Barriers to developing the nurse practitioner role in primary care—the GP perspective

Ali Wilsona, David Pearsonb and Alan Hasseyb


**Background.** Opportunities exist to develop an advanced nursing role in general practice and there is growing evidence that appropriately trained nurses can reduce cost and GP workload without compromising quality of care or patient satisfaction. Despite the shortfall of doctors entering British general practice and the difficulties doctors report in managing an increasing workload in primary care, few British practices have chosen to adopt this potential solution. An exploration of the barriers to the development of a nurse practitioner role is therefore timely.

**Objective.** To explore the views of British GPs regarding their attitudes towards developing an advanced nursing role in general practice.

**Methods.** A focus group study of GPs from four general practices in Yorkshire selected purposefully to represent a spectrum of experience in working with different nursing roles in general practice. Each focus group consisted of between 6 and 8 participants. A structured framework was used to elicit views, the group meetings were recorded and subjected to content analysis by two independent assessors. Inter-rater reliability was high (K = 0.921; 95% confidence limits 0.86–0.98).

**Results.** The study highlighted significant concerns by GPs with regard to the nurse practitioner role in general practice. Four themes were identified that may be impeding the development of advanced nursing roles in general practice. These are concerned with threats to GP status, including job and financial security, nursing capabilities, including training and scope of responsibility, and structural and organizational barriers.

**Conclusions.** There is a need to acknowledge GP concerns and encourage a more widespread debate about the appropriate mix of skills required in primary care. Joint educational events and the development of GP preceptorship may help to develop a greater understanding of the potential value of advanced nursing roles in general practice.

**Keywords.** Advanced nursing role, general practice, GP development, GP views, nurse practitioners.

**Introduction**

Since 1990 when a new GP contract was introduced, there has been a fourfold increase in the number of nurses employed in UK general practice. From that time the nurses' role and sphere of responsibility has expanded to support the GP and includes immunization, health promotion and chronic disease management, providing telephone advice and undertaking minor acute illness consultations. Recent NHS reforms have supported these developments and encouraged innovative ways to provide primary health care, particularly in those areas poorly served by current health care structures. Indeed in some Personal Medical Service (PMS) initiatives, doctors are conversely providing medical services to complement and support those offered by the nursing team and nurses have been encouraged to take on leadership roles within evolving primary care groups and Trusts (PCG/Ts).

A review of the evidence to support nurse for doctor substitution in 1995 acknowledged the potential of nurses to undertake between 30–70% of tasks performed by doctors but the authors suggested a change of skill mix would be premature, as this may be at the expense of quality.
Recent randomized controlled trial evidence from the UK and USA however, has concluded that consultations by nurse practitioners and family doctors/GPs give comparable patient outcomes and, in the case of the UK study, increased patient satisfaction.\textsuperscript{10,11}

Extending the role of nurses is not simply about replacing doctors. New roles might develop to fill the care vacuum in certain specialized areas, e.g. inner city deprivation, chronic illnesses, health screening and dealing with the rising health expectations of the public.\textsuperscript{12}

There is an impetus in many developed countries to adopt alternative ways of delivering primary care due to escalating cost and the shortage of doctors entering family medicine. In the UK, additional factors have included a perception of increasing patient demand, new management roles demanded of GPs and the need for greater attention to quality in the form of clinical governance. In addition, the emergence of PCG/Ts has introduced the potential for radical changes in service delivery.

Whilst UK GPs have, throughout the last two decades, been generally in favour of delegating workload to nurses,\textsuperscript{13} there has been concern by some doctors about the development of ‘independent practitioner’ status.\textsuperscript{14}

Such concerns are rarely made explicit but if widespread could seriously impede the wider introduction of a nurse practitioner role. In the US the experience of nurse practitioners over 25 years has suggested similar concerns can be overcome.\textsuperscript{15} Indeed the US now has 160,000 advanced practice registered nurses (including nurse practitioners), and all have some prescribing authority.\textsuperscript{16}

Our project aimed to explore GPs’ views of an advanced nursing role in primary care, to identify barriers associated with the introduction of nurse practitioners and consider how such barriers could be overcome.

Methods

Data were collected during four practice-based focus group interviews involving 25 GPs in four UK medical practices. This qualitative method allowed an exploration of attitudes towards developing the nurse’s role.\textsuperscript{17}

The four practices have between four and eight partners. All were training practices. They were selected purposefully to represent a spectrum of experience of working with different nursing roles\textsuperscript{18} so that potential differences in views of those with and without experience of the role might be considered. At the time of the study, one practice had employed a nurse practitioner for two years, one had a nurse practitioner in training and one was discussing the employment of a nurse practitioner. The fourth had no plans to employ a nurse practitioner.

