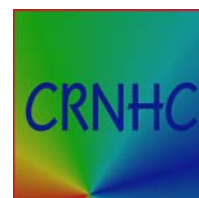

REPORT

Centre for Research into Nursing and Health Care



University of South Australia

Consumer Perceptions of Nursing and Nurses in General Practice

In collaboration with



Consumer Perspectives

and



Dept General Practice, Adelaide University

November 29 2002

Professor Julianne Cheek; Dr Kay Price; Ms Anna Dawson; Ms Kathy Mott; Professor Justin Beilby; Professor David Wilkinson

CONSUMER PERCEPTIONS OF NURSING AND NURSES IN GENERAL PRACTICE REPORT

RESEARCH TEAM

Professor Julianne Cheek	Director Centre for Research into Nursing & Health Care
Dr Kay Price	Assistant Director Centre for Research into Nursing & Health Care
Ms Anna Dawson	Project Manager Division of Health Sciences University of South Aust.
Ms Kathy Mott	Director Consumer Perspectives
Professor Justin Beilby	Head Department of General Practice, Adelaide University
Professor David Wilkinson	Pro Vice Chancellor Division of Health Sciences, University of South Aust.

CONSUMER WORKING GROUP

Mr Tony Wade	Chair CPPAC Consumer Representative
Ms Jan Donovan	Central Bayside Division of General Practice
Ms Margaret Brown	Health Consumers of Rural and Remote Australia
Dr Jenny Williams	Royal Australian College of General Practitioners
Ms Lynne Walker	Australian Practice Nurse Association

COMMONWEALTH DEPT HEALTH & AGEING

Ms Sarah Newsome

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- Carers Association of South Australia
- Chronic Disease Alliance
- McGregor Tan Research

Prepared for the General Practice Branch, Commonwealth Department of Health and Ageing as part of the Nursing in General Practice Initiative.

For further information regarding this project, please contact Dr Kay Price, Centre for Research into Nursing and Health Care, University of South Australia, City East Campus, North Terrace, Adelaide, South Australia, 5000. email: kay.price@unisa.edu.au

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Contents

Executive Summary	5
1. Introduction	9
2. Research design	11
2.1 Overview	11
2.2. The research plan	11
2.3 Methodological strategies	12
2.4 Data Collection	14
2.5 Data Analysis	16
2.6 Limitations	17
3. Participant Profile	19
3.1 Overview	19
3.2 Summary of participants	20
4. Findings	24
4.1 Introduction	24
4.2. Key concerns and misconceptions	25
4.3. Key variables and messages	40
4.4. Communication mechanisms	44
5. Discussion	46
References	50
<hr/>	
Appendices	
Appendix A: Analysis of Exposure Groups	52
Appendix B: Analysis of Elderly Groups	61
Appendix C: Analysis of Location Groups	71
Appendix D: Analysis of Usage Groups	77
Appendix E: Analysis of Carers Groups	82
Appendix F: Analysis of Chronic Diseases Groups	87
Appendix G: Consent form	92
Appendix H: Information sheet	93
Appendix I: Focus Group Questions	94

Tables and figures

Table 1 : Sampling Strategy	10
Table 2: Participants' Age (Exposure)	52
Table 3: Participants' Sex (Exposure)	52
Table 4: Participants' Usage of General Practice (Exposure)	52
Table 5: Presence of a Nurse at the Participant's General Practice (Exposure)	52
Table 6: Extent of Participants' Exposure (Exposure)	52
Table 7: Participants' Age (Usage)	61
Table 8: Participants' Sex (Usage)	61
Table 9: Participants' Usage of General Practice (Usage)	61
Table 10: Presence of a Nurse at the Participant's General Practice (Usage)	61
Table 11: Extent of Participants' Exposure to Receiving Services by a Nurse (Usage)	61
Table 12: Participants' Age (Location)	71
Table 13: Participants' Sex (Location)	71
Table 14: Participants' Usage of General Practice (Location)	71
Table 15: Presence of a Nurse at the Participant's General Practice (Location)	72
Table 16: Extent of Participants' Exposure to Receiving Services by a Nurse (Location)	72
Table 17: Participants' Age (Elderly)	77
Table 18: Participants' Sex (Elderly)	77
Table 19: Participants' Usage of General Practice (Elderly)	77
Table 20: Presence of a Nurse at the Participant's General Practice (Elderly)	77
Table 21: Extent of Participants' Exposure to Receiving Services by a Nurse (Elderly)	77
Table 22: Participants' Age (Carers)	82
Table 23: Participants' Sex (Carers)	82
Table 24: Participants' Usage of General Practice (Carers)	82
Table 25: Presence of a Nurse at the Participant's General Practice (Carers)	82
Table 26: Extent of Participants' Exposure to Receiving Services by a Nurse (Carers)	83
Table 27: Nature of Carer's role	83
Table 28: Participants' Age (Chronic Diseases)	87
Table 29: Participants' Sex (Chronic Diseases)	87
Table 30: Participants' Usage of General Practice (Chronic Diseases)	87
Table 31: Presence of a Nurse at the Participants' General Practice (Chronic Diseases)	87
Table 32: Extent of Participants' Exposure to Receiving Services by a Nurse (Chronic Diseases)	88
Figure 1 : Participant age	20
Figure 2 : Participant sex	21
Figure 3: Participant usage of General Practice	21
Figure 4: Extent of participant exposure	22
Figure 5: Language spoken at home	22
Figure 6: Participant birth country	23

Executive Summary

This study has been undertaken to provide to *The National Steering Committee on Nursing in General Practice* consumer perceptions of nursing and nurses in general practice. The report identifies key concerns and misconceptions held by consumers. Messages likely to influence consumers and communication mechanisms consumers would prefer to inform them about nurses and nursing in general practice are elaborated. The research was implemented and is reported in a manner that is premised on consumers as a key partner in the general practice partnership. Consumer perceptions are presented with due respect for their views, privacy, anonymity and confidentiality.

Perceptions of consumers were explored during 20 focus group discussions conducted across Australia. The research was given ethical approval by the Human Research Ethics Committee, University of South Australia and was conducted in September, October and November 2002. Focus groups were specifically constructed to incorporate the perceptions of consumers who were included in groups recruited around the dimensions of usage of a general practice; exposure consumers had had to general practice that had a nurse present; and the location of the consumer. Participants ranged from those who had received a service by a nurse in general practice to those who had not, those who attended a general practice many times annually to those who attended only a few times in a year or not at all. In addition there were specific focus groups with consumers who were carers, elderly (75 years plus), or who identified that they had a chronic disease. Findings provide insights about consumer perceptions towards receiving services from a nurse working in a general practice particularly in relation to quality of care, access to services, scope of practice matters and level of awareness of consumers to the existing and potential role of nurses and nursing in general practice.

In exploring the perceptions of consumers, the research findings identify that they have a lack of awareness and understanding about the scope (both actual and potential) of nursing in general practice. Key messages that have emerged from discussions with a wide variety of consumers are that while consumers' perceptions were framed by personal experiences, consumer learning about the scope of nursing increases with more exposure to services by a nurse. Familiarity of consumers with a specific geographic location does not necessarily inform them about available services. The general practitioner is a key broker in bringing about the necessary changes in how consumers receive services by a nurse, the nature and scope of those services and how consumers are informed.

Consumers who had had limited exposure to nurses had limited understanding of the range of possibilities of roles for nurses and relayed experiences based on

exposure to nurses within a hospital setting. The greater the participant's exposure to receiving services by a nurse in general practice, or where a consumer was a parent, carer or person living with a chronic illness, the more likely that they were to describe or to suggest roles for nurses other than routine tasks such as administering an injection or measuring vital signs. Examples of roles described that went beyond tasks included developing care plans, providing education and support, prescribing continuing medication, conducting pap smears, specific treatments and relaying test results. Regardless of the experience of receiving a service by a nurse, participants were generally positive about nurses working in general practices. Many participants considered that the creation of roles for nurses in general practices could have an impact (positive and negative) on the current nursing shortage. Concern was also expressed that the role may influence insurance and litigation matters for the general practitioner as well as the nurse. There was strong suggestion that creating roles for nurses may make the general practitioner more accessible to consumers.

Participants were also clear about what they did not want nurses to do. In particular almost universal concern was articulated around nurses undertaking a diagnostic role. The role of nurses from the perspective of consumers *must not* be as a substitution for doctors, *must not* take away the right of consumer choice, and *must not* result in an increase in cost to consumers. Another concern raised by participants was around nurses acting as gatekeepers to general practitioners. It did not matter what order the consumer saw the nurse and doctor (i.e. doctor first and then nurse or vice versa), the issue was that consumers wanted to be able to see the doctor if they wanted to.

While consumers acknowledged they would accept nurses working in general practices the main driver for consumers as to who did what in a general practice, was underpinned by the trust they had in general practitioners to employ suitable and competent persons to do the role required. While responses varied as to which level of nurse the consumer would prefer working in general practice, responses did highlight the lack of knowledge of consumers regarding different qualifications and roles of nurses. At the same time, however, opinions highlighted the trust consumers have in nurses to act within their level of competence. Added to this, participants indicated trust that nurses and doctors function within a Code of Ethics (interestingly they often thought it was the same code of ethics) and that they would maintain confidentiality and respect the privacy of consumers. Participants also expressed the need for doctors and nurses to show that they can work together. This was not to say that they should not have conflicting views about the consumer's health and well being rather such competing views should be resolved professionally and privately and with the good of the consumer paramount.

Consumers consider it important for nurses and general practitioners to present a united front and respect for each other's contribution when providing a service to a consumer or informing the public about any joint health initiative. Consumers generally expressed concern that this united front had not necessarily been evident to date in the public sphere. In light of this view and given the trust consumers placed in their general practitioner to employ appropriate personnel, it was not surprising that consumers considered the most appropriate mechanism to inform

them of any new developments in the general practice they attended was through the general practitioner her/himself. Peer endorsement also emerged as a powerful strategy to lead to acceptance of, and to reap benefits from, the introduction of nurses and nursing into general practices.

Recommendation 1

That the National Steering Committee accepts this report titled: *Consumer Perceptions of Nursing and Nurses in General Practice*, acknowledging that the report identifies key concerns and misconceptions of consumers, identifies key variables and messages likely to positively and negatively affect consumers, and identifies a range of generic and specific mechanisms consumers would prefer to inform them about nursing in general practice.

Recommendation 2

In planning strategies that will encourage better communication to consumers about nursing and nurses in general practice, the National Steering Committee are made aware that consumers consider:

- ❑ The general practitioner plays a key role in brokering change at the local practice level.
- ❑ It is a positive strategy having nurses work in general practice.
- ❑ It is important to consumers for nurses and doctors to present a united front to them while receiving a service.
- ❑ The consumer would be more influenced by strategies implemented at the local practice level. These strategies may include among other things:
 1. Personal introduction of nurse by general practitioner
 2. Direct mail out to local consumers by the general practitioner
 3. Practice newsletters
 4. Brochures and posters for local practice settings
 5. Use of signage at general practices (internal and external)
 6. Use of name badges with titles
- ❑ They would like to know more details about nurses' qualifications and the position description of the nurse vis-à-vis the role of the general practitioner, including the role and responsibilities of a nurse.

Recommendation 3

In the production of materials to better inform consumers, it is important that the National Steering Committee address how best to access those consumers:

- ❑ Who are located in remote settings.
- ❑ Who are irregular and/or low users of general practice services.

