The social and occupational characteristics of attached and employed nurses in general practice

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SUMMARY. We compared the social, professional, and occupational characteristics of nurses employed by area health authorities and nurses employed by general practitioners by interviewing random samples of 153 nurses in 113 practices situated in four rural and five urban area health authorities in England. The two kinds of nurse were similar in most professional respects but differed in their social characteristics, career patterns, and terms and conditions of employment. They also differed in the singleness of their commitment and the hours they worked in the study practices.

Introduction

FOR many years there have been two sources of nursing in general practice. Since the nineteenth century, local authorities have employed qualified nurses to provide care at home for the patients within a specified district and this responsibility was incorporated in the National Health Service Acts. Subsequently the Health Services and Public Health Act of 1968 encouraged these nurses to attend patients also in general practitioners' surgeries and in clinics. During the 1960s, concepts such as 'liaison' and 'attachment' were introduced to encourage a closer relationship with the general practitioners and to develop the ideology of the health team. After 1968, the number of practices to which nurses became attached increased considerably (Reedy *et al.*, 1976) and 67 per cent of general practitioners now say that they have attached nurses (Cartwright and Anderson, 1979).

In addition, some general practitioners have for many years employed nurses to work in their surgeries and carry out technical procedures such as injections and venepuncture (Taylor, 1954). The number of practices employing these so-called 'practice' nurses increased after 1966 when their salaries were partly reimbursed by the NHS and by 1975 (Reedy *et al.*, 1976) 24 per cent of the practices in England employed one or more nurses, with a total of over 3,100. Recently Cartwright and Anderson (1979) found that 36 per cent of doctors now employ their own nurses.

Thus, the employment of nurses by doctors has increased despite the progressive attachment to practices of nurses employed by the area health authorities. Although the work of these two groups appears to be complementary—the former in the surgery and the latter in the home—the employment of nurses by general practitioners is not favoured by the nursing profession (Skeet, 1978). They are felt to be isolated from the main body of nursing and compromised professionally by their employee relationship with doctors. The apparent predominance of technical (or medical) activities in their work is seen as a dereliction of the 'caring' ethic of nursing. There is also a belief that their pay and terms and conditions of service have not kept pace with nationally agreed criteria for the nursing profession.

For convenience we will refer to the nurses as 'attached' or 'employed' in the remainder of this paper.

Aim

Our study was designed with the following objectives:

1. To compare the social, professional, and employment characteristics of attached and employed nurses.

2. To examine their careers and occupational history and the extent of their commitment to the study practices.

Method

Three clusters of area health authorities in England were selected at random to represent different levels of nurse

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Table 1. Distribution of nurse respondents between practices.

	Attached nurse only	Employed nurse only	Combined arrangements: Attached nurse	Combined arrangements: Employed nurse	Totals
Number of practices	41	32	40		113
Number of nurses	41	32	40	40	153

Table 2. Social class of nurses in the survey (given in percentages).

Social class	Ever-married nurses: Attached	Ever-married nurses: Employed	Ever-married nurses: All	By head of household, Great Britain 1974
1	*16*	*10*	*14*	*4*
2	*50*	*54*	*51*	*15*
3 (Non-manual)	*11*	*7*	*10*	*20*
3 (Manual)	*14*	*26*	*17*	*32*
4+5	*6*	*3*	*5*	*26*
Other	*3*	*0*	*3*	*3*

employment and attachment in the practices. We then excluded practices with neither attached nor employed nurses and from the remainder we selected 113 practices of which almost equal numbers had each of the three possible combinations of nursing resources. From each of these practices, one nurse of each kind (as available) was selected at random and we interviewed 72 employed and 81 attached nurses (Table 1). The samples of nurses were weighted and thus we give our estimates of values only as proportions in the population. This sampling scheme and analysis ensure that our results are free from bias.

Results

When differences between values are specified in the text, these are significant at or below the one per cent level of confidence. Other levels of significance are specified in brackets.

