The University of Southern Queensland, Toowoomba, Qld.

THE ROLE OF NURSES IN GENERAL PRACTICE:

GENERAL PRACTITIONERS' AND PRACTICE NURSES' PERCEPTIONS

By

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Abstract

The role of nurses in general practice: General Practitioners' and Practice Nurses'perceptions is a study that identifies the beliefs of Practice Nurses (PNs) and General Practitioners (GPs) of the PN role and how those roles impact on the general practice. Ethnographic techniquess were used for this study, with data collected through interviews, observation and questionnaires. Interviews were conducted with four PNs and four GPs in practices that employed nurses in an increasedrole similar to that described in the Nursing in General Practice Fact Sheets (Royal College of Nursing Australia, 2002). Two practices were observed to identify work practices and the nurses' interaction within the practice.

The main finding of the study was the importance placed on the general practice team. Both GPs and PNs believed that working as a team was vital. They indicated that working together provided holistic care and enabled the practice to provide quality care. The role of the PN in this study was consistent with other studies in Australia. However, the nurses in this study appeared to have more autonomy in regard to care of people with chronic illness and the aged. Continuing education was considered important for the further development of the PN role. However, participants believed that the PN also needed to have considerable and varied experience together with good people skills.

To further develop the PN role innovative ways of providing education to PNs should be investigated to ensure nurses have the necessary skills to undertake their role. Payment issues in general practice should also be examined and addressed to ensure that PNs are able to be employed, and receive remuneration appropriate for their experience and job description.

Certification of Dissertation

I certify that the ideas, research, results and conclusions reported in this dissertation are entirely of my own effort, except where otherwise acknowledged. I also certify that the work is original and has not been previously submitted for any other award, except where otherwise acknowledged.

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Glossary of Terms

Practice Nurse – Nurse working with a GP or GPs in a General Practice

Advanced Practice Nurse - The Royal College of Nursing Australia states that:

> *Advanced practice nursing defines a level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, planning, implementation, diagnosis and evaluation of the care required. Nurses practising at this level are educationally prepared at post-graduate level and may work in a specialist or generalist capacity. However, the basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision-making* (RCNA, Position Statement. 2004: P1).

Increased practice – A term used in this study to describe a PN that includes in their practice many roles described in the Nursing in General Practice Fact Sheets, (Royal College of Nursing Australia, 2002).

CHAPTER ONE

1. INTRODUCTION

This study asked the question "What are General Practitioners and Practice Nurses' perceptions about the role of the Practice Nurse". To answer this question the data collection focused on:

a) the perceptions of the Practice Nurses (PNs) and General Practitioners (GPs) about the role of the PN
b) how GPs and PNs define the role of the PN
c) how they work together to complement each other's role
d) how they see the role developing in the future.

1.1 Objectives

The study identified:

1. what the participants perceived as the role of the PN
2. what qualifications participants believed PNs should have
3. what participants believed would ensure quality care in general practice
4. factors that impacted upon the working relationships of GPs and PNs
5. what participants perceived as being aspects of the practices' culture that would promote the autonomous growth of the PN.

1.2 Background

In recent years the Australian Government has introduced initiatives to increase primary health care in general practice (Department of Health and Ageing, 2004c). The government has put in place various incentives to both encourage the employment of the PN and to increase the amount of preventative health care undertaken within general practice. These initiatives encouraged the role of the PN to change to include such services as management of chronic diseases, health promotion and clinical support (Department of Health and Ageing, 2002). The PN also allows GPs to focus more on the roles of diagnosis and clinical care (Department of Health and Ageing, 2001a.) while the PN contributes to the holistic care of the consumer. It is therefore considered timely to discover from GPs and PNs:

1. their perceptions of what the role should include
2. the educational needs of PNs to undertake the role
3. how the culture of general practice accommodates this increased role
4. how the role has or hasn't contributed to the provision of quality care

As this study highlights practices with PNs working in this increased role, it will inform other GPs of the outcomes of the study, possibly encouraging more practices to employ PNs.

The PN role has developed further overseas than in Australia. For example in the UK in 2002, nurses were conducting minor illness clinics and providing triage and health promotion programs, with good results (Searle, 2002). Australia can learn from the United Kingdom's achievements. However, Australia isalso able to learn from the problems they have had. One of the problems identified in the UK is that more education of PNs should have occurred early in the development of the role of the PN (Crawford, 2002). It is therefore

important to identify what GPs and PNs believe are the qualifications needed for a PN to be competent and also what ongoing education is required to maintain skills and knowledge.

1.3 The working relationship

The working relationship between the GP and the PN is an important one, because they need to collaborate to provide the best outcome for the patient. Collaboration, however, is not always evident within general practice (Condin, Willis, & Litt, 2000; Paterson, Delmar & Najman, 1999; Blue & Fitzgerald, 2002). This study sought to identify the participants' perceptions of teamwork and collaboration.

This study complements the research projects of Cheek, Price, Mott, Wilkinson, Beilby, & Dawson. (2002) and Hegney, Buikstra, Fallon, Martin-McDonald, Patterson, Rees.(2004a), who sought to discover consumers' perceptions of PNs, and together the three projects explored the perceptions of all the key stakeholders of practice nursing. Together these projects add to the body of evidence, to progress the PN role and gain acceptance of it.

1.4 Methodology

In order to gather the perceptions of the GPs and PNs it was decided that the most logical methodology was Ethnography. As with every work environment, 'General Practice' has its own work culture, different from other nursing environments and cultures. This study explored aspects of the culture of the practices and discovered from the participants their beliefs and the issues surrounding the role of the PN.

Several methods of data collection were used to gain an understanding of the culture of these general practices in relation to the PN role. Firstly, interviews were held with four GPs and four PNs recruited from metropolitan, regional and rural areas, to discover what they perceived to be the issues regarding the PN role. Secondly, PNs were observed within two general practices in metropolitan and regional areas. Thirdly, all participants of both the interviews and the observations were asked to complete a questionnaire. Field notes were also kept through out the study. The field notes informed the interview questions and validated the data from other methods of data collection.

The results of this study and a discussion of these results are presented to the reader in chapters 4 and 5 respectively.

1.5 Thesis structure

Chapter Two reviews the recent literature regarding practice nursing and collaborative relationships, focusing on Australia and also briefly covering the role of the PN in the United States and in the United Kingdom. Chapter Three discusses the methodology of ethnography and how ethnographic techniques have been used in this project. Chapter Four reports the results found in this study and covers concurrently all methods of data collection. Chapter Five discusses this study in relation to the objectives identified earlier and compares the results to those of other studies. Chapter Six will review the previous chapters and make recommendations for future research and the advancement of the role of the PN.

As the role of the PN is changing, it was considered valuable to confer with general practices about how these changes are affecting their practice, and the impact the role has had on both the practice and quality of care the practice is able to offer. This study was aimed at PNs

working in the increased role and gives insight into some practices that have PNs working in that capacity, such as contributing to the management of chronic illness and the aged. The study defined the role of the PN from the GPs and PNs perspective, and the issues surrounding the scope of that role.

CHAPTER TWO

2. LITERATURE REVIEW

This chapter will discuss the literature relating to:

- the background of primary health care and how it applies to general practice
- government funding available to general practice
- how Australia has determined the way forward for practice nursing
- the role of the PN in Australia
- consumer perceptions of the role of the PN
- a comparison of PN pay rates compared to hospital nurse pay rates
- collaborative relationships
- practice nursing in the united kingdom
- practice nursing in the United States

The discussion of these issues will set the scene for the study 'The role of nurses in general practice: GPs and PNs perceptions'.

2.1 The history of the development of the concept of primary health care

One priority, decided by the World Health Organisation meeting in Alma-Ata (1978), would be to achieve health for all by the year 2000. Health was defined as being 'a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity' (WHO, 1978).

The Ottawa Charter followed in 1986. This charter proposed that increasing primary health care in communities was the best way to achieve the aim of health for all. Primary health care, as explained by the charter, is essential health care at the first level of contact for families and individuals, and should be accessible to people where they work and live (WHO, 1986). Primary health care aims to address the main health problems in the community, providing promotive, preventative, curative and rehabilitative services' (WHO, 1986). Inherent in the charter was the indication that nurses were ideally placed to provide this care. This was qualified, however, by the perceived need for many changes to occur in the culture of health care to allow nurses to provide primary health care (WHO,1986).

The principles of the Ottawa Charter have been carried through by further WHO meetings such as:

- the second WHO Conference on Health promotion in Adelaide, Australia in 1988 (WHO, 1988)
- the third WHO Conference on Health promotion in Sweden in 1991 (WHO, 1991)
- the fourth WHO Conference on Health promotion in Jakarta in 1997 (WHO, 1997)
- the fifth WHO Conference on Health promotion Mexico City in 2000 (WHO, 2000)

Primary health care was also on the agenda for the fifty-sixth World Health assembly, which was the twenty-fifth anniversary of the Ottawa Charter. It was stated at this conference, when reporting on Europe, that:

> *In some countries, well-coordinated multi-disciplinary teams of Primary Health Care professionals formed the first point of contact with the official health-care system. In*

> *other countries access to health care is through GPs, specialists or nurses, all working independently* (WHO, 2003: P3).

Primary health care and primary care are terms that are often used interchangeably, causing confusion (McMurray, 2003). The author differentiates between these terms as Primary care being the initial caring for a health problem and the continuing care of that problem. Whereas Primary Health Care 'may include primary (initial) care to address a problem, and it may also encompass a broad spectrum of activities to encourage general health and wellbeing' (McMurray, 2003: P35). McMurray further states that the goal of primary health care is to achieve sustainable health and wellbeing through the building of community capacity.

Although GP's in general practices in Australia have traditionally focused on primary care, they are being encouraged to increase their involvement in primary health care by the Australian government, through such incentives as Enhanced Primary Care (EPC) items and Practice Incentive Payments (PIP) detailed in the next paragraph.

2.2 Direct government incentives to encourage employment of PNs

The employment of PNs has been promoted by the provision of incentives paid to general practice through the PIP (practice incentive payments) scheme. Practices eligible for PIP are in areas considered by the Australian government to be areas of greater health need, such as the rural and remote areas and lower socio-economic areas, as well as practices servicing predominantly Indigenous clients (Department of Health and Ageing, 2001b). Within the

2001-2002 Commonwealth budget $104.3 million dollars were allocated to encourage more GPs to employ PNs. This money was directed at general practices that were eligible for PIP payments, but also provided funds for the education of nurses, and scholarships for nurses wishing to re-enter the workforce (Department of Health and Ageing, 2002).

In 2004, the Australian government introduced Medicare Plus. With Medicare Plus comes a new item number to enable GPs to claim for the services of allied health staff. This item is for provision of care on the GPs behalf for those patients with a chronic disease (Department of Health and Ageing, 2004a). Medicare plus has introduced two item numbers for care provided by PNs. These item numbers are for immunisation and wound care. An amount of $8.50 can be claimed per visit for either of these items (Australian Department of Health and Ageing, 2004b).

The above incentives were aimed at encouraging the employment of a PN. However, as described above were not available to every practice. Enhanced Primary Care (EPC) items have been available to all practices with the aim of improving quality in General Practice.

2.3 Indirect incentives in General Practice

In addition to the direct practice payments, the Australian Government has promoted primary health care and quality in general practice by introducing incentives for GPs to change their practice habits. For example in 1999, the Australian Government introduced EPC items. These item numbers are predominantly focused on chronic illness, particularly in those over 70 years of age (Department of Health and Ageing, 2004c).

They provide a monitory incentive to general practices that conduct:

- Health Assessments – a voluntary health assessment available to people over 75 and over 55 for Indigenous Australians.
- Multi-disciplinary care planning – long-term, planned, multi-disciplinary care available to people with chronic illness, which requires care from at least two other health professionals. The patient must be in the community.
- Discharge planning – a long-term plan for patients returning to the community from hospital
- Case conferencing – a meeting between a multi-disciplinary team. The team would include the GP and at least two other health or care providers. The patients may be in the community or in a residential aged care facilities (Department of Health and Ageing, 2004c).

It was stated in the report evaluating the EPC items, that GPs believed PNs are 'critical to the successful integration and implementation of health assessments and care planning into practices' (Wilkinson, D., Mott, K., Morey, S., Beilby, J., Price, K., Best, J., McElroy, H., Pluck, S., Eley, V. (2003).: P4). The EPC evaluation also stated that health assessments and care planning were taken up by practices more commonly than were case-conferences, because it was identified that it was difficult to organise meetings of numerous health professionals (Wilkinson et al, 2003).

2.4 How Australia has determined the way forward for practice nursing

A National Workshop on practice nursing in Australian general practice involving representatives from many medical and nursing groups was held in Melbourne in July 2001

(Department of Health and Ageing, 2001a). It was determined by the workshop participants that PNs could expand their role into many areas in general practice including:

- *providing clinical nursing services in the General Practice context*
- *coordinating patient services*
- *management of the clinical environment by assisting General Practice to meet relevant standards and legislative requirements*
- *health promotion and education by promoting patient, carer and community well-being*
- *sustaining general practice by contributing to better management of human and material resources*
- *improving health outcomes by contributing to and enhancing the management and prevention of ill health*

(Royal College of Nursing, 2001, Fact Sheet 1; P1-2)

The workshop also addressed the qualification requirements of PNs; codes of conduct; legal issues; employment issues and information needed to employ PNs. That workshop has basically determined the way forward for practice nursing in Australia. The 'Nursing in General Practice' Fact Sheets are a valuable tool for General Practice (Royal College of Nursing, 2001). Although many key groups were involved in this workshop, providing their expert opinion, it remains important to ascertain if the proposed services are acceptable to key stakeholders such as PNs and GPs.

Studies have been undertaken in Australia to determine the role nurses are taking within general practice. In this literature review studies have only been included from 1999 because this is when changes began to take place in Australia.

2.5 Role of the PN in Australia

Patterson, Del Mar and Najman (1999) conducted a study in one general practice division in South East Queensland. Telephone and mail surveys were carried out with 37 responses recieved out of the 67 PNs who were contacted. The researcher also interviewed 10 of the 37 respondants. The study found that PNs were working mainly as assistants to GPs. Duties included mainly basic treatment room duties as well as patient education and assessment. The duties PNs were undertaking were task orientated or as assistants to the GP. Some autonomy was noted with opportunistic education given to patients as they were being seen for another reason. Wound care was seen as an area that PNs were good at managing. However, as the GP had to see the patient on each visit to gain payment, little autonomy was seen as being achieved in the area. Some PNs who had midwifery training were undertaking ante-natal care and assessment of infant development.

Of concern to Patterson Del Mar and Najman (1999), was the lack of confidence the PNs had with “undertaking triage activities, monitoring patients following medical intervention and educating and counselling patients about health issues” (Patterson, Del Mar and Najman, 1999: P19). This led the authors to believe that PNs engaged in these activities should undertake further education. The authors reported that at the time the study was undertaken there were no accredited courses for practice nursing (Patterson, Del Mar and Najman, 1999). They reported that initial hospital based training was adequate for basic treatment

room duties in general practice. However, they believed that the ‘extended physical assessment skills, mental health assessment, counselling and health education/promotion (Patterson, Del Mar and Najman, 1999: p19)’ that are currently part of the tertiary based nurse education, are essential for the extended role proposed for PNs. Since most PNs are hospital trained this led the authors to believe that further education needed to be undertaken for these PNs to expand their role (Patterson, Del Mar and Najman, 1999).

Patterson, Del Mar and Najman (2000) reported that nursing duties were being delegated to receptionists in some practices. They stated that duties such as patient assessment, triage, Electrocardiograms (ECGs) and first-aid, were being carried out by receptionists, as were other duties such as, “sterilising and preparing clinical equipment, testing urine, applying and changing dressings, and assisting with minor surgery” (Patterson, Del Mar and Najman, 2000: P233). Other duties were reported less commonly. The practice of delegating nursing duties to receptionists was more common amongst practices not employing a PN (Patterson, Del Mar and Najman, 2000).

Another study was undertaken by Teresa O’Connor (2002). In this study a survey was sent to 153 practices across five Divisions of General Practice and had 98 PNs respond. Oconnors study had similar findings to that of the previously mentioned study. This later study also found that the majority of PNs are hospital trained. PNs duties in this study were divided into patient related (clinical) tasks, patient teaching, coordination activities, and EPC items (O’Connor, 2002).

PNs in this study undertook a range of clinical tasks including; patient vital signs and other observations, dressings, removal of sutures, and assistance with minor surgical procedures. PNs were also giving medications. PNs in the study indicated they were competent to carry out these procedures, and that most did not require further training for clinical tasks (O'Connor, 2002).

Coordination activities that were reported by PNs included some reception duties, contacting outside agencies, making appointments for and recalling patients. PNs also reported coordination surrounding the immunisation program. Very few PNs indicated they needed further education in this area (O'Connor, 2002).

Oconnor (2002) also identified that patient teaching was indicated as being a major role for PNs in her study. Teaching was involved with diabetes, asthma and wound management. The study found that, although PNs were reporting low levels of competence in patient education, they did not request further education in the area (O'Connor, 2002). Oconnor suggested that this might indicate a "low level of reflection on practices undertaken by the PNs surveyed" (O'Connor, 2002: P14).

Oconnors' study was carried out in 2001, only two years after the introduction of EPC items. It was reported that the five divisions within the study did not engage frequently in these items. However, PNs did indicate that they needed further education in relation to cares undertaken for EPC items (O'Connor, 2002).

It appears from these studies that little had changed from 1999 to 2002, both with the role of the PN and with the need for PNs to undertake further education.

In 2003, a study was conducted by the Royal Australian College of General Practitioners in collaboration with the Royal College of Nursing, Australia, 'to explore the current and future roles of nurses in general practice, the educational needs of PNs and GPs and the current educational programs available to support the role of nurses in general practice' (Watts, Foley, Hutchinson, Pascoe, Whitecross, Snowden.2004: Pxi). The study used a triangulation of qualitative and quantitative research and was conducted nationally.