Strategies may include among other things:

1. Use of programs for popular and multilingual talk back radio.
2. Use of electronic forms of communication.

Recommendation 4

In acknowledging that some consumers understand the term ‘practice nurse’ to infer a person learning how to nurse, it is recommended that the National Steering Committee give consideration to change from referring to nurses in general practice as ‘practice nurses’. In so doing, this strategy will remove any doubt by a consumer that the nurse is ‘in training’.

Recommendation 5

To address consumers’ need for nurses and doctors to present a united front, consumers’ perceptions indicate that an effective strategy may include among other things:

- ❑ Promoting a peer endorsement strategy to be put in place by general practitioners and nurses to make obvious the valuing and respect for the nursing and medical role at the local practice level.

1. Introduction

Informing and providing support for people who shape the structures and decisions that affect how general practice, as a system of care works, must involve all the key partners. The *Consumers Perceptions of Nursing and Nurses in General Practice* project is part of the partnership building process being put into place by ***The National Steering Committee on Nursing in General Practice*** as changes to the way in which general practice services are delivered in Australia evolves. This iterative and multiple layered exploratory research project makes visible the perceptions of consumers about nursing and nurses in general practice specifically in relation to:

- ❑ Key concerns and misconceptions regarding quality of care, access to general practice and other health services, scope of practice and level of consumer awareness.
- ❑ The key variables and messages that may positively or negatively affect their expectations, experiences and attitudes about nurses in general practice.
- ❑ The range of communication mechanisms they would prefer to inform them; both generic mechanisms and mechanisms specific to individual practices.

The research team for this project was:

Professor Julianne Cheek

Director, Centre for Research into Nursing and Health Care, Dean Graduate Studies, University of South Australia

Dr. Kay Price

Assistant Director, Centre for Research into Nursing and Health Care, Senior Lecturer School of Nursing and Midwifery, University of South Australia

Ms. Anna Dawson

Project Manager, Division of Health Sciences, University of South Australia

Ms. Kathy Mott

Director, Consumer Perspectives

Professor Justin Beilby

Head, Department of General Practice, Adelaide University

Professor David Wilkinson

Pro Vice Chancellor, Division of Health Sciences, University of South Australia

To facilitate the management of this project, the research team worked in collaboration with the *Consumer Working Group*, a sub-group of the national committee, and in particular with Ms. Sarah Newsome, from the Department of Health and Ageing, who provided advisory support. Members of the *Consumer Working Group* were:

Mr. Tony Wade (Chair) GPPAC Consumer Representative

Ms. Jan Donovan Central Bayside Division of General Practice

Ms. Margaret Brown Health Consumers of Rural and remote Australia

Dr. Jenny Williams Royal Australian College of General Practitioners

Ms. Lynne Walker Australian Practice Nurse Association

In the context of this project, the terms nursing and nurses are considered to be different. The point is made that this distinction is important to elaborate, as this project evolved with the understanding that the role of nurses in general practice is different to the role of nursing in general practice. This project was based on an understanding of nursing as the product of nurses' actions that were in turn based on an individual's specific education, knowledge and skills. While consumers articulated their perceptions of specific skills that nurses could/did perform in a general practice, this did not infer that consumers were able to elaborate the role of nursing in general practice. Participants acknowledged a lack of understanding as to what nursing was and what students of nursing were exposed to during their education. Further, the term practice nurse raised many different perceptions for consumers with some perceptions revealing practice nurse to mean a student or a nurse with limited experience. Given this perception, the term nurses in general practice utilised in this report, maintains consistency with publications of professional nursing organisations (see for example Australian Nursing Federation).

The Department of Health and Ageing sought from the research team a qualitative approach to the research. As Denzin and Lincoln state¹:

Qualitative research means different things ... Nonetheless, an initial, generic definition can be offered: Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of meanings people bring to them. (p.3)

This research located members of the research team as facilitators of focus group discussions with consumers in their everyday world to identify and make sense of how consumers give meaning to nursing and the role of nurses in general practice so as to inform future developments. This approach fits well with views of consumer organizations. As part of the national and international consumer movement, there has been increasing recognition of the need to involve consumers in research and as consumer organizations have highlighted²:

Consumers' research is not market research or just research into consumers' views. Rather, it provides a way of ensuring close links between research priorities and consumers' knowledge. (p.2)

The recommendations forwarded in this report provide to the **National Steering Committee** possibilities of ensuring closer links between policy initiatives and consumer knowledge.

¹ Denzin NK and Lincoln YS, 2000, Introduction: The Discipline and Practice of Qualitative Research IN: Norman K Denzin and Yvonna S Lincoln Eds. Handbook of Qualitative Research 2nd edition, Chapter 1, Thousand Oaks, California; Sage Publications Inc.

² Consumers' health forum, 2001, A Guide for consumers doing health research, CHF Ref:269, ISBN: 1 876034 35 1

2. Research Design

2.1 Overview

This iterative and multi-layered exploratory research project brings forward for analysis, the perceptions of consumers about nurses and nursing in general practice collated from focus group discussions across Australia. A consumer in this project refers to an individual who may be a direct user of a general practice, or a potential user, and not only to those who receive a service but also to those who need this service. The research was given ethical approval by the Human Research Ethics Committee, University of South Australia and was conducted in September, October and November 2002.

The process of consumer data collection and analysis by the research team was informed by an ongoing critical literature reflection, and conducted alongside the deliberations of the *Consumer Working Group*. This iterative approach of considering and including a range of stakeholder perspectives, provided the means by which the researchers can inform *The National Steering Committee on Nursing in General Practice* how to manoeuvre through the complex issues that surround the focus of this project – nurses and nursing in general practice.

2.2 The research plan

To strengthen this project's design in bringing forward the diversity and depth of the consumer perspective, the research team employed the technique of triangulation (see Patton³). In this study three means of triangulation were employed, namely,

- Data (drawing on a variety of data sources including perceptions from a variety of consumers, and the perceptions of members of the *Consumer Working Group*),
- Investigators (the use of different researchers with expertise in qualitative research, consumer-driven research and understanding of multidisciplinary professional issues), and
- Methodological approach (the use of multiple qualitative analytical methods).

³ Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods*. Newbury Park, California, Sage Publications Inc.

As is recommended by the *National Resource Centre for Consumer Participation in Health*⁴, and acknowledged as being appropriate by various groups^{5 6}, focus group discussions were conducted to enable consumers to elaborate their expectations, experiences, key concerns and misconceptions, successes, solutions and other elements of perceptions of nursing and nurses in general practice. The 20 focus groups of consumers were assembled with the assistance of specific members and networks of the research team (Carers Association of South Australia Inc. and the Chronic Illness Alliance), and a subcontracted recruitment agency with oversight from the Project Manager.

The research team collated participant profiles (see Chapter 3) which did not contain personal details or personal health information of participants (other than health information voluntarily offered by the chronic disease group participants). The subcontracted recruitment agency complied with the *Privacy Act 1988*; written consent of all participants was obtained and a copy of the Information Sheet (see Appendix G & H) was provided to, and discussed with, all participants prior to the conduct of the focus group.

2.3 Methodological strategies

As is accepted practice in qualitative research, the sampling methodology was purposive in that the aim was to provide a rich source of data about the phenomena of concern⁷. The basis of purposeful selection is “selecting *information-rich* cases for study in depth” where information-rich cases are “those from which one can learn a great deal about issues central to the purpose of the research” – hence the term purposeful selection⁸. While everyone is recognised as being a consumer of health services from time to time, the focus of attention for this project was with consumers whose primary experience of general practice services was as a receiver rather than as a provider.

The purposeful sample for this study was selected from six (6) states namely; Australian Capital Territory, Queensland, Northern Territory, New South Wales, Victoria and South Australia (refer Table 1). A range of recruitment methods were employed in this qualitative research in order to rapidly assemble a representative and comprehensive participant profile. These included:

⁴ National Resource Centre for Consumer Participation in Health *Fact Sheet No. 2 Methods of consumer participation*, <http://nrccph.latrobe.edu.au> accessed 9th May 2002

⁵ Draper, M 1997, *Involving consumers in improving hospital care: lessons from Australian hospitals*, Health Services Outcomes Branch, Commonwealth of Australia, Publications Production Unit.

⁶ NSW Health Department, 2001, *Partners in Health – Sharing information and making decisions together. Report of the Consumer and Community Participation Implementation Group*, NSW Government Action Plan, Sydney, Better Health Centre – Publications Warehouse.


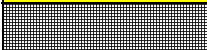





⁷ Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods*. Newbury Park, California, Sage Publications Inc.

- ❑ utilising market research recruitment agencies (using purposive sampling in particular locations as advised by the Department of Health and Ageing in order to recruit specific consumer categories)
- ❑ utilising contacts and networks of the investigators (to bring together specific consumer groups – e.g. Carers Association of South Australia, Chronic Illness Alliance)

Table 1: Sampling Strategy

SAMPLING STRATEGY and RRMA category ⁸							
CATEGORY OF VARIABLE	TYPE OF GROUP	SA	ACT	QLD	NT	NSW	VIC
EXPOSURE (E1 -E3)	E1		Canberra		Alice Springs		
	E2	Kadina		Buderim			
	E3					Maitland	Brighton
USAGE (U1 - U3)	U1				Alice Springs		Daylesford
	U2		Canberra			Katoomba	
	U3			Brisbane			Ballarat
LOCATION (mix of U1-U3 and E1-E3)	Other remote	Leigh Creek					
	Metro					Manly	
	Small rural			Buderim			
	Large rural			Toowoomba			
CARERS	1	Adelaide					
	2	Adelaide					
ELDERLY		Adelaide					
CHRONIC DISEASE							Brighton

⁸ Australian Institute of Health and Welfare (AIHW) 1998. Health in Rural and Remote Australia: The first report of the Australian Institute of Health and Welfare on rural health. AIHW Cat. No. PHE-6. Canberra: AIHW.

Colour Reference	RRMA Category	Number of focus groups
	Capital Cities	10
	Other Metropolitan centres	1
	Large Rural centres	2
	Small Rural Centres	2
	Other Rural Areas	2
	Remote Centres	2
	Other Remote areas	1

Category	Descriptor
Exposure	Participants' experiences of a service by a nurse
E1	Consumers who have not had an experience of a service by a nurse in general practice
E2	Consumers who have had experiences in the last two years
E3	Consumers who have had experience for greater than two years
Usage	The extent to which a consumer attends a general practice each year
U1	0 – 5 times per year
U2	5 – 10 times per year
U3	10+ times per year
Location	Consumers' place of residence
Other remote	According to classification in the AIHW publication
Metro	According to classification in the AIHW publication
Small rural	According to classification in the AIHW publication
Large rural	According to classification in the AIHW publication
Carers	Carers of elderly person
	Carers of young person
Elderly	Consumers greater than 75 years +
Chronic Disease	Consumers who self-identified that they had a chronic disease

In all of the focus groups there were only two consumers who were themselves nurses and when this was identified to the group, the facilitator reminded these participants to approach the discussion from the view point of a receiver rather than a provider of services.

2.4 Data Collection

Focus Group Discussion Schedule

Focus groups of between 75 – 90 minutes in duration were conducted with refreshments available for participants. The format of the discussion generally followed the same flow but was dependent upon the nature of the focus group members. On arrival of a participant, the facilitator and assistant introduced themselves and requested that participants read the Information Sheet and sign the Consent Form if agreeing to participate. Participants were offered refreshments and an introduction to the research followed when all participants had arrived and written consent had been obtained. Following introductions,

hospitality arrangements, re-affirming confidentiality and consent for taping of sessions the facilitator reviewed the purpose of the focus group introducing the research as being funded by the Department of Health and Ageing. The assistant took notes of the session.