Confidentiality and anonymity of opinions was agreed at the outset, hence the names of participating practices are not given in this paper.

Analysis

The focus group interviews were audio-taped and transcribed to allow systematic analysis.\textsuperscript{19} The ‘framework’ method of qualitative data analysis was chosen to allow the information to be studied in a transparent and systematic way.\textsuperscript{20} The transcripts were studied repeatedly and themes identified. These themes were then coded and charted to identify the main issues arising as a barrier to developing nurse practitioners.

Content validity was ensured by the facilitator clarifying and summarizing views throughout the focus group interviews and obtaining agreement from participants.\textsuperscript{21} The transcript analysis was checked by two independent raters, allowing an assessment of inter-rater reliability. Measurement using Cohen’s kappa demonstrated a high degree of consistency between coders ($K = 0.921$; 95% CI 0.86–0.98). We believe our data are ‘generalizable’ within similar practices in the UK.\textsuperscript{22}

Results

We identified four main themes from our research. A commentary on the context of the views expressed is given where appropriate.

Threats to the doctor’s role

GPs from all practices were concerned about the consequences of a change to their consultation ‘mix’ due to nurses dealing with the “easy consultations”. A typical surgery might include a mix of straightforward and complex consultations. The need for ‘quickie’ consultations to accommodate those that are more complex and requiring additional time was regarded essential to ensure the smooth running of the surgery and to minimize stress.

“I think if we delegate all the nice physical medicine bits to nurses, even the bits that are interesting like diabetes and asthma, then we would be left with all the heartsinks.”

“. . . then we’d get really stressed.”

This fear had been realized in the practice that employed a nurse practitioner. They believed their workload had changed, but not decreased.

“We see all the difficult patients now . . . it has left me feeling more pressurized.”

Doctors with no experience of a nurse practitioner expressed concern about becoming deskilled. Parallels were drawn with present experience, where practice nurses performed activities previously carried out by doctors such as asthma and diabetic care.
To some the threat was more dramatic including loss of status and self-esteem.

“You know, it can be threatening, we’ve got all this training and was it all necessary? Why the hell am I going through all this training?”

“We might do ourselves out of a job.”

Are nurses up to the job?

There was concern that only doctors had the necessary training, skills and intellect to adequately assess patients and diagnose disease and a general lack of confidence expressed in the ability of nurses to take on the nurse practitioner role. Whilst this might be based on knowledge of traditional nurse ‘training’ one doctor had strongly held beliefs about the intelligence of many nurses.

“I have a problem in some cases with basic intelligence . . . There are some nurses not intelligent enough to do these advanced jobs.” (Isolated opinion)

There was widespread agreement that confidence could be developed through personal experience but only then would individuals feel comfortable about devolving responsibility.

“I think it’s more to do with (the doctor) carrying the can than anything else.”

“If you had an independent practitioner working in private practice I don’t think we’d be too bothered about what she was doing with her patients. But if you had an independent nurse that we’d contracted for, then we would be more concerned.”

The practice with experience of a nurse practitioner initially had had similar concerns but these fears were allayed as a result of working closely with her.

“We didn’t have complete confidence initially but very quickly developed that.”

GPs also raised concerns about overconfident nurses.

“It’s about appropriate confidence (with nurse practitioners). It isn’t just the title it’s the personality. If they’re prepared to bullshit instead of saying I don’t know. I think I’m more frightened of the over confident nurse than the under confident one.”

“Yes. You’re rather irritated by the under confident one but frightened definitely by the over confident ones.”

Amongst those GPs with no experience of working with the nurse practitioner, there was a belief that nurse training at present was generally inadequate for an advanced role.

“These nurses have not done nine years of apprenticeship. They are not trained to diagnose.”

“. . . there are so many things you have to know it still takes the same amount of training as we’ve done.”

“. . . in time there may be no distinction between doctors and nurses but I can’t see it happening with less training than now.”

Even doctors from the practice with the nurse practitioner expressed concerns about the training issue. They believed that whilst adequate training was available it was generally expensive and time consuming and without financial help from external sources was beyond the reach of many practices.

“One of the problems is training . . . (it) needs to be sorted out.”