The study divided nursing responsibilities into four areas: clinical care, clinical organisation, practice administration, and integration. Watts et al (2004) believed that these areas further validated the roles indicated in the RCNA Nursing in General practice kits. They believed that the PN role should be a specialty area of nursing (Watts et al 2004).

The study identified five areas that impacted on the PNs role. These being,

- Professional characteristics of the nurse,
- The practice's patient population,
- The business orientation of the practice,
- Localised practice and community resources,
- Structural arrangements at a national level

(Watts et al 2004: P31).

The participants of Watts et al's study did not foresee the role changing a great deal in the future. Perceived exceptions were that they expected the PN to support quality in general practice and primary health care. There was also some indication by PNs that they would like the role to turn into one that is more autonomous (Watts et al 2004).

Similar to Patterson, Del Mar and Najman (1999), Watts et al (2004) found that education of PNs was largely informal, and was often 'on the job'. They suggested that the quality of educational approach and content were largely not assessed, neither was the appropriateness of the content. They stated that the current education system for PNs 'does not foster reliability and dependability in training' (Watts et al 2004: p40).

Teamwork was stressed as being important to the participants of the Watts et al (2004) study. The research also indicated there was evidence to suggest that many PN and GP teams do work well together. Doctors in the study identified that they needed further training in skills related to working within a team (Watts et al 2004).

Participants in the study indicated that the current Medicare arrangements hindered the collaborative practice of the PN. They believed that the funding arrangements devalued the nursing role and forced them to take on the role of 'hand maiden'. The authors stated that incentives such as the PIP allowed the PN to work more autonomously, but these were not available to all practices (Watts et al 2004).

Two studies have addressed the public perception of the role of the PN and what consumers believed to be appropriate roles for the PN.

2.6 Consumers perception of the role of the PN

Two studies recently undertaken examined the role of the PN from the consumers' perspective, (Cheek et al, 2002; Hegney et al, 2004a). The study by Cheek et al (2002) was undertaken through the University of South Australia on behalf of the Federal Government. This study held 20 focus groups with consumers throughout Australia. The Hegney et al (2004a) study was carried out from the Centre for Rural and Remote Area Health, University of Southern Queensland. This study held 17 focus groups and was undertaken in Queensland. The Hegney et al study also included 10 interviews with a diverse range of consumers including Indigenous consumers and consumers with mental health problems. In general, the results of these two studies could be combined, because the perceptions of consumers about many of the findings were the same.

Both studies found that most consumers have little knowledge of what a PN does in general practice. This impacted on their ability to be able to comment on the role of the PNs, with many consumers using their experience of nurses in hospitals to form an opinion. Consumers in both studies indicated that they were comfortable with PNs undertaking a procedural type of role, as long as it did not require decision-making. They were, however, less comfortable with roles that included diagnostics, pap smears and prescriptions. The level of comfort with an expanded PN role did not vary with the level of contact the consumer had with a PN role within the Hegney et al (2004a) study. However, consumers in the Cheek et al (2002) study, who had less contact with a PN, were less confident in the advanced practice role.

One concern of consumers in both studies was that PNs would act as ‘gatekeepers’ to the GP, thereby decreasing access to the GP. All consumers believed that they should be allowed the choice of seeing the PN or the GP. They thought that they would like to be introduced to the PN through the GP and that this would give them more confidence in receiving care from the PN. Consumers also believed that the PN should be clearly distinguishable from the rest of the staff at the practice so that the consumer would know they were receiving care from a PN and not the receptionist.

Consumers also believed that the PN role had the potential to increase access to the GP. They believed that the PN could take some of the work load off the GP, thus giving the GP more time to spend with consumers, thereby freeing up availability of appointments.

Concern also surrounded the area of payment of the PN. Consumers believed the PN should receive payment but they did not want the service to cost more.

Consumers in both studies believed that, if they trusted their GP, they would trust that the GP would employ a PN with suitable qualifications and experience. They believed that the PN and the GP should work well together and should present a united front to consumers.

Those consumers who had experience with PNs were satisfied over all with the care they had received. They believed that the caring role the PN played added to what the general practice was able to offer. For example, participants in both studies indicated that they believed that PNs were approachable and caring and these qualities allowed them to build a rapport with

the PN. Consumers also noted that once they trusted the PN, they would often seek their opinion, rather than taking the time of the GP.

These studies showed the need for consumers to be better educated regarding the role of the PN. Too often, consumers did not know what a PN did. The studies also highlighted the need for GPs to be openly supportive of the advanced PN role in order to gain the confidence of consumers.

The Hegney et al (2004a) and Cheek et al (2002) studies have provided in-depth information on how consumers viewed the advanced role of a PN. It therefore was apparent that similiar questions should be asked of GPs and PNs to discover how GPs and PNs regarded this advanced PN role. This study therefore, aimed to gain the perspective of GPs and PNs from general practices where PNs already work in an increased role.

The role of the PN has, in many situations, changed over time. Many PNs have responsibilities equivalent, at least, to senior nurses within the hospital ward situation. It is important therefore to investigate if there is parity of wages between these positions.

2.7 PN Remuneration

The remuneration for PNs are significantly lower than that of the public hospital State Award for registered nurses (See Table 2.1).

Table 2.1 Nurse pay rates

Classification	**Doctors rooms /week**	**State award /week**
a) Registered Nurse Level 1		
1st Year	577.50	705.55
2nd Year	601.10	739.45
3rd Year	622.70	774.50
4th Year	648.20	809.60
5th Year	-	844.65
6th Year	-	897.85
7th Year	-	915.10
8th Year	-	950.25
b) Registered Nurse Level 2		
1st Year	766.10	966.50
2nd Year	779.80	993.90
c) Registered Nurse Level 3		
1st Year	840.70	1108.25
2nd Year	858.40	1135.05

Source: Queensland Nurses Union 2004, Queensland Division of General Practice, 2003

However, it is possible that many GPs pay more than the award rate. For example, the Practice Nurse Employment Pack developed by the Queensland Division of General Practice states "in General GPs are offering higher than award rates to attract suitably qualified personnel" (Queensland Division of General Practice, 2003. P13).

The remuneration of the PN may influence the role the PN takes with the general practice, which in turn can also reflect the way in which the GP and PN work together.

2.8 Collaborative Relationships

Henneman (1995) describes collaborative as being 'a process by which members of various disiplines share their expertise' (Henneman, 1995: p363). This is a very simple explanation and Henneman (1995) also states that the process is very complicated and requires that all participants understand their contribution to the decision making process (Henneman, 1995).

Patterson and McMurry stated that :

> *Collaborative practice between registered nurses and medical practitioners has been the subject of discussion, debate and research for decades. However, despite purported positive outcomes from such interdisciplinary functioning, it has been the exception rather than the dominant pattern in health care* (Patterson and McMurray, 2003: P43)

Patterson and McMurray (2003) proposed a model that was patient centred and had both PNs and GPs collaborating to provide quality patient care. They believed that the PN could take on the role of team leader, referring to other disciplines when necessary. The roles should be flexible and be determined by the individual's expertise and the patient's needs. This model, they stated, would 'better reflect the attributes of collaboration, where nursing and medical practice retain unique elements but have areas that overlap' (Patterson and McMurray, 2003: P45).

Henneman (1995) stated that nurses were largely responsible for the lack of collaboration between nurses and doctors. She believed that nurses have lacked a sense of identity about the contribution they make to patient care. Henneman also believed that nurses blame doctors for this lack of collaboration. Nurses, she stated, have attempted to build independent roles rather than interdependent roles, leading to distrust between the two professions and fostering a view that physicians are the enemy and that it is only nurses who care about the patients. Collaboration requires that there is mutual respect and trust, which is built up over time between members of the team (Henneman, 1995).

Henneman (1995) noted that Florence Nightingale defined nursing as a unique profession. Florence Nightingale, she stated, viewed nursing as having both dependent and independent roles; however the independent role was lost in the mid-nineteenth century as the medical role evolved. Medicine became more research based, and therefore scientific, when the education of physicians was moved from the hospitals to universities. This scientific approach was not the same for nurses. The intellectual scope of undergraduate preparation led to a significant gap between the two disciplines in terms of their scientific basis (Henneman, 1995). This impacted on the ability of nurses and physicians to collaborate and nurses were relegated to handmaiden status. Henneman (1995) therefore believed that, for physicians and nurses to collaborate successfully, nurses need to build their own disciplinary knowledge, and identify what the contribution of nursing can be.

In another paper, Henneman, together with Jan Lee and Joan Cohen (1995), reported that ‘effective group dynamics play a pivotal role in the promotion of collaboration. Factors that

promote collaboration include excellent communication skills, respect, sharing and trust' (Henneman, Lee & Cohen, 1995: P106). They commented that trust is built over time through getting to know one another and through communication and sharing.

The same authors believed that collaboration necessitates an organisational structure that is horizontal rather than hierarchical (Henneman, Lee & Cohen, 1995). Participants in the group need to be able to act autonomously and rewards should be put in place to recognise the group as opposed to individual accomplishments. They believed that nursing as a profession is caught up with establishing the uniqueness of the role, rather than recognising the synergism that results from various disciplines working together (Henneman, Lee & Cohen, 1995). It was also stated by them, that distrust and disrespect serve as barriers to collaboration and are in part brought about by the philosophical and socialisation processes of nursing that fail to recognise the contributions of other disciplines to health care. They stated that there are benefits to the individual involved in a collaborative team:

> *Individuals who are involved in collaboration benefit from the supportive and nurturing environment it creates. Collaboration substantiates the unique and important contribution made by an individual, hence reinforcing feelings of competence, self-worth and importance. The 'win-win' attitude that accompanies collaboration promotes a sense of success and accomplishment in meeting individual as well as team objectives (Henneman, Lee, & Cohen, 1995: P107).*

Blue and Fitzgerald (2002) concurred with Henneman. They stated that 'as medicine has consolidated, nurses have struggled to develop a professional identity and to find ways of working with doctors that are rewarding and productive' (Blue & Fitzgerald. 2002: P315).

In their study they found that there needed to be 'equality, respect, and appreciation of each other's professional skills' for a professional relationship to flourish (Blue & Fitzgerald, 2002: P315). They believed that the building of trust took time and required mutual respect, and that when nurses were experienced, communicated well and displayed confidence, doctors were more likely to trust them. They also reported that collaboration increased when nurses 'were both assertive and co-operative in their relationships' (Blue & Fitzgerald. 2002: P321).

Willis, Condon and Litt conducted a study in 1999 to determine the relationship between PNs and GPs in Australia. In this study they reported that there was very little shared care occurring. There was a clear division of labour with the GP being the initiator and supervisor and the PN depending on the doctor for the flow of work. They indicated that this was due to a number of factors such as:

1. Although PNs performed some tasks independently and were at times consulted, PNs were seen as a practice resource. They were not seen as 'practitioners with their own separate domain of nursing knowledge that might bring a different dimension to patient care' (Willis, Condon & Litt, 2000: P243).

2. There was 'significant power and status differences' (Willis, Condon & Litt, 2000: P243) between GPs and PNs. The authors attributed this to such things as the GPs education and knowledge, and also their gender and age. They believed that most importantly this discrepancy of power and status was due to the GP being the employer, whereas the PN is the employee and often works part-time, giving them less engagement in the workforce.

Due to the power and status difference they found that shared care between the GP and PN was difficult (Willis, Condon & Litt, 2000).

3. Some GPs believed that there 'were medico-legal problems of accountability' (Willis, Condon & Litt, 2000: P244) within the practice of shared care. It was identified that PNs are covered by their employer for litigation. The GP as the employer is therefore ultimately responsible for the overall direction of patient care, and because of this, wanted to retain control over the work of the PN (Willis, Condon & Litt, 2000).

4. Some GPs believed that if they delegated functions such as 'health education, counselling and initial teaching of equipment use' (Willis, Condon & Litt, 2000: P244) they were not in fact providing holistic care. GPs viewed holistic care as broad based care being provided only by them, whereas nurses perceive holistic care as being multi-disciplinary care coordinated at times by nurses (Willis, Condon & Litt, 2000).

5. Most PNs in the study did not attend practice meetings, preferring instead to have informal lines of communication (Willis, Condon & Litt, 2000).

6. Medicare reimbursement arrangements were described as being a structural impediment and fostered a conservative relationship between the GP and PN. The authors stated that the fact that a GP needed to over see the PNs work was 'frustrating and an inconvenience for themselves and their patients' (Willis, Condon & Litt, 2000: P275).

Despite the lack of shared care, PNs were valued highly within the General Practices of the study and effective working relationships had been built that enhanced patient care (Willis, Condon & Litt, 2000).

In his keynote speech to the inaugural PN conference in Bunbury, Western Australia, Dr Bruce Lervy (2003) discussed the aspects of functional and dysfunctional teams.
He noted that the major attributes of a functional team included:

- tasks being undertaken by the person most appropriate for them
- there being no jealousies as to roles that previously belonged to another member of the team
- team members giving each other mutual support
- corporate responsibility being shared by all in the team

As noted earlier, the advanced role of the PN is still evolving in Australia. The next section examines how PNs work in the UK.

2.9 Practice Nursing in the United Kingdom (UK)

In the UK (Phillips. 1998; Robinson. 2002a; Robinson. 2002b; & Searle. 2002), nurses are running minor illness clinics with physicians available if the nurse needs to refer care. They are prescribing some medications and are diagnosing and treating minor illnesses. PNs are also providing services to women such as pap smears and breast examinations. The PN also provides health screening and health advice (Phillips. 1998; Robinson. 2002a; Robinson. 2002b; Searle. 2002).

Chronic illness management has been suggested as a role for PNs in the UK (OXYCHECK, 1995). The Oxford and Collaboration health check (OXYCHECK) trials evaluated the effectiveness of health checks performed by PNs. Overall it was found that, of the population assessed, over three-quarters needed follow-up intervention due to the number of risk factors identified by the PNs. This study found that health checks and the care provided by a PN brought about dietary changes and reduced cholesterol levels. The study acknowledged that the benefits of health assessments would only be realised if they were sustained over time (OXYCHECK, 1995).

The Southern Heart Integrated Care Project (SHIP), conducted in the UK, explored the follow-up care of patients discharged from hospital with cardiac disease where care was delivered by PNs. The results indicated that patients were comfortable with receiving follow-up care from a PN. A major benefit of the program was that patients received reassurance regarding their illness. Additionally, the role also increased people's access to health care. PNs were seen as having more time to spend with patients. The importance of the PN having a high level of knowledge was highlighted by patients and was identified as a major factor in acceptance of the PN in this role (Wiles, 1997; Wright, Jolly, Speller & Smith, 1999; Wright, Wiles and Moher, 2001).

In 1993, a study by Atkins, Hirst, Lunt, & Parker,(1993) investigated the self-perceived education needs of PNs in the UK. Their findings were very similar to that of the two Australian studies by Patterson et al (2000) and O'Connor (2002). They found that PNs felt inadequately prepared, especially for the roles of patient education, health promotion and for their role in chronic disease management. PNs in this study mainly focused on their need for

education for clinical tasks and improving their skills (Atkins et al, 1993). Crawford (2002) confirms these findings. She reported an interview with a PN in which the PN stated that nurses were not necessarily well prepared for their role. The PN believed that if an educational standard had been set early in the development of the PN role in the U.K, it could have prevented many problems further on (Crawford, 2002).

Dr Bruce Lervy (2003), in his keynote speech to the inaugural PN conference in Bunbury, Western Australia, informed the audience that PNs in the U.K contribute at different levels. He stated that these levels include the PN with an extended role: the nurse as practitioner; as Physician assistant; as Nurse partner and Nurse employer.

PNs also are employed in the USA, albeit in different roles to that of those in the UK and Australia.

2.10 Practice nursing in the United States of America (USA)

'Advanced Practice Nurse' is a term used in the USA to describe a nurse practitioner (NP), or certified registered nurse anaesthetists, certified nurse midwives and clinical nurse specialists (CNS) (Murphy-Ende, 2002).

Nurse practitioners have gained a masters degree, and as primary care providers are able to write patient prescriptions, refer patients to emergency care services or specialists and authorise hospital admissions (Murphy-Ende, 2002). That author also stated that due to a house staff shortage in the late 1980's, the NP role was implemented as 'house staff substitutes' in acute care settings so that medical practitioners could focus on more complex

care demands. Subsequently, ‘the acute care NP position developed, blending the dimensions of nursing and medicine into collaborative practice’ (Murphy- Ende 2002, P 107).

A nurse practitioner will often provide services to the disadvantaged within a community. For example, a nurse-managed clinic at Northern Arizona University provides a free service to people who ‘fall between the cracks’ of the health system (Craig, 1996). Clients are given a nursing assessment and are given advice as to lifestyle changes. The service also helps clients to manage chronic illness. If a client needs to see a physician, that is arranged; the physician, however, is not always on the premises. The nursing staff also arranged referrals to other health personnel. (Craig, 1996).

Katon, Korff, Lin, Simon, (200l) described a proposed stepped care approach to the management of chronic illness. His model, similar to that of the case-management approach used in the UK and suggested as a model in Australia, incorporates patient education, monitoring, counselling and follow up of patients with chronic disease. This model, it is suggested, allows the PN to provide continuity of care at the general practice level, with specialists contributing where necessary (Katon et al, 200l).

As the health system in the USA differs from the Australian system, it is very difficult to draw comparisons between the roles and education standards. The United States has further developed the nurse practitioner role as described above, which is quite different to that of the PN working in collaboration with a GP in Australia.

2.11 Conclusion

This chapter has given a background of the PN role in Australia, the UK and USA and has laid the scene for this study. The following chapter will describe the methodology used as the bases for this study, and the data collection techniques used.