Social characteristics of the nurses

At the time of the survey, the attached nurses were younger on average (41·6 years) than the employed nurses (47·6 years) of whom 18 per cent were older than the retiring age for women. The employed nurses were more likely to have been married than the attached nurses, the marriage rates being 92 per cent amongst the former and 75 per cent amongst the latter. The figure for all economically active women aged 20 to 64 in the UK in 1974 was 79 per cent (Central Statistical Office, 1975, 1976). However if the 'ever-married' rates at the different age groupings for the sample of attached nurses are applied to the sample of employed nurses, then only 75 per cent of the employed nurses could be expected to be ever-married. Thus the difference in marital status of attached and employed nurses is unlikely to be due to their different age structure.

Table 2 shows that the ever-married attached and employed nurses do not differ in the distribution of social class but all the nurses differ in this respect from the working population of Great Britain in 1974 (Central Statistical Office, 1975, 1976), being biased towards social classes 1 and 2. This finding does not appear to be accounted for by the influence of a medical relative

Table 3. Qualifications of the nurses (given in percentages).

	Attached nurses	Employed nurses
Basic qualifications		
SRN	*73*	*90**
SEN	*27*	*10*
Other qualifications		
SCM or CMB Part 1	*34*	*35*
RSCN or RFN	*4*	*8*
HV Cert.	*5*	*5*
NDN Cert. or SEN Cert. in DN	*80*	*9*
Other nursing qualifications	*36*	*29*

*Includes one nurse with the RMN qualification.

SRN State registered nurse.
SEN State enrolled nurse.
SCM State certified midwife.
CMB Central Midwives Board.
RSCN Registered sick children's nurse.
RFN Registered fever nurse.
RMN Registered mental nurse.
HV Health visitors.
NDN National district nurse.
DN District nursing.
Cert. Certificate.

because in the unweighted sample there were only two nurses with a father and three with a husband in the medical or a related profession.

These nurses also had similar commitments to dependants in the same house, there being 79 per cent of the attached and 68 per cent of the employed nurses with one or more children living at home. On average, each type of nurse had the same number of children. Only 13 per cent of the ever-married attached nurses and none of the employed nurses had children aged four or under at home. Amongst all the nurses, only six per cent had any other dependent relatives living at home.

The careers and occupational history of the nurses

Table 3 shows that as expected (DHSS, 1976) a significantly higher proportion of attached nurses have the SEN qualification. If the district nursing certificates (which have no equivalent in treatment room nursing) are excluded, then attached and employed nurses are identical in the number of nursing qualifications held, 55 per cent of all the nurses having at least one further qualification. The average age at qualification is higher for enrolled nurses than for registered nurses, being

