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Role and training of nurses working in departments of genitourinary medicine in England and Wales

1. Role

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Introduction

During the past decade the number of cases treated in departments of genitourinary medicine (GUM) in the United Kingdom has increased by over 50%. In contrast to this increase in workload, the number of clinics in England and Wales has hardly altered, and the consultant establishment has risen by only 20%, to an amount barely adequate to deal with the number of patients attending ten years ago.

The increase in patients could be absorbed in several ways; by medical staff working longer hours and reducing their consultation time for each patient, by reducing the number of diagnostic examinations and tests, or by delegating to nurses and other supporting staff tasks usually carried out by doctors.

In 1977 this department carried out a study of the facilities, organisation, and diagnostic and notification criteria in departments of GUM in England and Wales. The results of the study were reported in a series of papers.[1-7] Data indicated that nurses were given varying amounts of responsibility, but the study had not been designed to inquire in depth into the role and training of nurses in departments, and these indications come from the answers to three short questions directed at consultants. We decided that a more comprehensive survey was required, and therefore designed one to define the types of duties and delegated tasks that nurses in clinics could or already perform. We took the opportunity to explore the attitudes of doctors and nurses to theses tasks and investigated the recruitment of nursing staff. We also collected information to assess the amount of training available to, and the job satisfaction of, nurses.

Methods

When we planned the present study there were 189 departments of GUM in England and Wales. We decided to take stratified random samples of 96 clinics, which would provide the required estimates with acceptably low standard errors. Stratification was by the size of the clinic, measured by the number of patients seen yearly, and by details of the nurses' current duties obtained from the previous study in 1977.

We designed separate standard questionnaires to obtain information from doctors in charge of clinics (table I), and senior nurses responsible for running the areas for men and women (table II). Any doctor in the sample who worked in more than one clinic was interviewed in the one where he spent most time. If a nurse running the clinic areas for men and women was responsible for both, only that senior nurse was interviewed. If each area was run by a separate nurse of similar seniority, both nurses were interviewed. Thus

TABLE I *Points covered by questionnaire for doctors*

1. Hospital, sex, and year of qualification.
2. Medical staff complement.
   No of hours doctor personally present in sample clinic.
   Other clinics for which responsible.
3. Teaching commitment to nurses.
   Topics covered and methods used.
4. Delegation of work to nurses (amount, type, and whether doctor present or absent from clinic at time when delegated task performed).
5. Future role of nurses in clinics.
   Training schemes.
6. Recruitment problems and suggestions for improvement.

TABLE II *Points covered by questionnaire for nurses*

1. Age, sex, and marital status.
   Professional grade, qualifications, and length of time in post.
2. Nursing staff complement, grades, and hours worked.
3. Duties currently carried out by nursing staff, and whether doctor present or absent from clinic.
   Percentage of time spent on various duties.
4. Training received.
   Interest in further training.
5. Original reason for choosing the specialty.
   Job satisfaction.
   Expansion of nurses' role.

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in 96 clinics we interviewed 69 doctors and 118 nurses. All the interviews were conducted by one person (JSR).

We sent letters explaining the study and asking for co-operation to the consultants and divisional nursing officers responsible for each of the 96 clinics in the sample. All 96 clinics agreed to take part in the study.

Results

FACILITIES AND MEDICAL STAFF

The random sample of 96 clinics served urban and rural populations throughout England and Wales. Many clinics did not have independent premises, a suite of rooms, or an outpatient area designated for use by the department of GUM for an allocated number of hours per week. Some hospitals did not employ a full time doctor of GUM. A nurse who generally worked in the clinic was, however, usually available. The nurse would be called on to give help whenever she was on duty. Thus nurses were available to provide a service for patients for an average of 13 hours a week when there was no doctor in the clinic.

Only limited demographic information was collected from the 69 doctors interviewed. Fifty eight (84%) were men and 11 (16%) women. The average number of years since qualificatiion was 24 (range 10-43) years. The doctors were asked about the hours that they spent in their main clinic and, if they worked in any other National Health Service clinics, the number of hours these occupied. Fifty six (81%) worked in more than one clinic, and the mean number of hours spent in the clinic where the interview took place was 14½ a week. Most medical staff in the study clinics were consultants (24, 34%) and clinical assistants (26, 38%).