CHAPTER THREE

3. METHODOLOGY

This chapter will discuss the methodology of Ethnography. It will explore the different ways in which ethnography is interpreted and used and the interpretation this study has followed. The chapter will then examine the method used to discover what GPs and PNs beliefs are regarding the role of the PN.

Ethnography originated from anthropology, where travellers used to bring back stories from other civilisations and describe the culture to others. These accounts were originally gained through questionnaires (Denzin and Lincoln, 2000).

In starting this study I had limited knowledge of the role of a PN. I knew nurses worked in General Practice, but in common with other nurses working outside this environment, I had little idea of what their role entailed. My interest came when reading the research proposal for the project at the University of Southern Queensland titled ‘Consumer Perceptions of Practice Nurses’ in which I was involved as the research assistant. When reading this project I could see the benefits of the increased role of the PN in improving health care to the general population, especially to the elderly and those with chronic illness. Of interest to me was the role that these nurses could take and also how they interacted with other health professionals in general practice.

Having limited knowledge on the topic was both an advantage and a disadvantage. The main advantage was that there I had no preconceived ideas about the role of PNs and therefore a limited expectation of what might be found. The disadvantage was that there was also little idea of what to ask or to look for. A quantitative study was precluded, as it was important in order to answer the research questions that participants are able to express their opinions and what is of importance to them. Quantitative research has too many boundaries for this to occur, as the researcher has to ask the correct questions to get the appropriate answer. The researcher therefore risks missing out on important data that had not been expected. Therefore, since I had limited knowledge of the area, the qualitative methodologies were explored.

As it was apparent that I was not an expert and the potential PN participants were, ethnographical techniques appeared to be the best way to collect data. In this methodology participants are the experts in the area being studied. As Handwerker (2001, p4) notes 'ethnographers don't have subjects, we ask people to help dispel our ignorance'.

Ethnographical techniques also seemed appropriate to this research, as the study is researching a group of people and how a relatively new role has impacted on that group of people. This distinguishes ethnography from other qualitative methodologies because it is used to describe culture. Handwerker (2001: P 66) described culture as being "the knowledge people use to live their lives and the way in which they do so." Similarly Denzin and Lincoln (2000: p852) describe culture as being "composed of those understandings and ways of understanding that are judged to be characteristic of a discernible group...its features must have some lasting quality - durable enough, at least, to be acquired by newcomers to a

group”. Denzin and Lincoln (2000) also comment that this definition can be applied to both a small and a large group of people. Therefore, although ethnography was traditionally used to describe an ethnic group and/or a group of people isolated from other cultural groups, it is now also used to collect data about groups within communities that can be distinguished by the definitions above (de Laine, 1997; Roberts & Taylor, 2002).

3.1 Classic Ethnography

Ethnography developed further when researchers would, at times, spend years living in another culture in an attempt to understand the people. Field notes were used to document what was being observed, and the Ethnographer became totally immersed in the culture (Denzin & Lincoln, 2000). The advantage of this was that the ethnographer was in the group for such an extended period that the people would not put up any pretence in front of the researcher and the researcher would then be able to see life as it really was (de Laine, 1997). The disadvantage was the time factor and also that the researcher risked losing his or her objectivity as they became emotionally involved with the group (de Laine, 1997). It is increasingly less likely today that a researcher will be allowed the luxury of spending many years completing one piece of research as in this fast paced world as results are needed quickly (Handwerker, 2001).

Since the early days of ethnography there have developed many different forms of the science and it is now a term used very loosely within qualitative research. Denzin and Lincoln (2000) state that ‘thousands of works written in many languages and genres have been encoded as ethnographic. Researchers can and do describe the same material in many different ways, using different formats, styles and genres’ (Denzin & Lincoln, 2000: P459).

Ethnography as a methodology is therefore very diverse and can be interpreted in many ways. I have therefore focused in this chapter on giving explanations of ethnographic methodologies that I considered appropriate for this study.

3.2 Critical Ethnography

Critical Ethnography focuses on the political reasoning behind the actions of people within the group. It is especially interested in who holds the power within the group and how they are socialised to accept that (de Laine, 1997; Roberts & Taylor, 1998). The objective of critical ethnography is to 'empower research participants, including the researcher, through joint critical reflection on the constitution of their interpretive frameworks' (Bruni, 1994). Critical Ethnography therefore brings about change by allowing the group to see, from an outsider's point of view, how they interact and how power is distributed.

This methodology had some merit because it was expected that the power base in general practice would be a major influence on the role of the PN. However, as I am only focusing on those practices with PNs working in an increased role, my aim was not to bring about change within these practices, but to describe how they are working and interacting together. I have therefore undertaken this research at a descriptive level.

3.3 Quick Ethnography

Quick ethnography was developed in the 1970's in response to 'the accelerating rate of change in the world and a lessening of financial support for long-term research' (deLaine, 1997: P114). By using quick ethnography the researcher aims at achieving the advantages of anthropological methodologiess without spending great amounts of time in the field

(deLaine, 1997). Quick ethnography uses the same data collection methods as other ethnographic methodologies; however, it is done over a shorter period of time. The most important aspect of quick ethnography is that the researcher must plan well before going into the field. The research questions must be clear and the researcher must remain focussed for the research goals to be achieved (Handwerker, 2001). The researcher is also more likely to use questionnaires as part of their data collection (deLaine, 1997).

3.4 Focused or Mini Ethnography

Ethnography can also be described as either maxi or mini. Maxi is the classic form of ethnography looking at a large group of people such as a village, whereas Mini looks at a lower level of social organisation such as a hospital ward or, as in this study, a GPs rooms (deLaine, 1997).

This study is similar to quick ethnography as the fieldwork was completed over a relatively short period of time, and also to Mini Ethnography as it focuses on a small group of people. The project only looks at those general practices that have PNs working in an increased role. The increased role for this project is defined as PNs who are taking on more duties than that of the traditional PN such as health assessments, contributing to chronic disease management and triaging. The project therefore does not look into general practices that do not have a PN or only have a PN working in a limited role.

3.5 Data collection methods in Ethnography

In reviewing the literature of ethnography (Agar, 1996; deLaine, 1997; Schensul, Schensul & Le Compte, 1999; Denzin & Lincoln, 2000; Handwerker, 2001), it was established that ethnographers use multiple means of collecting data. Such as:

- Observation
- Interviewing
- Questionnaires
- Field notes
- Literature review

Not all researchers will use all methods of data collection in a study. Which methods of data collection are used for a study appears to depend on the researchers' preferences, and the group to be studied. Ethnographers also have many varying opinions on how ethnography should be conducted (Agar, 1996; deLaine, 1997; Schensul et al, 1999; Denzin & Lincoln, 2000; Handwerker, 2001). These differences of opinion and the validity of methods will be discussed under each method of data collection heading.

Regardless of the mix of data-collection methods, the multi-faceted approach of ethnography allows the researcher to look at the culture from different angles and see answers to questions in different ways. It also allows the researcher to validate collected information by being able to view the incident in the field or discuss the incident with another participant to ascertain if that is normal practice within the group (de Laine, 1997). The following section is an explanation of each of the methods of data collection.

3.6 Observation

Observation is described by de Laine (1997,P141) as 'including semi-structured and informal, conversational-style interviewing and document analysis'. Observation in this study means observing behaviours in two general practices and undertaking informal interviews whilst in the general practice.

The length of time involved in direct observation of a group varies between studies. Some ethnographers will spend years in the field while at times direct observation is not undertaken at all (Roberts & Taylor, 1998). While observing, a researcher may be:

1. a participant observer - which means that they become part of the group being observed
2. an observer only - not taking part in the group at all and observing from outside the group
3. a partial participant / observer - interacting to some extent with the group but not becoming part of the group (de Laine, 1997).

While observing participants, the ethnographer is learning from those participants, who are the experts in the area. Ethnographers therefore take a "one down" role, like that of a student (Agar, 1996). This is how the observations were approached in this study.

Agar (1996) suggested that interviews and observation mutually interact with each other. He also suggested that observation can be used to inform interviews and that interviews can also inform areas to be observed. He stated that observation is essential as it helps the ethnographer to give accounts of events, which may not be identified at interview because, in interviews, participants may leave some issues out (Agar,1996).

3.7 Interviewing

This section will discuss unstructured, semi-structured and structured interviews.

3.7.1 Unstructured Interviews

Unstructured interviews (also called informal interviews) are generally the interviews undertaken in the field whilst observing the culture. These interviews do not have predetermined questions or answers and follow a conversational style (Handwerker, 2001; Agar, 1996; deLaine, 1997; Denzin & Lincoln, 2000).

Handwerker (2001) describes this method of interviewing as ranging from casual conversations to controlled gossip, and suggests that the most valuable data are that collected through controlled gossip. The researcher may probe for information whilst undertaking the interview using such techniques as reflective listening where the researcher repeats what the participant has said back to them, encouraging them to elaborate and ensuring that the meaning is correctly interpreted (Handwerker,2001. Agar, 1996). Interviews are not taped or notes taken. The field notes are written after the interview (deLaine, 1997).

3.7.2 Semi-structured interviews

Semi- structured interviews have an interview guide rather than a set of questions, and the guide can be revised during the research. The guide is used to jog the researchers' memory to make sure all topics are covered in the interview (de Laine, 1997). Although a guide is followed the interview takes direction from the conversation, exploring other issues as they arise (Roberts & Taylor, 2002). As in unstructured interviews, the researcher uses such

techniques as reflective listening (Handwerker, 2001; Agar, 1996). Whilst undertaking ethnography, the findings are continually analysed. This allows for validation to occur across interviews. This validation involves identifying similarities and differences between participants, allowing the interviewer to change prompts accordingly. This process continues until there are no new data and all the research questions have been answered. Thus, the guide for semi-structured interviews evolves throughout the research (de Laine, 1997. Schensul et.al. 1999. Handwerker, 2001).

3.7.3 Structured Interviews

Structured interviews have a defined set of questions and the researcher adheres to those questions throughout the interviews, and the questions are put in the same way and same order to each participant (Denzin & Lincoln, 2000). This style of interviewing also includes closed-ended questions where the answers to the questions are limited (de Laine, 1997). Structured interviews allow the researcher to pursue specific questions and can be undertaken face to face or can be delivered as a written questionnaire.

3.8 Questionnaires

Handwerker, (2001) describes various methods of undertaking structured interviews. One method used in this study is the Likert Scale, which allowed for multi-dimensional variables to be measured. This scale, which gives the participant a range of answers for each question, can measure such things as feelings (Handwerker, 2001). In this study, the Likert Scale gauged the level of comfort of participants in regard to specific nursing duties.

Field notes, although a very different means of collecting data to the questionnaire, also add to the body of knowledge and inform questioning.

3.9 Field notes

The researcher generally writes up field notes after interviews or direct observation. This is another area of ethnography where opinions differ about what should be included in field notes, and their importance to the research process. One argument against the use of field notes is that they are usually not written while in the field, as this can interfere with the research process; rather they are written up after being in the field, thus relying upon the researcher's memory (Agar, 1996). To overcome poor recall, de Laine (1997) stated that field notes are best recorded as soon as the researcher leaves the field. She recommends reliving the day and going through events in chronological order following the flow of events. This she believes increases accuracy (de Laine 1997).

Agar (1996) had a different opinion to that of deLaine (1997). Agar believed that due to their potential inaccuracy, field notes should not try to capture everything within the culture but be focused on particular topics. He believed that field notes consisted of two kinds of things:

> *first, some ideas from observation to follow up with interviews, or some observations/questions to follow up that came from interviews; second, some things you have noticed that you want to get to eventually* (Agar, 1996: P162).

He believed that once you have used your field notes to gain more understanding they are no longer needed.

This study is an adaption of Agar (1996) and deLaines (1997) research approaches. Most field notes were verified by data from interviews and the field notes therefore put aside.

However, there were times when the field notes added depth and therefore value to the other data and were presented in the Results chapter.

The literature review gave initial information to the researcher about practice nursing and also increased the researcher’s depth of knowledge throughout the research process.

3.10 Literature review

The literature review is an accepted method of gaining prior knowledge of the area to be researched and is also used for the researcher to compare their results to those of other studies. Agar, however, commented that reading literature prior to undertaking an ethnography can give bias to the research and ‘cloud your mind with other peoples mistakes and misconceptions’ (Agar, 1996: P76).

As stated previously, to undertake a quick ethnography the researcher must be prepared before going into the field and have the research planned and research questions clear. Contrary to Agar’s (1996) beliefs, the researcher in this study needed to discover from the literature the important issues regarding practice nursing, before being able to plan the research. This kept the research process informed and allowed the researcher to discover if issues raised in the literature were important to participants within this study.

3.11 Data Analysis

As ethnography uses many methods of data collection to gain understanding of a group, data analysis starts at the beginning of the study (de Laine, 1997). Whilst undertaking informal interviews, theories are generated. In this study, this is when the interview guide was

developed, and themes about areas of importance identified. Semi-structured interviews, formal interviews, observation and more informal interviews then validated these initial theories, showed variations in opinion, or generated new themes entirely (deLaine, 1997. Schensul et.al, 1999. Handwerker, 2001). Finally the data were analysed under the theme headings with variance in opinions identified under these themes.

The methodology of ethnography as described has formed the foundation for the method of undertaking this study. This chapter will now detail the method of data collection and analysis.

3.12 Method of data collection and analysis

The first step of the project was to develop its aims and objectives (see Chapter 1). These were developed after an initial literature review, which revealed the historical issues regarding the role of PNs. They were also informed by numerous unstructured interviews with PNs. The recruitment of participants into the ‘consumer perceptions of practice nursing’ project provided an opportunity to meet many PNs in the Toowoomba area. Additionally, many unstructured interviews were undertaken when contacting PNs from outside Toowoomba. The consumer study therefore allowed access to PNs as well as providing an opportunity to discuss the issues of practice nursing. In the same study, where a PN was a member of the reference group, unstructured interviews with the PN provided further insights into practice nursing. Additionally, time was also spent discussing the PN role with a colleague. These informal means of gathering data continued throughout the study and proved invaluable points of contact to clarify issues that had been seen or heard, allowing validation of the findings. Both the PN from the reference group and the colleague have

strong ties within the PN community and their experiences enabled findings to be put into the perspective of the broader PN community. Whilst gathering data by informal means, field notes were kept of issues important to the study, which would be followed up in interviews. Cross checking emerging data throughout the study as just described enabled the researcher to ensure that the data being collected was both credible and dependable. This ensured that the experience was not only applicable to one participant. However in order to fully describe the participants beliefs, beliefs of one participant are at times included in the results and will be highlighted to the reader as coming from only one participant.

3.12.1 Participants

Participants for interviews were recruited through the recommendation of the Toowoomba and Queensland Divisions of General Practice, through suggestions of contacts or after having initial contact with the practice during the consumer study. Potential participants were approached to take part in the study, either directly or through the initial referral source. On contact, the study was explained to them, and if they expressed interest a copy of the ethics proposal for the study was sent. Interviews were held in a venue where the participant was comfortable, preferably in their own environment. All but one of the interviews was undertaken in the work place, the other being interviewed at the University of Southern Queensland. A total of four female PNs were interviewed and four GPs, three males and one female. Participants ranged in age between thirty and sixty years of age, with five of those participants being between forty and fifty. In order to increase the transferability of the research interviews were held in rural and city areas. Two practices were observed, one in a regional area and one in an outer metropolitan area.

3.12.2 Interviews

The interviews were semi-structured. The interview guide was developed at the beginning of the study, and as the project evolved other prompts were added (Appendix A). Throughout interviews the natural flow of conversation was followed with the author only referring to the prompts to ensure all areas had been covered. This method ensured that all participant beliefs about practice nursing were covered, from the perspective of the participant. Reflective listening was employed to ensure that it was understood what the participant was trying to explain. Interviews lasted between 30 and 90 minutes and were largely dependent on the time the participant had available to them and the time it took to collect the data. Time limitations were apparent in the GP interviews as the majority of these were conducted during their working day and therefore had to fit in with patient appointments. Interviews were taped for later transcription.

By the end of these interviews, it was believed that data saturation had been achieved. However, on further reflection, it is apparent that although the objectives were achieved, further investigation is warranted into the culture of general practice. Also, it is now apparent that saturation could never be achieved, as although practices have commonalities, they are all individual cultural groups.

Before the interview commenced, the participants were asked to read the plain language statement and to sign a consent form (Appendix B). It was explained to them that they could cease the interview at any time and that they could also withdraw from the study at any time by contacting the researcher through the channels provided on the plain language statement.

3.12.3 Observation

Direct observation was used in this study to put in perspective the results found in other methods of data collection and to gain a better understanding of the working realities of general practice.

Both the GPs and the PNs being observed were given a plain language statement and asked to sign a consent form (Appendix C). Also, the researcher signed the agreement stating that confidentiality would be upheld in any information collected about patients in their practice. The researchers' nursing registration certificate was supplied and it was agreed to only undertake patient contact under the direct supervision of the PN. Interaction with patients was, however, kept to a minimum with the researcher taking a partial participant / observer role. Two practices were observed for eight hours each. Time limitations did not allow a longer time to be spent in the practice. This was compensated for by building a relationship with the PN in each general practice. The first PN observed was one of the PNs the researcher had had many casual conversations with about practice nursing and was therefore not intimidated by being observed. With the second practice visited, time was spent with both PNs depending on what was happening at the time. The researcher had had contact with one of these PNs during the consumer study and was therefore known to her. Nurses are used to having student nurses with them and are able to relate to people in that role. The researcher therefore took on a role like that of a student. This role also was helpful when explaining the researcher's presence to patients, who was usually introduced to them as being a nurse undertaking a study for the university by spending the day seeing what PNs do. Patients are also familiar with the student role. This was an accurate description, because the researcher was in fact a student learning from the nurses what is involved with being a PN.

