Middle Articles

GENERAL PRACTICE OBSERVED

Extended Use of Nursing Services in General Practice

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Nursing Services in a General Practice—An Experiment

Our practice comprises a partnership of two doctors with a list of about 5,500 patients during the first nine months of this year. The practice covers a radius of about 5 miles (8 km.). We were faced with a difficult situation at the beginning of the year, as it was obvious that a major outbreak of measles was imminent, in addition to the other common infections.

There seemed to be three main problems. Firstly, the practice is situated in a "designated" area which is rapidly expanding because of overspill. There are more new patients than can be comfortably accepted if a satisfactory standard of medical care is to be maintained. Secondly, there is a large rural area to be covered, but both the partners are also heavily involved with hospital work. Thirdly, there is a lack of suitably experienced doctors willing and able to undertake this wide spectrum of work.

It was thought that the scope of work, both in hospital and in the care of greater numbers of patients, could be done efficiently and properly provided that time was not wasted with minor problems, especially unnecessary visiting and revisiting and routine procedures in the surgery. Nevertheless, the ordinary patient is not in a position to know whether a particular situation needs the visit of a doctor or not. The Ministry of Health circular puts the onus of decision on the doctor, who often has only the verbal history of the patient, possibly second-hand from a neighbour or relative. Further, revisiting is desirable and necessary in certain cases where the progress of the patient needs to be assessed professionally and skilfully. There was one more disquieting factor; because of the good will in the practice, we found the patients, knowing we were working under strain, often helped by not asking for a visit but for advice and a prescription to be left; we felt that this was not a desirable practice.

Hence we decided to appoint an experienced nurse to help in the clinical work of the practice for about 20 hours weekly, with the following duties:

- (1) The reception and assessment of requests to visit and other messages, from 8.45 to 10.30 a.m.
- (2) Visiting new calls after consultation with the doctors in those cases where there was doubt about whether a visit by doctor was necessary.
- (3) Immunizations and desensitization procedures during surgery.
- (4) Assistance at the antenatal clinics.
- (5) Revisits and routine visits to elderly and disabled people.

It was obviously necessary for the nurse to have a fairly wide experience, preferably with outpatients, and to be a car driver. From the beginning we decided to employ her for three and a half hours in the morning and two afternoons a week, and to pay her top salary scale and a car allowance on a per mile basis.

Instructions to the Nurse

The nurse received all the incoming requests for visits and advised and recorded them. Our patients with problems have always been able to speak personally to the doctor; and in these cases, or when the nurse was in doubt, the nurse was instructed to put the call through to the doctor. After conferring with the partners she visited the requests for first calls. The doctors meanwhile went on to their hospital duties. If in her opinion any patient needed immediate attention the doctors could be contacted at the hospital.

All patients visited were to have their temperature and pulse recorded, together with a short clinical history, followed by the nurse's impressions and suggestions. This was all to be recorded in a report book which was to be kept in the surgery. The nurse would then deal with the request in one of the following ways:

- (1) In the nurse's opinion a doctor's visit was not necessary, nor was it necessary for the patient to visit the doctor at his surgery, and the household could be reassured.
- (2) A doctor's visit to the house was not necessary, but the patient was fit to visit the surgery and an appointment was arranged.
- (3) Common-sense measures were suggested or the nurse would recommend some mild medicine be prescribed by the doctor—for example, a simple cough linctus or antacid.
- (4) If a common infection was found or suspected—for example, measles—the nurse was usually able to make a provisional diagnosis and report it to the doctor, who would visit the patient when he was in the neighbourhood.
- (5) If pyrexia was present or other disquieting symptoms in the absence of a known epidemic condition, the nurse advised the household that the doctor would be calling later on.
- (6) The doctor was contacted urgently.

It was emphasized to the nurse that if the family in any way indicated they would like the doctor to call personally this did not happen once. In fact, in the course of over 700 calls this did not happen once, and in only three cases was a call later requested for the doctor personally to visit after the nurse had called. In each of these three cases no reason was found to disagree with nurse's assessment of the case, neither did the patients want anything apart from reassurance.

The numbers in Table I exclude all visits requested after 10.30 a.m. and all midwifery calls.

TABLE I.—Number of Visits Made

	Nurse	Doctor 1	Doctor 2
Total No. of visits January to October	744 + 41 (2 in 1 house)	800	285
Total No. of first visits	537	560	228
" " " revisits advised by nurse	86	10	57
" " " " " " doctor	111	230	No. of visits not recorded
Emergency visits during surgery	10	first revisits	

We found that if a conference was held at about 12.30 p.m. the cases could be discussed and action agreed on. Occasional checks were made by the doctor on families visited if further reassurance seemed necessary or where there was an element of doubt. This was found to be increasingly unnecessary as the scheme began to be known to the patients. It was soon found that there was a great preponderance of nurse calls to young children and revisits to elderly people. This is, of course, in line with the general visiting pattern of general practitioners, but the doctor visits proportionately increased in the age ratio of 10 to 60. It was our impression that, as the scheme became more widely known, the threshold at which a visit is requested has become lower and a visit of the nurse is specifically asked for.