NURSING STAFF AND DUTIES

We interviewed 118 nurses, each responsible for a combined clinic (74) or the male or female patient area of that clinic (44). Most interviewees were female (79, 67%), married (85, 72%), and of sister level (58, 49%). The mean length of time in their present post was 6·7 (range 0·5-36) years, and the average age of those interviewed was 45·1 (range 24-64) years. Thirty (25%) of these nurses had trained in the hospital where they were interviewed, and only one had trained outside the UK. Sixty five (55%) of the nurses interviewed had more than one qualification.

Of a total of 344 nurses employed in the sample clinics, 117 (34%) were shared with other departments. Most of them were of sister or charge nurse or of staff nurse grade. Two hundred and twenty five worked full time (37½ hours a week). The shortfall in full time staff was 10 (one clinic had four full time nurses fewer than necessary), and the shortfall in part time staff was 11.

TABLE III *Mean percentage of working week devoted to nursing duties in the clinic*

Category of duties	*Senior nurses*	*Other nurses*
Clerical and administrative	14·9	10·9
Statistical returns	3·8	1·5
Patient care	49·7	57·8
Clinical duties (extended role)	21·8	22·5
Advisory	9·8	7·3

The duties of nurses in clinics were grouped under five headings: clerical and administrative, statistical returns, patient care, clinical duties (the extended role of the nurse), and advisory. In addition, we recorded whether each of these duties was carried out by the senior nurse (interviewee) or her deputy, other nurses in the clinic, or a technician (non-nursing member of the Institute of Technicians in Venereology). The interviewees were asked to complete a time sheet to try to assess roughly how much time nurses devoted to each of these duties during an average working week. Table III shows which duties took priority.

Clerical and administrative duties

According to the time sheets completed by the nurses interviewed, the mean proportion of time in a working week spent by senior nurses carrying out clerical tasks was 15% but the maximum was as high as 72%. In smaller clinics there was often no receptionist or the receptionist doubled as the doctor's secretary and contact tracer, which meant that nurses spent time finding notes and registering patients. Ordering stores, recalling patients by letter, and attending administrative meetings were the prerogative of senior nurses, whereas the clerical and reception work was fairly equally shared between the other nurses.

Statistical returns

Consultants in charge of clinics are required to make yearly returns to the Chief Medical Officer of their respective countries of the number of cases of specified disease seen in their clinics. Twenty three (24%) of senior nurses, five (6%) of more junior nurses, and three (12%) of the technicians in the sample were responsible for establishing diagnoses from patients' notes and recording them for the statistical returns. This duty accounted for 3·8% of the average working week for senior nurses and 1·5% for others.

Care of patients

This entailed the traditional role of nurses in outpatient departments and, as expected, accounted for the largest percentage of time assessed (49·7% for senior nurses and 57·8% for other nurses). Performing venepuncture and preparing and chaperoning patients

TABLE IV *Mean time senior nurses spent performing various tasks as percentage of time spent on clinical duties (extended role)*

	Mean % of time
History taking	7·5
Examining patients and taking genital tests	36·3
Special procedures, such as prostatic massage or bimanual examination	4·4
Performing microscopy	50·2
Ordering treatment	1·6

during examinations were tasks carried out by most nurses, and nearly as many undertook such procedures as urine testing.

Clinical duties

The duties grouped under this heading were those considered to represent the "extended role" of the nurse. These consisted of taking histories, examining patients and taking genital tests, performing microscopy, and prescribing treatment. These duties represented 21·8% of the working week for senior nurses and 22·5% for other nurses. To examine this area in more detail we asked the senior nurses to analyse the time they devoted to the various categories of clinical duties. Most time was spent on microscopy, followed by examining and taking genital tests (table IV). This breakdown of time relates only to the 21% of the total working week devoted to clinical duties (table III).

History taking — Just over 7% of the time devoted to clinical duties was taken up with history taking. Senior nurses were asked if they regularly took histories from new patients when a doctor was either present or absent from the clinic, or in both circumstances (table V). In twenty two (23%) of the 96 clinics, senior nurses regularly took histories from new patients, whereas in only three more clinics (26% in all) histories were taken from patients at a follow up visit. There was little difference between the percentage of clinics in which other nurses and technicians took histories from new patients (11 clinics, 11·5%) and at follow up (12 clinics, 12·5%).