The PNs also understood that they were asked to participate in the study because their practice was considered to have PNs working in an increased role in relation to the usual PN role. This also put them in the role of teacher. Notes were taken immediately when leaving the practice, rather than during the observation, as the participants might have been intimidated by notes being taken.

3.12.4 Questionnaires

Questionnaires were given to each participant prior to the interview or at the end of the observation (Appendix D). The questionnaire was based on that given to consumers in the Hegney et al (2004a) consumer study

3.12.5 Data Analysis

Analysis of this project was conducted in a progressive way. The first stage was in the field while collecting informal information and interviewing. Themes were developed around the issues that were identified as being important to practice nursing. Through subsequent interviews, clarification of these themes and variance of opinion within the themes was noted. New themes were also added after being identified by the participants. After all interviews were completed, the transcripts and field notes were analysed, seeking variance of opinion and further themes. After additional themes were clarified, both the themes and variances of opinion within those themes, were reported on.

The questionnaire was analysed using a simple comparison of frequencies within each level of comfort. Further testing was not possible due to the small number in the study.

3.12.6 Limitations of the study

There is no doubt that the use of ethnographical tecniques as the study method has added strength to the findings by creating a better understanding of the culture. In particular, credibility was gained from data collected by informal interviews or conversations. This enabled the researcher to establish whether themes identified in interviews could be confirmed by others outside the study. The triangulated approach of ethnographical techniques used also included written questionnaires and observation, further validating the findings. It is believed that this study has identified some issues within the culture of general practice as a whole, because some issues would be generic to all general practices and some transferability has therefore been achieved. The transferability of this study however is limited as it only looks at practices with PNs working in an increased role and some issues may be only relevant to other general practices with PNs working in an increased role. This study has attempted to describe the issues identified by PNs and GPs in general practices with PNs working in an increased role in order to give insight into how these practices have accommodated practice nursing, and the benefits of PNs working within the practice.

3.12.7 Ethical issues

Ethics approval was sought from and granted by the University of Southern Queensland Ethics Committee Reference Number: H03STU259 (Appendix E). The data and tapes have been stored in a locked filing cabinet at the University of Southern Queensland. The information kept on computer is only accessible by password, and the password is changed every ninety days. After completion of the study, all information has been put onto CD-ROM and all materials pertaining to the study will be destroyed after five years.

3.12.8 Conclusion

This chapter has sought to give a simple explanation of Ethnography and its major principles. It has explained how these principles have been applied to this study, and the benefits of using this methodology. The method of undertaking this study has also been explained, as have the methods of analysing the data. Throughout this chapter, explanations have been given about how participants have been informed and their rights explained. The following chapter will detail the results of the research.

CHAPTER FOUR

4. RESULTS

This section will identify the GPs and PNs perceptions of PNs. There are three different data sets reported in this chapter. The first are the perceptions of the participants obtained from interviews. These are in *italics.* The second data set are the field notes from my observations. These are written in Arial. The third data set is those collected from the survey.

Twelve themes were identified in the study. The major theme was teamwork within the practices. Participants believed that teamwork was essential in general practice and the concept of teamwork is evident in most of the themes. Teamwork is therefore discussed as a theme individually, but is also discussed throughout this chapter where it is relevant. The other themes discussed in this chapter are:

- Communication systems
- Role boundaries
- How PNs become accepted by consumers
- Payment of the PN
- Payment of the GP
- Important characteristics of general practice
- How PNs add to general practice
- Training and qualities of the PN
- Factors that determine the role of the PN
- Actual and possible roles of the PN

- Choice of practitioner.

4.1 Team Work

Teamwork was considered essential to all participants interviewed and was apparent in practices that were observed. The staff of both practices were seen to work together as a team. The team included the GPs, PNs, receptionists, and practice managers. All of these team members made their own unique contribution to the practice itself and to patient care. As my field notes state:

Each person in the practice appears to contribute to the patients' care, including receptionists, PNs and GPs.

The GP was considered the team leader; however, practices had varying degrees of collaboration between the GP and the PN. Practices with PNs working in more increased roles were observed to have the most collaboration.

As my field notes state:

Still under medical control; comment: 'got to keep Dr's happy'. However there appears to be respect between all staff.

During interviews both GPs and PNs, but more predominantly the GPs, discussed the importance of a team approach to patient care. Two GPs explain the importance of the team:

> *The team includes the receptionist; everybody who is working for you...It includes the cleaners that come in at night. The team aspect of it allows flexibility and a wider range of services, not everything falling onto the one individual...So, you would hope*

that the receptionist can do her job, which may be very important. She may have to rearrange priority for a patient to come in. So, if she doesn't do that, and they arrive six hours later because that is the earliest appointment, and they have had severe chest pain for that time, then that is not good quality care. And that had nothing to do with the doctor or the nurse. It was due to the receptionist. So, you have got to have a team approach, where they can then pass information and patients on to other members of the team. They can't treat the chest pain, but they can make sure that they can channel it correctly and in reasonable time.

I guess you are looking at each of the skills or you are looking at the skills of any part of the team – the care team – and that requires, I guess, some trust in the other members. The RN has to trust the doctor's skills, and, I guess, the team approach is one of trust and of building up that trust due to successful episodes of patient care.

It was noted in fieldwork, from discussions with PNs, that for the PN to work in an increased role there needed to be good collaboration between the whole team but especially the GPs and PNs. Roles needed to be negotiated between the whole team to empower the PN to work in their role and the PN needs to feel empowered to be happy in that role.

It was apparent in practices that appeared to be harmonious, that all members of the team were valued for their input. Participants believed that the PN was able to offer a unique perspective and added to the GPs perspective. They felt that this approach gave the consumer more holistic care. As one PN explained:

There is no doubt doctors come from quite a different perspective to nurses. I think that is where we feel we have got the whole box and dice here, because our patients

are having, more often than not a combination of nursing assessment with medical assessment. So, having the two together, I think, we can be more assured that there is going to be holistic care given.

For the team approach and collaborative care to exist, communication between all members of the team needs to occur. Participants were asked how this occurred.

4.2 Communication systems

Communication in some practices was described by participants as being 'open', allowing a cross-over of ideas to occur between the GP and the PN.

One PN discussed communication in her practice:

If it is significant enough to require it – where you really need to sit down and have a round table - no problem. The doctors will always make – the doctors here will always make themselves available. More often than not, we are grabbing them in between patients…Because especially here it is a very busy practice, a very busy practice. And I think what we have got to also keep in mind that it is a business and time is money. And any time that we take out of the doctor's day is time we are taking him away from seeing patients. So, a lot of the time – if there are issues that need to be addressed fairly quickly, the e-mail system is very good. They always tap into their e-mails and promptly return that. But more often than not I am grabbing them as they are walking past or they come in here and see me. This is the benefit of having me located here, centrally, because it does make for accessibility both ways.

Examples of open communication were;

Written – PNs wrote in the patient notes what they had done for the patients and what their observations were.

Verbal - Communication between staff was usually informal. For example they were observed to have brief conversations about patients when the opportunity arose.

E-mail - The other main form of communication observed was via e-mails sent by the PN to the GP. The role of e-mail was to keep the GP up to date with patients allowing them to have input whilst not taking time out of patient consultations.

Staff meetings – practices mentioned having staff-meetings. These meetings are used for general issues but are also used in some cases to discuss patient management.

It is apparent from the team environment portrayed by the participants that PNs want to contribute to patient care in a team environment. However, as documented in the field notes: some GPs not included in the study, and some consumers stated that PNs are trying to take over the GPs role, by encroaching into areas that are seen as GPs work. It was therefore important to discover the participants' perceptions about the issue of role boundaries.

4.3 Role Boundaries

The general consensus of the participants in this study was that PNs make a valuable contribution to General Practice and have different skills to offer than the GP. They can therefore enhance what the practice has to offer and are not be a threat to the GPs role.

As one PN commented:

> *But then I think also, as nurses here, we know our boundaries. And we know where we are comfortable. And I don't think it should ever be a matter of taking over a part*

of somebody else's role, because we are all there to work together. And I think that works really well. I mean, more often than not, as a nurse, I am bringing to the attention of the GP, issues such as incontinence time and time again that they weren't aware of. They might not be aware of certain nursing practices that we can utilise. And they are very open to any suggestions that you make.

One PN saw the role as adding to the service the GP has to offer and saw the GPs role as providing the initial and majority of the care and the PN being able to add value to that care. As she stated:

Well they're the primary care giver I think and I suppose we're just the complement, but we're the complementary medicine to them, that we're there to, even the rapport between us and the patient is helpful for the patient and the doctor as well, I think we can be that link. So...I think we complement each other rather than someone trying to be bossier than the other one if you want to put it that way.

GPs and PNs believed that, together with other members of the practice, they were able to provide quality care, and when working as a team, role boundaries were not such an issue. As these PNs commented:

Oh I think it would have to be a team thing, I don't think you could ever be seen as being an independent provider of services. I see the nurse's role as being complementary, not independent and it would depend on the practice how you would manage that.

Yeah, can't we share the responsibility of primary health care? Because there's so many things that doctors know that I don't know but I think the shoes on the other foot as well.

Both GPs and PNs also believed that each member of the team has unique assets to contribute to the team. Respect for each team member's contribution to the team also meant that role boundaries were not as important. As this PN commented:

But certainly their knowledge base is much broader than mine, their training is more extensive, but there are certain things that nurses perhaps have a better feel for and their understanding and their training perhaps is more focussed on that.

It was apparent from the above comments that the PN was a well-accepted part of the team. Of interest to me was how this acceptance is transferred to the consumers of these practices.

4.4 How PNs become accepted by consumers

Participants believed that the PN needed to be seen as part of the practice. They felt that if consumers see the PN around the practice and are familiar with the PNs presence, they are more likely to accept care from the PN. As one GP explained:

I mean we've had minimal, I'd say zero, problems with the patients accepting the nurses. Yeah, I really think we've had minimal to zero problems with (it). The layout of our place, the physical layout of our place is quite open and the nurses are in and out and sort of up to the front desk a fair bit. And so I think that the patients know that they're, you know they're part of the team.

Being referred by the GP and being introduced by the GP was thought to be important to make consumers comfortable to accept care from the PN. Participants also believed that if people can see there is good communication between the GP and the PN, they will then usually be comfortable with accepting care from the PN. As one GP commented:

> *I think that a large part of the time they see us together or they see the nurse first and we're called in so I think the communication between us makes them quite comfortable with the nurse. With wound dressings and things, once they've become familiar with the nurse, they're happy to see the nurse for the majority of the time and to allow them to do the dressings.*

Over time the PN builds up a relationship with patients and gets to know them on a personal level. PNs believed that this was important as this relationship allowed patients to build confidence through familiarity with the PN. PNs reported that they take a very personal approach in getting to know patients and that they get to know the patients on a more personal level than the GPs. This also allows the PN to gain insight into patients' needs that otherwise would not be gained. As a PN explained:

> *I think if they like their doctor they know that the doctor would have a good working team provided in that practice. But you certainly do, as a PN, develop a great rapport with your patients even though you know some of them. They come regularly and they feel confident and they often open up more to the PN than to a doctor sometimes.*

Participants were asked about their perceptions of how the general practice should be remunerated for the work of the PN. They were also asked about the PNs payment and working conditions.

4.5 Payment of the PN

Many of the PNs indicated that, as they were required to have an increased responsibility and skill level, they should be paid accordingly. Some of the PNs in the study were being paid above the award rate for a PN, and saw this as an indication of being valued by their employers. Others felt that they should be paid more but continued in the role regardless of the pay differential. One PN commented about the PNs level of pay:

> *I think you have got to be prepared to pay for the quality of nurse that you are wanting in a practice. And I think nurses in general practice haven't historically been the very experienced, up-to-date nurses, because of the level of pay. You know, they pay at the base rate of an RN1 but the responsibilities put on those nurses to do as much as what they do doesn't equate. So, the GPs just have to – if they want quality, they have to be prepared to pay for it.*

Some PNs were working as a casual employee on a continuing basis. This did not give them any stability of employment, or any of the benefits that come from being employed on a permanent basis. As this PN commented:

> *In the private sector, you know, out there, from what I can gather from a lot of the other nurses, that like we're on casual rates, we don't get holiday pay, we don't get sick pay… if you've been there more than even a month, you're supposed to be*

considered part-time, you know permanent part-time, so then your rate of pay would change and so forth like that. I think it's really a hard thing, I mean that's what you accept when you go into the job so you know that anyway but it seems... they mostly have the nurses on the casual so they don't have to pay holiday and sick pay.

In this study there was little commonality of thought in regard to how the practice should receive payment for the nurses work or if the amount currently received is adequate for the service they provide. Following are the participants' diverse beliefs regarding payment for PN work.

Most participants in the study, and more so in metropolitan areas, believed that the GP was providing a service to the community by employing a PN as they do not individually bring money into the practice. This lack of income was countered by the fact that the both the GPs and the PNs believed that because the practice had a PN they were able to provide a better service to the community. Both the GP and PN from one practice also suggested that when a patient pays for a GP consultation they pay for a team approach, so the PNs wage is included in the fee they charge. One GP commented:

Well, basically the RNs here don't get any outside funding. It is all funded from the practice. Now, if they are doing care plans, then the government is paying for – the agency is paying for care plans. Some of that will go to the doctor, the rest of it goes to the practice, out of which the RN would be paid. And that payment is for a team approach. It pays the receptionist. It pays for some care. And it is only in a very large practice like this, I guess, that can mean this economy of scale, where you may have a few dollars to spend on a PN.

One participant felt that even when the GP saw the patient the payment did not cover the cost of the PN. The GP may only spend minimal time in the room and charge accordingly whereas it has taken the PN a much longer time to carry out the procedure. As the GP explained:

> *see dressings it's the same situation – I've got to go in and see the dressing and the level at which we charge, whether it's a Level A or Level B consultation, really depends upon the amount of time that I spend in the room…So if I go in and I say, 'yes continue as, I'm happy with that wound, continue with what we're doing', and walk out, that's a Level A consultation, because I've spent minimal time in that room, which is worth about ten, oh I think it's nine dollars bulk billed. But for the nurse, the nurse might then spend you know fifteen minutes washing it down and...re-dressing it, etcetera, etcetera, etcetera, but I only, you can only charge that, which means all sorts of financial issues.*

It was thought that the GPs inability to receive remuneration for a PNs work does limit the role a PN plays. Some participants believed that if appropriate remuneration was not received for a service, the PN would not be given the time to undertake that service. They would therefore be most likely to only allocate time for those activities that they receive payment for. As a PN explained:

> *I mean I can see practice nursing being a very, very important contribution to primary health care and I can see the role can extend given the training and you'd have to have some Medicare rebates to make it work as well… so if there's no*

remuneration you will find that nurses won't be allocated time to perform those skills unless there is something in it as well.

Participants were unsure of the best way to receive payment for PNs work. They thought that either the PNs work could be paid through the Medicare system as either an MBS item number for a specific procedure charged through the GP, or the PN could have their own MBS item number and be able to charge in their own right. The GPs saw fewer complications with the first scenario. As a GP commented:

It's hard to know what the, what the financial model would be with that you know I guess if they're employed by us, should we be able to charge for those services and employ the nurse to provide the service I think that that's probably a reasonable thing to do. As for the nurse being part of the practice and charging out those things, I think that's a more difficult model in this day and age to work with. When you're looking at a private model and overheads and how they contribute to the overheads etcetera but yeah I think that the lot of the, we're very negatively affected by not being able to charge for the nurse's responsibility.

In casual conversations some GPs stated that having a PN makes money for the practice. As the field notes state:

Conversation with a GP: after asking what he thought of PNs, GP stated "They can bring a lot of money into the practice"

One GP interviewed also believed that the PN is able to bring money into the practice by increasing the amount of patients seen. As the GP stated:

I guess by providing a good service, we attract more business to the practice. So you're basically subsidising the nurse a lot of the time. And you know, looking at incentives, that you can use the nurse for particularly - well health, good health checks. They can analyse the database, look at people who haven't had their cholesterol done for a long time or really need check ups, etcetera, so you can use their skills to do that, which we don't have time for. And that generates income by bringing people in for regular checks that you just don't get around to doing.

How the GP receives payment also impacts on the overall income of the practice and therefore on the role of the PN.

4.6 GPs Payment

An issue that has also been given a large amount of media attention is the debate about whether a GP should bulk bill, where patients are not required to meet any cost of the service or whether the practice should charge an amount on top of what the government pays. Participants were asked what their feelings were about these payment options.

Some participants believed that the consumer received better care by practices that were not bulk billing. As one GP stated:

go through a non-bulk billing practice'…Because they're not going to rush you, they're going to give you more time, they're going to give you more value for service and you would be prepared to pay for that.

Most participants believed that people should contribute to their health care provision. However, they believed that exceptions should be made for people receiving government

pensions. It was suggested that the practices would also adjust the amount of payment required according to the needs of the patient. As one PN stated:

> *I feel that everyone should be able to pay something to go to the doctor. For instance in our practice we now don't bulk bill…Only pensioners and people with disability pensions. Health Care card-holders all pay at a reduced rate but they're only expected to pay the gap on the day if they can. We really are flexible that if they can't pay then they just wait till the cheque and then the Medicare cheque to come in and so forth so we're not too hard on them.*

One participant also believed there were two groups of patients: those that expect to pay for their health care and those that don't. The participant believed that a person's willingness to pay is not relative to the person's income. As the GP commented:

> *We look at the total scan of people from people that believe that they should pay nothing for their medical care right to people that are quite happy to either pay full or certainly subsidise their own medical care.*

The cost of visiting the GP was seen by participants to be important to some consumers, but not at the cost of quality. As this GP explained:

> *They are looking for good quality care at reasonable out of pocket expense…And I guess they are looking for premises that are accredited under an outside agency.*

The author believed that consumers would not only base their decision on which practice to attend, based on the personal cost, but there were also other variables influencing their

decisions. Participants were therefore asked what they believed to be important to consumers.

