



Australian consumers' expectations for expanded nursing roles in general practice



Choice not gatekeeping

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While research has focussed on the current and potential role of the practice nurse (PN) in Australia, the acceptability of this role by consumers has not been investigated. In 2002, two independent studies were carried out into consumer perceptions of PNs. A discussion between the two groups of researchers at the inaugural National Practice Nurse Conference in 2003, identified significant similarities in the findings of these studies. This article reports the combined findings as they relate to consumers' desire for access to the health practitioner of their choice, and their concern that PNs may assume a gatekeeping role. These perceptions may have significant impact on the acceptance of PNs across Australia.

Gatekeeping is not a new phenomenon. It has been employed for many centuries with a common aim – controlling access to goods or services valued by others.¹ In the 21st century, the term 'gatekeeping' is often used to describe the actions of health professionals who exercise control over the demand for access to health care, particularly access to specialist services.² The relationship between the client and the gatekeeper is unequal – with power resting with the gatekeeper.³

In the general practice environment, the power and influence of the medical receptionist in determining access to the general practitioner has been noted.⁴ Usually it is the

receptionist who is the sole intermediary for contacts between the patient and the GP and, as such, often acts as a gatekeeper. Recent Australian government initiatives to increase the number of nurses employed by GPs and expand their role, raises the possibility of a new 'gatekeeper' in the scenario – the practice nurse (PN).

Background

In recent years, the Australian government has promoted the role of nurses in general practice through the provision of financial support to GPs who employ PNs. The 2001–2002 commonwealth budget allocated \$104 million

to encourage more GPs to employ PNs.⁵ In 2003, a further \$102 million was allocated.⁶ The Medicare Plus package included a Medical Benefit Scheme item for PNs work involving immunisation and wound management.⁶

The potential role and function of the PN in Australia was discussed at a national workshop in July 2001.⁷ The workshop participants believed that the PN role was complementary to that of the GP, and noted that expansion of the PN role could increase the level of services offered in general practice. The National Steering Committee on Nursing in General Practice identified a number of priorities in developing this area of nursing that included building the capacity of divisions of general practice to support nursing, ensuring appropriate and accessible training and upskilling opportunities, and developing networking and mentoring systems for PNs. Government funding has enabled the execution of projects to address these priority areas and to initiate, through the Australian Nursing Federation, the development of competency standards for both enrolled and registered nurses in general practice.

Evaluations of primary care services delivered by nurses in the United Kingdom suggest that appropriately trained nurses can undertake functions previously undertaken by GPs. Importantly, the nurse can provide a more cost effective service with no diminished quality and high levels of patient satisfaction.^{8,9}

Until recently, limited research has been undertaken on the actual role of PNs in Australia, and these studies tended to be limited to particular geographical areas or patient population groups.¹⁰⁻¹⁶ However, their findings have now been supported by a national study undertaken by The Royal Australian College of General Practitioners (RACGP) and the Royal College of Nursing Australia (RCNA) which found wide diversity in the role resulting from the professional characteristics of the nurse, the practice's patient population, the business orientation of the practice, localised practice and community resources, and structural arrangements at a national level.¹⁷ This study ascertained that the PN role currently encompasses four overlapping dimensions:

- clinical care
- clinical organisation
- practice administration, and
- integration.

However, there is still debate in nursing and medical circles about what the focus of the role should be. Lauder et al¹⁸ suggest that nurses and GPs in rural and remote areas should be interchangeable and that the focus should be on the competency of the person delivering care rather than the right of one discipline (medicine) to perform a particular role. In contrast, Campbell¹⁹ believes that public acceptance of nurses as GP substitutes would be poor, stating that a better role for nurses in primary care would be health education and illness prevention. Hence, there was a great need to canvass general practice perceptions and expectations for nursing roles in this domain of health care.

The studies

The first study involved 170 consumers selected from four Australia States (New South Wales, Victoria, Queensland, and

South Australia) and the two territories. In contrast, the 106 participants in the second study all lived in Queensland. In both studies, participants were from metropolitan and nonmetropolitan areas and included carers of young and elderly people, the aged, young people, indigenous Australians, people with a mental illness, those who had experience of PNs, and those who did not. The geographical classification used in both studies was the Rural, Remote and Metropolitan Areas Classification.²⁰ Both studies were qualitative in nature utilising purposive sampling methodology.²¹

Recruitment of participants for both studies included multiple strategies such as employing market research recruiting agencies, utilising contacts and networks of the investigators (eg. carers' associations and chronic illness support groups), and leaving information brochures at individual general practices or divisions of general practice.

Both studies used focus groups as the main data collection method. However, the second study also conducted 10 individual interviews, and the first study held workshops with key stakeholders to ensure that recommendations made from the analysis of their research findings were informed by nursing, medical and consumer organisations. All interviews and focus groups were tape recorded. Demographic data were collected in both studies.

The data analyses for both studies followed Ekman and Segesten's²² method which included the following steps: each transcript was studied group-by-group, by sampling of groups, and whole of data collated to give a sense of the whole; themes, categories and recurrent patterns were identified group-by-group, by sampling of groups, and whole of data collated; and summative themes and research findings were developed.