“The Health Authority (in our case) paid for the training and her salary whilst that was happening. It’s an innovative thing so that paid for everything. From idea to actually her coming to work in the practice it took 4 years.”

Constraints in the system

Doctors in two of the focus groups thought that the inability of nurse practitioners to independently prescribe would be a barrier to patients seeing them. A consultation with a doctor was more efficient for the patient, because “. . . they get the complete package if they see us”.

However, doctors with experience of a nurse practitioner reported that patients did not appear to find this a problem, although arrangements had been made to ensure prescriptions were signed quickly at the end of the nurse consultation.

The financial structure of UK general practice was considered to be a major constraint on employing nurse practitioners. At present, most UK GPs directly employ their nursing staff, receiving a proportion of the costs from reimbursement. Nurse practitioners generally require a higher salary than their practice nurse colleagues and the additional expense would put significant pressure on the staff budget and may require a personal investment by the partners.

“If you give them more responsibility in their job then they will want to have an equal share in the practice organization . . . and there’s the financial issue. The doctors may not want to share out the dosh more equally.” (laughs)

“You are taking a reduction in pay because you have to pay the nurse to do the job.”

If the financial burden was borne by someone else however, this barrier could be overcome.

“It depends on the system. If you could get the state to pay for this without affecting GMS no problem at all. Then you’d say it’s a wonderful, absolutely wonderful thing.”
Patients want to see a doctor
Doctors strongly believed that for many reasons patients wanted to see doctors and would be resistant to seeing nurse practitioners. This was thought to be most likely with elderly patients who were used to the nurse acting on the instructions of the doctor rather than independently.

“Historically the nurses did what the doctors said. They did the bidding of the doctor. You know, you get sorted by the doctor but then he or she may ask the nurse to do something. I would say the elderly population would see that as the way it used to happen. Or still does.”

Patients consider the doctor as the appropriate person to make diagnoses, particularly when they perceived their condition to be serious.

“They (patients) are looking for a diagnosis when they go to a doctor believing that they are the people who diagnose.”

“If they (patients) think it could be something serious ... they miss out the nurse.”

Patients legitimize their illness by seeing a doctor, they may not by consulting a nurse practitioner. Indeed the ‘system’ perpetuates this belief, as it is only the doctor who has the authority to sign a sickness certificate to authorize absence from work.

“Some people benefit from the experience of coming to the surgery and seeing the doctor and are then more able to go back to their relatives after they’ve seen the doctor and . . . ”

“. . . and therefore I’m ill.”

“. . . and that carries more street-cred than seeing the nurse.”

It was acknowledged that many of these barriers are historical in nature and that the situation would change with experience. The following exchange illustrates this view.

“Twenty five years ago every patient would have come to see the doctor for changes in asthma medication.”

“. . . but now they know that nurses do modify treatment they go along to see the nurse rather than coming to see the doctor.”

“. . . yes, patients attending the diabetic clinic are becoming happier about seeing the diabetic nurse as opposed to the consultant and accept the change in treatment there. So patients here could see the diabetic nurse.”

“I am sure patients, even nine years ago, if the nurse was suggesting a change in treatment then they would not accept it, whereas now, they tend to accept that. I suppose they have had to.”

Patient education is also considered important.

“If patients know the problem can be sorted out by a nurse they can refer themselves appropriately.”

“I’m not sure that those patients who come the first time for a problem will always go to the nurse first. They would come to the doctor with their problem and it’s only when we say the nurse practitioner could have seen this, they know how to use them.”

Discussion
The information obtained is generalizable within the stated context—that is larger UK training practices. We consider it likely that barriers found amongst GPs in this context are likely to be prevalent amongst other GPs. Further qualitative work with non-training practices, smaller practices and amongst GPs without experience of nurse practitioners would be valuable to explore these ideas further.

We have identified a number of concerns held by GPs, which may impede the development of advanced nursing roles in general practice. These broadly fall into three categories. Those that threaten the GPs’ status including job and financial security, those concerned with the nurses’ capabilities including training and scope of responsibility and those concerned with structural and organizational barriers.

These views were held with remarkable consistency between the groups with no or little experience of the nurse practitioner. The practice with experience of working with a nurse practitioner as a team member admitted that they had initial concerns but considered the difficulties in employing her were more than outweighed by the positive contribution made to the practice.