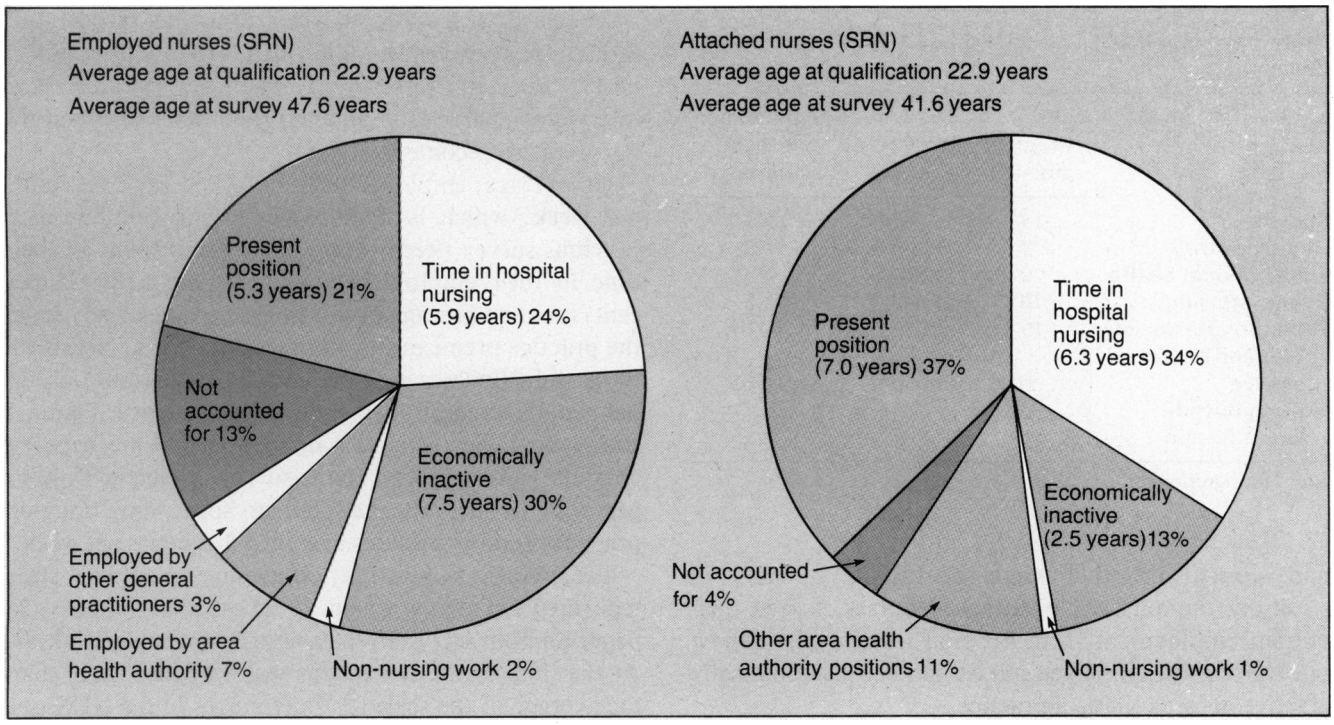


Figure 1. *Careers of attached and employed nurses (SRNs only).*

31·5 and 22·9 years, respectively. For this reason and because there were relatively few enrolled nurses in the sample we will consider only the careers of the attached and employed nurses who were state registered.

Figure 1 shows that their careers differed in two respects apart from the minor and possibly fortuitous difference (significant at the five per cent level) in the time spent in their present position. Employed nurses were significantly older than attached nurses and this finding is mirrored by the difference in the periods during which each kind of nurse had been economically inactive since qualifying. Alternatively, this difference can be expressed by saying that whereas 65 per cent of the attached nurses had been economically inactive (for 3·9 years, on average) amongst the employed nurses, 95 per cent had been economically inactive (for 8·0 years, on average).

All the nurses were trained in hospital-based nursing schools but whereas 45 per cent of the employed nurses had trained at a medical teaching hospital, only 18 per cent of the attached nurses had done so—a significantly smaller proportion. This finding is not related to their social class based on their fathers' occupations but it is associated with their educational attainment on leaving school. Table 4 shows that amongst the registered nurses who subsequently became employed by general practitioners, those who trained at a medical teaching hospital were significantly more likely to have O- or A-level passes. Associated with this finding is a significant difference in the school-leaving age which was 16·8 years on average amongst those who trained in a medical teaching hospital, and 15·8 years amongst those who trained in other kinds of hospital.

Table 4. Type of nursing school and highest pre-nursing qualification obtained (given in percentages).

	Attached SRNs[1]		Employed SRNs[2]	
Location of nurse training school	CSE or no passes *(40%)*	O or A level passes *(60%)*	CSE or no passes *(35%)*	O or A level passes *(65%)*
Medical teaching hospitals	*11*	*21*	*17*	*64*
Other hospitals	*89*	*79*	*83*	*36*

[1]Difference in proportions not significant.
[2]Difference in proportions significant beyond 0.1 per cent.

A majority of the nurses (59 per cent) had worked before training as a nurse, one third of these (29 per cent) in a health-related occupation. Only 22 per cent of the nurses had received any further education not connected with nursing and this was mainly on secretarial courses (42 per cent) or at a technical college (29 per cent). None had been to a university or polytechnic.

After qualifying, identical proportions of attached and employed nurses (43 per cent) had become ward sisters and seven per cent had held the post of matron or its equivalent. There was no difference in the hospital ward or department in which the nurses had worked most recently—34 per cent on a surgical ward, 27 per cent on a medical ward, and 17 per cent in accident and emergency, outpatients or a pathology department. Table 5 shows that, apart from hospital work, the nurses had undertaken similar types of nursing since qualifying but although equal proportions had worked for agencies, significantly more of the employed nurses

Table 5. Other nursing jobs since qualification (given in percentages).