The nurse's 785 visits were made up as follows: 485 to children under 10, 133 to patients over 65, and 167 to others. From the report book we were able to compile Table II, which shows the numbers of first visits performed by the nurse and roughly the type of case.

TABLE II.—*First Visits Made by Nurse*

Common infections, measles, mumps, chicken-pox, etc. . .	187
Rashes without pyrexia	19
Catarrhal colds and coughs without pyrexia	62
Infections with pyrexia	96
Diarrhoea and vomiting	66
Others—e.g., injury, social, oedema, abdominal pain, history taking	97
Emergency	10

The method of working of the two doctors differs. Doctor 1 is the elder, with a much larger proportion of older and chronic sick patients, and it is from him most of the revisit requests emerge. Doctor 2 has a number of hospital anaesthetic appointments together with the bulk of the practice midwifery (about 114 cases per annum); hence most children under the age of 10 years are in his care, and it is from him that the highest proportion of first nurse visits emanated. The proportion on a typical spring day would be: three first nurse visits requested by Doctor 2, one or two nurse revisits requested by Doctor 1, one nurse revisit, and one nurse routine visit. Thus a very high proportion of patients anxious about their own or their children's health do not actually appear to need a personal visit by the doctor. This is emphasized by the fact that there was not one complaint about the scheme. However, on many visits the nurse was asked to see other patients at the same time; she was able to do this without undue stress, though this may be a source of minor irritation to a general practitioner with a full visiting-list.

Of 440 first visits to children only about 10% required a doctor's visit that day. The period surveyed covered a parallel epidemic of measles and chicken-pox, and here the nurse's help proved invaluable. The confirmation of the condition with general common-sense advice, to settle with the later visit by the doctor, proved to be very popular with all classes of patients. Another fact was the early recognition and treatment of enteritis in infants and the institution of the standard regimen.

Questions to Patients

It was appreciated that many people who had been used to sending for a doctor might not accept the visit of a nurse, however well trained she might be. Hence it was thought essential

Replies to Questionary

	Yes	No
Did you find it a help for a nurse to advise you whether a visit by doctor was necessary?	179	3
Did you find the visit of nurse helpful?	185	2
Were you satisfied with the result of the visit?	186	2
Did you later visit doctor?	63	120
Have you any further suggestions?	33	congratulatory replies, 1 unfavourable

to find out the reaction of the various patients. A questionnaire was sent to every household visited by nurse. At its head was a letter outlining its purpose, and a dotted line underneath indicated that it could be torn off and returned anonymously if so desired.

A total of 260 copies of the questionnaire were sent out to all the households visited and we received 189 replies, although the postage was not prepaid.

The answer that exceeded our expectations was under the heading "suggestions." About 26% of the households visited had something to say on this subject, and their comments show there is a very definite demand for this type of service. There were many comments on the great help given; several people said that the National Health Service would be greatly improved if the practice were extended. In particular we found that there is a need among mothers of infants and young children for expert advice about when to summon the doctor, the opinions of neighbours and relatives being notoriously unreliable. We found that elderly patients are glad to be revisited, but like a doctor to see them the first time. One other fact emerged—families with problems appreciated the visits, as they knew they had time and opportunity to discuss apparently trivial matters with which they would not bother the doctor for fear of wasting his time. Nevertheless, knowledge of these factors often helped in assessing an individual patient. On the other hand, we found that problem families were best left to the county authorities, who have the machinery and time to deal with the many difficulties involved.

We strictly excluded nursing procedures on the district, as it was thought that the county district nurses might think that this was an unwarranted intrusion into their province. As a general rule, therefore, the nurse did not visit any family which was in the care of a district nurse. On the other hand, we found that she could complement the work of the health visitors, especially with premature babies and congenital defects; these she could weigh regularly at home and take prescriptions ordered by the hospitals; moreover, she could give courses of immunization at home.

Developments

As the scheme developed considerable changes were made. Firstly, we realized that the initial time allocated to the nurse was grossly inadequate, and this was increased to about 27 hours. Since 1 October 1967 we have acquired a new partner and over 2,000 new patients, and we envisage that there will be enough work for a full-time nurse. Secondly, we found the use of a trained nurse to assess incoming calls invaluable, and we soon found that patients were asking specifically for the nurse.

One of the more worrying happenings in general practice is the apparently urgent call during a busy surgery. During the period under review the nurse went out immediately to assess the situation with instructions to report at once in 10 cases. The final assessment of these was as follows: two coronary thromboses (doctor and ambulance were sent for); two falls (sent to hospital); one appendicitis (doctor visited after surgery); two fits (first aid, and doctor visited later); two epistaxes (first aid); and one sudden death (arrangements made).

Like many others, we also found that there are a surprising number of duties apart from immunizations and routine injections for a nurse to do during surgery—for example, routine blood pressures, skin reaction testing, detailed history taking, and ear syringing. Moreover, during antenatal clinics routine blood pressures, testing of urine, weighing, and the preliminary medical history could be done by nurse before the patient was seen by the midwives or doctor. We found that by restricting her duties to these items the relations between the different types of nursing staff were happily maintained.

