

# General Practice Observed

## Further nursing care in general practice

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Primary health care teams are well established in British general practice, and further progress will come from re-evaluating the roles and tasks of team members. The practice described here consists of five partners and one trainee serving an urban population of about 17 000. There is a well-integrated team of nursing, social, and lay workers.<sup>1</sup> As there are too few attached district nurses, the practice also employs its own. This paper describes the work of two of these nurses in family planning and well-woman screening.

### Family planning

When the practice decided to undertake formal family planning a nurse was employed to carry out the major part of this commitment. She had attended a local authority family planning course for doctors and nurses and held the approved certificate of the Family Planning Association; one of the doctors in the practice had been trained on the same course. The doctors and nurse met several times before the clinics started and made policy decisions about screening procedures, their frequency, and their recording and designed a family planning record (see figure). They decided to standardise the oral contraceptive preparations used and put all new patients on one of two low-dose oestrogen preparations. If acceptable to the patients all those on preparations containing higher doses of oestrogen would be switched to a lower dose. Two intrauterine devices would be discussed with patients, the copper 7 and the Saf-T coil. It was emphasised to the nurse that any patient wanting to consult the doctor should be encouraged to do so. A doctor would always be available to give any urgent advice during the clinic. The nurse was introduced to the other members of the primary health care team and her role was described to them. She meets the team once a week.

### PROCEDURE

A notice in the waiting room told patients that a family planning clinic was operating in the practice and that appointments could be made for it. Patients completed form FPC 1001 and the receptionists inserted a family planning record into the National Health Service record envelope. The date of registration was recorded on the corner of form FPC 1001, which was detached and stapled on to the family planning card. This confirmed that the patient had registered and reminded the receptionist of the date of reregistration. The receptionists were told that patients requesting repeat prescriptions for oral contraceptives who had not consulted the doctor about contraception for over 12 months were to be given an appointment to attend the family planning clinic. Patients who had been seen within 12 months were to receive a six-month repeat prescription and then to attend the clinic. In a fairly short time all patients already on oral contraceptives had a record card in their notes and had registered as official family

FAMILY PLANNING RECORD							
Christian Name:				Surname:			
D.O.B.:				D.O.B.:			
Gravidity: <input type="checkbox"/>	Parity: <input type="checkbox"/>	Family History:		Stroke:		Diabetes:	
Medical History: Serious Illness:				Gynae. Opn.:			
Headache:		Migraine:		V.V. 's:		Thrombosis:	
Heart Disease:		Jaundice:		Epilepsy:		Depressive Illness:	
Menstrual Formula: _____							
CP 1594 11/75							
Date	Notes	Method or Name of Pill	Weight	Urine	BP	VE	Smear

Family planning record card, 19 cm × 11.5 cm, which can be inserted into the NHS record envelope.

planning patients. These patients are now followed up entirely by the nurse and are seen by her each year for consultation, advice, and blood pressure measurement. Patients with a greater risk of side effects are seen more often. A cervical smear is taken at least once every five years.

Patients considering starting contraception sometimes see their own doctor to discuss alternative methods, but most go directly to the nurse. After the nurse has taken a relevant history according to the headings on the record card she and the patient decide on the most appropriate form of contraception.

**Oral contraceptives**—If the woman decides on the pill routine blood pressure measurement, breast palpation, and a cervical smear are carried out. If the new patient has seen only the nurse the doctor also sees the patient to carry out a bimanual examination of the pelvic organs and examine the heart for previously undetected valve lesions and as a double check of suitability for oral contraception.

**Intrauterine device**—If an intrauterine device is thought most appropriate the device is inserted by the doctor with the nurse as assistant. The nurse checks six weeks after insertion that the coil threads are visible and that the patient has no untoward symptoms. Yearly follow-up is then carried out by the nurse.

**Pregnancy**—During the last few weeks of pregnancy all patients are routinely advised to see the nurse to discuss the choice of contraception after pregnancy. The subject is again discussed by the health visitor at her statutory visit 14 days after birth and by the doctor and midwife at the six-week postnatal examination. The family planning nurse is thus closely linked with health visitor and midwife during and after pregnancy.

**Home visits and follow-up**—Through frequent meetings with the district nurses, health visitor, and social workers, the family planning nurse can contact those in greatest need of contraceptive advice, who are often those least likely to seek it. She has paid home visits to patients in social class V and unmarried mothers and has brought some of those needing an intrauterine device to the surgery for insertion. Through patients' doctors and the National Health Service record cards she can become aware of the medical problems of patients and help to guide them more accurately in their choice of method. She can also follow up problems such as obesity, hypertension, and vaginal discharge as part of her routine clinic work, following the doctor's suggested protocol. The doctors, in accordance with established teaching,<sup>2</sup> introduce the subject of contraception in

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consultations around teenage problems, abortion (spontaneous or induced), menstrual disturbance, marital problems, and when taking a history from new patients. Such patients can be directed to the family planning nurse for appropriate advice and care.

#### VALUE OF THE CLINIC

In one year in the practice the nurse has carried out about 1200 consultations that would otherwise have been undertaken by the doctors. When staff and resources are limited it is essential to use both more effectively. Delegating some work to nurses seems an appropriate way of freeing doctors to use their skills in treating patients whom only they can help.

This clinic is experimental and its medicolegal defensibility has never been tested in a court. Nevertheless, another experimental family planning clinic, where the concept of care by nurses has been carried even further, has been extremely successful.<sup>3</sup> Accordingly, the doctors in the practice do not feel particularly at risk of litigation, and nor does the nurse because of the medicolegal cover provided by her membership of the Royal College of Nursing.