Findings

When the data were pooled, the two groups of researchers found consistency in the results, revealing that consumers in both studies raised similar concerns. From the findings, which fit within the concept of

gatekeeping as defined by Corra and Willer,¹ consumers were quite clear that they did not want any structure or any person (eg. the PN) to limit their choice to access services. The other recurring theme related to the control exerted, through the lack of flexibility within the practice, to restrict both the choice and type of service available.

Consumers raised the importance of having ultimate choice about whom they wanted to see – they did not want any choices taken away. They wanted to be able to choose the PN as well as the doctor, instead of the doctor, or not to see the PN at all. Consumers were concerned that if more PNs were employed they may act as gatekeepers to the GP:

'I wouldn't want to... be book[ed] in for the doctor and then see a nurse without being told beforehand. It's like going to the hairdresser and the apprentice doing your hair when you always have had the qualified hairdresser and not being asked' (study 1 participant).

Issues around choice were framed by perceptions about cost and awareness of issues relating to nursing in general practice. Availability was often limited by location and, in some cases, consumers mentioned the age of a person and therefore their associated ability to question as a barrier to accessing services:

'The only thing that would concern me is if someone like my parents, who wouldn't question someone in authority or if they were not happy with the nurse's decision, would just accept it' (study 1 participant).

The consumer having absolute choice was fundamental to acceptance of the initiative – this was of particular importance to the groups who had no experience of PNs. A key message that emerged from both studies was that while consumers' perceptions were framed by personal experiences, consumers were also aware that clinic processes may influence their views about nurses in general practice. For example, if the PN was introduced into a 'triage' role in the practice and would assess all patients on arrival, consumers were concerned that the PN may decide which practitioner (PN or GP) she/he deemed the most appropriate person to meet their needs rather than having the choice.

This scenario was considered to remove what they valued most – their opportunity to make a choice. However, many participants who had experienced PNs' assessment and triage in the general practice setting were happy for them to undertake these activities before seeing their doctor. Other participants, especially those who had not encountered a PN, were less comfortable with this as a role for the PN:

'I would feel uncomfortable with that, because I am going to see the doctor not the nurse... I am going there because I am sick and I want to see the doctor not the nurse' (study 2 participant).

Consumers with children, carers and grandparents saw the benefit of the PN for triage and management of the family. Some consumers also thought there was a role for PNs in triage over the phone:

'I would ring up sometimes to say one of the kids was sick and did she think I should bring them into the doctor and they were helpful that way... and sometimes they said 'no bring them in now' or 'wait another day' (study 2 participant).

When other members of the group raised the idea of PNs' involvement in triage and assessment, most people readily agreed a PN would be useful in a triage role. This was seen however, as initial first aid and assessment before seeing the doctor. Most considered that if a PN undertook these roles it would improve access to the doctor.

Consumers believed that the PN must not act as a gatekeeper to the GP (nor the GP a gatekeeper to the PN), nor should the PN be a substitute for the GP. The concern about the substitution of GPs by PNs was particularly evident in rural and remote areas where choice of services is already limited. It was apparent that consumers in these areas would not accept any further erosion of an already limited primary care service.

The focus of nearly all consumers was for the PN to enhance general practice services not substitute for the GP:

'I wouldn't want a nurse to be too protective of the doctor so that she will try not to let you see the doctor if you really want to' (study 1 participant).

Discussion

In contrast to what some nurses in Australia see as the role of PNs in general practice,¹⁸ it is clear that consumers did not want the PN to be a substitute for the GP. They saw the role of the PN as enhancing general practice services, not replacing them. Certainly in Australia, where patients have always had the right to choose the general practice (and usually the GP within the practice), it is apparent that consumers would not accept a service where this choice was curtailed. Similarly, consumers would not accept the substitution of a GP with a PN unless the choice to do so was theirs.

Similar to other studies,⁸ the consumers who had previously had contact with a PN, could see that PNs could undertake initial assessment, while still maintaining quality of service. In both studies, the consumers with previous contact with a PN expressed satisfaction with the care they had received and in some cases, the PN had worked as a positive gatekeeper assisting the consumer with access to other health services.²² It is apparent that in these cases, consumers see the PN as assisting them with progress through the health care system.²³

Linked to assessment is the role PNs can play with telephone triage. Nurses have worked successfully in telephone advisory services in Sweden²⁴ and the USA,²⁵ and it is apparent that the majority of consumers were satisfied with this nursing gatekeeping role. However, Lee et al²⁶ suggested that consumers were less compliant with advice given by a nurse compared to that given by a GP.

The majority of consumers in the two studies did not believe that seeing a PN instead of a GP would necessarily result in higher levels of patient satisfaction. It is acknowledged, however, that in many cases the consumers in both studies had not experienced the type of PN role now in place in the UK.

Conclusion

Clearly this study has implications for general practice. It is apparent that consumers attending practices where PNs are employed will not

tolerate the PN being substituted for the GP. Additionally, consumers noted that if a PN was employed and the consumer believed that the PN could best meet their needs, they should be able to make an appointment with the PN without having to consult the GP first. This would, with the exception of immunisation and wound care, have financial implications for the practice as there is currently no Medicare item for the visit to the PN in such cases.

Conflict of interest: none declared.

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