At each focus group, participants were reminded that there were no right and wrong answers to any question and that it would be expected that there may be varying experiences and opinion amongst participants. Participants were informed that one of the roles of the facilitator would not be to interrupt discussion unless the focus of the discussion shifted to a topic that was not appropriate. Facilitators would for example make comments like:

We have to keep our focus tonight which is in a general practice, where you go to see your doctor.

No not specialist clinics like a cardiac specialist or something. We are talking about your local GP.

Participants were assured of anonymity and that there was no requirement on any of their parts to inform the group of any personal health details. The facilitator would refer the participant to the Information Sheet identifying the issues that would be addressed under the headings; quality of care, access to services and scope of practice. Appendix I contains the question format utilised by the facilitators.

At times it was necessary for the facilitator to ask probing questions, so as to explore the focus of interest. To encourage discussion, the facilitator built on previous remarks by a participant and ensured that participants took the opportunity to elaborate their perceptions. In bringing the focus group discussion to a close, the facilitator recapped points made and sought feedback from the participants about these points. Participants were invited to make any comment and were sincerely thanked for their involvement and informed about the way in which their commentary will inform the report that will be prepared for the Commonwealth.

Workshop with Stakeholders

Mindful of the necessity of incorporating the full spectrum of stakeholder perspectives including consumer perceptions, the research team conducted a workshop with the *Consumer Working Group* and Department representatives, to explore and discuss the Draft Final Report. This workshop provided an opportunity to engage with all interested groups and policy makers to ensure that all points of view had been considered in the final report presentation. The input of the *Consumer Working Group* enriched the recommendations that evolved from the analysis of the research findings by bringing together the perceptions of nursing, general practitioner and consumer organisations. Where required, amendments were made to the report prior to submitting to the ***National Steering Committee on Nursing in General Practice***.

2.5 Data Analysis

As has been highlighted, focus groups are an appropriate method of data collection in this type of research. Focus groups were conducted with participants purposefully selected. The focus groups were audiotaped with the consent of participants and transcribed for analysis. The analysis, broadly following Ekman and Segesten⁹ involved:

- ❑ Each transcript was studied; transcripts by group-by-group, by sampling of groups, and whole of data collated were studied to give a sense of the whole;
- ❑ Themes and categories were identified group-by-group, by sampling of groups, and whole of data collated;
- ❑ Recurrent patterns were identified group-by-group, by sampling of groups, and whole of data collated; and
- ❑ Summative themes and research findings were developed.

The method of data analysis is described below.

Level one: Descriptive Analysis

In this stage (which occurred alongside all other data collection stages) the corpus of material was read in order to describe consumer perceptions, and the different types of presentations and/or ways in which a participant speaks about nurses and nursing in general practice. On an ongoing basis the researchers carefully read all data collected to elicit patterns of meaning, contradictions and inconsistencies. Contrasting ways of thinking and exceptions to patterned routines, that include contradictory descriptions, were examined. This is in keeping with Norman, Redfern et al.¹⁰ who point out that the “formulation of the categories is done inductively by sorting the incidents [issues] into clusters that seem to group together” (p. 594). Data was initially clustered under:

- ❑ Experiences of consumers
- ❑ Identification of nurses
- ❑ Roles/scope – currently, possibility, and what it shouldn’t be
- ❑ Qualifications of nurses
- ❑ Relationship between doctor and nurse
- ❑ Clinic process
- ❑ Confidentiality and privacy

⁹ Ekman, I. and K. Segesten (1995). “Disputed power of medical control: the hidden message in the ritual of oral shift reports.” *Journal of Advanced Nursing* **22**: 1006-1011.

¹⁰ Norman, I., S. Redfern, et al. (1992). “Developing Flanagan's critical incident technique to elicit indicators of high and low quality nursing care from patients and their nurses.” *Journal of Advanced Nursing* **17**: 590-600.

- ❑ Costs
- ❑ Messages and communication mechanisms
- ❑ Other

Level two: Thematic Analysis

This stage drew on the first stage analysis to generate a table of themes. Thematic analysis of data collected contributed significantly to build a comprehensive picture of consumer perceptions in relation to the objectives of the project. The themes informed the critical analysis and the development of recommendations arising from this project.

Level three: Critical Analysis

In addition to analysing data collected the researchers have worked with the *Consumer Working Group* and together have embarked on a process of critical reflection. Reflection enables members to stand back from what has been written, and to review emerging findings in light of what they have learnt and how their views may have changed.

2.6 Limitations

Many of the sensitivities that surround this project have been elaborated and discussed in the documents: *Consumers' Expectations of General Practice in Australia* (April 1999) and *Partnerships in General Practice: A Discussion Paper* (June 1999). Some specific and sensitivity issues relating to the project included:

The role of nurses in general practices has been varied and this research has highlighted that there are circumstances where some persons undertaking assisting roles for the general practitioner have been thought by consumers to be nurses but consumers had no evidence to support the assumption that they were a nurse. In the initial proposal to the Commonwealth, the research team also highlighted that there would be some general practices where the role of a nurse has also been limited, for a variety of reasons, to attending to wounds, taking blood and generally working under the direction of the general practitioner. As has been explored and demonstrated in this report, the experience of nurses working as inter-professional practitioners, performing health assessments, directing care services and coordinating case conferences etcetera, is not yet at levels in the community where the experience can be explored with consumers. Therefore, perceptions were in the main explored from what is expected or hoped for; and currently held views about the role of nurses and nursing, and indeed the role of a general practitioner.

Further, while the focus groups were designed to include persons with similar exposure and usage of general practice services, and as well the location of this practice, it became evident during focus group discussions and from information collated about participants that there were a few occasions when the intended

design of a focus group contained one or two consumers who had exposure to the services of a nurse and a consumer who thought they had but had not.

Issues associated with the recruitment of participants to focus groups were generally overcome by the way in which participants were approached by the researchers or the sub-contracted recruitment agency. There were situations reported to research team members of people being suspicious about the invitation to attend a focus group. It was understood that focus groups for research are not in every person's experience and an invitation to attend a focus group with people you do not know, with limited understanding of what may happen, may well be treated with suspicion or fear.

In undertaking this research, there was acknowledgement that care must be taken to ensure participants have minimal barriers to their involvement in the groups. Participants did receive a reimbursement for their participation and venues for the focus groups were located to be accessible for people particularly those with mobility impairments.

The *Consumer Working Group* and the research team agreed that different strategies were needed to ensure the perceptions of people from certain cultural backgrounds were heard. In understanding that working within their own community networks is a more effective strategy than utilising interpreters, the decision was made, like that of the specific investigation of the Indigenous consumer perspective, to be outside of the scope of this particular study.

However, whilst persons from different cultural backgrounds and Indigenous participants were not targeted specifically, they were most certainly welcomed to participate in this research. Random selection did result in that occurrence.

The need to complete the project within a short time frame meant that decisions had to be made regarding what could realistically be achieved in order to provide useful information to assist the deliberations of the *National Steering Committee into Nursing in General Practice*. Rather than conduct wide consultations with large numbers of consumers and consumer organisations, the focus was upon gaining a broad overview of consumer perceptions from specifically identified groups so as to capture the diversity of perceptions.

3. Participant Profile

3.1 Overview

Individual focus group participants were asked general demographic questions and specific questions that were collated into a participant profile. Data collated enabled consumers to be allocated to a specific focus group as questions related to the extent of their exposure to receiving a service by a nurse, the frequency of attendance to a general practice and the location of residence. While the focus groups were designed to include persons with similar exposure and usage of general practice services and as well the location of this practice, the collection of the above information enabled a check of information collated about participants. The responsibility to collect profile information of participants was undertaken at the time of recruitment either by the subcontracted recruitment agency or the research team. To provide a detailed overview for the Department of Health and Ageing of those consumers who were participants, data collected has been assembled in the figures that follow.

3.2 Summary of all participants (Usage, Exposure, Location and Special Interest groups)

Figure 1 Participant Age

Participant Age								
Age range	18-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
Number of participants	14	23	25	40	28	17	20	3

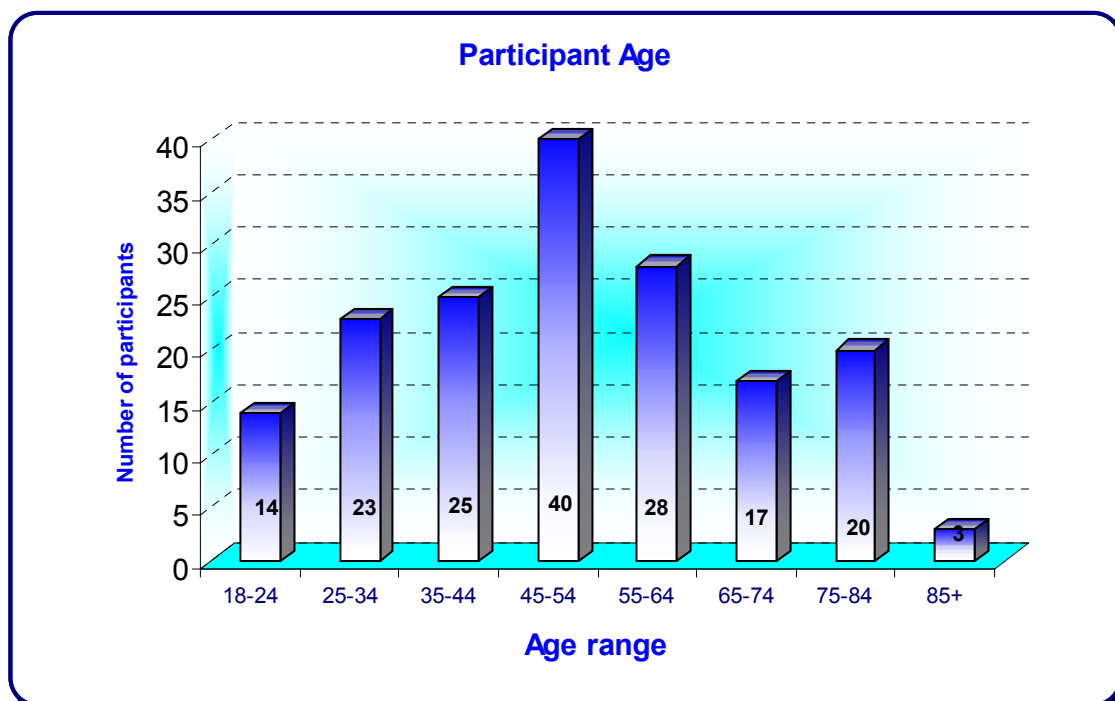


Figure 2 Participant Sex

Participant Sex		
	female	male
Number of participants	103	67

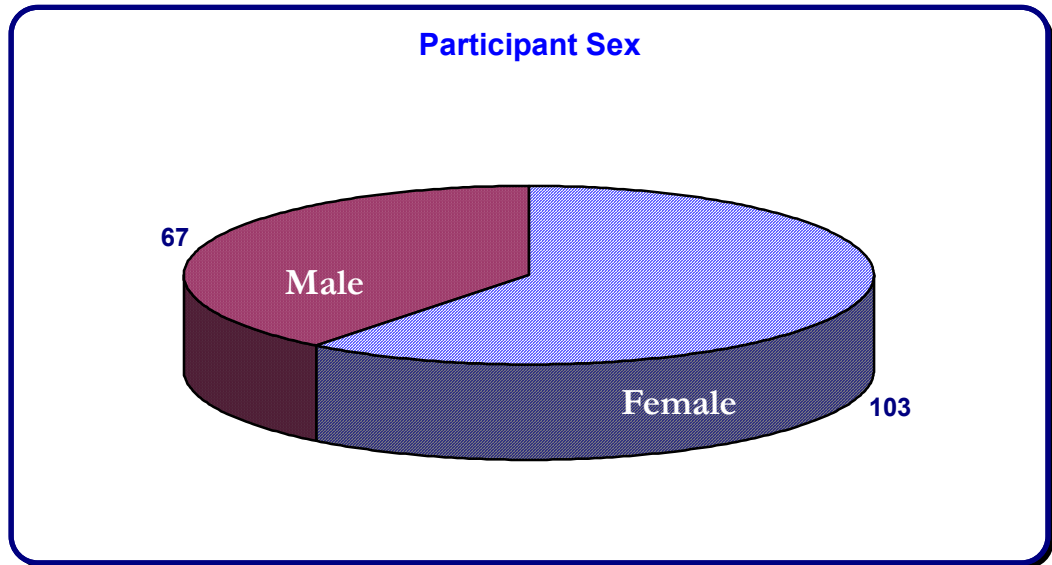


Figure 3 Participant Usage of General Practice

Participant Usage of General Practice			
Number of visit per year	U1 (0 - 5)	U2 (5 to 10)	U3 (10+)
Number of participants	73	45	52