#### Well-woman clinic

Unlike the family planning nurse, who was recruited on a part-time basis especially to run the clinic, the nurse who was trained to run the well-woman clinic was already a full-time nurse-receptionist. The practice decided State-registered nurses were too highly qualified to be engaged in day-to-day documentation and filing and, with the advent of trained receptionists, were rarely needed for reception work. So the nurse could extend her consultative and clinical roles.

The main aim of the well-woman clinic was to ensure that all women aged 35 to 60 had had a cervical smear within the last five years. When patients attended for this, however, the nurse or doctor would take the opportunity to carry out a more comprehensive health check.

#### SCREENING PROGRAMME

The receptionists systematically screened all the records of women aged 35 to 60 and sent a letter inviting all those who had never had a cervical smear or who had not had one for over five years to make an appointment to see the nurse or their doctor to have this carried out. The letter was signed by the nurse and gave a list of the sessions when either a nurse or a doctor would be available. Care was taken to avoid sending for the chronically housebound or those who had had a hysterectomy. When the patients were seen by the nurse she had the medical record available and could make some general inquiries about well-being and their current health problems. She then took a menstrual history and a urinary history. If she detected important abnormalities in the menstrual history—for example, intermenstrual or postmenstrual bleeding—she referred the patient to her doctor. She routinely examined the urine for sugar and albumin and if there were any abnormal urinary symptoms she also sent a specimen for bacterial culture. If the patient complained of lassitude or looked unduly pale she measured the haemoglobin. The nurse examined the breasts and while she was doing this she showed the patient how to examine them herself. She also gave the patient a leaflet on breast examination to take home. The nurse then palpated the abdomen, feeling principally for any abnormal masses, inserted a vaginal speculum, visualised the cervix, and took a cervical smear. The patient was told to contact the nurse later for the results of the various tests, and these were brought to the attention of the patient's doctor.

A State-registered nurse is trained to use medical records, take relevant histories, and carry out breast and abdominal examinations, but using the vaginal speculum and taking cervical smears are new to her. The nurse was given a short "refresher course" on taking genitourinary histories and on breast and abdominal examination. She was instructed how to use the vaginal speculum and she and the doctor who trained her took many cervical smears together and inspected many cervixes. She was provided with the relevant books and articles from the library of the local postgraduate centre.

#### RESPONSE AND FINDINGS

The overall response from patients was disappointing in that only

about a quarter of the patients invited came for their cervical smear. Nevertheless, this amounted to about 600 women having a cervical smear, over half of whom had never had a smear test. About one in five patients had a trichomonas infection detected in the cervical smear, but few had associated discharge necessitating treatment. About one in 10 of the patients had symptoms—for example, intermenstrual or postmenopausal bleeding—or signs—hypertension, cervical polyp, significant discharge—requiring referral to the doctor for further management. Hence a small but significant number of patients previously tolerating unpleasant symptoms or disregarding potentially dangerous ones received medical help.

Perhaps the most important and successful feature of the whole programme was the fact that 90% of the patients presented to the nurse for examination despite being offered an appointment with either the nurse or their own doctor.

There is nothing particularly unique about a well-woman clinic.<sup>4-6</sup> The importance of our clinic is that it was run almost entirely by the nurse, again freeing the doctors to concentrate on areas where their skills are more definitely needed.

Should any litigation ensue as a result of any shortcomings in care in this clinic, the main defence would centre around that fact that the nurse has been trained and is considered competent to perform the examinations delegated to her. For her own personal protection she has to be a member of the Royal College of Nursing. The document *The Duty and Position of the Nurse*<sup>7</sup> contains a statement jointly agreed by the British Medical Association and the Royal College of Nursing, and there is nothing in that statement that would preclude the type of consultations carried out in this well-woman clinic.

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*Several patients work in a fibreglass factory making fibreglass boats. What is the danger of inhaling fibreglass particles and thereby damaging their lungs? Are special precautions necessary in working with the many different resins used in such work?*

So far no long-term ill effects have been seen in workers exposed to glass fibres.<sup>1</sup> Studies with small animals, however, have shown that intrapleural implantations of finely milled glass fibres produce mesotheliomas.<sup>2</sup> The types of glass fibre used in boat building are generally so large as to be non-respirable. (Cutting and finishing of glass reinforced plastics has little effect on fibre diameters.) Styrene monomer is liberated during resin application. Investigations in small glass reinforced plastics workshops have invariably found styrene concentrations far above the current threshold limit value (TLV). (TLV = amount of a substance, usually expressed as parts per million in air, to which a man may be exposed for eight hours a day, five days a week, for all his working life without ill effects.) Long-term exposure of man to styrene has caused both central and peripheral nervous system disturbances. The former may result from inhalation, the latter from skin contact with styrene. Symptoms of overexposure have included listlessness, anorexia, nausea, vomiting, impaired night vision, lesions of the peripheral nerves, and disabling psychiatric conditions.<sup>3</sup> Furthermore, detrimental psychophysiological effects have been found around TLV levels.<sup>4</sup> To avoid ill effects from styrene, workshops should be fitted with efficient extraction systems where the fumes enter into the workplace air.

<sup>1</sup> Enterline, P, and Henderson, V, *Archives of Environmental Health*, 1975, **30**, 113.  
<sup>2</sup> Stanton, M F, and Wrench, C, *Journal of the National Cancer Institute*, 1972, **48**, 797.

<sup>3</sup> Axelson, O, *Occupational Medicine*, ed C Zenz, p 816. Chicago, Year Book, 1975.  
<sup>4</sup> Goetell, P, et al, *Work Environment and Health*, 1972, **9**, 76.