We were anxious about a possible tendency to prescribe appetite suppressants without a careful follow-up. Accordingly we decided to prescribe only a week's supply, and that the nurse should do weekly weighings; further supplies depended on a gradual loss of weight. To our surprise, a weight-losing group soon developed, and we noted that patients in this group were voluntarily giving up taking the pills and often losing weight faster than those on suppressants. Two full clinics have now formed. We are also proceeding with the formation of an anti-smoking group, and the demand for this is already high.

Discussion

It is too early to evaluate all the implications of this project or to assess accurately the advantages and dangers inherent in its application. We think it is sufficiently important, however, to put our experience on record, realizing that there must be critical comment and observation. We think there is an opening in a practice such as we have described for a full-time nurse carrying out the duties we have outlined. This is no position, however, for the newly qualified State-registered nurse. At least four years' post-qualification experience is necessary, preferably up to the standard of staff nurse or sister in a casualty outpatient department or in a ward for acute cases, where not only ill people are encountered and have to be assessed but the problem of human relationships between the profession and the patient together with their relatives is of paramount importance.

We think that the scheme shows that there is a much wider field of work for the experienced nurse than has been thought possible in the past. The S.R.N. of today has a wide education and her training takes her a long way beyond the traditional nursing procedures; one of the criticisms of nursing today when a nurse leaves hospital is that a large amount of her time is occupied in nursing procedures which in hospital would have been left to nurses in their early training period. We think that the modern nurse is in a position to assess whether a patient is ill enough to need the visit of a doctor; in other words, we are placing her in the position of a sister with a responsible hospital position. It was noticeable during the nine months that the main calls fully dealt with by the nurse concerned patients at the extremes of age, and we found that in the nurse's opinion working men and women who requested a visit usually needed the visit of a doctor.

We have found in practice that the whole concept is acceptable to the majority of our patients. It is most important for patients to know that the nurse is not a substitute for the doctor, and in fact is trying to help the latter arrive at a decision. In fact we found that the nurse is far more apt to err on the patient's side than on the doctor's. Nevertheless, many people may query the possible dangers of using nurses for first visits. There is, on the one hand, always the possibility of the mistaken assessment of the case; on the other hand, this is so with any doctor, for no professional person is free from errors of judgement. Looking back over the past, we think that the incidence is not likely to be higher in the case of an experienced nurse. We have taken the attitude that the partners are responsible for all the acts of the nurse, but it is the view of the Royal College of Nursing that the nurse should be indemnified and protected in the event of litigation on her own account; this, we understand, is possible in a similar manner to the medical profession.

We would like to emphasize that we think the following points are essential:

(1) That the employing doctors satisfy themselves, by inquiry and personal assessment, of the ability of the nurse to undertake this type of work.

(2) That the written report *must* be entered of each patient visited, together with the temperature, pulse rate, full history, and the nurse's opinion.

(3) That there should be personal consultation and agreement between the doctor and nurse about the conduct of each individual case.

Unless the above criteria are strictly observed a disastrous situation may occur at any time. If this type of scheme is used as a form of cheap medicine, as a barrier between the patient and doctor, or is embarked on without careful thought and planning, we believe it a retrograde step. In practice it is our impression that far from lessening the amount of work done by doctor the amount of consultative work has actually increased; this, however, can be only a subjective impression owing to the increasing number of patients, but it is already apparent that the total travelling time by the doctors has already diminished.

We think it is essential for a full secretarial service to be maintained, and that the nurse has the same facilities as the doctors for documentation and dictation of letters. It is also extremely important that the correct relationship be maintained with the local health authorities, and for this reason no nursing procedures are undertaken on the district. The attendance of midwives at the antenatal clinic is encouraged by the local health authorities, and on these occasions the work of the nurse is restricted to initial documentation and history, urine tests, and blood pressure estimation. In our opinion the nurse in the circumstances described is best employed direct by the practice rather than by the county service. On the other hand, the nurse must make herself fully conversant with all the services available through the county.

At present nurses employed in this way would seem to forfeit their superannuation rights under the National Health scheme, and this would seem to merit critical attention. From the practical standpoint the hours worked are especially suitable to part-time nurses—that is, 8.45 a.m. to 4 p.m. from Monday to Friday—and may tap a source of nursing strength hitherto unavailable.

We feel certain that in this field of work there is a great future, and that the nurse entering it will at some time in the future have special training—in fact this would seem essential. We think that two months' instruction in the methods of general practice and the various forms used by the executive council, followed by four months' attachment to a suitable practice with an assessment at the end, might merit serious consideration.

Summary

Over a nine months' period a State-registered nurse has been used for helping in the clinical work of a general practice in a semirural area with about 5,500 patients. Provided a nurse with the right temperament and extensive clinical experience is obtained, and suitable safeguards are used, we think that she can be used for making first visits to patients, and the replies to a questionnaire sent to the patients showed that most patients agreed and welcomed the scheme.

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