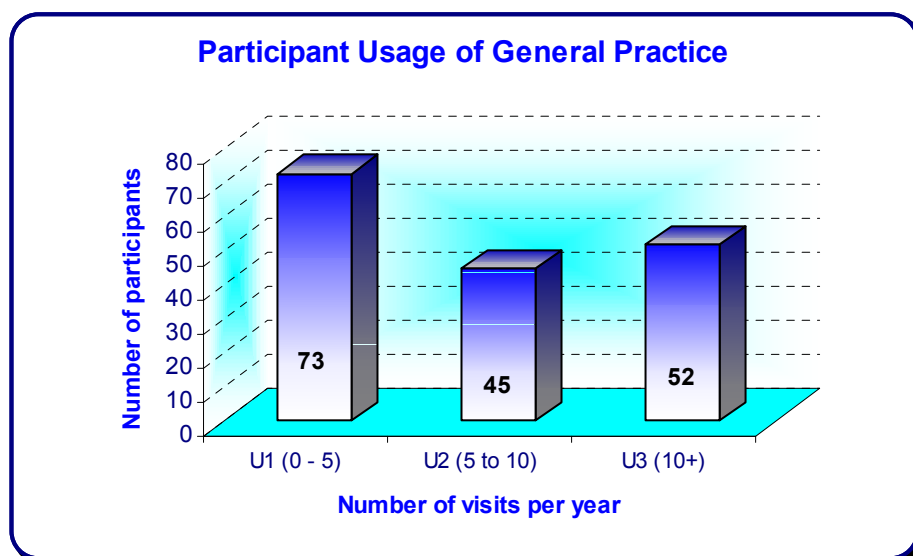


Figure 4 Extent of Participant Exposure

Extent of Participant Exposure						
Period of exposure	E1 (none)	E2 (post Jan '02)	E2 (>1 yr, < 2 yrs)	E3 (> 2 yrs)	> 4 years ago	No response
Number of participants	97	20	22	23	5	2

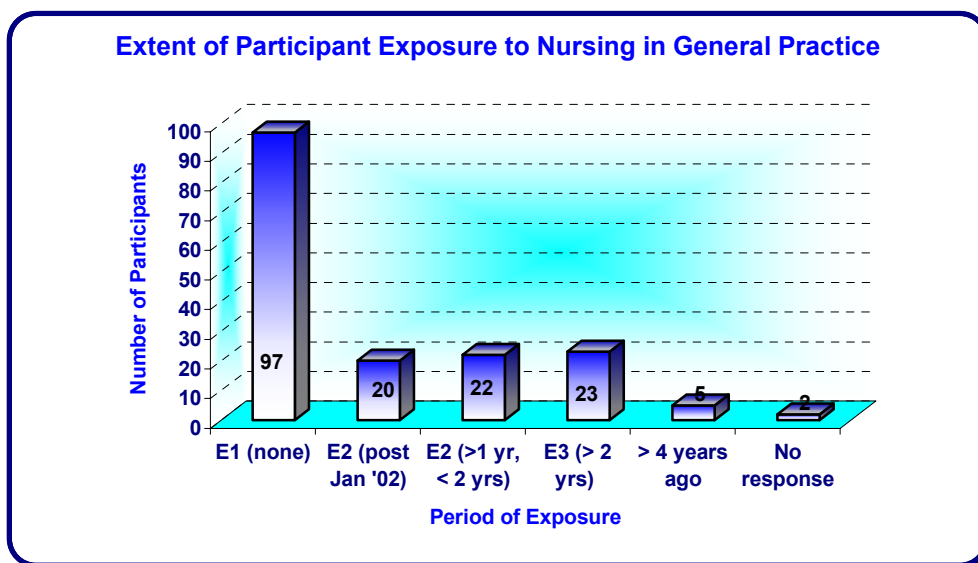


Figure 5 Language Spoken at home

Language Spoken At Home			
Language spoken	English	Other	No response
Number of participants	155	8	7

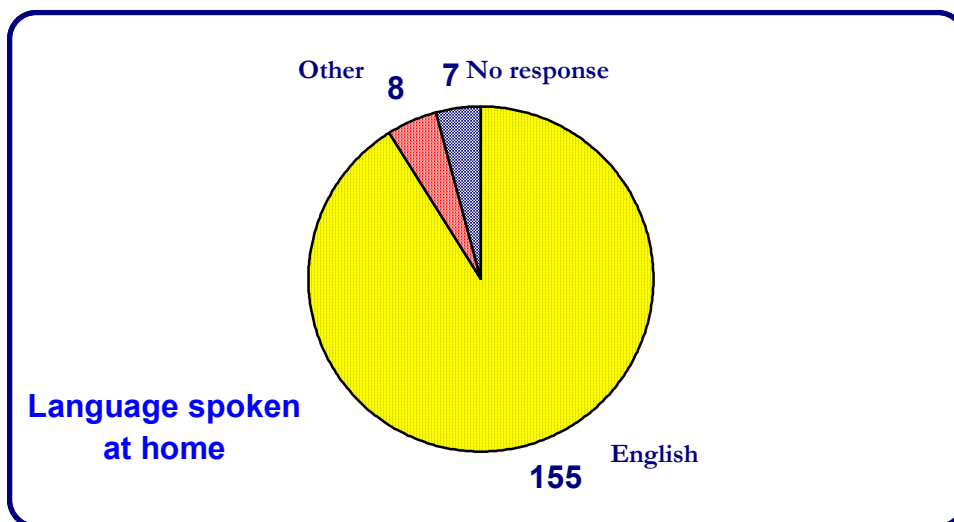
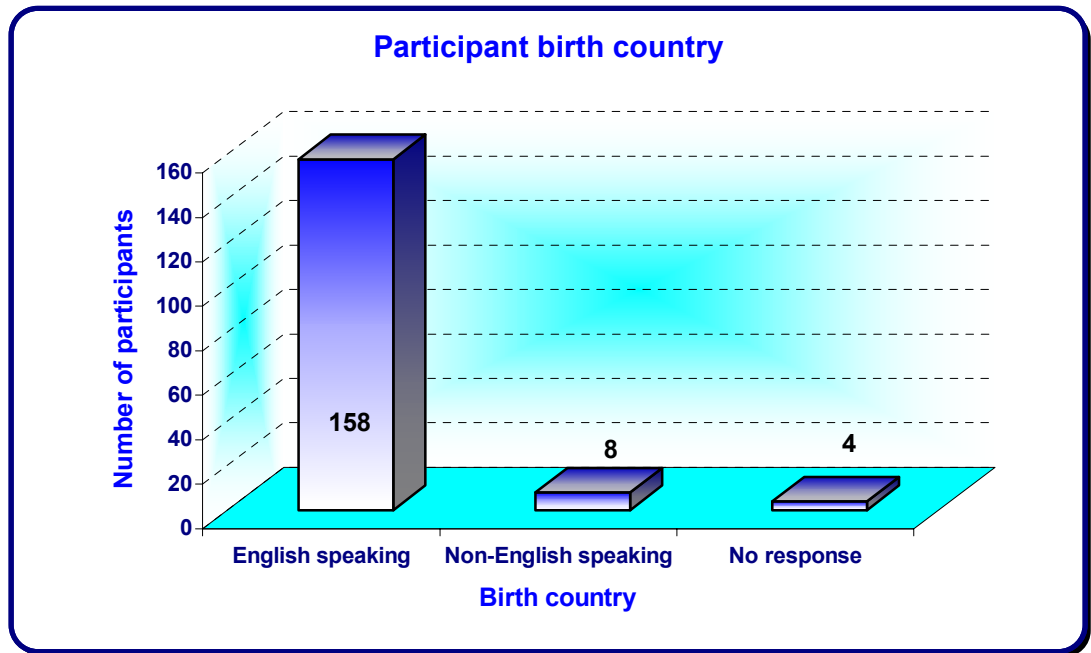


Figure 6 Participant Birth Country

Participant Birth Country			
Birth Country	English speaking	Non-English speaking	No response
Number of participants	158	8	4



4. Findings

4.1 Introduction

In this chapter, overall findings from all focus groups are presented highlighting specific issues that may have pertained to one category of group (e.g. exposure, usage, location and special interest groups) rather than all groups. Readers are directed to the appendices to review the specific findings of the various categories (exposure, usage, location and special interest groups).

Recurring messages/themes identified from the research are outlined below under each of the objectives that the *National Steering Committee* has required the research team to address. These objectives were:

1. Explore the initial perceptions of nursing in general practice to identify key concerns and misconceptions, particularly regarding quality of care; access to general practice and other health services; scope of practice; and level of consumer awareness.
2. Identify the key variables and messages that will be likely to positively and negatively affect consumer expectations, experience and attitudes to nursing in general practice.
3. Identify and prioritise the range of communication mechanisms consumers would prefer to be used to inform them about nursing in general practice to inform future resource development. This may include both generic mechanism and mechanisms specific to individual practices.

Within the topics of quality of care, access to general services and scope of practice, the *Consumer Working Group* had identified a number of issues associated with consumer perceptions of nursing in general practice and requested of the researchers to ascertain consumer knowledge and expectations regarding:

- awareness to a nurse employed in general practice and services offered,
- nursing role and the different roles of nurses,
- nurses' qualifications and the speciality areas they practice,
- nurses' skills and the areas they have experience in,
- relative role of the doctor and nurse in diagnosis,
- relationship between doctor and nurse and their relative roles,
- clinic process,
- nursing role in assessment and 'triage',
- communication and interpretation of test results and diagnosis,

- ❑ nursing role in referral to other services,
- ❑ confidentiality and privacy issues,
- ❑ availability of nurses,
- ❑ flexibility of the practice to consumer choice,
- ❑ distinction between nursing roles in primary care,
- ❑ potential changes to cost structures of the practice,
- ❑ cost to the consumer to access the nurse and doctor.

These topics form the framework for the presentation of findings that follow.

4.2 Key concerns and misconceptions

Concerns and misconceptions of consumers were framed by their personal experiences and throughout the focus group discussions, consumers often needed to be oriented back to focus on the general practice setting rather than on the hospital setting or visiting a specialist. Unless the consumer was a parent, carer or a person living with a chronic illness, those with little or no experience of nurses in general practice found it difficult to think outside their personal experiences to consider new models of care, to consider gaps in services and new roles for nurses.