TABLE V *No (%) of clinics (out of 96 studied) in which senior nurses took histories*

	New patients	*Follow up patients*
Only when doctor present	3 (3·1)	8 (8·3)
Only when doctor absent	8 (8·3)	6 (6·3)
When doctor present or absent	11 (11·5)	11 (11·5)
Total	22 (22·9)	25 (26·0)

TABLE VI *No (%) of clinics in which senior and other nurses examined female patients*

	Senior nurses (96 clinics)	*Other nurses (80 clinics)*
Diagnostic genital tests from new patients	15 (15·6)	11 (13·8)
Tests of cure for candidiasis and trichomoniasis	30 (31·3)	21 (26·3)
Tests of cure for cervical gonorrhoea	24 (25·0)	18 (22·5)
Cervical cytology	22 (22·9)	14 (17·5)
Bimanual examination	3 (3·1)	0

The doctors were also asked if they delegated to nurses history taking from new or follow up patients. In 10 clinics doctors said they delegated taking histories from new men and women patients (and in 21 clinics at follow up) while they were in the clinic. Only 14 doctors claimed to delegate this task in their absence.

Examining and taking tests from patients and performing microscopy — These two duties accounted for most of the time taken up by the nurses' extended role, 36% of which was spent examining patients and taking tests and 50% performing microscopy. Tests from male patients were taken usually by male nurses, occasionally by female nurses, and sometimes by technicians, of whom there were 14 in the study.

In similar numbers of clinics for men senior nurses (in 39% of clinics) and other nurses (in 41% of clinics) took urethral tests from new patients and did so on follow up attendance (senior nurses in 44% and other nurses in 43% of clinics). In smaller numbers of clinics senior nurses (in 21%) and other nurses (in 19%) took rectal tests from new patients, and in 23% and 24% of clinics, respectively, did so at follow up. Prostatic massage was performed only when a doctor was present in the clinic, except in three clinics where the senior nurse occasionally performed this procedure in the doctor's absence.

Nurses in fewer clinics for women (senior nurses in 15 (15·6%) clinics and other nurses in 11 (13·8%) clinics) took diagnostic genital tests from new patients, and most took vaginal tests of cure for candidiasis and trichomoniasis (table VI). Only female nurses took specimens from female patients, and technicians were not used in clinics for women except occasionally with microscopy.

Prescribing treatment — Most clinics in England and Wales keep supplies of the prescribed drugs on site, which ensures that patients receive treatment. Most doctors have a treatment policy, there is easy accessibility to the necessary drugs, and in some circumstances nurses may prescribe for the patients.

TABLE VII *No (%) of clinics in which senior and other nurses prescribed treatment*

Conditions	*Senior nurses (96 clinics)*	*Other nurses (81 clinics)*
Non specific infection	17 (17·7)	4 (4·9)
Gonorrhoea	18 (18·7)	4 (4·9)
Trichomoniasis	15 (15·6)	3 (3·7)
Candidiasis	19 (19·8)	2 (2·2)
Sexually transmitted viruses	9 (9·4)	3 (3·7)
Scabies or pediculosis pubis	12 (17·7)	3 (3·7)
Syphilis	1 (1·0)	0

Nurses were asked who ordered treatment for several individual infections in the presence or absence of a doctor. They prescribed treatment for several conditions, usually by arrangement or after consultation with a doctor. This did not necessitate writing a prescription as drugs were available on the premises in these clinics. The number of clinics in which senior nurses ordered treatment according to clinic policy varied for different conditions but ranged between 15 (15·6%) and 19 (19·8%) for the common diagnoses of non-specific genital infection, gonorrhoea, trichomoniasis, and candidiasis (table VII). According to the nurses this could occur in most instances when the doctor was not in the clinic.

The doctors, however, did not entirely confirm this when asked what instructions nursing staff were given if no medical staff were available and patients needed treatment. Four doctors said nurses were advised to see, examine, and treat after consulting a doctor, a few said nurses were advised to see, examine, and treat patients without prior medical consultation.

Advisory duties

Included in this category were answering patients' queries over the phone or in the clinic, contact tracing, and counselling and teaching patients. Answering patients' queries was largely the responsibility of senior clinic nurses (86%). Contact tracing was performed by few nurses (30% senior and 7% other) and by 12% of technicians. Both counselling and teaching patients were carried out by large numbers of nurses and technicians, and were generally considered by them to be important parts of their role.

Discussion

The consultant staff in departments of GUM continually try to improve the image of the speciality by raising standards of care for patients and staffing levels to cope with the increasing workload. Despite the increasing numbers of new patients attending clinics in the UK, most departments of GUM are forced to struggle with premises and facilities that have not improved or expanded rapidly enough. Too many clinics are still situated at the rear of hospital complexes in old or cramped premises that are difficult to find, and nurses often have to adapt premises for the clinic hours by moving furniture and equipment.