	Attached nurses	Employed nurses	Significance level of difference
Midwife	15	18	NS
Health visitor	4	8	NS
Occupational health	9	14	NS
Agency nursing	10	10	NS
Other private nursing	16	39	<0.01
Forces and prison service	0	8	<0.05
Nursing outside Great Britain	8	7	NS

NS = Not significant.

had worked in other kinds of private nursing. In addition, the majority of attached nurses entered their present employment from hospital work whilst almost one third of the employed nurses had been economically inactive before joining a practice.

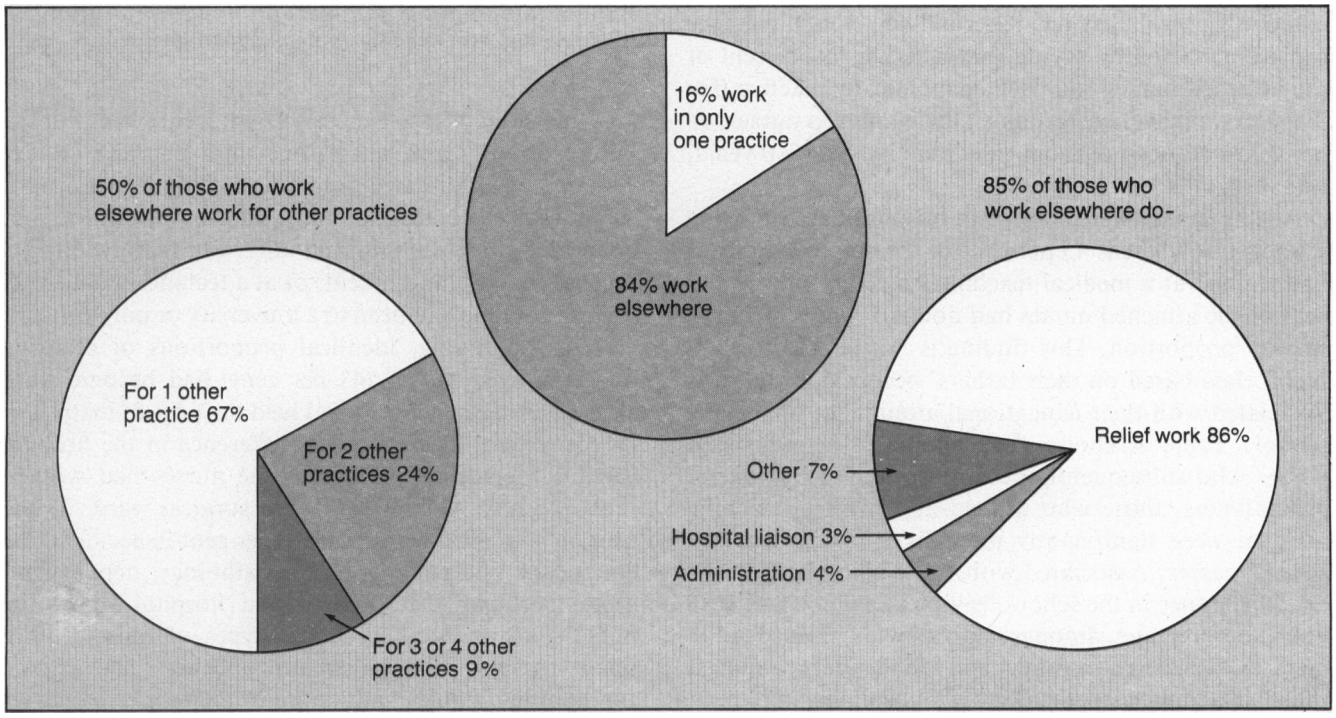
Employment, conditions of service, and pay

Just over half the nurses were recruited through a personal enquiry to employers but whereas attached nurses themselves enquired to an area health authority, employed nurses were usually approached personally by a general practitioner or a member of his staff. The remaining nurses were recruited through friends or the press. Employed nurses were then less likely to make a formal application, to be interviewed or to receive a written contract (Table 6) although practices of three or more general practitioners were significantly more likely to conform with accepted practice in this respect. Although the area health authorities formally interviewed nearly all their nurses, only four per cent of these interviews included the general practitioner to whom the nurse was to become attached.