Awareness of nurse employed in the general practice and the services offered

Consumers willingly and easily identified injections, wound care, dressings, taking measurements (BP, weight, etc), taking bloods, first aid, counselling/support role as roles a nurse undertook in general practice. A lesser number of consumers raised that nurses could provide education. A grey area where consumers had diverging views was the role of nurses in education, providing test results, and health monitoring (note that they did not see the doctor's role in health monitoring either – only for treatment of illness). Carers raised different perspectives to other consumers.

No-one worries about the health of the carer, it would be nice if there was some sort of appointment for the carer to have a wellness check with the nurse. Everybody in general. Some problems can be solved before they get worse. It would be nice to know where your health is at in general. Looking at the family in a holistic way. Being a carer and stressed, some things may be missed that could take a lot of stress off carers. (Carer of younger person)

I was unwell and I had to go to see the doctor but had to take my husband with me, because he could wander off if he wasn't with me, and get panicky and

confused. It would have been great other than the receptionist to have somebody there to watch him so that I could go and see the doctor privately because I have no one else to help me look after him. You need help in those situations. (Carer of Older person)

Consumers had less understanding of the nurse's role in making referrals to other services and providing test results. Consumers did not want nurses to have a role in diagnosis of life threatening or serious conditions. Some consumers were happy to see a nurse for triage prior to seeing the doctor whilst others felt that their role should be in follow up care after seeing the doctor.

Basically the role I think nurses should play is to look after the patient in-between visits. When I am sick I am down and depressed so it is important to have them keeping patients mentally well. (Consumer Usage 1)

Many consumers from the exposure groups or consumers who said they had received a service by a nurse, expressed surprise in that they had not considered, prior to their participation in the focus group, how it was that they identified if the person was a nurse. In situations where the nurse did not wear a name badge, the consumer assumed that due to the service being performed that the person was a nurse. Where people were from small rural areas, there was a general awareness of the person employed as a nurse. Some consumers acknowledged that having a nurse in the general practice changed the dynamics of the practice.

Nurses can change the dynamics as well, they can be a comfortable presence sometimes, especially if a person is anxious, or afraid to ask the doctor for more details. If a nurse is there and usually a woman there is an element of comfort and fall back especially if you are not too comfortable with the doctor for some reason. Having a nurse would be welcome at times. (Consumer Usage 2)

Many consumers saw the nurse as being able to provide a supportive role and being approachable to ask questions as a benefit to having a nurse in a general practice. Carers in particular acknowledged the supportive role a nurse can play.

I think it would be good idea to take the child away while you spoke to the GP. Most of our kids have real issues about us talking about their problems. Yes even just part of the session to be more open to the GP. (Carer of a younger person)

Consumers, whose experience was in knowing the person to be a nurse, stated that this awareness came through the nurse wearing a name badge or the nurse being introduced as such by the doctor. There were consumers whose experience was for the nurse to have a specific room in the general practice they attended and for this room to be identified as the nurse's room. Though they did not necessarily know if the nurse was a Registered Nurse (Registered Nurse Division 1 in the State of Victoria – henceforth abbreviated to RN Div 1) or an Enrolled Nurses (Registered Nurse Division 2 in the State of Victoria – henceforth abbreviated to RN Div 2). Likewise some consumers did not know if the person providing them a service was a nurse.

I go to a clinic and I haven't seen a nurse there. I had a smear and the doctor called for assistance but I didn't think she was a qualified nurse, I didn't see a nametag. There might be one there but I haven't seen her. (Elderly consumer)

Nursing role and the different roles of nurses in general practice

There was minimal awareness of nurses' qualifications, and therefore little awareness of scope of practice of nurses, amongst consumers from most of the focus groups. In particular, there was little awareness of the RN Div 1 and RN Div 2 differentiation, need for RN Div 1 supervision of RN Div 2 and legislative requirements of the different professions. Consumers were not aware whether RN Div 2 needed to be supervised by RN Div 1 and there was little awareness of the difference in scope of practice of RN Div 1 versus RN Div 2.

There were consumers who knew of nursing specialties in the hospital setting but were unable to conceptualise in terms of general practice (other than in NSW where some participants had greater awareness of the nurse practitioner movement). Consumer perceptions identified that there was little awareness to the scope of practice of nurses in general practice in terms of prophylactic care, education, health promotion, and as has been mentioned, many consumers (other than carers) had difficulty in thinking outside their previous personal experiences. In situations where the general practitioner personally introduces or promotes the nurse through brochures/newsletters etc, then many consumers said they would accept the nurse without asking questions about qualifications.

If you were going to a new surgery and your doctor said anytime you could call the nurse or see the nurse if you had any doubts, if they reiterated that fact that would give you confidence about using them. (Consumer Exposure 3)

Consumers hoped and assumed that nurses would work within professional boundaries determined by their respective qualifications.

There were consumers who preferred nurses to wear uniforms vis-a-vis receptionists.

The nurses who have some sort of uniform always look clean and crisp whereas people who are wearing what look like day clothes you don't know where they have been, what they have been doing. (Elderly Consumer)

There was some confusion about the title of 'practice nurse' i.e. a nurse not yet qualified? Also, there was confusion over title of nurses – consumers as participants, generally older persons, often used the title 'sister'.

I am of the old school, I do believe when you go to the doctor's surgery you call them doctor and the nurse sister. That is me. That is respect for their profession. (Consumer Large Rural location)

The majority of consumers recognised nurses could be male or female, and few had any issues with seeing either. Many female consumers did elaborate an

advantage in having female nurses performing female-related services rather than the male doctor and vice versa for male services and a female doctor. Some consumers voiced that they wanted only RN Div 1 at the general practice. Different to this view, some consumers thought that you should have the most qualified nurses in hospitals performing specialist care and allow less qualified nurses to work in the general practice. Still for others, they did not voice concern about which nurse provided the service, as long as they 'did a good job'.

Nurse's qualifications and the specialty areas they practice

Most consumers elaborated little knowledge of specialties though some female participants spoke about the benefits of a nurse being female if the general practitioner was a male. Some consumers who were females and needing to go to a general practitioner for their pap smear spoke about the nurse being suitably qualified to do this procedure (though males were not so certain as to the ability of a male nurse being able to do prostrate check procedure).

A minimal number of consumers had knowledge of nurses' qualifications in midwifery, oncology, remote area nursing and nurse practitioners. No consumer elaborated an understanding of the practice area of immunisation as a specialty – only as nurses giving injections, though some participants had received the service of immunisation by a nurse. Only consumers with chronic disease, a serious illness or who were parents or Carers saw an extended role for nurses in education and support. Though when other consumers were asked to consider this extended role, many agreed that there was room for this role.

Nurse's skills and the areas they have experience in

Consumers were more able to identify nurse's tasks rather than the "role" of nurses or nursing in a general practice. Many consumers spoke of nursing being related to caring and supportive roles rather than clinical decision-making roles. Many consumers raised that they did not want nurses to be involved in diagnosis of conditions particularly if there was any suggestion that the condition may be, or was, serious.

In between a caring and supportive role, and their wish for nurses not to diagnose there was a vast grey area between what consumers understand to be the skills of nurses. Often what consumers believe to be a nurse's skill is based on a hospital experience, which is the context they normally consider and witness nurses in.

Relative role of the doctor and nurse in diagnosis

There is a widely held belief among consumers as participants that doctors have the necessary education for diagnosis whilst not necessarily so for nurses.

You will always look for the doctor's diagnosis regardless of what the nurse says. They have much more qualifications and you build up a relationship with the doctor. (Consumer Usage 3)

Doctors have a reputation for doing so many years of study I see the nurses being experienced in caring and following up care where doctors are trained to diagnose. (Consumer Capital City)

For many consumers it was difficult for them to elaborate what nurses could do in a general practice, but when asked what consumers did not want nurses to do, the responses they gave were very clear. For example;

Tell me are there any things in general practice that nurses shouldn't do? Prescribing drugs, anaesthesia (the local one), general diagnosis. I would expect them to have an opinion, but to give it to the doctor not the patient (Consumer Usage 1)

What don't you want the nurse to do? Diagnose you. They are not qualified. (Consumer's response to facilitator's question Exposure 3)

Some consumers could differentiate between the different levels of diagnosis and identified that the nurse could do some first aid and triage assessment. Having said this, consumers elaborated that they had a problem with nurses diagnosing independent of the doctor – the dominant view was that diagnosis should be the doctor's role.

Yes and no because there are some very nasty illnesses that present as other things and a nurse might say you have the flu when really you have meningococcal disease. They really need to check with the doctor. (Consumer Usage 1)

However, consumers' perceptions were that there is a role for nurses in educating patients following diagnosis by the doctor.

Yes like the old days when they told you what to do to keep your heart healthy and what to eat etc. (Consumer Usage 3)

In relation to prescribing, there were contradictory views expressed by consumers in relation to whether a nurse could prescribe or not. For some of those consumers who were on long-term medication, for example blood pressure management, they felt that the nurse could take the BP reading and then give them a repeat script if their measurement was appropriate. This was not the case for all consumers.

Something she could do is fill out scripts for repeat medication so you don't have to see the doctor, she could take your blood pressure and if it is fine then she can write out another script. The doctor only sees you for a short time when you go back for a script so a nurse or sister could do that. (Consumer remote location) Maybe. I would prefer a doctor do it. The doctor needs to check your condition before he continues with the script. (Consumer Exposure 2)

Continuity of service by the same service provider was considered by many consumers to be an indicator of quality of service.

The worst thing is continuity of doctors. If you have long-term problems, you can get 5 different views on the same problem. ... It gets to the stage that I won't go to the doctor up here anymore, I am thinking of going further a field to get continuity. (Consumer remote location)

Relationship between doctor and nurse, and their relative roles

A small number of consumers voiced concern that nurses and doctors did not seem to work well together and there was some awareness of conflict between doctors and nurses based on the consumers' experiences in hospitals. This conflict was troublesome for some consumers. An exchange between some consumers in a focus group is reported below to highlight the sentiment amongst many consumers.

It is disappointing that as far as we have come in society that there is still rivalry between doctors and nurses.

My brother-in-law is a chiropractor and it is the same there with physiotherapists. Society is always talking about one health and working together for the community and it doesn't happen....

Yes. Stress the recognition of working in conjunction....

Ultimately in the end they should both be working towards the same thing, the shared care of the person. (Consumers Exposure 3)

Consumers felt that open conflict or divergence of medical opinion about their condition between nurses and doctors would make them feel insecure and alarm them but not because there was this conflict. What consumers felt was that it was important for discussions to occur between nurses and doctors (with the potential for conflict) when they, the consumer, was not present. Many consumers articulated that a second opinion from the nurse would be valuable and increase the quality of their care. Indeed many consumers strongly link the relationship between nurses and doctors to quality of care.

I think there is an additional advantage in one way in saying that you are seeing two people and a second opinion is always a good thing. It can offset the quality perhaps of the doctor or the nurse without casting any dispersion. (Consumer Usage 1)

Consumers spoke about desiring nurses and doctors having a united front in relation to any change so as to gain acceptance by consumers.

If you were going to a new surgery and your doctor said anytime you could call the nurse or see the nurse if you had any doubts, if they reiterated that fact, that would give you confidence about using them. (Consumer Exposure 3)

It would only work to have nurses in the doctor's surgery if the doctor respected the nurse on his level. He has to show in front of people his confidence for her. Treating her as an equal. (Consumer Capital City)

There were some consumers who thought that nurses should have equal recognition in the practice by having their names and qualifications listed in the practice similar to the general practitioner.