4.7 Important characteristics of general practice

The participants identified that there were five factors that they considered consumers would believe are important characteristics of general practice. These were: interpersonal skills, competence of staff, cost of attending the practice, the service provided, and the appearance of the practice.

Participants believed that the interpersonal skills of everyone in the practice are important to consumers. This includes the reception staff's attitude and presentation, in welcoming and being first contact for the person. The nursing staff need to build a relationship with the patients over time. Participants felt that it is important that a GP listen to patients and give them time, especially on their first visit to the practice. They also believed it important for the GP to build a rapport with the patients in their care. As one GP stated:

> *It comes down to a relationship that is established with the GP and I firmly believe that the first consultation is really, really important and that if you give the person time, get to know them, show that you're interested and give a more comprehensive service… I think other issues of, I mean I think the, the attitude and presentation of your reception staff and the billing type, their way of approaching all that is important, but I think that comes down a bit on the list.*

The competence of both the GP and the PN, but mainly the GP, was thought to be important to consumers by participants. They believed that consumers would want a quality GP who

knows their field and has a good reputation. Participants believed that consumers value a GP who refers patients to specialists when necessary. As one PN commented:

> *Knows their medical field. Has a great rapport with their patients; makes the patient feel at ease. Is able to refer when needed, rather than trying to do something all by themself...that's probably it.*

Participants also believed that consumers are looking for a practice that provides a good service and should include many services under the one roof. They thought that the practice needed to be accessible to consumers; this included not only physical access but also access to appointments, and appropriate waiting times for appointments. They felt they needed to provide co-ordinated care which included referral to other services and management and planning of their future care such as with the aged. As one PN commented:

> *Well, I think they want accessibility and they want a caring service. And I think the more you can provide under the one roof, the more that it is appealing to people, because they don't want to have to be going off – you know, if you can supply pharmacy and allied health, those sorts of things, I think that to make a medical centre exactly that, incorporating as many different areas of the health system as possible, I think that is very appealing to people.*

They also believed that it was important to consumers that the practice maintained confidentiality and privacy. One GP discussed this issue:

> *Confidentiality yeah privacy I think and privacy and respectful care I suppose.*

It was believed that consumers are attracted to practices that are well established and appear professional. They also believed that consumers would want a practice to be accredited. Female GPs were also seen to be more popular especially with female consumers, and that people prefer a practice with several GPs. As this GP explained:

> *So yeah I mean you look at, what number do they ring up, yes I think they tend to ring up the ones who are presented as a group practice, the ones who have got the reputation for doing a comprehensive service. Once they get in the door, I mean I think that they're, I think people are similarly interested in a well presented, professionally run practice. I think the days of your little sort of cottage industry, practice out the back of the house are totally, totally gone. Then the next thing down once they've got in the door and have seen a GP once or twice, I mean I think there is a certain degree of sex discrimination. I think female GPs are probably a bit more popular than male GPs, by about fifty/sixty, oh about sixty percent.*

The comments regarding what the participants believed consumers want from general practice, were largely focused on what the GP could provide for the consumer. The author asked participants what they believed PNs could add to general practice.

4.8 What PNs add to general practice

Participants believed that having a PN in the practice added to the service the practice could provide to consumers. Participants identified advantages affecting the GP, consumer and the service.

4.8.1 Effect on GP

Having a PN helps to improve the GPs service by contributing in areas of expertise to the care of the consumer, but they also enable the GP to have more time. This time can then be spent on other aspects of the consumer's care, as well as other aspects of the practice. As one GP explained:

> *They (PN) add value to the medical team. And that is right from the start. So, they add value in the treatment they give, which is right from the physical treatment to the psychological help, empathy. They bring to the practice an ability to free up a lot of the doctor's time, even if that is, you know, "What are we going to do with this wound?" We discuss it. It is not me walking in and saying, "Do that, do that, do that".*

4.8.2 Effect on Consumers

It was believed by participants that having a PN improved the quality of the service the practice was able to provide, making it a more comprehensive holistic service. They reported that consumers, especially the elderly, valued the extra service. One PN explained the PN impact on patient care:

> *They feel they have had individualised care, you know, someone has taken the time to actually look closely at them. They are not old and been forgotten. You know, a lot of them get that impression, and that is probably one of the big things. The feedback I get from patients is, 'I can't believe that this service is available through the medical centre', and, you know, how good it is, and that, 'You take the time to listen to me and have such a close look at me'. And they really appreciate that and they don't feel like, you know, they have just been seen for 10 minutes and they are billed and*

out they go…So, you know, I think it is all about quality. And the feedback we get from patients is always – 99.9% very favourable for the service that we are providing. And I think it is also good public relations for the medical centre. I think having the nurse go out and do the assessment in the home - that's accepted so well by the patient, is actually giving quality to the GPs care, because they see me as being sent out by the GP and I am the extension of the GP.

One PN believed that she was in an ideal position to provide care to people in the community. As she explained:

I have got ready access to medical information that I need. You know, I need all these things when I make referrals and communicate with services. Services also need to know the nitty gritties about diagnosis and implications, health implications. And I am able to provide that, because the GP – I have got the GP right here. I have got that resource. So, it is a two way street. So, also the services are able to get information more readily, because (a) they can tap into me, which is easier than taking the time from the GP, and (b), I can easily tap into the GP and get them the information they want. So, that works out very well. So, the nursing services often ring me.

This statement was confirmed by the field observations where it was apparent that the PN coordinated the care of consumers, especially the elderly. For example the field notes state:

PN organising care for elderly lady, discussing issues with the family and GP and contacting services.

Another important contribution of the PN to the General Practice service is that they generally build a relationship with people. There is a perception on behalf of the PNs that consumers appear to be more comfortable with the PN and seem to tell the PN things that they would not tell the GP. This, they believed, gave a more complete picture of the consumer's issues that need to be addressed. Two PNs elaborated:

> *And there are basic issues that are often overlooked by doctors, and they are the first ones to admit that. And often it can also be because they haven't been given the information by the patient. Patients are more likely to tell a nurse something rather than a doctor. And I think there is two reasons for that. I think it is because nurses are seen as the care-givers and are seen to be the listeners and more sympathetic. And I think the other reason is they see that the doctor is too busy and they don't always want to trouble him with the – what they may see as minor, but could actually be quite significant, have a significant impact. And we see that quite a bit actually.*

> *Yeah, because often, even though the doctor has had a patient there for a long time, he probably doesn't always know their lifestyle, living and so forth whereas the patient you know can open up easily to us I think, than to their doctor. They go to the doctor with a complaint and that's what they focus on when they go to the doctor - they want that fixed.*

4.8.3 Effect on service

It was indicated that the PN assisted the practice in the administration area by keeping up to date about procedures and passing this information on to the GP. PNs also, in some practices, had the role of developing protocols and getting the practice accredited. As one GP explained:

Which we were unaware that we would gain (from the PN) is a whole quality management cycle and the...the administrative ability to be able to monitor what's happening and all the, all the protocols and all that sort of thing. I mean I haven't the time to do that and our docs haven't got time to do that and (PN) knows how to do it and so we're quite happy for her to do it. I mean the (PN) got us through our accreditation and she did an excellent job of it. She did a heap of background work to get us through that and that's fine and I think that the place runs more efficiently and does better because of that.

For a PN to add value to a general practice they need specific qualities and training. Participants were asked what they believed these to be.

4.9 Training and qualities of the PN

With the expansion of the PN role it is important that the PNs have the appropriate level of education to fulfil the requirements of their position. Participants were asked what they saw as the appropriate education of the PN in undertaking these roles. The sub-themes within this theme were: that the PN should be appropriately prepared educationally for the increased practice role, particularly if they were specialising (i.e care of asthma and diabetes), and that the PN should have continuing professional education.

Participants generally felt that experience was more important to the role than education. All the participants stated that firstly, the PNs must have considerable and varied nursing experience in hospitals. Community experience was also considered to be very valuable for the PN who has to have both a good knowledge of services available in the community, and a knowledge of what peoples' needs are in the community. As one GP explained:

Well they should be, well, when we interview people, I guess we're looking for someone who's had well-rounded experience, varied experience. The ideal person has done some general ward work as well as emergency work in the hospital and perhaps also people who have done some community work and they need to be Registered Nurses obviously.

Extra training was considered important for PNs undertaking education and management roles with specialties such as diabetes and asthma. Most felt that in-service training and workshops are the best way to increase knowledge in these areas. As one PN commented:

But I think generally, PNs won't look at doing that sort of formal education. They will probably look at topic specific up-skilling, like asthma management and wound management, diabetic management and if those courses are really relevant to what they're doing in general practice it would be very useful and would improve the services that nurses can provide.

Another PN suggested that PN training should be similar to that of the GP after completing university to ensure that the training they are undertaking is appropriate to the requirements of the position. As she commented:

I think if you are looking at a PN who is going to partake in general practice medical care, then I think they should be under the same sort of training requirements as a doctor who now comes out of university. They cannot go straight into unsupervised medical care as a GP...So, if you are going to do that, then you probably need a training program that is appropriate to the requirements of the job that you expect them to do.

It was considered essential that education is ongoing and PNs needed to continually update their skills. As this PN explains:

> *Well, in those areas, certainly the education and training is part and parcel. You know, you need to be kept up to date with those chronic conditions if you are going to be a valuable nurse clinician. I mean, it is just part and parcel of your duty of care really, your professional commitments to stay up to date.*

One PN suggested that PNs should have to undergo competency assessment on a regular basis to ensure that the PNs skills were current. She felt that PNs needed to be using their skills to remain competent in them. As she stated:

> *there should be a lot more follow-up on, accreditation, stuff like that. There should be more spot checks so they make sure that everyone is up to date with what they're doing because things are changing so often, so quickly and plus people fall into bad habits if they're not checked or if they're not forced to revise their skills. So for that to happen I think that there would have to be an awful lot of training and a lot of assessment so that people aren't given the wrong advice.*

Participants were asked what they felt were the qualities a nurse needed to become a PN. The participants identified that it was important that the PN be able to work as part of a team. From the GPs perspective the PN was expected to contribute to the team, but not to take over and make too many changes within the practice. As this GP explained:

> *Took on a nurse and basically it didn't work out...she came in and tried to change things.*

A general practice is also very isolated from peers for the PN, and the GP is usually very busy consulting. It is therefore necessary for the PN to be able to work independently, without too much supervision. As one GP explained:

> *I think you know you do need somebody who's got initiative and can be a little bit self-directed but also knowing how to work as a team I think would be the major skill they require.*

PNs believed that time management was important to the PN role. As identified by one PN:

> *You've got to be able to deal with the emergency and quickly catch up and co-ordinate the rest of the care with the patients in the practice and those patients are fine about waiting for an emergency, I mean that's not a problem. But you've got to be able to be very organised, time management is hugely important; in this particular practice anyway.*

Good interpersonal skills were considered an essential quality of a PN. One PN considered interpersonal skills to be the most important asset of the nurse, as she explained:

> *I think experience overrides all that and the type of person you are. I think sometimes you know nurses are born and you can't manufacture them and if you're a caring person it doesn't matter what qualifications you've got there behind you, as long as you've had the experience I think you can cope in it.*

Participants were asked what roles they felt PNs could undertake given that they had received the appropriate training.

4.10 Factors that determine the role of the PN

The role a PN takes is linked to the capabilities of the PN. One GP commented that it is the PNs responsibility to know their own capabilities and to work within their scope of practice. He expected that the PN would alert him if they did not feel comfortable with any task allocation, and that the PN would possibly get further education to undertake that duty. As he stated:

> *Yes. I would also expect, if the RN was not happy with what she was doing or if she felt it was outside her expertise, then I would expect her to voice that opinion and talk about it; either to get more training, or at that particular point in time, to hand it over or discuss it.*

It was discovered that it was not only the PNs capabilities or the practices needs that dictated the PNs role. The PNs role was dictated by the attitude of the GP and the physical environment.

4.10.1 The attitude of the GP

The GPs influenced what the role was allowed to be, as one PN explained:

> *So if your GPs aren't progressive or allow you to do all of that then you're not going to do it so I think the environment you're working in is going to dictate what you can do and can't .*

Two GPs in the study had had previous experience with nurses working in an advanced role. These GPs appeared to be more accepting that the PN was capable of this expanded role, and were not threatened by feelings that the role encroached on what they saw as their role. As one GP commented:

> *Not really. I mean, nurses already do most of those jobs ...-or a lot of them, depending where they are. If they are military out in the sticks in the tents with the Army, then they are doing perhaps everything up to a point in time when they know that they have to move that patient on, whether it is an injury or sickness or illness or whatever*

4.10.2 The physical environment

The role of the PN may also be affected by the physical constraints of the premises. One PN commented that she would be unable to undertake procedures that needed privacy, as she did not have a dedicated private area. She explained:

> *It's not very often that you'd have a room like this where you could actually put a patient into and the treatment rooms are not appropriate for that sort of care so you'd actually need to have a purpose built practice to actually accommodate that sort of privacy.*

Most other practices were observed to have a consulting room provided for the PN. As these fields notes state:

> The practice layout included a separate consulting room for the PN as well as a more open procedure room for dressings, and a room for respiratory assessment.

> The practice had a central nurse's station surrounded by private treatment rooms.

There was some suggestion, when undertaking informal interviews, that other members of the practice also influenced the role of the PN, however this was not substantiated in the observation of practices or in the formal interviews.

4.11 Actual and possible roles of the PN

Data were collected regarding the role of the PN through interviews, and also through a questionnaire, using the Likert scale to gauge the level of comfort with tasks.

The role of the PN varied between the different practices. However, there were some tasks that all PNs undertook in their duties. Both in interviews and in the questionnaires the duties listed below were all considered as the PNs role. They were:

- Taking blood
- Asthma assessment
- Assisting the GP
- Stock control
- Getting resources for people such as home care, and arranging ACAT assessments.
- Syringing ears
- ECG's

- Spirometry
- Sterilisation
- Administration
- Recalling patients for GPs
- Undertaking promotions such as meningococcal vaccination’s

All of the GPs and PNs interviewed were comfortable with the PNs performing the above tasks. In all practices, PNs were also carrying out vaccinations; participants, however felt this could be a more independent role, than the way it was presently organised.

4.11.1 Vaccination

All PNs interviewed gave vaccinations, and this was considered a normal part of the PN role. Some of the participants believed that a PN should be able to administer a vaccination whether it was a routine vaccination or a travel vaccination, without a GP ordering it. They believed that it wasted the time and resources of the GP to see every patient who is given a vaccination. One GP who ran a vaccination clinic noted:

> *So we actually had our Registrar run it, so she (the Registrar) saw the patient for thirty seconds, the patient then went through to the nurse who gave the injection, issued the bill and then the patient was out, type of thing. It worked efficiently but it could’ve been done just as efficiently without the doctor involved at all. I don’t actually see a problem with that, I mean I guess you’ve got those peculiar patients or those occasional patients where there might be a contra-indication for giving it or whatever, but is the Registrar really going to pick that up any more than the nurse? I don’t know. But with the, because with this one we’re doing tomorrow, because it’s*

not Medicare rebatable, because it's a business we're doing, so you can't charge through Medicare for that. Oh there are all sorts of rules. The Medicare rules are very, very complicated. I don't see a problem with the nurse going and doing it. Now the question is, should she be vaccination endorsed and the other question is because she'd be doing it offsite, on her own, if somebody did have a reaction, would she have the skills to be able to manage that reaction? Okay, so there are some questions involved in that and I'm...I'm unclear on that in my own mind. I mean to be honest, I think if she had choofed off and done the necessary training which included the management of reactions then I don't see why she couldn't do it.*

* at the time of the study these items were not rebatable.

Similar to vaccination, wound management was also generally well accepted as a PN role.

4.11.2 Wound management

Wound management was also generally considered to be a PNs role, however, the extent of the PN's input varied. In some practices the PN was considered the expert in the area and the GP merely looked and made some suggestions. In other practices it was the GP who made the decisions about wound care with some input from the PN. Some GPs believed that they had the ultimate responsibility for the patient and therefore they made the decisions about patient care. Many of the PNs and GPs interviewed believed that it wasted the GPs time having to check dressings (at the time of the interviews this was necessary to obtain payment), and also wasted the time of the patient. One PN interviewed liked the GP to check dressings.

In this study the participants believed that the PN had good knowledge and skills in regard to wound management and it was therefore not necessary for the GP to always see a wound. Most GPs and PNs believed that it would be preferable if the PN was able to receive payment for the dressing without the GP sighting the wound at every visit. It was, however, noted that the GP seeing the patient also covered other needs the patient had. As one PN stated:

> *Well, our doctors are really good that way, that we do have control over it. But the doctor likes to see them, see how they're progressing anyway. And there's often that, if they come in for dressings, they want to ask him other things. Or they ask us other things so we, we have much control what goes on their dressings and provide that role as in to advising I suppose the doctor what we feel, you know what to put on and so forth.*

These data were confirmed by the data from the questionnaire where all 9 participants were 'very comfortable' with PNs managing the treatment of wounds and one participant was 'somewhat' comfortable.

The participants were also accepting of the PN taking more responsibility in the management of chronic illness.

4.11.3 Chronic illness

In the questionnaire six participants were 'very comfortable' and 4 were 'somewhat' comfortable with the PN managing the chronic illnesses of consumers. Participants were

similarly comfortable with the PNs role of collecting interview/observational data. In all the practices interviewed, PNs undertook assessments such as spirometry. In some practices the PN educated patients regarding their chronic illness one-on-one. In contrast, other practices employed a specialist nurse in the area (e.g., diabetes). These nurses conducted group sessions or had one-on-one consultation with patients. As this GP stated:

> *With them, we do have a diabetic nurse who comes out …she comes specifically to do the diabetes so we, she has a booking column.*

In the practices observed PNs were seen to be undertaking spirometry and were also seen to be providing education regarding diabetes.