On average, employed nurses worked for 23·1 hours per week, which is identical with our findings in a previous survey (Reedy *et al.*, 1976), and spent all their time in their employers' practices. One fifth (21 per cent) spent an average of 4·5 hours per week away from the practice premises, mostly on home visits. Nearly all the attached nurses worked a 40-hour week but only 16 per cent devoted all their time to one practice. Figure 2 shows how the remainder divided their time between commitments unrelated to the survey practices. Only 52 per cent of the attached nurses spent any time on practice premises and this averaged 2·2 hours per week.

Table 6 also shows that, on average, employed state registered nurses were paid £1·25 an hour—that is, 35 pence an hour less than the average for attached SRNs. At the time of the survey this was 11 pence more than the average of the scale for staff nurses in the NHS (see Appendix) but 25 pence less than the average of the scale for a nursing sister grade 2. Employed state enrolled nurses also received less on average than attached SENs but the number of nurses is small and the difference is not significant. The pay of employed SRNs varied more than that of any other group—from £0·51 to £2·21 per hour—and the rates were significantly higher in proportion to the time they spent in nursing activities as opposed to reception and administrative work. Employed nurses also received more pay (five per cent level of confidence) if they were members of the Royal College of Nursing and (at the 10 per cent level of

Figure 2. *The commitments of attached nurses.*



confidence), if they worked in an urban area health authority or were employed in a group practice. Their rates of pay were not affected either by the attachment of a nurse to the practice, by the number of their contracted hours, nor by working in a health centre. In contrast with the attached nurses, rates of pay did not increase significantly in proportion with their total duration of service. Apart from pay, the employed nurses were given less leave than attached nurses (including bank holidays) and only 15 per cent of them had a pension or superannuation scheme to which their employing general practitioners contributed.

There was no significant difference between attached and employed nurses in their membership of the Royal College of Nursing and similar organizations (Table 7).

In-service training

Whereas 91 per cent of the attached nurses said that they had access to continuing education, this applied to only 32 per cent of the employed nurses. In practice, 29 per cent and 64 per cent, respectively, of the attached and employed nurses had never received any continuing education during their present employment. On the other hand, 35 per cent and 11 per cent, respectively, of the nurses attended lectures and other educational events regularly and 26 per cent of the employed nurses said that their most recent course had been organized by the area health authority.

Table 6. Employment, conditions of service and pay.

	Attached nurses	Employed nurses	Significance level of difference (where appropriate)
Written application	*93%*	*36%*	
Formal interview	*93%*	*63%*	
Formal contract or letter of appointment	*96%*	*44%*	
Contracted hours	38.8 hours	23.1 hours	
Annual leave	5 weeks	3½ weeks	
Bank holidays (England)	8½ days	7 days	
Hourly gross pay			
Registered nurses			
mean	£1.60	£1.25	<0.1
range	£1.12-2.02	£0.51-2.21	
Enrolled nurses			
mean	£1.14	£1.01	NS
range	£0.92-1.44	£0.68-1.42	
Proportion receiving			
Expenses	*100%*	*60%*	
Overtime pay	*84%*	*68%*	NS
Pension/super-annuation schemes	*94%*	*15%*	

NS = Not significant.

Table 7. Membership of organizations (given in percentages).

	Attached nurses	Employed nurses
RCN	*50*	*46*
NALGO	*8*	*0*
COHSE	*8*	*0*
NUPE	*1*	*0*
Other	*7*	*13*
RCN plus any of above	*4*	*4*
None	*33*	*44*

RCN Royal College of Nursing.
NALGO National and Local Government Officers Association.
COHSE Federation of Health Service Employees.
NUPE National Union of Public Employees.

Discussion

Apart from district nursing certificates, attached and employed nurses are equally well qualified and have had similar hospital experience and appointments. They differ in the tendency for attached nurses to have pursued their careers through NHS organizations, whilst employed nurses have done more private nursing and nursing for non-NHS government agencies. Attached nurses tended to enquire purposively to an area health authority or to have heard of an area health authority job through friends who were nurses, which suggests that they may be orientated towards institutional nursing. Employed nurses have been involved in less orthodox forms of nursing, of which their employment by general practitioners may be seen as another facet.

