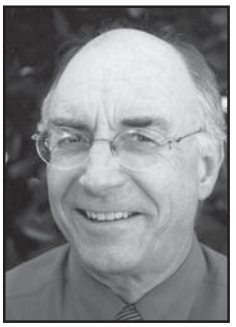
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

General practice developed as a subset of medical practice in the early 19th century but was, until quite recently, regarded as the poor relation of the medical profession.[1] There were no Chairs of General Practice in our universities until the early 1980s and we were not formally recognised as a vocational branch of medicine until an Order in Council modified the Medical Practitioner's Act in November 1999. In 1950 an editorial in the *Lancet* stated that:

'Within the profession there is indeed a very real, if unavowed, difference of opinion: on the one hand are those who see no future for the general practitioner except as an appendage to the hospital service, while on the other are those who believe he must be brought back to his former position as a highly responsible doctor. Somewhere between these opposites are those who hold, by no means unreasonably, that ideally the practitioner should concern himself less with organic disease and more with elementary psychotherapy and preventive medicine.'[2]

Fortunately, the new millennium has begun with a strengthening of primary health care and general practice is finally being recognised for its contribution to the care of the community.

However, there are parallels between the historical public and professional perception of general practice and the relationship that practice nursing has with it. Thirty-five years ago practice nurses were no more than an idea:

'The image of a responsible practice nurse who is able to take responsibility for jobs delegated by the overworked GP of the future is a viable one consistent with other trends apparent at this time. The practice nurse would, in line with other health-related professionals, join the queue for better education and training, in her case by becoming a product of the programmes already being offered at some technical colleges and universities or by attending expanding inservice education programmes. The trend towards better education is already under way, as is the trend toward a multidisciplinary education to be used in the delivery of health care "beyond germ theory". Further, such a responsible better trained nurse, rather than being threatening, could in the future invite increased consumer participation in both the planning and effecting of a health service in the community...Cooperative planning by doctors and nurses would make the practice nurse arrangement one of the best things that has happened in our system, killing more birds with one stone than have hitherto been acknowledged!'[3]

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In the early 21st century, although the dream has been partially realised, we are still some distance from providing a fully integrated primary health care service in which nurses and doctors work as equal members of a team, contributing their skills to patient care to advance the health of the community.

Inevitably, when considering the changes that have taken place in general practice nursing over the years, I thought about my own experiences. In 1974, when I started my first (solo) general practice in a small suburb, I employed one receptionist. At that time she was working as a shop assistant and had no prior experience of medical reception work, but she turned out to be a gem. She was recommended to me by a public health nurse and I taught her what I thought was important for a receptionist to know. She answered the phone, made appointments, sent off claims, tested urines, counselled patients and generally ran the practice while I consulted, gave immunisations, took cervical smears, changed dressings, sterilised equipment, washed bandages and did all of the other things that one needed to do to care for patients. She worked with me for more than 15 years. At that time the practice nurse subsidy had only been available for rural practices as a 50% subsidy from 1970. In 1977 this scheme was extended to urban general practitioners and, in 1978, when I was joined by two partners, we took advantage of the scheme and employed our first practice nurses. They did what we asked them to do (most of the time) but they did not see patients independently. Gradually their role developed and they became skilled in patient education and monitoring patients

who had chronic illness. They were trained in smear taking and immunisation management and they developed relationships with other primary health care workers more effectively than the GPs had done. Before long they had become indispensable but not independent.

There must have been many other ways in which GPs and practice nurses learned to work together. One of the more enlightened was a scheme that was developed at Otumoetai Health Centre in a suburb of Tauranga. This practice first employed nurses in 1968 and then joined the 100% rural subsidy scheme in 1976. By 1985 the centre had five GPs and five full-time practice nurses. The nurses were each attached to a particular GP for two-week rotations. They saw the patients before the GP and determined what they had come for and made any necessary preparations or performed relevant tests before the doctor saw the patient. Any new patient to the practice was seen by a nurse who documented their medical history and family details. The nurses ran their own clinics, including special clinics for asthma, enuresis and diabetes. They visited patients at home and in the local hospital in a van subsidised by the local Hospital Board. Interestingly the nurses were employed by the Tauranga Hospital Board and not by the practice.[4]

However, I suspect that Otumoetai was an exception. Most practice nurses were employed by individual practices and subsidised through the Department of Health scheme until that was incorporated into the capitation funding formula for those practices that took up this option.

The role of the practice nurse was described when the scheme was first introduced. The practice nurse:

'Should be regarded as an extension of the doctor. Her function is to relieve him of tasks which he has been undertaking which could be done equally well (or even better) by the nurse, so giving the doctor more time for work which only he can do.'[5]

This description, written only 24 years ago, provides some insight into why concerns about primary health care nursing continued to be expressed.

In 1999, a report to the National Health Committee on locating nursing in primary health care stated:

'NZ has considerable investment in nurses and currently subsidises general practitioners to employ the majority who work in primary health care as practice nurses at a cost of $30 million per annum. It is questionable as to whether this now represents value for money or whether it is based simply on history. The practice nurse subsidy is one of several barriers to the development of primary health care nursing.

In addition to practice nurses, primary health care nursing is established in communities at a number of levels and through contributions from various contracts, such as well child services, home health, domiciliary nursing, health promotion, communicable disease screening and management. Not only has this led to fragmentation of service delivery but also there are gaps and duplication of services and confusion surrounding the roles of the various nurses. It is argued that the contract culture has altered nursing to a commodity. This reduces the strength and usefulness of nursing and supports a medical and reductionist health service focus on what are often deeper family and community health problems that would benefit from a more holistic or "global" response.'[6]

Has this situation improved in the last seven years?

This issue of the journal has a strong focus on practice nursing. In the theme papers there are comments about what we have done well, but what comes through more strongly is what we could be doing better. The way in which nurses are employed is still seen as a barrier to professional equality. There are problems with recognition of their contribution, organisation of their services and the way in which they are remunerated. As an example of how nurses can provide primary health care to isolated communities, Debs Dillon describes her role as a nurse practitioner in a remote practice with very little hands-on medical support. The CME papers for this issue also focus on topics that have particular relevance for nurses. Finally, we have an unsolicited reflection from a retired GP obstetrician providing his perspective on the provision of primary care obstetric services.

The way in which nurses are employed is still seen as a barrier to professional equality

We understand that *NZFP* is mainly read by GPs. Please take this opportunity to share this with your nursing colleagues. We will try to ensure that each issue has something in it for all members of the general practice team and that this will help to encourage collaboration and enhance patient care.

References

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