One PNs position was solely for the management of people with complex needs and she had a large role in the management of patients with a chronic illness. As she stated:

> *So, that is why there is a lot of work for me, because that is primarily my role, because I am looking after those with complex needs... and, you know, chronic health conditions.*

This PN also commented that for those patients with care plans, the care plans help the hospital when the patients are admitted. She stated that the hospitals contact her when patients from her practice are admitted, and she is able to provide them with the current care plan. As she stated:

> *if we have done a care plan or a care plan review on a complex patient who has gone into the hospital, we will actually send in our latest care plan…which actually lets them see what we have worked on recently, what services are*

> *involved with the patient. And the feedback we have had from the ward staff has been, you know, they find that very valuable in their discharge plan.*

Care of the elderly is also closely related to chronic disease management, as many elderly people will also have chronic illness, which impacts on their ageing process. However there are some aspects of care that are predominantly provided for the elderly and these are now discussed.

4.11.4 Care of the Elderly

The PNs in this study all took part in the care of the elderly. For the purposes of this study I have identified the elderly as those people usually over 75 years who need extra support due to the ageing process. All PNs took a large role in the EPC over 75 health check, stating that they do 80-90% of the assessment following which it is finished and signed off by the GP.

One issue raised by one participant with regard to health assessments was that there is an inequality in the payment for health assessments, in that some GPs would just do the health check only and not follow up on problem areas identified and still get paid for it. Other practices, though, did health checks thoroughly and followed through on issues raised in the health check and only received the same payment. One GP discussed this issue:

> *They don't pay – a lot of times with the patients with complex needs, what you get back through the Medicare incentive doesn't cover it, because it can take hours of liaising and to-ing and fro-ing with services and staff, ongoing communication and follow up. So, you know, that is very much a part of health assessment and the care planning process. So, what I think has been happening out there a lot with the GPs*

and the health assessments is they pick the shortest pro-forma and it is a tick and flick…The health assessment is done, billed, that's it. Whereas there is no accountability for what have you done about any issues identified from that health assessment, you know. So, our paperwork is fairly extensive... Yes. So, you can be doing them or you can be doing them well.

In communities with a high elderly population, the PNs had a large role in the management of the elderly. For example, going to people's homes and checking the environmental safety, assessing medications and identifying how the person coped with day-to-day living. The information obtained through these visits allowed referrals to occupational therapists and other relevant services to be made. The PN participants also believed that they reduced the numbers of patient falls by making home visits and assessing the environment. One PN discussed the importance of assessing people in their homes:

It is the only way to do proper holistic assessments, because what you see over the desk is not always the true picture at home. You know, you will go out to the home and it will have newspapers up to the windows, you know, and just an absolute mess. You can see the clutter or you can smell the incontinence as soon as you walk in. But when they come up here to see you, they are freshly showered and dressed, so you are not able to pick up on the same issues… There are quite a number of – environmental safety, I think, is probably one of the important things. And we are very much into preventative health. And doing proper environmental safety assessments, we are preventing those fractured hips. And there is no doubt that if we weren't doing what we did, there would be a lot more admissions.

The PNs organised for people to be assessed by the A.C.A.T (Aged Care Assessment Team). This assessment, as well as providing rating for high or low residential care also meant that respite care could be organised for people when carers needed time away or their situation changed, requiring them to need residential care. Having an A.C.A.T assessment done is also beneficial to hospitals for discharge planning, potentially reducing time in hospital waiting for an ACAT assessment. As one PN explained:

> *We inundate ACAT. I think, in the last couple of years since I have been here, they have really noticed a difference. But, you know, it is very necessary for future planning with the frail elderly or carer situations. You know, carers that you can tell that there is a potential strain – level of strain. We need to have an ACAT, because what happens is all of sudden something happens to the carer and we have got to find emergency respite. What would have to happen if we didn't have the ACAT is hospitalisation, ACAT, in hospital and then onto somewhere.*

During observation in the field, the PNs in one practice were observed to take a large role in managing the care of the elderly. The PN consulted with family members with regard to the patient's needs, and she would then follow through on those perceived needs by going to the patient's home if necessary to re-assess their needs. She arranged for ACAT assessments and organised respite care and helped families to organise nursing home placement. She was observed to go to a patient's home following their discharge from hospital, where she arranged for emergency care and organised medications.

Three questions were asked relating to the PN care of the aged in the questionnaire. The first question, doing home safety checks for risk of falls resulted in seven participants being 'very

comfortable' and three being 'somewhat comfortable'. In the second question, checking medications patients are currently taking, six participants indicated they were 'very comfortable', three were 'somewhat uncomfortable', and one GP was 'somewhat uncomfortable'. All ten participants indicated they were 'very comfortable' with PNs managing aged care (i.e., accessing services and coordinating allied health professionals). These results confirm the qualitative results indicating that participants are generally comfortable with PNs taking a role in aged care management.

The word 'triage' was used by the participants as one way PNs assess the immediacy of need for care by the GP. PNs need good assessment skills to identify the patients' acute health needs.

4.11.5 Triage

Triage as described above is widely accepted as a PN role. Triage involves assessing patients and assigning priorities in the care of those patients, such as deciding if the patient should be seen sooner than the current appointment time. This triage role differs from that used in the hospital because the PN does not use the Australian Triage Scale.

In one practice observed:

> Triage was a large part of the PN's role as the practice booked patients as they came through the door for appointments and did not book appointments for further ahead than that day. Anyone who felt they needed to be seen or that the reception staff felt needed to be seen more quickly than their place in the bookings were seen by the PN and assessed. The PN would take initial action if necessary and place the person in the GPs list at a time that was appropriate to the patient.

In all practices participants reported that if a patient arrived in obvious distress, the PN would first assess them and undertake any necessary tests (e.g., ECG, spirometry), then have the GP see the patient as a matter of urgency. PNs also observed the waiting room, and identified any patients that needed to be seen sooner than their appointment time. As one GP commented:

> *Accidents, whatever, for instance, injuries, can certainly be triaged by good RNs. They can then make decisions and prioritise on whether they need a doctor straight away or whether they can put a dressing on or do something any way. And then reprioritise that patient to the doctor's medical care. It may be they just need a dressing, a pat on the back, and they are quite okay. And a good RN is able to do that.*

PNs were often required to triage over the phone. In this situation, and if something sounded serious, the PN advised patients to come and see their GP. As one PN stated:

> *We're are often used you know. A phone call inquiry comes in, receptions says, 'I don't know if this is urgent or not', it comes to us and then we asses whether there's a need. I think patients sometimes just need reassurance and speak to someone medical and, 'no that's not so important, it can wait until tomorrow', or 'maybe if you come in straight away'.*

PNs in rural areas also had a slightly different triage role in that it is not as easy for patients who live out of town to come to the practice. The PN therefore had more pressure to correctly triage over the phone and assess if that person needed to come to the GP that day or

if the problem could be solved by treatment at home. One of the rural PN participants stated that in this situation the PN had to know her limitations. As she explained:

> *That's the biggest thing. That's because yeah the advice, a lot of people are an hour away and things like that and they want to know whether they really need to come. Also knowing your limitations and actually passing it on to the doctor if you are concerned.*

When asked in the questionnaire how comfortable they would be with the PN being the initial contact at the surgery in an emergency, nine participants indicated they were 'very comfortable' and one participant indicated they were 'somewhat comfortable'. This indicated that triage is an accepted role for the PN, for the participants in this study.

Diagnosis and treatment of minor illnesses takes the triage role a step further. Participants were asked their beliefs regarding the PN role in the diagnosis and treatment of minor illness.

4.11.6 PN role in the diagnosis and treatment of minor illnesses

In general, participants were not as comfortable with PNs diagnosing and treating minor illnesses. In the questionnaire five participants indicated they were 'very comfortable' (four PNs and one GP), one PN and one GP were 'somewhat comfortable', one PN was 'undecided' and two GPs were 'somewhat uncomfortable'. PNs appeared to be more comfortable with the role than GPs.

Some PNs believed that GPs would be uncomfortable with PNs diagnosing and treating minor illnesses and would not accept them in that role. They also thought that such a role might not be accepted by PNs themselves. As this PN commented:

> *To be honest I don't know whether you could then say, that you could actually put a cut off point. Some nurses perhaps would say that that's not their role at all and they wouldn't feel comfortable with it. I don't want to be a doctor but I do see that I can manage the simple things and often we do over the phone. Very very delicate situation to look at diagnosis and nurses and GPs I, GPs wouldn't like it would be my guess, most GPs. Maybe I'm wrong but that would be my perception. Perhaps that perception that I have should be overcome but I don't think that they would like us diagnosing, only from my experiences.*

PNs stated that they would 'play the game' by asking all the appropriate questions and performing the correct tests. By documenting their findings they believed they lead the GP in the right direction for a diagnosis. As one PN explained:

> *So I tend to change my line of attack and find another way to present my opinion often I just document, and write down what my findings are in the patients' records. So I'm not actually diagnosing, but I'm actually indicating from what I've taken from their history, that I feel I know what's going on. Paint them a picture of things, yeah okay, they're all the questions I would of asked and perhaps not leave too many questions unasked as well so instead of just saying, 'blah, blah, blah', I just tie it all together. So it's a different way of showing them that you're actually trying to help them and save time for them too. Because if they can see that basically I've asked all those questions and I've actually perhaps done some of the work for them and they*

may re-ask the questions, but often these particular GPs here won't, they'll just accept what I record.

Another PN stated that through experience she was able to diagnose but believed PNs are team players and therefore are better at collaborating with the GP. As she explained:

I think the doctors would very – they wouldn't be very happy about that, because they don't see nurses as diagnosticians. And perhaps we are not, but I think just with our level of experience over the years, you do become quite good at clinically diagnosing. But I think as nurses too, we are very used to being a team player. And okay, we are generalists. We can address most issues, but I think in general practice, there should always be that collaboration, that collaboration with your GP. You can highlight areas of concern and make suggestions, but I think to actually come out and be a diagnostician would be a fairly risky business.

There was general consensus by both GPs and PNs that nurses can diagnose minor illnesses given the appropriate training. There was concern, however, that what might present as a minor illness might turn out to be a major problem. This differential diagnostic skill identifies the need for PNs to know their limitations and refer problems out of their scope to the GP. It was also stated that if PNs undertook this role they would have to have good follow-up of patients in place, so they could ensure the patients' safety. One GP discussed this issue:

I think that there's a breadth of thinking and that doctors are trained to have it and it's a doctor's responsibility. I think nurses are very good at following protocols and

> *knowing the area that they know and that they've been trained and taught up in. But I think that there's a breadth that there is certainly, I mean we have medical students and registrars at our place and when I'm talking, when we're talking to our students, our med students, that's always something that's got to sit the whole way through. You know in the middle of the flu epidemic, you're going to get your meningococcal and in the middle of your diarrhoea epidemic you're going to get, you know, whatever it is that's serious, your colitis or whatever. If somebody comes in with a presentation you can click quite quickly into that common thing you've always, as I say, we just teach our registrars. You always, for every consultation, you've got to ask yourself a question, what's the serious diagnosis here that I might be missing and I think that...yeah that would be my main concern there and I think,*

Some of the GPs interviewed believed that it was not the PNs role in general practice to diagnose. Some GPs also felt that a nurse diagnosing is not what nurses are good at. They believed however that, nurses are good at following protocols. Other GPs, especially those previously exposed to nurses who were diagnosing, were more accepting of this role. As one GP commented:

> *I mean it's a training thing and it's what they're good at and what they're not good at and I don't think that's one of the things that they're trained in and that's part of their skills.*

As with the diagnosis and treatment of minor illnesses participants were also unsure if a PN should prescribe.

4.11.7 Prescribing

Both GPs and PNs were fairly undecided about nurse prescribing. In the questionnaire, one GP and one PN were 'very comfortable', two PNs were 'somewhat comfortable', two GPs and two PNs were 'undecided', one GP was 'very uncomfortable' with nurse prescribing. One PN did not indicate any level of comfort, however, she wrote that she would be comfortable if she had the appropriate training.

During interviews participants were not positive about a PN prescribing role. They stated that the GP should review the patient's chart before prescriptions were written. As one GP commented:

> *I mean I have concerns about that. I guess I never really see the repeat prescription as a, I mean we do repeat prescriptions over the phone because people can also write and say, 'I want this you know, I'm out of these scripts', and we will do them. We're pretty tight in saying that we don't guarantee that service and if on our review of the chart we're uncomfortable with it, we won't do it. Some GPs have stopped doing that, stopped doing prescriptions over the phone and that sort of thing. But even then, I think in a way a doctor's got to do that review of the chart to make that decision because all sorts of peripheral thoughts and checks and balances come into your mind when you make that decision. I don't think nurses are that good at reviewing charts and I think it's more than, it's not just doctors hand writing because our charts are electronic now...I think it's...concepts of why doctors write certain things in the chart.*

Another role for the PN can be the provision of women's health services.

4.11.8 Women's health services

Issues surrounding women's health are probably the most contentious in regard to the role of the PN.

Table 4.1 Level of comfort with women's health services

SERVICE		Very comfortabl	Somewhat comfortabl	undecided	Somewhat uncomfort	Very uncomfort
Giving Ante- and Post- natal care and advice	GPs		2		2	
	PNs	2	1	1	1	
Doing well-baby checks	GPs		3	1		
	PNs	2	2	1		
Giving family planning advice	GPs	1	2		1	
	PNs	2	1	1		1
PAP smears	GPs	1	2			1
	PNs			3	1	1
Breast examination	GPs	1	1	1		1
	PNs		1	2	2	

As can be seen by the data in Table 4.1 above giving ante- and post- natal care and advice and doing well-baby checks were accepted as duties that could be part of the PN role by the majority of PNs, with one PN, however, being 'undecided' and one 'somewhat uncomfortable'. GPs however, were split in regard to the role of ante- and post-natal care with two GPs indicating they are 'somewhat comfortable' and two indicating they are

'somewhat uncomfortable'. PNs who were also midwives, reported in interviews that they would be comfortable undertaking Ante- and Post-natal care and doing well-baby checks. They commented that they would like to give more post-natal care and believed that their skills could be utilised more. They reported that they gave breast-feeding advice when asked by mothers. PNs also commented that the PN should be midwifery trained to undertake these duties. As two PNs commented:

> *Yeah, yeah I probably could do, yeah I'd like to see more in the post-natal stage of, we don't have, cause I've been, I left midwifery to go to the general practice so I do like the babies and see we only usually see them, oh when they initially come back after about five days and then we just weigh them and so forth like that, but we don't have much, unless the doctor picks up on a problem they might be breastfeeding and so then we step in and can give them advice. So I think I'm probably comfortable looking at the babies.*

> *Well we do have a midwife here and I think that would be very good for them to take over the role and it probably should be resourced a lot more than it actually is. We also have a breastfeeding consultant who's done her lactation course and then we've got a lot of resources in them and they probably don't get utilised as much and I think if you don't utilise them then you lose them so, but definitely the midwives, yeah definitely I think they can be resourced.*

Giving family planning advice is also reasonably well accepted as a possible duty. The interview data indicate that PNs would be comfortable giving family planning advice if they had a private area and if they had appropriate education. As this PN commented:

It's not very often that you'd have a room like this that you could actually put a patient into and the treatment rooms are not appropriate for that sort of care so you'd actually need to have a perfect built practice to actually accommodate that sort of privacy that would be alright I think. Family planning advice - the same reasons. I'm not that sort of skilled but if I had the training I probably would.

PNs undertaking breast examinations and PAP smears were both contentious areas within this study. As Table 4.1 indicates, level of comfort differed between participants. PNs were more uncomfortable with these procedures than GPs were. Some participants (both GPs and PNs) believed that with appropriate training PNs could undertake both these procedures, however, others did not. The GP that did not feel comfortable with PNs undertaking PAP smears felt that GPs undertake other assessments while they are doing a pap smear. If the PN undertook the procedure, it would therefore mean the patient would have to come back for a second appointment with the GP. One GP also mentioned that it would erode the GPs skills. As these GPs expand:

I guess, RNs could be trained for that, but once again, that training would have to be fairly extensive gynaecologically. So, that if a patient that was being – had a pap smear from an RN – may also need a PV from the doctor. So, would that save anything? I don't know. Maybe not.

Okay, so yeah it depends what sort of pap, you know why we're doing a pap smear. If it's part of a general check up, it's basically pap, skin, breasts, thyroids, that's basically what my typical check up would be, then yeah I don't see a huge problem, but if it's part of a, you know a physical examination where I'm interested in doing

something then, then the logistics of it make it seem well, 'why bother, just do it yourself'.

Another GP worried that a PN would find it difficult to make a decision- if a lump was found in a breast. As he explained:

And it's totally...it's totally different feeling a lump and handing it over to somebody and having to then take the diagnostic responsibility for where we're going to go with that thing and what are we going to do with it. You know and you can get your mammogram and everything else, but then they're always normal, you always end up with the big decision after they put the needle into it or not.

Another area of primary health care that needs to be addressed in general practice is that of preventative health.

4.11.9 Preventative health

There were three questions on the comfort scale that related to preventative health measures.

Table 4.2: Level of comfort with preventative health role

	Very comfortable	**Somewhat comfortable**	**Undecided**	**Somewhat uncomfortable**	**Very uncomfortable**
Providing education related to health issues GPs	4				
PNs	5	1			
Assessing risk factors for disease e.g. heart disease, diabetes GPs				1	
PNs	4	1		1	

Giving lifestyle advice GPs	3	1			
PNs	4	1	1		

The results in Table 4.2 indicate that participants were mostly comfortable with the preventative health care role, except one GP and one PN who were 'somewhat uncomfortable' with assessing risk factors for disease. Participants believed that they would require appropriate education to undertake these roles.