Doctors, dentists etc have a certificate on the wall so we can see they are qualified why can't nurses have their certificate in their own space as well. (Consumer Chronic Disease Group)

A recurring view amongst consumers is represented in the following quote:

You have to trust in the nurse as well. If she thought there was something amiss she would refer you on to the doctor. It comes back to the respect between the doctor and nurse. If you know the doctor respects the nurse then you feel the same, have confidence in them. (Consumer Usage 2)

Clinic process

Consumer's perceptions were grounded in their experiences – e.g. sole general practitioner practices or multi- general practitioner practices, their previous exposure to nurses in general practice and the specific process their practice used. There were diverse views but two potentially contradictory strong themes:

- ❑ Should only see general practitioner first, and then follow up care can be done by the nurse under direction of the general practitioner
- ❑ See nurse first for triage, and then go on to see the general practitioner if necessary, *as long as* the nurse didn't act as gatekeeper or inhibit the consumer from seeing the general practitioner.

The other day I was sick with pleurisy and the girl was at the desk and she said the doctor was solidly booked for 3 days, and I asked to speak to the sister and I told her I would like to see the doctor and she managed to get me an appointment with the doctor after she saw me. (Elderly Consumer)

Sometimes if you see the nurse first, they can pick up on something where as the doctor is always in a hurry and then refer it to the doctor. They listen to you a bit more. They might pick up on other things. (Consumer Exposure 2)

The particular view of a consumer depended on the issue requiring them to attend a general practice, their trust and knowledge of the nurse's skills/experience/qualifications. For some, hearsay was important i.e. personal recommendation.

Overriding these themes is the trust of the consumers in the general practitioner to only allocate tasks and scope of practice to a nurse that the general practitioner believed appropriate for that individual – consumers trusted the general practitioner to provide the right person for the job.

You have a level of trust with your doctor, so if the doctor says the nurse will do this, you have confidence in the nurse then. (Consumer Capital city)

In terms of whether the consumer saw the nurse by appointment or whether the nurse was 'floating', there was acceptability of both and an understanding of benefits from each method.

Nursing role in assessment and "triage" prior to seeing the doctor

Consumers who had had little or no experience of receiving a service by nurses in general practice found it difficult to push outside the boundaries of their experience of general practice to envisage this role for nurses. Counter to these, consumers who had had this experience of nurses in the general practice setting were happy for a nurse to undertake assessment and triage prior to seeing their doctor. Some consumers who had had only service experiences by a doctor stated that they wanted only general practitioner services.

If I have a criticism with the practice I go to, the doctor insists that you always see him. I feel sometimes it is a wasted visit if I am trying to get the results of a blood test and everything is normal. I could make a phone call to the nurse and save time and effort. (Consumer Exposure 2)

I have been to a couple of practices one where there was a nurse and one where there wasn't. The one thing I noticed was that there where there was a nurse they take you aside and do all the routine tests like blood pressure, weight etc so that when the doctor sees you it is already done and he can spend more time with you. (Consumer Large Rural location)

I would feel uncomfortable with that, because I am going to see the doctor not the nurse. If the nurse is to give me results, or stitch me up because the doctor is busy that is fine but the bottom line is I am going there because I am sick and I want to see the doctor not the nurse. (Consumer Usage 3)

My doctor is really good but often we can't get in because he is so busy. My daughter has a low immune system and gets lots of infections, the onset can be quick and nasty and sometimes I can't get in. A lot of it is urine sampling and I think a nurse could test that and follow up afterwards. Tomorrow is not an option sometimes. (Carer of younger person)

When other members of the group in discussion raised the idea of nurses involvement in triage and assessment then most people readily agreed to a nurse having a useful role in triage and initial first aid and assessment prior to seeing the doctor. Most considered that with a nurse undertaking these roles that in so doing this could free the doctor so as to improve access to the doctor. Others went further to say that they were happy to see a nurse as a practitioner as long as the choice to see the general practitioner was theirs, no matter what point in their treatment (this view was especially prominent in NSW).

It will probable come to that in the country because you can't get doctors to go to the rural areas, they are starting it with nurse practitioners now and if that was

the sort of service, I would be perfectly happy to see them because they are highly trained, with good qualifications. (Consumer Usage 2)

Consumers believed that the nurse must not act as a gatekeeper to the doctor, nor should a nurse want to be a substitute for the doctor. The focus of nearly all consumers was for the nurse to be available clearly as an enhancement of the general practice services not a substitution of the nurse for the doctor.

She doesn't really diagnose, the doctor is always there or she can get him on the phone and work out what she is saying. The nurse is really the doctor's second arm. (Consumer Remote area)

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. (Consumer Usage 2)

Consumers with children saw the benefit of the nurse for triage and management of the family- i.e. for advice, postnatal care, etc (similarly important for carers and grandparents). Some consumers also thought there was a role for nurses in triage over the phone, also acting as a resource person in this regard.

My main experience was mainly injections when I had young children. 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. They would explain things to me which sometimes helped and sometimes they said no bring them in now or wait another day. (Consumer Exposure 2)

Communication and interpretation of test results and diagnosis

There are mixed views amongst consumers in relation to a nurse informing consumers about test results and diagnosis – no dominant view prevailed and this was regardless of previous exposure to a service by a nurse, usage of general practice service or location of consumer. Some consumers presented a view that relayed they would be happy to receive results from the nurse if they can choose who they get results from (i.e. voluntarily choose the nurse), and are informed by the general practitioner about the nurse's qualifications and ability to give out results.

I think nurses are very skilled so it wouldn't worry me. Especially the ones that have been around for a long time. (Consumer Chronic Disease group)

Some consumers felt that if the result was in any way "bad news" then the doctor should inform them so that they could go on to explain the implications of the result and be able to answer their questions. While some others felt that nurses had better communication skills and more time and so should give out results. There were other consumers who wanted the doctor to tell them to be followed by the nurse who had time to explain to them the results. Other consumers did not have a strong opinion about from whom they should receive results/ diagnosis information.

If you had a routine blood test, nothing is wrong, then it doesn't matter. But if there has been something wrong with you and the results are bad you would want that from somebody you had developed a rapport with, you would have some kind of empathy then. (Consumer Usage 1)

There was an expectation amongst consumers, as participants, that if nurses are interpreting results that they should have the knowledge and expertise to do so. Many raised concerns about litigation issues.

I guess nurses could be good for describing to asthma patients how to use the medication and signs to look for, young mothers with immunisations, that would all save the doctor time. You could see the doctor first and then the nurse to explain fully about medications, or whatever. It would have to be done according to a system so as not to get into litigation problems. (Consumer Exposure 2)

It was considered by some consumers a good idea for nurses to give results in order to increase access to services, decrease waiting times to see the general practitioner, decrease demand on general practitioner time, etc. Some consumers identified being frustrated with a general practitioner making them come back to receive test results and being charged when the result was “good news”. Some consumers stated that they choose not to keep appointments made to follow-up test results.

Confidentiality and Privacy

There was little variation between usage and exposure groups in relation to confidentiality and privacy, but there were differences between location groups. Most consumers made the assumption that nurses followed the same code of ethics, which some called the ‘Hippocratic oath’, that doctors did and therefore they would as a matter of course respect the consumer’s confidentiality and privacy. Consumers had no knowledge of what this code of ethics entailed but considered nurses as professionals who worked within a code of ethics.

Always thought that there would be some type of across the table ethics that both the doctor and the nurse fall under especially if they are working together in the general practice. Clear guidelines that they must adhere to. (Consumer Exposure 3)

Doesn't bother me. They all have the same ethical training as in privacy. (Consumer Exposure 3)

In a general sense there were no concerns in relation to confidentiality and privacy, although consumers from some small rural and remote locations had had cause for concern due to personal incidents in the past. Some individual consumers did voice concerns about confidentiality and privacy, especially in relation to the practice’s receptionist as well as to the role of a receptionist.

It has happened before, but not that often. It used to happen so often that one doctor that was here permanently actually carried certain notes with him. ... The people that were working here at the time, the reception staff were the problems. (Consumer remote location)

Most consumers felt happy that the nurse and doctor would share and exchange information about them relevant to furthering their care, but wanted to ensure that if they asked either health professional to keep information confidential then that would be respected.

If you really want something kept confidential you ask for it. (Consumer Exposure 2)

Availability of nurses

Consumers linked availability of nurses with continuity and quality of care issues. They raised issues relating to the national nursing shortage that they considered would impact on the availability of nurses to work in the general practice setting. Indeed, concerns were expressed that if nurses worked in general practices that this would take more nurses from hospitals.

This whole concept has a problem. There are not enough nurses now... (Consumer small rural location)

It would be great to have a nurse but where do you get them from, there is a shortage. (Carer of Elderly Person)

Every time you open the paper, there is a new ward that can't be open because of the nursing shortages. (Consumer Usage 2)

Though some other consumers considered that being able to work in a general practice may make nursing more attractive to some and therefore assist in the nursing shortage by increasing the numbers coming to the profession and bringing others back from retirement. Consumers who believed that having nurses working in general practice could possibly bring more nurses to the profession or back to the profession expressed this view because of family-friendly and socially friendly hours vis-à-vis hospital hours. This perception was framed by consumer's awareness of scope of practice and what nurses are permitted to do – i.e. consumers were insightful to ask why an RN would become qualified to do only injections in a surgery?

We never saw my mum when I was little, she was a nurse. So a 9 – 5 job would be great. (Consumer Usage 2)

Some consumers considered that nurses would be more available and accessible than general practitioners but other consumers raised concerns that nurses could also become difficult to see if they became overworked, identifying this to be a potential problem particularly in practices with many general practitioners. Consumers were not concerned by part-time working hours of nurses in the main, although some consumers did express the wish that their nurse in general practice was available more often, rather than just a couple of days per week. Some consumers considered this as a way in which the consumer could receive continuity of services.

Flexibility of the practice to the consumer's choice

Consumers raised on their own accord the importance of having the ultimate choice about which they wanted to see - they do not want any choices taken away. They want to be able to choose the nurse as well as the doctor, instead of the doctor, or not to see the nurse at all. Consumers did raise concern that nurses may potentially act as a gatekeeper to the doctor and they spoke strongly against this happening.

I wouldn't want to turn up, be booked in for the doctor and then see a nurse without being told beforehand. It is like going to the hairdresser and the apprentice doing your hair when you always have had the qualified hairdresser and not being asked. (Consumer Capital City)

Issues around choice were framed by perceptions about cost and the consumer's awareness of issues relating to nursing in general practice. Consumers spoke about how they exercised their choice to see who they wanted and how they went about seeking someone when they wanted. Availability was often limited by location and in some cases, consumers raised the age of a person and 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 my mum would just accept it. What level does it cut off where they are not qualified to give someone that type of advice? (Consumer Exposure 3)

Absolute choice to the consumer was expressed as being fundamental to acceptance of the initiative – this was of particular importance to the groups who had not had any experience of nursing in general practice – they wanted to know that if this was introduced they still maintained some control.

Nursing role in regard to referral to other health services

Consumers felt it was good to have the nurse as the resource person for the practice, to inform them of community services though not necessarily health services. This role for nurses was most valued by parents/grandparents caring for children and for carers and consumers with chronic disease. Consumers generally wanted the doctor to make referrals to other health professionals, although some considered that for some health professionals (i.e. not specialists) then this could be a role for the nurse.

