Negotiating the future

The development of family health nurses and family nurse practitioners in remote and rural Australia

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Despite full blooded banners in the medical press such as: 'GPs fight nurses' power',[1] The Royal Australian College of General Practitioners' (RACGP) position on nurse practitioners has, since 1998, been one of support for the role within a collaborative model. The college has yet to extend its support to the concept of 'independent nurse practitioner' with access to their own Medicare provider number, and the following statement may help explain why:

'Given the probability that primary care nurses can undertake many, if not all of the functions which are currently the province of the GP, and can do in a more cost effective manner, it therefore seems logical to adopt a policy of role interchangeability in which what matters, is that the person occupying a given role can practice competently, rather than focussing on which professional tribe should have a given right to fulfill this role'.[2]

The National Rural Faculty of the RACGP has no quarrel with Lauder and his colleagues over the belief that nursing roles in rural communities differ from urban practice due to influences such as geographical location, population differences and their health needs. We also well appreciate that nurses in many remote locations are the sole health professional on site, and manage everything that walks through the doors (and indeed, much that occurs outside them), although the experience of our members is that many of these nurses also enjoy the remote clinical support of an experienced (and probably equally remote) GP.

What Lauder et al appear to be arguing is the need to change the 'nurse practitioner' role into one of independent 'family nurse practitioner' with a role interchangeable with a GP, and to alter the current 'practice nurse' role to one of a more community based and autonomous 'family health nurse'.

The practice nurse in Australia does not have prescribing rights and works in a primary health care setting driven by the professional medical expertise of the GP. In a seminal Australian study, Condon et al[3] found that medicolegal and employer-employee constraints confine the relationship between GP and practice nurse to one of delegation rather than shared care.

To alter this relationship requires change on levels well beyond the practice itself, such as Medicare and medical indemnity. It also requires a change in GPs' philosophical orientation toward holistic care, a feature particularly valued in rural general practice.[4]

Considering the proposed role of the family nurse practitioner, what evidence is there that such a change is desirable?

The World Health Organisation Advisory Group of Nursing and Midwifery may well report that: 'throughout the world, nurses are the largest and best positioned workforce element in rural health care', but are they so – and in sufficient numbers – in rural and remote Australia? There may have been some improvements in recruitment and retention strategies for rural and remote nurses (including scholarships and practice nurse incentives for general practice) since the Association for Australian Rural Nurse called, in 1999, for action on declining numbers in rural areas,[6] but we are still waiting for parity between the calibre of recruitment and retention strategies aimed at the medical profession and those for other health professionals.

Then there is the probability 'given' above that 'primary care nurses can undertake many, if not all of the functions which are currently the province of GP'. The research adduced can easily be countered with other equally plausible studies.

For instance, Shum et al[7] show patient satisfaction with nurse practitioner consultations is slightly higher than for those with GPs, but research also reveals that 31.5% of those who saw a nurse would rather see a GP next time round (compared to 2% of those seeing GPs preferring a nurse next time). Kinnersley et al[8] found that the number of 'same day' patients consulting a nurse practitioner who would choose a GP next visit was 48%.

Meanwhile a study comparing the cost effectiveness of nurse practitioners and GPs by Venning[9] finds no significant differences for health care costs, patterns of prescribing or health status outcome

between GPs and nurse practitioners (but only if length of consultation and return rates for practice nurses were controlled for). Whitecross[10] cites a randomised controlled trial in the USA which shows convincingly that nurse practitioner involvement in general practice over a 12 month period reduced demand on GPs by two-thirds, enabled a 22% increase in the practice list overall, and resulted in higher satisfaction ratings for the nurse practitioners. But each nurse practitioner had only half as many patients as each GP.

One of the problems with much of this research is that it depends on the patient's perception of quality of care. As Cheek et al[11] find, consumers do not want nurses to be responsible for diagnosing 'life threatening or serious conditions'. Another is, as the authors of the Cochrane review cited by Lauder et al admit, the variable definition of the nurse practitioner role. If the concept of 'advanced practice' differentiates the community health nurse orientation of the family health nurse from their more clinically independent family nurse practitioner, Whitecross cites a UK definition of advanced practice as 'characterising an individual who is innovative and extending the boundaries of nursing practice and who is educated to masters level'.

Nurse practitioners in rural and remote Australian are, by virtue of the work demands placed upon them by their patient population, nothing if not innovative and extending of boundaries. But how many are clinically educated to masters level and willing and able to enter rural and/or remote practice? Enough to offer an immediate and more cost effective workforce solution to the one currently preferred by government – the importation of doctors trained by governments overseas? Especially if, as Lauder et al suggest, these nurse practitioners are extended the same professional status and contract terms as their medical counterparts.

Let's face it, the rise of the independent nurse practitioner in Australia is not some ineluctable force that GPs, as a barrier to be overcome, will either have to succumb to or suffer the consequences of. Just as professional boundaries between the medical and nursing professions are best negotiated, so is change in them.

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