Additionally some PNs believed that the GP would like to initiate education and the PN would follow up. As one PN commented:

> *Um...providing education related to health issues. I suppose that one, and assessing for risk factors, I would be comfortable with lots of training in that but I don't particularly, I mean I see the assessing of risk factors as a nurses' role and providing some education support but I think GPs might like to be steering that.*

Although mostly comfortable with the preventative health role PNs were not as comfortable with giving test results to patients.

4.11.10 Test results

Most PNs were uncomfortable giving test results to patients. They believed that patients often ask questions that they would be unable or unwilling to answer. Some PNs, however, felt comfortable in giving test results if the GP had clearly written a comment on the results for them. Participants also felt that giving out test results over the phone had privacy implications. Two PNs commented:

Test results are an issue... from the medico-legal perspective and just, you know, with nurses we have got to be very careful about information that we give, looking at confidentiality as well. And giving test results over the phone, I think, is always a very risky business, because you can't always be assured who you are talking to at the other end. And certainly we are very selective about certain results and we will make sure that those that are abnormal results, quite often they have been – the doctor will talk to them personally or they always make a comment about what we tell the patient. It will be – comment from the GP will be, 'Make an appointment, all results okay, discuss next visit'. So, we are very careful about staying within that framework of the advice that the doctor has given.

We just go by that. We are, you know, we are not, we are not interpreting results ourselves, and we will never get into that. But the difficulty we have with people is because they – particularly if they know you are a nurse giving results – because they will want more information.

Although the level of comfort has been ascertained for the roles suggested above, there would be variances between what individual patients will want the PN to do for them. Participants were asked if the patient should have a choice in whom they see.

4.12 Choice of practitioner

Participants believed that consumers should have the choice to see either the PN or the GP. The participants identified that they would accept consumers not wanting to see the PN. As one GP stated:

So, a few of those say, 'No, look, I would really like you to do that'. And that's fine. It is not a problem. Others, I will say, 'No, look, the sister should do this and she can do this'…You can tell fairly quickly whether they think you are moving them on or not. Here most of the time they would just see that as part of the team effort.

Conclusion

This chapter has reported the findings of the study, from field notes, interviews and questionnaires. As explained in the methodology chapter all methods of data collection were used to substantiate the other methods. Only a small amount of field notes were reported on as usually they were discarded after they were proven within the interview or questionnaire data. The following chapter will discuss the findings in relation to the current environment and literature.

CHAPTER FIVE

5. DISCUSSION

This chapter will bring forward the issues identified in this study that are important regarding the role of the PN and the culture of general practice. The chapter has been set out under the headings of the objectives for the study, as well as under headings of issues the participants believed to be important.

5.1 What the participants perceived as the role of the PN

Many aspects of the PNs role are well accepted in General Practice. The findings of this study vary little from those of Patterson, Del Mar & Najman (1999) and O'Connor (2002) in relation to these roles. Activities such as: taking blood, asthma assessment, assisting the GP, stock control, getting people resources, syringing ears, ECG's (electrocardiogram), spirometry, sterilisation, administration, recalling patients for GPs, and undertaking promotions such as meningococcal vaccinations are commonly done and acceptable to the participants. Following are the issues surrounding specific roles of the PN

5.1.1 Vaccination

All PNs in the study gave vaccinations and most commented that this should be able to be done without a GP supervising. With the advent of Medicare Plus, it is now possible for a PN to administer vaccinations after the GP has written a script and receive payment for it through Medicare (Australian Department of Health and Ageing, 2004b). Although it is argued that this payment is small, it should allow for a better allocation of human resources

within general practice, as the PN will not need to be supervised to administer vaccinations. This will mean that the GP is able to spend time on other areas of their role. Another area acknowledged by Medicare Plus is the management of wounds.

5.1.2 Wound management

It was found in this study as well as being documented in previous studies (Patterson et al, 2000; O'Connor, 2002; Willis et al, 2000), that wound care is an area that PN make a large contribution to in General Practice. Patterson et al (1999) found that GPs recognised nursing expertise in wound management and largely left the management of wounds to the PN. They also found that patients, as well as PNs, were irritated by the fact that GPs had to see the wound in order for payment to be received. The findings from this study confirmed Patterson et al's (1999) work, with both PNs and GPs believing the PN to be capable of managing wounds without the GPs overseeing their work. Medicare Plus also allows a payment for a nurse only consultation (Department of Health and Ageing, 2004a). However, considering the time consuming nature of many dressings, the payment of $8.50 per visit probably does not cover the cost of the PN and of the consumables used. PNs undertaking wound management needs to be assessed as opposed to other community services such as domiciliary nurses to ascertain if the cost benefits outweigh the cost of a domiciliary nurse visiting the patient's home. If it is in fact more cost efficient for wound management to occur in General Practice more incentives should be put in place by government to encourage general practice to provide this service. Other benefits of the patient visiting the practice for wound management, is that it builds the relationship between the patient and the PN. With that familiarity it is possible other aspects of the patient's care, such as management of chronic disease or difficulties in coping at home, can be identified and dealt with.

5.1.3 Chronic disease management

In both the U.K and the United States nurses are taking a greater role in chronic disease management, with studies indicating that this role is of benefit to the community (Oxycheck; 1995, Wright et al. 1999). Chronic disease management is one of the areas that the National Workshop on practice nursing in Australian General Practice indicated as a role for PNs (Royal College of Nursing, 2001).

In Australia, although management of chronic illness is identified in the facts sheets as a role for PNs (Royal College of Nursing, 2001), little research has been undertaken to determine the effectiveness of such a role. The randomised control trials have trialed managed care of chronic illness by care teams with nurses leading some of these teams. These trials however have been inconclusive as to the effectiveness of managed care (Esterman, 2002). All PNs within this study were contributing in some way to the care of people with chronic illnesses. In one practice the role of the PN was to manage people with complex needs. Other PNs who had a generalist role were not as involved with management of chronic illness and were more involved with specific aspects of management such as education and support. It is believed by the author that strengthening communication between the acute care (hospital), and the general practice would encourage better organised patient care and develop a greater understanding of the PN role within the acute sector.

This role is supported by the EPC items, which encourage continuity of care between the acute sector and the community (Department of Health and Ageing, 2004c). O’Connor (2002) reported that PNs were seeking further education in undertaking roles to contribute to

EPC items. Participants in this study also believed that PNs would need further education regarding specific diseases such as diabetes and asthma management. At a State level, the Queensland Government in the 20-20 directions statement indicates that a better balance should be achieved between the acute and community sectors and specifically indicate that General Practice should be taking a larger role in the management of chronic illness (Queensland Health, 2002). This statement also suggests that better management in the community will lead to less admissions to hospital (Queensland Health, 2002).

In this study, the PN who managed patients with complex needs was an example of how this approach could work. She described the benefits she had found with increased communication between the hospitals and general practice. She stated that ward staff in hospitals had found the information received from the practice as valuable. Both Patterson et al (1999) and O'Connor (2002) also found that PNs were contributing to the management of chronic illness through education for diabetes and asthma. In the majority of cases, the patients being managed with chronic illnesses were elderly. This is not unusual as there is some crossing over between the management of chronic disease and aged care management because chronic disease often complicates the ageing process.

5.1.4 Care of the Elderly

With the advent of EPC items and the over 75 (over 55 for Indigenous Australians) health check, general practice has been encouraged to take a pro-active approach to management of the aged within the community (Department of Health and Ageing, 2004c). PNs in this study believed they were ideally placed to be able to assess peoples' needs and liase with other services to meet those needs. Wilkinson et al (2003) also found that PNs are critical to

the implementation of health assessments. This study has shown that PNs make a valuable contribution to over 75 health checks, and are able to put in place measures to assist with the needs identified from this assessment. However, it is unfortunate that this follow-up role is not acknowledged as payment is not made accordingly for those practices that follow up with the needs identified. Presently a practice is paid the same amount no matter how in-depth the assessment or what follow-up care they provide. PNs in this study follow-up patients undergoing health assessments with such things as referrals to occupational therapists, consultations with family members and assisted where appropriate to organise nursing home placement, organised medications, and organised respite care.

One participant believed that their role in obtaining ACAT assessment following the health assessment for the frail aged was particularly important. The participant believed that having an ACAT assessment in place meant that if something happened to the carer they were able to place the aged person in respite care, whereas if this were not in place the aged person would need hospitalisation.

In addition to these aforementioned roles, the PN role could be further developed in the management of the aged. For example, consumers in the Hegney et al (2004a) study were very accepting of the PN managing the care of aged people in collaboration with the GP.. The PNs role is diverse as the PN has to manage not only chronic illness and aged care but also have advanced assessment skills to enable then to triage patients.

5.1.5 Triage

Triage is well documented as a role of a PN in Australia (Patterson et al.1999, O'Connor. 2002). Triage also was a large role of the PNs within the practices in this study, whether it was to monitor the waiting room or to have a triage role similar to that in a hospital emergency department. The triage role in this study varied according to the needs of the practice and in some practices it was vital to patient management, such as in the rural practice and the practice observed where 'on the day appointments' were made. This is an area that required them to be skilled to enable them to identify patients' needs for medical attention. The consumer studies showed that consumers are comfortable with the PNs undertaking a triage role, however, consumers in both studies did not want PNs to have a gatekeeper role and therefore reduce their access to the GP (Hegney, Price, Patterson, Martin-McDonald, Rees, 2004b). Consumers believed that the patient should have a choice of who they see (Hegney et al, 2004a&b; Cheek et al, 2002). The participants of this study agreed with this, supporting a patient's right to choose who they see. Progressing from the triage role would be the role of diagnosis and treatment of minor illnesses, where the PN would not only require good assessment skills but would also initiate treatment for the patient.

5.1.6 Diagnosis and treatment of minor illness

PNs diagnosing and treating minor illnesses was not identified as occurring in this study or in other literature within Australia (Patterson, 1999; O'Connor, 2002). In the U.K and the United States nurses are involved in the diagnosis and treatment of minor illnesses with doctors only being consulted when necessary (Phillips, 1998; Robinson, 2002a&b; Searle, 2002. Craig, 1996; Murphy-Ende, 2002). The PNs interviewed were more comfortable with

PNs having this role than were the GPs. The GPs who had been exposed to nurses diagnosing and treating minor illness were somewhat more accepting; considering this, it is possible this is an area that PNs could develop into in the future. This is an area that needs further investigation as GPs, PNs and consumers in both consumer studies were somewhat apprehensive about PNs taking this role (Hegney et al, 2004a; Cheek et al, 2002). Further education would be vital for PNs to diagnose and treat minor illnesses. In the treatment of minor illnesses the PN would at times be required to prescribe medications.

5.1.7 Prescribing

Participants were generally undecided regarding this role. In Australia this is not a role that PNs have undertaken, except for Nurse Practitioners in isolated practice (Qld Health, Environmental Health Unit, 2002). However, in the United States and the U.K nurses have been prescribing some medications under guidelines and with appropriate education (Murphy-Ende, 2002; Robinson, 2002 a & b). Participants of this study indicated that if this were to become a role for PNs they would need appropriate training. As with diagnosis and treatment of minor illnesses, prescribing medications was seen as a role that would require further investigation if it were to become a PNs role. Both consumer studies also showed that consumers are confused whether PNs should include in their role the prescription of medications (Hegney et al. 2004a; Cheek et al. 2002). Unlike prescribing medications, it is not uncommon in Australia for nurses to take a role in women’s health. However, the nurses providing this care are not usually in general practice

5.1.8 Women's health

Patterson, et al (1999) reported that antenatal checks and assessing infant development were fairly frequent activities undertaken by the PN. These roles surrounding maternity care and baby care were also generally well accepted in this study. It was indicated that midwives could easily take part in this care, especially with breast-feeding advice. Some PNs in the study indicated that midwives were giving some of this care in general practice but could provide more. The majority of participants felt that this was a role only for trained midwives.

Giving family planning advice was generally well accepted in this study as a possible role of PNs in general practice given an appropriate space within the practice and the necessary education. It was not observed or indicated as being a current role. This is a role however that nurses in are undertaking in the community setting (Offredy, 2000).

Breast examinations and PAP smears, as with the consumer studies, was seen as a role where participants differed widely in their level of comfort. Nurses in Australia are currently attending to PAP smears in the community health setting (Offredy, 2000). Patterson et al (1999) did find that a small amount of PNs were undertaking PAP smears, therefore although it was not found in this study it is a role that PNs are taking. It is therefore acceptable by at least some of the community and could be an area that PNs in Australia develop in their role.

5.1.9 Preventative health

Most participants were comfortable with PNs undertaking assessment and education related to disease and providing lifestyle advice. O'Connor (2002) found that PNs reported low levels of competency with the role of patient education however also found that PNs did not

indicate that they wanted further education in the area. This she suggests needs further investigation. Participants in this study believed that PNs would require further education to have a role in preventative health. Preventative health care was not observed in the practices within this study. However, it was reported that PNs were recalling patients for cholesterol checks and it is possible that opportunistic advice was being given. This concurred with Patterson et al (1999) and O'Connor (2002) who described in their studies PNs undertaking similar roles. The role of preventative health or primary health care was identified by the National Workshop on Practice Nursing in Australian General Practice (Royal College of Nursing, 2001) as a role that PNs should be including in their practice. Another role that a PN may take in general practice was the giving out of test results.

5.1.10 Test results

Most PNs in this study were uncomfortable with giving out test results, however some were comfortable after the GP had seen and commented on them. This role will probably vary between practices as it did in this study and should only be part of the role, as with all possible roles, if all parties are in agreement.

Although GPs and PNs are generally comfortable with many roles, the individual patient may prefer to see only the GP or believe they only need to see the PN. Participants in this study felt that consumers should be able to choose if they see the GP or the PN, and they would allow patients to make this choice. This concurs with the consumer studies (Hegney et al. 2004a; Cheek et al. 2002) in that consumers wanted to be able to have choice about which they saw.

In order to undertake the roles discussed above, PNs and GPs were asked what qualifications and qualities the PN would require.

5.2 Qualifications and Qualities of the PN

Participants considered varied experience was more important than formal education for the role of PN, however, it was considered important for the PN to have further training to undertake an expanded role. That such education should be ongoing was also considered important, as was the regular assessment of competence to undertake various procedures. Participants in this study suggested that PNs would prefer to have education that is role specific and prefer to have this provided through in-services and workshops. Patterson et al (1999) and O'Connor (2002) also found that additional education was needed for the expanded PN role. Australia has the opportunity to learn from what the U.K has learnt in hindsight (Atkin et al, 1993; Crawford, 2002), that education be addressed while the PN role in Australia is still in an early developmental stage. PN education should therefore be established and innovative ways to assist PNs to access education should be investigated.

According to the participants of this study, qualities such as good interpersonal skills and time management skills are important in general practice. It is also important that a PN be able to work as part of a team. As the team was considered by all participants to be important, it is suggested that, for the PN role to expand within a practice, a team environment should be fostered. Participants believed that all members of the team contribute to the quality of care the practice is able to provide.

5.3 What ensures quality care in general practice

Participants in this study generally had similar views about what consumers want in general practice to the consumers in the Hegney et al. (2004a) consumer study. They believed that consumers want all staff to have good communication skills, especially the GPs, who should listen to their patients. Participants believed that PNs needed to build a rapport with patients over time. They also believed that waiting times for appointments were important, as was confidentiality. Differing from the consumers (Hegney et al, 2004a; Cheek et al, 2002), some participants in this study thought consumers would want a coordinated approach to care and would be more attracted to a well-established practice. Additionally, the participants in this study believed that female GPs were seen to be more popular as were practices with more than one GP.

PNs were thought, in this study, to contribute to quality within general practice by giving the GP more time with patients and by contributing in certain areas of expertise. Participants felt that PNs were able to discover different things from patients, as patients seem to be more comfortable confiding certain things to the PN. They believed that this gave a more complete picture of the person's health needs, therefore improving quality of care. Participants in the Hegney et al (2004a) consumer study also believed that they were able to confide in the PN with some things they were not comfortable in disclosing to the GP or did not want to bother the GP with.

PNs took a large role in the accreditation of the general practice process, putting in place protocols and keeping up-to-date with procedures and passing that information on. These are areas that GPs find difficult due to time constraints.

Whilst taking a large role in general practice and contributing to the quality of care a practice is able to provide, payment of the PN was an issue that most participants felt was important.

5.4 Payment of the PN

With the expanding role and added responsibility of the PN, it is the author's opinion that the PN should be paid accordingly. Traditionally, PNs have been paid at a much lower rate than that of nurses working in hospitals, however some practices are recognising the expertise of their PNs and are paying them at a higher than award rate. These findings have been previously documented by Condon, Willis and Litt (2000), who stated that the starting salary for a PN is approximately $2000 less than a nurse in the public sector. They also commented however, that some GPs are recognising the PNs skills in general practice and are paying above the award.

How the practice receives remuneration for nursing work needs to be explored further. Some practices contend that they are not reimbursed for the PNs work; others comment that they are able to make money from having a PN, and yet others believe it is part of the total service. Due to this variance of opinion in regard to remuneration it is not possible to make further suggestions in regard to the issue without undertaking a cost-effectiveness study. Payment of the PN had some affect on the working relationship of GPs and PNs in that it often portrayed how the PN is valued. Other factors of employment, however, were also important to the participants.

5.5 What factors impact upon GPs' and PNs working relationships?

The practices in this study generally worked together as a team and it was apparent to the researcher that the more open the communication and equal the relationship the better the team worked together. Participants reported that trust was also important to the building of a team. It appeared that it did not matter how increased the PNs role was within the practice, if the PN and GP agreed on the role, the team was reported to work well together. Participants portrayed to the researcher the importance of the team in general practice and of all members working well within the team.

Henneman, Lee and Cohan (1995) reported that "…effective group dynamics play a pivotal role in the promotion of collaboration. Factors that promote collaboration include excellent communication skills, respect, sharing and trust". These attributes were demonstrated in most of the practices within the study.