There are a lot of services out there but finding out about them, like the community bus, the pathology service that comes to your house, community health, so maybe a nurse should have a list of all these services so that the more elderly people can be informed because they need them. (Consumer Exposure 3)

My son had an x-ray and it was convenient to go in and see the nurse organise the x-ray. I went and had it done and then saw the doctor after. It was great, time saving. You don't have to wait to see the nurse whereas you have to sit between 1 –2 hours for an agreed appointment. (Consumer Exposure 3)

I think there is a role for nurses in surgeries for people like us but it took me 5 years before I found out about ... so we went to the physio and then she said you can access OT. It was only through talking to other people and I think maybe there is a place for nurses in surgeries to actually refer people. (Carer of younger person)

I see it the other way around. I don't think a nurse would be qualified enough to do the referring, I see a nurse as the other way around, it is up to the doctor to refer you to the nurse. (Consumer Usage 2)

Facial expressions of some groups participants showed that they had not thought of a nurse being able to make a referral but on reflection strongly supported the notion that nurses could inform them of community based services. Indeed many participants acknowledged that they knew little of other community services and identified gaps in health services depending on their location.

Most things are governed by legislation about what nurses can and can't do. They can't write out x-ray reports, prescriptions. If they could it would save a lot of time if the nurse could write out the referrals for x-rays and things. (Consumer Usage 3)

Distinction between nursing roles in primary care

Consumers' perceptions revealed little awareness of what was meant by primary care generally, though many were aware of community nurse roles, and some in terms of a historical community nursing model and nurses for childcare. There were consumers who raised questions and concern about the potential conflict between these community roles as they perceived them and the role of nurses in general practice. Some consumers articulated that if the nature of general practice were to change this would require a 'big mindset change'.

If you are thinking of instituting a new system you will need to spend months or years telling the public. (Consumer Usage 2)

Views expressed by consumers give weight to the position that they have minimal understanding of terms like "primary care". They did, however, acknowledge the general practitioner as first point of contact, but reiterated that for many diverse reasons, that they often limit the occasions that they go to general practitioners.

I don't like going to the doctor. I found in some instances and I know I have an earache, they won't pick it up or something, so I don't go unless it is really serious. (Consumer Usage 1)

There is much to be gained in identifying expanded roles for nursing in general practice using the available evidence of the positive contribution nurses can make to consumer outcomes and quality of health care particularly for people with chronic illness, complex needs and multiple issues. Though as one consumer noted:

The doctor would have to step back and accept that the nurse can do those things. Doctors are great but so are nurses. Doctors have to allow nurses to have some initiative to make decisions on whether people need to see the doctor.
(Consumer Usage 2)

Potential changes to cost structure of the practice

There were varied opinions amongst consumers with a few sceptics verbalising a concern that this project was in some way preparing consumers for changes to cost structures. That is, that there was to be an increased cost to them as a consumer with a few consumers asking if there were any hidden agendas in undertaking this research for the Commonwealth.

Generally consumers related a view that it was appropriate for a nurse to perform services they were qualified to perform and then be compensated for this service, but at a lower rate than doctors (who were viewed as more qualified).

I would not pay more than I do to see my doctor. It would have to be less surely because they are less qualified. (Consumer Exposure1)

I wouldn't pay \$40 to see a nurse when I pay that to see a doctor. (Consumer Usage 2)

But the question was raised by some consumers that if the nurse can do a procedure normally undertaken by the general practitioner, why the cost for that service from the general practitioner had been as high as it has been. Others said if the quality of service provided was the same they would pay the same for it – a perception that raises consideration for payment for a service, not specifically payment for the service by a professional. An example of an exchange between focus group participants related to cost structures is presented below:

It should be the same. If a nurse renders you a service as competently as a GP, they are entitled to the same fee as the doctor. ...

No, the reason they shouldn't be paid the same is because that service that they have rendered doesn't require the training that the doctor has had so it is not necessary for us to pay for that level of qualification for that level of service...
(Consumers Exposure 3)

Many consumers, particularly from rural settings identified how the costs for services prevented them receiving services. Like many other consumers, they projected that if nurses did undertake commonly required services possibly at a lower cost to them personally then they clearly liked the idea of paying less for the

service by a nurse. There were also consumers who articulated that if the nurses completed the routine services then the doctor would be able to see more people and in this way would not have a reduction in income.

*Facilitator: If you saw a nurse what would you expect that fee to be?
Less. If a nurse can do what a doctor can do, if you go to a GP and you are in there for 5 minutes and you pay \$34 and then you sit with a nurse for 30 minutes and she gets less than that what is the difference, why should the GP get more for less time. (Consumer Rural Exposure 2)*

If you came in at the initial level would you be prepared to pay. And if you had been told that the nurse was cheaper and you thought I could get away with the nurse seeing me, would you do that or do you always go in at the doctor level and the doctor says well from now on you will need continuing treatment but you can see the nurse. I am not sure I would be happy if I had to see the doctor first if I knew a nurse could deal with it. I would like to have the choice. Access could be given much more readily. (Consumer Usage 2)

There were many consumers who thought that the services by general practitioners were costly and they also spoke about nurses being underpaid. Having said this, some consumers were also aware of the impact of increasing the nursing role on the economic position of the practice.

Cost to the consumer of accessing the nurse as well as the doctor

What consumer perceptions clearly identified was that they certainly would not tolerate any double payment that may result if they need to see both health professionals on the same day. Consumers stated they should pay only for the doctor's visit. For follow up nursing after a doctor's visit e.g. dressings or removal of stitches, they want this to be an MBS item or incorporated into the cost of the initial doctor's visit. If they were seeing the nurse for a service separate to the doctor some consumers would be happy to pay for that service but at a reduced fee.

If I am going to get the same information from both then the question is why is the doctor getting paid so much if I can get the same information or service from a nurse. (Consumer Usage 2)

*It should be the same, if the nurse renders you a service as competently as a GP they are entitled to the same fee as the doctor.
No, the reason they shouldn't be paid the same is because that's service that they have rendered doesn't require the same training that the doctor has had so it is not necessary for us to pay for that level of qualification for that level of service. (Consumer exchange Exposure 3)*

Consumers who had exposure to nurses in general practice responded in the following ways to being asked how they would react to being charged for having a service done by a nurse:

I wouldn't like it.

That would be strange. It is unheard of.

It should be one service for the practice. (Consumer exchange Exposure 3)

4.3 Key variables and messages

The conduct of the focus groups proved a positive strategy that many consumers acknowledged had an influence on their expectations and attitudes to nurses in general practice. The majority of participants verbalised positive messages about being involved in the activity with many indicating that they had learnt a lot from being involved.

Areas that were not well understood by participants included the scope of nursing in general practice, the role and qualifications of different nurses, how to identify who the nurse is in a general practice, under whose direction the nurse functions, persons or organisations responsible for nurses' actions, the code of ethics to which nurses and doctors work, the contribution of primary care and the role of consumer and professional organisations. What was clearly articulated was that consumer choice must not be jeopardised by either the scope given to the role of nurses in general practices or any increases in cost to the consumer to receive a service.

As one younger consumer elaborated:

The general perception of nurses is that they are under qualified and not as good as doctors and you shouldn't pay attention to them. So you need some propaganda to turn that perception around and say why they are valuable. Some doctors have a very high opinion of nurses but then there are some that have a very low opinion and their patients as well. (Consumer Usage 1)

In the sections that follow, positive and negative variables are listed and the key messages to be delivered to consumers are identified.

Positive variables

The list that follows identifies the variables that are likely to affect consumer expectations, experiences and attitudes to nurses in general practice:

- ❑ Consumers want a choice of who they want to see
- ❑ Importance of trust in the nurses abilities
- ❑ Information needed to be given from nursing associations about qualifications and scope of practice of nurses and what is nursing in general practice
- ❑ Good working relationship between doctor and nurse
- ❑ United front between doctor and nurse to the consumer/patient regarding clinical care
- ❑ Potential for decreased costs for certain services
- ❑ Consumers considered there would be increased accessibility of doctors by bringing nurse to the practice
- ❑ Positive previous experiences with nurses (in hospitals etc)
- ❑ Value of professional experience of the nurse, leading to a good reputation

Negative variables

Variables that were likely to affect consumer expectations, experiences and attitudes to nurses in general practice in a negative way were:

- ❑ Nurses as substitution for the doctor rather than an enhancement to the role of general practitioner
- ❑ Nurse acting as gatekeeper to doctors, as a barrier to accessing the doctor
- ❑ Poor general practitioner/nurse in general practice relationship
- ❑ Visible conflict and differing opinion between nurses and doctors
- ❑ Lack of experience of nursing staff (e.g. new graduates)
- ❑ Past negative experiences of nurses and nursing (very few)
- ❑ Litigation issues
- ❑ Insurance (professional indemnity) issues
- ❑ Issues relating to nursing shortage and how bringing nurses into general practices would impact on this (e.g. do not take more nurses from hospitals)
- ❑ Inability to differentiate between roles of nurses

- ❑ Increased cost to the consumer

In relation to insurance and litigation concerns, consumers expressed the following views.

Wouldn't it be beneficial for the doctor to see his patients because he is the one that has the insurance, the nurse answers to the doctor so if anything goes wrong, he is held responsible? (Consumer Large Rural Location)

One possibility would be that the nurse sets up as an individual in the surgery as her own business, that may help with litigation, the nurse was separate to the practice and the doctor also, each would accept their own responsibilities. (Consumer Usage 2)

Key messages

As has been elaborated throughout this chapter, consumers want to have a choice about whether they see the doctor or the nurse. While most consumers were very positive about having nurses work in general practices, this strategy from their perspective had to increase their choices, not reduce them. Clearly the consumer perceives the role of a nurse in general practice as one to enhance general practice services. The role of a nurse in general practice is not to replace or substitute the doctor if that is what they wanted.

The key messages for delivery to consumers at the national level are:

- ❑ Qualifications – the range of qualifications for nurses and what they mean in terms of levels of skill and responsibility
- ❑ Roles – what potential roles nurses can play in a general practice context
- ❑ Privacy and confidentiality – what code of ethics nurses work within
- ❑ Nurses are not a substitute for doctors- nurses have different roles, skills and responsibilities and they enhance rather than replace the general practitioner
- ❑ Nurses are not gatekeepers to the doctor – consumers will decide if they wish to see the doctor. Nurses in general practice will not restrict choice.
- ❑ Nurses and doctors are part of a team in a general practice – they will work together to meet consumer needs.
- ❑ Insurance – nurses are covered by insurance elaborating how.

The key messages for delivery to consumers at the local level are:

- ❑ Qualifications – what specific qualifications the nurse(s) in the general practice holds.
- ❑ Experience and skills – what experience and skills the nurse(s) in the practice has that relates to their role.
- ❑ Roles – description of the role(s) the nurse(s) has/have in the practice.
- ❑ Availability – when the nurse(s) work in the practice
- ❑ Clinic Process – how to make an appointment or access the services the nurse offers and how the nurse and the general practitioner work together.
- ❑ Privacy and confidentiality – what rules apply to nurses.
- ❑ Cost – if any fee is charged.

To promote consumer understanding and awareness of nursing in general practice, consumer perceptions inform us that a range of materials are needing to be developed to address the information needs of consumers and to promote understanding about nursing in general practice. The materials need to:

- ❑ Be consumer focused in their content
- ❑ Be readable and understandable
- ❑ Be agreed amongst the key stakeholders
- ❑ Be accessible to people whose primary language is not English
- ❑ Be accessible to people who have disability, including hearing, visual and intellectual/cognitive impairment
- ❑ Be flexible for local adaptation

This range of materials needs to be comprehensive to ensure all relevant information is covered including:

- ❑ Qualifications
- ❑ Skills and experience of nurses
- ❑ Relationships between the doctor and nurse and clinic processes
- ❑ Roles and boundaries
- ❑ Insurance issues
- ❑ Privacy and confidentiality rules
- ❑ Choice of provider within a practice
- ❑ Availability/accessibility
- ❑ Costs

The term “practice nurse” should be avoided to remove any connotations of nurses in general practices being “in training”.