In these circumstances the sexually transmitted disease (STD) service is fortunate to retain the nursing staff that it does. The average senior clinic nurse identified in the study was female, of sister grade, aged 45, married, and had been in post for six years. In addition, 52% of senior nurses had more than one qualification, and the other grade of nurse most often employed was that of staff nurse. Thus in general the nursing team in clinics is of a high calibre.

Though there were 90 doctors in the 96 clinics sampled in the study, their principal medical support was from clinical assistants, usually general practitioners exployed on a sessional basis. The mainstay of the doctors' support therefore seemed to be the regular nursing staff. This is particularly relevant as 81% of the consultants worked in more than one clinic. Many of these peripatetic doctors mentioned how time consuming travelling between clinics became and that delay in reaching clinics was inevitable, which left nursing staff to cope with waiting patients. The study shows that nurses were on hand for patient care for a mean of 13 hours a week longer than medical cover was available. Provided that nurses are adequately trained and receive support from medical and senior nursing staff, this deficit in medical cover, though not ideal, need not seriously jeopardise patient care. It is clear, however, that both medical and nursing staff are working under less than ideal circumstances, and that these must be a disincentive to joining the specialty.

The main role of nurses is that of caring for patients. Administrative and clerical tasks are also part of the role of nurses in varying degrees, and are often unpopular, as nurses prefer to spend time with patients rather than paper.

In recent years the concept of the extended or expanded role of the nurse has aroused much discussion in the medical and nursing professions. The terms "expanded" and "extended" are often used interchangeably, though the trend is to use "expansion" of the nurse's role in nursing and "extension" of the nurse's role in medicine. The DHSS and Welsh Office circular on the extending role of the clinic nurse states that "nurses in both primary and specialist health care have been increasingly involved in tasks, procedures and decisions which have in the past been a medical responsibility.[8] It further states that "the clinical nursing role in relation to that of the doctor may be extended in two ways, by delegation by the doctor and in response to emergency. Where delegation occurs, the doctor remains responsible for his patient and for the overall management of treatment, and the nurse is responsible for carrying out delegated tasks compe-

tently." The Briggs Report considered the question of overlapping functions, and it emphasised the need for closer co-operation between the two professions in the best interests of the patient.[9]

The types of duty in the nurses' extended role influence how the medical profession feels about any expansion of the nurses' function. For example, microscopy is a skill that is essential for diagnosis in a busy clinic and is acknowledged by most doctors and nurses as a duty that could be well carried out by nurses. History taking, however, is a task that many doctors felt should not be left to nurses. Medical training equips doctors to take a thorough history of disease and be alert to other medical problems. Medical history taking in a structured form is, however, already successfully performed by many groups of nurses, including midwives and family planning nurses. Since the implementation of the nursing process, nurses have been routinely taking nursing and general histories from patients in most specialities. In view of the pressure of time and workload in clinics, therefore, it may not be bad practice for nurses to be trained to take a basic medical history and alert the doctor to any problem or symptom outside their capabilities or expertise. This approach has been used for some time in North America.

Examining patients and taking genital tests could also be considered an extension of the nurse's role. In the study many doctors said they would be unable to provide a service if they did not delegate some portion of the examinations to nurses. Delegation was only to nurses trained and trusted by the doctor and when the nurse agreed. Provided that patients were seen by the doctor during the consultation, there was no anxiety about the tests being performed by nurses.

Certain groups of nurses, namely occupational health nurses and midwives, have long been legally able to prescribe treatments and drugs for patients. The occupational health nurses are granted indemnity to prescribe under the Medicine Act by a blanket prescription from the doctor in charge, and midwives prescribe certain drugs to women in labour. In the study when treatments were ordered by nurses, the drugs were given from those stocked on the premises and according to the doctor's treatment policy. No drugs were given without some consultation with a doctor, even though this was sometimes done retrospectively. The nurses ordering drugs were few, and they were experienced in the specialty

Most nurses advised patients. Some said they would like further training to equip them to answer patient queries with more confidence and would like the opportunity to develop this part of their role.

The study has shown that nurses working in GUM carry out several duties delegated by doctors, which has been responsible for shoring up the clinical service. If this is to occur doctors and nurses must trust each other and be happy with what is happening, and the nurses need proper training.

We thank for their patience all the nurses and doctors we interviewed.

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