Collaborative practice was seen in this study mainly in the areas of chronic disease and aged care. In these areas PNs were seen to be providing valuable information and contributing towards patient care and planning. Another area in some practices was that of wound management where the PN had a large input into management of the wounds. One practice displayed collaborative practice with the PNs triage role. This differed from the Condon Willis and Litt (2000) study, in which they found that little shared caring for patients was occurring between GPs and PNs.

Some fear was reported to the researcher from GPs and the public, of PNs trying to take over the GP's role. Whilst this was a finding in the Hegney et al (2004b) study, this was not the

experience of the participants in this study and was not what the PN stated they aspired to. Instead they believed they should work as a team and together contribute to holistic patient care, each team member adding a unique perspective. Whilst working as part of a team it is also important to discover how the PN achieves autonomous growth.

5.6 What aspects of the culture promote the autonomous growth of the PN?

It is the belief of the author that the PNs growth in general practice depends on and relates to the growth of the General Practice Team. A nurse in general practice is not an independent practitioner but a member of a multi-disciplinary team combining to provide holistic care to consumers.

It has been shown in this study that PNs are able to make a large contribution to general practice. In these practices it is perceived that the PN not only assists the GP but also makes a contribution specific to nursing, thereby giving consumers better care. With many advantages being evident from having a PN it is difficult to understand why more practices are not employing a PN. Money is often given as a reason; perhaps too, fear of change or lack of understanding of the collaborative model and fear of the substitution model are further reasons. Condon Willis and Litt (2000) also suggested that GPs are fearful of litigation from the PNs work.

5.7 Conclusion

This chapter has reviewed the results and compared them with the current literature on practice nursing. This chapter has also demonstrated how the objectives of the study were achieved. It is evident when reviewing the data that the distinguishing feature of the practices

is the team environment where all members of the team contribute to patient care and are respected for their input.

CHAPTER SIX

6. CONCLUSION

This chapter will revise the previous chapters and identify the important aspects of the study. It will also highlight the factors that the author believes to be important to general practice and the PN role.

This study used ethnographical techniques to determine PNs and GPs perceptions of the PN role. Ethnography uses multiple means of collecting data and in this study included interviews, observations, and questionnaires. Interviews were conducted with four PNs and four GPs in practices classified in this study as having PNs working in an increased role. Two practices were observed to identify work practices and interaction in the practice.

The Australian Government, through various initiatives, has encouraged GPs to employ PNs. This has been aimed at improving quality of care and increasing the primary health care being offered through general practice. An area that the government has focused on providing incentives for is that of chronic illness and also the aged.

In 2001 a national workshop was held to discuss issues surrounding the role of the PN and identify work areas for the PN to undertake in general practice. That workshop resulted in the RCNA Nursing in General Practice Fact Sheets (2001). These Fact Sheets cover identified work areas that a PN can undertake, legal issues, and employment issues to guide the general practice in employing a PN. The roles suggested in these fact sheets were evident

to varying degrees within this study. The recent RCNA and RACGP study (Watts et al, 2004) also identified that PNs are moving into roles identified in the Fact Sheets.

Consumer studies by Cheek et al. (2002) and Hegney et al. (2004a) have shown that the public is ill-informed in regard to the PN role, and has little knowledge of what a PN is able to contribute to their care. Despite this lack of knowledge consumers were generally happy to receive care from a PN for most clinical roles. Consumers were more apprehensive about roles that would have the PN diagnosing. Having the choice, of which the consumer consulted in the practice, the GP or the PN, was also important to them. Consumers also identified, that they wanted the GP and PN to communicate well and portray a united front to the consumer.

The PN roles identified in this study were similar to those in Patterson, DelMar and Najman,(1999) and O'Connor (2002); however, the PNs in this study appeared to have more autonomy in regard to care of people with chronic illness and the aged. This appears to be an extremely valuable part of the role as the management of these groups of patients is time consuming. Despite this, they are areas where the PN is able to provide a unique contribution. As was reported by the PNs in this study, this is due to consumers telling the PN things they won't tell a GP and the fact that consumers are receiving both a medical and nursing assessment.

Education has been identified as important in the development of the PN role (Patterson, Del Mar & Najman, 1999; O'Connor, 2002; Watts et al, 2004). This factor was also identified in this study, especially for increased roles such as management of chronic illness. In this study,

PNs indicated that they had a preference for in-service training or workshops from which to gain further knowledge. How education and training is offered should be further investigated to ensure that PNs are prepared for their role in general practice.

Participants also identified in this study that a PN should have considerable and varied experience as well as other characteristics such as being able to work independently and possessing good people skills. Participants believed that good people skills allowed the PN to contribute to the team.

Funding arrangements should be decided for general practices to enable remuneration for PNs to be officially at parity with that of nurses within the public hospital system. Participants believed that remuneration should reflect the level of expertise and responsibility of the PN. With the role expanded, as it is in some practices, the PNs are taking on a more independent role, which they feel should be appropriately remunerated.

As was identified in the Watts et al's (2004) report, this study found that teamwork is essential in general practice. Participants in this study believed that teamwork between all parties in general practice improves the quality of care the practice is able to provide. Participants in this study considered that PNs are able to contribute to the holistic care of the patient. They also believed that the PN was a valuable link in the community for hospitals who could get an up-to-date picture of a patient through the care plan developed by the GP or PN. It was also easier for other health professionals to communicate with the PN at the practice who could in turn liaise with the GP (or assist them directly) rather than trying to contact the GP directly. There in no doubt that the PN role added to the care GPs were able

to provide. The PN also enabled the GP to spend more time with patients where their expertise was needed. PNs in this study believed they were best able to provide care within a team environment.

This study has identified that the role of the PN is dependant on various factors such as the experience of the PN, the needs of the community the practice is providing for and the physical lay-out of the practice. It is also dependant on the beliefs and experiences of both the GP and the PN and also on how much mutual trust and respect they have developed.

This study has several recommendations to enable the role of the PN to increase. In some cases, policy changes are required, in other cases the changes could be implemented by current education and training providers.

Recommendations:

Recommendation 1: That the financial situation of how general practice receives payment for a PNs work should be reviewed by the Australian Government to identify a method of payment that allows appropriate remuneration for the increased role of the PN;

Recommendation 2: That if PN are to work in an increased practice role, they should be appropriately remunerated. The Relevent Nursing organisations should ensure that the lack of parity in remuneration between PN and nurses working in the public sector are addressed. Additionally, the PN award should include different remuneration rates for PNs which reflect the different levels of PNs (beginning to advanced) similar to that of hospital nurses and PNs in the UK.

Recommendation 3: That current education and training providers should introduce innovative methods of educating PNs to ensure that education and training is accessible to PNs and appropriate to their lifestyle. In particular, PNs wish to access training which is conducted as inservices or in workshops.

Recommendation 4: Education and training providers should be ensuring that programs offered to PNs includes all aspects of the role as detailed in the

Nursing in General Practice peoplecarequality fact sheets, Royal College of Nursing Australia. (2001). They should also be identifying where the role could advance in the future in order to ensure that PNs have the knowledge to advance their role further.

Recommendation 5: The team approach to providing care is believed in this study to improve patient outcomes and management. Nursing and Medical organisations should therefore work together to assist and encourage PNs and GPs to work collaboratively to achieve quality care for patients. Education and training providers should also introduce programs to assist nurses and doctors in developing the skills necessary to work within a multidisciplinary team.

Recommendation 6: That Education should be undertaken by Government bodies and the Division of General Practice to ensure the public as well as general practice is aware of the PN role and what the role can add to patient care.

Recommendation 7: Further research should be conducted to inform how the PN role fits into the Australian health care system and how the role adds value or could add value to the current system.

Recommendation 8: Ways of identifying what a general practice employing a PN is able to offer to consumers should be explored to enable both consumers and other health care providers to ensure the full utilisation of these services.

Conclusion

This chapter has reviewed the previous chapters by identifying the important issues that have been raised by this study and other studies. In reviewing the findings of this study and of others, recommendations have also been made for the future growth of the PN role.

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Appendix A

Doctor and Nurse Interview Guide

1. What factors influence quality of care in general practice?

Prompts:
- access
- cost
- choice
- facilities
- privacy
- clinical expertise of health practitioners (HPs)
- interpersonal skills of HPs
- coordination of care
- appropriate referral to other HPs/services
- level of explanation of condition/treatment
- degree of collaboration with patient
- nurse being from same cultural background e.g., Indigenous

2. How do you think nurses in general practice do/will affect the quality of care offered by the practice?

3. What services do you think are appropriate for nurses to undertake in general medical practices and why?

Prompts:
- triage (clinic/telephone/home)
- phone advice/counselling
- physical examination and history taking
- screening tests like Pap smears & breast examination
- general health assessment/risk appraisal
- well baby check
- ante & post natal care & advice
- diagnosis & treatment of minor illness/injury including ordering pathology & radiology tests
- coordination of chronic illness care eg diabetes, asthma, hypertension
- referral to other HPs/services
- health education
- grief/trauma counselling
- explanation of test results
- home visits

4. What services do nurses at this practice currently provide and why?

5. What qualifications and training do Practice Nurses require?

6. How do you think a GP and a nurse should work together?

7. If nurses were to take on expanded roles in general practice, what do you think is necessary to ensure confidence and acceptance? From both the practices point of view and the consumers.

8. You often hear people worried that nurses are encroaching on the doctors role. How do you answer that?

9.What do you see the nurses role as being

NURSES ONLY
10. What if anything limits the scope of services you are able to provide?

11. Why do you want to be a Practice Nurse

DOCTORS ONLY
10. What does the Practice NursePN bring to the practice.

Appendix B

PLAIN LANGUAGE STATEMENT

The University of Southern Queensland, with support from the Queensland Division of General Practice, is conducting a study into consumer perceptions of Practice Nurses. To gain a more complete picture of what the role should be, it has been decided to also interview General Practitioners and Practice Nurses to determine their perceptions of the Practice Nurses Role.

The data collected from doctors and nurses will also be used in a thesis for the Master of Health Program at the University of Southern Queensland, by the interviewer Sharon Rees.

You will be asked to complete a brief questionnaire to collect some background data prior to an interview. The interview will be audio taped for later transcription, allowing the researcher to analyse the data and determine the major themes.

Your interview will be kept strictly confidential. At no time will any names or practices be referred to in the report or thesis. Your involvement will also not be discussed with any individual outside the research team. All questionnaires, tapes and transcriptions will be held in a locked filing cabinet at the University of Southern Queensland for five years, and then be disposed of as confidential waste. All information kept on computer can only be accessed by password, by Mrs Rees and Professor Hegney.

Should you wish to withdraw from the study at any time you may contact Prof Desley Hegney or Sharon Rees on the numbers below. If you decide to withdraw, your questionnaire, the interview tapes and transcriptions will be destroyed.

Once the study has been completed and the information analysed, the report will be written. A summary of this report will be made available for you to read. This will be in November 2003.

Any questions regarding the study can be directed to:
Mrs Sharon Rees, Project Officer, Centre for Rural and Remote Area Health, University of Southern Queensland. Telephone: 4631 5450. Email reess@usq.edu.au

Professor Desley Hegney, Centre for Rural and Remote Area Health, University of Southern Queensland, Toowoomba Queensland. Telephone: 4631 5456   Email hegney@usq.edu.au

Perceptions of Practice Nurses/Medical Practitioners

Consent form

I ____

Of ____

____
(address)

have read the plain language statement and agree to participate in the study. I am aware that my participation is voluntary, and that I can withdraw from the study at any time by contacting Sharon Rees or Professor Hegney. I agree that the information I contribute to the study can be published as long as I cannot be identified in any way.

Signed: ____________________________________

Date: ______________________________________

Appendix C

PLAIN LANGUAGE STATEMENT

The University of Southern Queensland, with support from the Queensland Division of General Practice, is conducting a study into consumer perceptions of Practice Nurses. To gain a more complete picture of what the role should be, it has been decided to also interview General Practitioners and Practice Nurses to determine their perceptions of the Practice Nurses Role.

The data collected from doctors and nurses will also be used in a thesis for the Master of Health Program at the University of Southern Queensland, by the interviewer Sharon Rees, also included in this study will be observing Practice Nurses during a working day.

Any information gained during the day will be kept strictly confidential. At no time will any names or practices be referred to in the report or thesis. Your involvement will also not be discussed with any individual outside the research team. All notes will be held in a locked filing cabinet at the University of Southern Queensland for five years, and then be disposed of as confidential waste. All information kept on computer can only be accessed by password, by Mrs Rees and Professor Hegney.

Should you wish to withdraw from the study at any time you may contact Prof Desley Hegney or Sharon Rees on the numbers below.

Once the study has been completed and the information analysed, the report will be written. A summary of this report will be made available for you to read. This will be in November 2003.

Any questions regarding the study can be directed to:
Mrs Sharon Rees, Project Officer, Centre for Rural and Remote Area Health, University of Southern Queensland. Telephone: 4631 5450. Email reess@usq.edu.au

Professor Desley Hegney, Centre for Rural and Remote Area Health, University of Southern Queensland, Toowoomba Queensland. Telephone: 4631 5456   Email hegney@usq.edu.au

Perceptions of Practice Nurses/Medical Practitioners

Observation Consent form

Doctor

I____
Agree to allow Sharon Rees to observe the Practice Nurse at my clinic during the nurses' working day. I have sighted her nursing registration; however acknowledge she will only assist the Practice Nurse under her direct supervision, taking on the role of student.

Signed ____ Date__________

Nurse

I____
Have read the plain language statement and agree to be observed by Sharon Rees during my working day. I have sighted her nursing registration; however acknowledge she will assist me only under my direct supervision, taking on the role of student. I acknowledge that I can withdraw from the study at any time by asking for the observation to cease or at a later date by contacting Sharon Rees or Professor Hegney. I agree that the information I contribute to the study can be published as long as I cannot be identified in any way.

Signed____ Date__________

Observer

I Sharon Rees agree that I will only assist with patient care under the direct supervision of the Practice Nurse. I agree to be bound by the rules of confidentiality and privacy with respect to any patient contact at this practice.

Signed ____ Date__________

Appendix D

QUESTIONNAIRE FOR INTERVIEWS

Please circle only one response unless otherwise instructed.

1. Are you?

Male	1
Female	2

2. What is your age?

20 to <30	1
30 to <40	2
40 to <50	3
50 to <60	4
60 to <70	5

3. Please tell us the postcode of the town or area where you work.

____

4. How many doctors work in your practice?

Only one	1
2 to 5	2
6 to 10	3
More than10.	4

5. Does the practice you work in have doctors that are? (circle all that apply)

Male	yes	no
Female	yes	no

10. The following are services that a Practice Nurse could provide, following relevant training. Please place a tick in only one of the squares to indicate how comfortable you would be with nurses providing that service

	Very comfortable	Somewhat comfortable	Undecided	Somewhat uncomfortable	Very uncomfortable
a) Giving Vaccinations					
b) Managing treatment of wounds					
c) Diagnosis and treatment of minor illnesses					
d) Doing routine health checks					
e) Giving patients test results					
f) Doing Breast examinations					
g) Doing Pap smears					
h) In consultation with the doctor overseeing the management of chronic illnesses i.e diabetes, asthma, heart disease					
i) Giving health advice over the phone					
j) Being the initial contact at the surgery in an emergency					
k) Providing education related to health issues					
l) Assessing risk factors for disease e.g. heart disease, diabetes					
m) Doing well baby checks					

	Very comfortable	Somewhat comfortable	Undecided	Somewhat uncomfortable	Very uncomfortable
n) Giving ante and post natal care and advice					
o) Counselling and/or grief counselling					
p) Giving follow up care post discharge from hospital					
q) Giving Family planning advice					
r) Doing home safety checks for falls risks					
s) Managing aged care i.e accessing services, coordinating allied health professionals					
t) Giving lifestyle advice					
u) Checking medications patients are currently taking					
v) Prescribing legally sanctioned medications following medical guidelines					
w) Performing routine tests such as; ECG's and Spirometry					
x) Performing medical tests for insurance					

z)Are there any other services you feel a Practice Nurse could provide?

____

Appendix E

TOOWOOMBA QUEENSLAND 4350
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The Office of Research and Higher Degrees

Postgraduate and Ethics Officer
Telephone: 0746 312956
Facsimile: 0746 312955
Email: bartletc@usq.edu.au

27 March 2003

Ms Sharon Rees
Department of Nursing
Faculty of Sciences
USQ

Dear Ms Rees

Re: Ethics Clearance for Research Project, *Perceptions of Doctors and Nurses of the role of the Practice Nurse*

The USQ Human Research Ethics Committee recently reviewed your application for ethics clearance. Now that you have addressed the concerns of the Committee your project has been endorsed and full ethics approval is confirmed. Reference number H03STU259 has been assigned to this approval.

The Committee is required to monitor research projects that have received ethics clearance to ensure their conduct is not jeopardising the rights and interests of those who agreed to participate. Accordingly, you are asked to forward a written report to this office after twelve months from the date of this approval or upon completion of the project.

A questionnaire will be sent to you requesting details that will include: the status of the project; a statement from you as principal investigator, that the project is in compliance with any special conditions stated as a condition of ethical approval; and confirming the security of the data collected and the conditions governing access to the data. The questionnaire, available on the web, can be forwarded with your written report.

Participants in your project should be advised that, if they have a concern regarding the implementation of the project, they should contact The Secretary, Human Research Ethics Committee USQ or telephone (07)4631 2956. Please note that you are responsible for notifying the Committee immediately of any matter that might affect the continued ethical acceptability of the proposed procedure.

Yours sincerely

C. Bartlett

Christine Bartlett
Postgraduate and Ethics Officer
Office of Research and Higher Degrees

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University of the Year
2000 - 2001