Consumers consider it important for nurses and general practitioners to present a united front and respect for each other’s contribution when providing a service to a consumer or informing the public about any joint health initiative. Consumers generally expressed concern that this united front had not necessarily been evident to date in the public sphere. This finding focuses attention on the roles of media, professional organisations and the nature of a tertiary education curriculum for nurses (including vocational education programs for RN Div 2), doctors and other health professionals in promoting a view of collegiality and teamwork amongst health professionals. Critical to the success of consumer partnership structures in general practice, is the involvement of all partners in the negotiation of their roles within the context of the partnership and in negotiating and agreeing on their respective rights and responsibilities.

4.4 Communication mechanisms

Consumers as participants reinforce the centrality of general practitioners in the initial treatment and management of a specific injury/illness. Further, consumers from across all the focus groups identified that the level of trust in their general practitioner to employ or engage the services of a competent person to perform specific tasks was significant. It is therefore not surprising that the dominant mechanism consumers preferred to inform them of change was the general practitioner her/himself.

The general practitioner is a key broker in bringing about change and personally informing a consumer, modelling the value and respect for the nursing role were considered by consumers to be imperative strategies.

It would be nice if a doctor has his name on the door which he does it would be nice to know the name of the nurse who is in attendance as well. (Consumer Exposure 2)

The biggest problem would be to handle the attitude change in the public. They want to see the doctor, if you are asking them to see the nurse, you have to have re-education of people to get them to understand and are the doctors going to wear the cost of an additional person, if something goes wrong who do you sue? We live in a litigious time now. Are the doctor’s for it? (Consumer Usage 2)

A dissemination strategy needs to be developed at the national level to ensure strategic delivery of information to consumers. The dissemination strategy should:

- ❑ Be focused primarily at the local level, both within practices and the broader community
- ❑ Use peer (consumer to consumer) based strategies through consumer organisations at the national, State and local levels via written and oral means
- ❑ Utilise existing practice based consumer communication mechanisms such as practice newsletters, signage, posters, brochures, qualification certificates on the walls, name badges with titles
- ❑ Encourage direct communication about nursing in general practice via the GP and the other practice staff, including the nurse(s)
- ❑ Specify a role for Divisions of General Practice to promote communication about nursing in general practice to their members
- ❑ Promotes a role for national nursing and medical organisations to encourage better communication to consumers about nursing in general practice by their members, including development of a Standard and criteria within the RACGP Standards for General Practice
- ❑ Strategically uses electronic forms of communication such as existing websites used by consumers for general practice and health information
- ❑ Strategically uses the media to disseminate key information about nursing in general practice through talk back radio, television chat shows and feature articles in the print media

5. Discussion

The exploration of consumer views and experiences is a means to strengthen the voice of diverse groups of consumers as well as an effective undertaking that has been proven to work to make health care services more responsive to individuals' needs.¹¹ The research team has identified key concerns, misconceptions, variables and messages likely to influence consumer perceptions of, and communication mechanisms consumers would prefer to inform them about, nursing and nurses in general practice. These will in turn inform future resource development.

While everyone is recognised as being a consumer of health services from time to time, the focus of attention for this project was with consumers whose primary experience of general practice services was as a receiver rather than as a provider.

The role of nurses in general practices to date has been varied. This research has highlighted that there are circumstances where some persons undertaking assisting roles for the general practitioner have been thought by consumers to be nurses when in fact the consumers were unable to state if they are or are not a nurse. In the initial proposal to the Commonwealth, the research team also highlighted that there would be some general practices where the role of a nurse has also been limited, for a variety of reasons, to attending to wounds, taking blood and generally working under the direction of the general practitioner. As has been explored and demonstrated in this report, the experience of nurses performing health assessments, directing care services and coordinating case conferences etcetera, is not yet at levels in the community where the experience can be explored with consumers. Therefore, perceptions were in the main explored from what is expected or hoped for, and currently held views about the role of nurses and nursing, and indeed the role of a general practitioner.

The researchers have found that in terms of consumers contributing their perceptions to this research, that perceptions were framed by their personal experiences. Consumers with little or no experience of nurses in general practice found it difficult to think outside of their personal experiences to consider new models of care and to consider gaps in services and new autonomous roles for nurses. Throughout the focus groups, many consumers needed to be oriented back to focus on the general practice setting rather than clinic/hospital/specialist. Across all the focus groups and with minimal variation between what was identified as exposure, usage, location and special interest groups, there was widespread acceptance of there being a role for nurses in general practice. There

¹¹ Bastian, H. 1998, 'Speaking Up For Ourselves: the evolution of consumer advocacy in health care', *International Journal of Technology Assessment in Health Care*, 14:1.

was a clear view that this role must not be a substitute for the role of a general practitioner. The nurse in general practice was to enhance general practice services, not replace services. Consumer perceptions about the role of a nurse in general practice identify that this role should not act as a gatekeeper to a consumer visiting the general practitioner nor take away the choice that a consumer wants in deciding who they would prefer to deliver a specific service.

An overwhelming concern that consumers expressed was that a nurse working in general practice should in no way affect their right to this choice. Services provided by a nurse in a general practice were perceived by consumers to be a mechanism to enhance the quality of care provided to a consumer. Quality of care from a consumer perspective related to continuity of care, the nature of the relationship with the nurse/doctor, access, availability, skill and experience and that for some if the above were present, then qualifications were not essential. There were consumers who spoke about concerns that litigation issues were seemingly 'getting out of hand' and expressed concern that the nurse may 'get caught up in this'. Nurses were considered by consumers to be approachable; they were viewed as being able to increase efficiency for the doctor and the patient, and nurses seemed to be under less pressure for time – described by some consumers as 'less stressed'. The comforting, reassuring, supportive roles of nurses were recognised and appreciated, as were the availability and accessibility of nurses at the general practice and over the phone. Indeed, consumers talked about nurses bringing a culture to the practice of efficiency and organisation.

With nurses in general practices, many consumers envisaged increased continuity of care, support and linkage to resources and services as consumers considered nurses likely to be more available, accessible and approachable. Consumers also perceived that nurses could undertake services that would in turn enable a general practitioner more time to see more consumers.

Consumers as participants acknowledged a limited understanding about nursing. While consumers articulated their perceptions of specific skills that nurses could perform in a general practice, this did not infer that consumers were able to elaborate the role of nursing in general practice. Further, consumers acknowledged that their perceptions about the scope of a role for nurses was informed by their understanding of 'general practice' as a system that they access when needing a specific service for their ill health or injury rather than a system for preventative health care.

A key issue arising from this research is that general practice services are considered by many consumers to be for sickness care. Often this has arisen for consumers because they considered the costs inhibited them from going, their own busy lifestyles and limited access to see a general practitioner and waiting times were prohibitive. Further, the size of practices and workload of many general practitioners influenced a consumer's ability to receive continuity of a service by one general practitioner. There were consumers who articulated that they have taken on self-diagnosis and self-prescribing until and unless they absolutely have to go to a general practitioner. Amongst most consumers there was no concept of lifestyle management being taken on through the general practice, though this was something that carers highlighted they needed. For many

consumers when asked specifically about nurses having a role in lifestyle or health monitoring they saw this role as a self-responsibility. This awareness then raises the question of where consumers get information about maintenance of a healthy lifestyle from and how they determine what is quality information or otherwise.

While consumers' perceptions were divided as to whether a nurse in general practice was an RN Div. 1 or RN Div 2, the trust placed in the general practitioner to employ the most appropriately qualified and competent person, was confirmed by consumers as participants to be a most important indicator. This perception of consumers needs to be considered in relation to the acknowledgment by consumers about a general lack of awareness about the different types of nurses and the differences in their skills and knowledge. The role of the nurse is presented from the perspective of consumers as being under the direction of the general practitioner while acknowledging the skills and attributes of nurses as professionals. Further, the term 'practice nurse' raised many different perceptions for consumers with some perceptions revealing practice nurse to mean a student or a nurse with limited experience.

Consumers elaborated the general practitioner to be the health professional that they consider will diagnose their problem or illness given the additional qualifications and experiences when compared with nurses. A nurse in general practice, from the perceptions of consumers, has the time and caring characteristics consumers believe enable nurses to have a significant role in providing support, health information or in assisting the consumer's understanding. Further the nurse has an ability to inform and network a consumer to appropriate health and community resources and for the provision of first-aid and follow-up care. These views of nurses having the skills and knowledge to provide information and follow-up care were particularly evident amongst consumers who had received a service by a nurse in general practice, who were carers or parents/grandparents of younger people and who lived in rural areas. Some consumers portrayed how having nurses in general practice brought back a role for the general practice rather than the general practitioner's practice. Consumers felt that open conflict or divergence of medical opinion about their condition between nurses and doctors would make them feel insecure and alarm them but not because there was this conflict. What consumers felt important was for discussions to occur between nurses and doctors (with the potential for conflict) when they, consumers, were not present. Many consumers articulated that a second opinion from the nurse would be valuable and increase the quality of their care. Indeed many consumers strongly link the relationship between nurses and doctors to quality of care.

What consumer perceptions clearly identified was that they certainly would not tolerate any double payment that may result if they needed to see both health professionals on the same day. Consumers stated they should pay only for the doctor's visit. For follow up nursing after a doctor's visit e.g. dressings or removal of stitches, they want this to be an MBS item or incorporated into the cost of the initial doctor's visit. If they were seeing the nurse for a service separate to the doctor some consumers would be happy to pay for that service but at a reduced fee. Consumers have concerns about the ways in which services by a nurse in general practice may influence insurance and litigation matters as well as the

nature of general practice services. As well, they are aware of a nursing shortage and question whether the initiative to have nurses in general practice will have a positive or negative effect on recruitment and retention of nurses in hospitals.

Consumer choice and continuity of care were therefore considered essential (in terms of choosing access to either general practitioner or nurse and having available and accessible health services) and must not be jeopardised by either the scope given to the role of nurses in general practices or any increases in cost to the consumer to receive a service.

Most consumers utilise general practice services for diagnosis and treatment of illness or injury. If general practice services are to include health promotion/lifestyle monitoring or preventative care services, then a significant education program to bring about a mind-set change will be required as most consumers, with their own busy lives and a view of general practitioners as always busy, do not currently utilise general practice in this way. Most consumers do not understand what is meant by primary care.

Consumers generally acknowledge a lack of awareness of the levels of nurses' qualifications and what these qualifications enable, the different nursing roles and what the scope of nursing is or can be. The trust placed in a general practitioner is such that whoever is performing a task in a general practice, the consumer believes that the general practitioner would have only employed this individual because they were competent to perform the task. Likewise, consumers trust that nurses would not perform a service they did not have the competence or experience to do.

Consumers consider it important for nurses and general practitioners to present a united front, to value the role each play and respect for each other's contribution when informing the public about any joint health initiative. This was important in order to maximise acceptability and to achieve desired outcomes. Consumers generally expressed concern that this united front had not necessarily been evident to date in the public sphere. This finding focuses attention on the role of professional organisations and the nature of tertiary education curriculum for nurses (including vocational education programs for RN Div 2), doctors and other health professionals in terms of promoting collegiality and teamwork.

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