of nurses were also opposed to their clinical role in general practice being expanded. This was particularly true of diagnostic functions. However, more nurses than doctors were in favour of nurses undertaking a diagnostic role in the surgery. They apparently feel less threatened by this issue than doctors, despite the implications adopting such a role may have on the professional status of nursing (Bowling, 1980). Although the nurses expressed a certain amount of confusion over the issue of an expanded role, the prospects for delegating more clinical, if not diagnostic, tasks to treatment room nurses appear good. However, most nurses felt untrained for an expanded role and said that a national training course for treatment room nurses was essential. The Joint Board of Clinical Nursing Studies (1978) has rejected the idea of a uniform

national training course, on the basis that courses should be organized locally, catering for local needs. But until delegation patterns are more uniform and nurses receive the same amount of training in treatment room work, confusion and controversy over the types of task which can be delegated are likely to continue.

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Adverse reactions to prescribed drugs in the elderly

Of 1,998 patients consecutively admitted to geriatric medicine departments in England, Wales and Scotland in 1975–76, 81.3 per cent were receiving prescribed drugs at the time of admission. Adverse reactions were noted in 248 patients, representing 15.3 per cent of prescribed drug takers. In 209 of these patients, it was thought that an adverse reaction had contributed to the need for admission to hospital. Full recovery from adverse reactions and sequelae occurred in 68 per cent of those with such reactions. Hypotensive drugs, anti-parkinsonian drugs and psychotropics carried the greatest risk of adverse reactions, although the largest single number of adverse reactions (60) were due to diuretics, which were by far the most commonly prescribed drugs (37.4 per cent of sample).

Source: Williamson, J. & Chopin, J. M. (1980). Adverse reactions to prescribed drugs in the elderly: a multicentre investigation. *Age and Ageing,* **3**, 73.