Many of the concerns expressed by the other practices may arise from a lack of information about the education and training undertaken by nurse practitioners. GPs are familiar with teaching their nurses specific clinical tasks themselves. Most primary care nurse practitioner programmes require a practice-based preceptor who is available to work closely with the nurse in training. This builds on models familiar to GPs and should help to develop a greater understanding of the capability of the nurse.

Where nurses are trained in specific aspects of clinical care they have helped reduce cost and GP workload, whilst increasing patient satisfaction with care. Such studies show that nurses are capable of carrying out extended roles. However, our study exposed a reluctance to believe such evidence without also developing a personal confidence in the nurse in question. A recent study exploring these phenomena from the USA, concluded that personal experience with a primary care nurse
practitioner was associated with significantly more favourable attitudes compared to those without such experience.24

Such anxieties may also be linked to the lack of clarity with regard to the legal responsibilities of the GPs should a nurse practitioner employed by them make a mistake resulting in harm to the patient. This position may become irrelevant as PCGs become PCTs and nurses can be directly employed by the Trust who would assume legal responsibility under such circumstances. In the meantime the development of evidence-based guidelines, which may provide some legal protection for both the nurse practitioner and the GP, are urgently required.

In its recent review of nursing roles, the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) has chosen not to recognize the role or the title of ‘nurse practitioner’.25 This has obvious implications for regulation, and can only hamper the development of a recognized specific educational basis for nurse practitioner practice.

Whilst the GPs in our study were concerned that patients only reluctantly ask advice of a nurse, recent experience with NHS Direct suggests that patients are confident with the nurse as a first point of contact for many of their concerns.26 Williamson et al.27 explored the acceptability of an advanced nursing role in general practice and found a clear consensus between GP, patient and nurse practitioner on the appropriateness of nurse consultations. Nurse practitioners are able to carry out their responsibilities safely and effectively.28 The literature supports no evidence of poor patient satisfaction with nurse practitioner care but rather RCT evidence concludes the opposite.10

The rate of expansion of medical knowledge will require radical thinking about how knowledge and responsibility for different aspects of patient care are shared. The shift from secondary to primary care requires GPs to have new and more specialized skills. GP concerns about “doing ourselves out of a job” would appear therefore, to be somewhat misplaced. The challenge will be to ensure that the skill mix is appropriate. Nurse practitioners are unlikely to be simply concerned with encroaching on medical territory, but with identifying care gaps28 and providing a holistic service to patients.29

Conclusion

There are increasing pressures within primary care requiring a rethink of roles, responsibilities and skill mix. The use of suitably trained nurses to extend their sphere of responsibility may be an appropriate way to manage the demand without compromising quality or patient satisfaction.10,27 This study, however, has highlighted significant concerns by UK doctors where they lack experience of working with nurse practitioners, particularly in relation to cost, sphere of responsibility and employment structure.

Their widespread introduction into general practice would be a major departure from the traditional provision of primary health care in the UK and so, despite the supporting policy context, such a change is likely to proceed slowly. GP anxieties regarding the employment of nurse practitioners will be fuelled whilst the definition of the nurse practitioner’s role is unclear, the title is misused by those without specific training, and the UKCC fail to acknowledge the role.

How can such barriers be overcome? There is a need to disseminate the increasing evidence that nurse practitioners offer an appropriate solution to the difficulties doctors face in providing high quality services to their patient population, and to share personal experiences where GPs work successfully with nurse practitioners. Informal interpersonal networks, which characterize British general practice, provide an ideal medium to nurture such an interest and explore and resolve anxieties. US experience suggests that joint doctor and nurse practitioner networks can help to develop collaborative working.15 Similarly, joint educational events and the development of general practice based preceptorship, is likely to develop a greater understanding of the potential of nurse practitioners in primary care and increase confidence in their ability.

Health Authorities and PCG/Ts may also assist this process by minimizing the organizational and financial constraints involved in employing nurse practitioners by providing flexible employment arrangements, in much the same way that they have promoted and encouraged salaried doctors. We are yet to see how the new Workforce Confederations, who will be responsible for the training and education levies, might support training for nurse practitioners.

We believe our findings have exposed concerns that are likely to be held in similar general practice groups across the country and suggest that, before nurse practitioner roles can become widespread, these concerns need to be addressed. Indeed qualitative work amongst practice nurses may demonstrate equivalent concerns within the nursing profession. The exploration of professional attitudes towards the employment of nurse practitioners is an essential precursor to a debate about how barriers may be overcome, and about the appropriate skill mix and employment arrangements required to manage primary health care services in the future.

References