The two kinds of nurse differ in the duration of their economic inactivity and, when working, in their choice of part-time and full-time employment. However, they have the same commitment to children and other dependants and the difference in their solutions to this classic dilemma of women argues that there may also be differences in their values and attitudes concerning their maternal and work roles. Whilst there is incomplete information about the strategies by which nurses reconcile their dual commitment to full-time working and a home (Hockey, 1976a), it is well established that nurses returning from economic inactivity look first for part-time work and the flexibility to meet family commitments (Hockey, 1976a). These also suit general practitioners, who tend to prefer older married women with children as staff (Williams and Dajda, 1979).

An important effect of a late return to nursing is loss of skill and confidence, and the absence of any other than 'ad hoc' training for the employed nurses is an anomaly. It is encouraging that a proportion of employed nurses had attended area health authority courses recently provided for by a Staff Training Memorandum (DHSS, 1975). Compared with the attached nurses, many aspects of the employed nurses' terms and conditions of service were anomalous despite their

identical membership of negotiating organizations. As expected, the attached nurses' pay and holiday entitlements were based on national agreements and the processes by which they became employed conformed with usual management practice. Amongst employed nurses these processes were less formal and there was inequity in the predominantly lower wage rates, fewer overtime payments, and shorter holidays. It is possible that some general practitioners began by paying their nurses adequately but were unable to keep up with the inflation of salaries and wages. There was also a period when family practitioner committees were unable to increase reimbursements for ancillary staff by more than five per cent per annum.

When our data were collected, only a minority of employed nurses had a written contract but since 1978 the Employment Protection Consolidation Act has required all those in employment for 13 weeks or longer and working 16 or more hours to have a written contract of employment. Despite the lapse of time since the survey, some general practitioners may still be unaware of the law in this respect and a formal reminder may be appropriate, perhaps through the family practitioner committees. However, our data show that general practitioners in group practices and health centres are the better managers in several respects and usually general practitioners distinguish between nursing and other ancillary activities by paying more for the former. Indeed some nurses were being paid much more than national norms.

In view of the frequently expressed anxiety about the consequences of negligence by either attached or employed nurses, it is a reproach both to general practitioners and area health authorities that one third of all the nurses were not members of the Royal College of Nursing or a trade union to give them independent protection against litigation. Employed nurses are not covered by their employer's subscription to a defence society and under certain circumstances, area health authorities might abrogate their responsibility for defending attached nurses and indemnifying them against damages. Whether members of the Royal College of Nursing or not, employed nurses suffer from lack of representation in matters of pay and conditions of service. Despite the formation of a few local groups of practice nurses and of a Society of Primary Health Care Nursing within the Royal College of Nursing, there appears to be no organization which can speak on their behalf with the general practitioners. The employed nurses also suffer by being geographically dispersed whilst their part-time status necessarily impairs their capacity to negotiate with their employers.

Our data also cast doubt on the purposes for which nurses employed by area health authorities are attached to general practices at all. Whereas the employed nurses are selected (by various means) by general practitioners and then work exclusively with the patients of those general practitioners, it was rare for a general practitioner to be involved in the appointment of a nurse who subsequently became 'attached' to his practice. Once attached, only half the nurses spent any time on practice premises. Indeed only 16 per cent worked for one practice whereas the remainder divided their attention between up to three other practices as well as clinics and other activities. It is not surprising that in an earlier study (Reedy, 1980) we found that in 40 per cent or more of the practices in some areas, the general practitioners and area health authorities disagreed whether they had an attached nurse or not. On the nurses' side there has recently been doubt about the meaning and effect of attachment (Hockey, 1976b; DHSS, 1977; Lamb, 1977) and if an exclusive relationship between a nurse employed by an area health authority and a general practice is believed to be the key to creating teamwork in the community, then our data suggest that attachment is not being effective in that respect at least.

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Addendum

Pay scales for nurses employed in the National Health Service at the time of the survey are available from the author. Enquiries about current rates of pay and other aspects of nurse employment should be made to the Secretary, Society of Primary Health Care Nursing, Royal College of Nursing, Henrietta Place, London W1.