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Patients' perceptions of changing professional boundaries and the future of 'nurse-led' services

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Nurses are increasingly being employed instead of doctors in some areas of work. This article examines this phenomenon in relation to a 'nurse-led' Personal Medical Services Primary Care Act pilot scheme. As part of an evaluative project, we examined the way in which patients understood and constructed nursing roles in the context of their use of primary care services in a socially deprived area. Whilst professional roles are established to some extent as the result of negotiation between and within professions and with government policymakers, patients' perceptions also affect whether or not changes are accepted, and the extent to which new roles gain legitimacy. Our evaluation took the form of a case study with questionnaires, in-depth interviews and observations. This particular paper is based mainly on data obtained from interviews with patients who had experienced the nurse-led service. The results showed that some patients attributed high status to the nurse by emphasizing that the nurse leading the practice was highly qualified, and other patients reconstructed the role and thought of the nurse as a doctor. This latter interpretation was derived from the patients' descriptions of core activities such as diagnosis and treatment, and other factors such as an absence of uniform. However, the most important factor that affected whether or not patients accepted a 'nurse-led service' related to the way in which the service met their needs. This seemed to be more important than perceptions of professional identity. The nurse-led service continued to provide the social support and continuity of care that the patients valued, and which had been provided by their previous general practitioner. The provision of these aspects of care appeared to be more important than whether or not the service was nurse-led or doctor-led. It is important to consider patients' perceptions of policy innovation when establishing new services.

Key words: nurse-led; nurse practitioner; nurse specialist; primary care; professional roles

Introduction

Nursing in primary care contexts has diversified and expanded in recent times. There have been changes in skill mix (Sergison *et al.*, 1997; Jenkins-Clarke *et al.*, 1998), with nurses increasingly being employed instead of doctors in some areas of work (Pearson, 1998). Concern about cost-effectiveness, the shortage of general practitioners (GPs), pressure from nonmedical professionals seeking role development, and the need to provide adequate primary health care for certain population groups have all contributed to these changes in skill mix (Williams *et al.*, 1997). The aim of this paper is to examine aspects of these changes in

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relation to Personal Medical Services (PMS) Primary Care Act pilot schemes.

As a result of the NHS (Primary Care) Act 1997, 'nurse-led services' (i.e., those which are principally managed and run by nurses) have developed. These are new phenomena within the NHS, and are part of the first wave of Personal Medical Services (PMS) Primary Care Act pilot schemes (NHS Executive, 1998). These schemes, once called Primary Care Act Pilot (PCAP) sites, promote flexible work and practice arrangements. Some have GPs and nurses working in partnership, some have salaried doctors employed by a Community Trust, and eight of the 85 schemes are led by nurses. At the moment, nurses are leading practices in areas that have had poor provision of general medical services in the past, and where there is a shortage of general practitioners (Gardner, 1998a, b; Latham, 1998; Kenny, 1999; Schofield, 1999). Taylor and Esmail (1999) suggest that in some parts of the country, particularly deprived areas, a quarter of the GPs will soon be lost, mainly due to the impending retirement of Asian GPs. In these areas policy-makers may view a nurse-led service as one feasible alternative to the traditional GP-led model of primary care.

The term 'nurse-led' signifies an expanded role for nurses in primary care. Apart from its specific association with the PMS Primary Care Act pilot schemes described above, the term 'nurse-led' has its origins at a number of different levels. It has been used generically in official documents to denote a particular direction of nursing in the new NHS. The White Paper, *The New NHS: Modern, Dependable*, released in December 1997, refers to nurse-led clinics and extended roles for nurses working in community services (Secretary of State for Health, 1997). The term 'nurse-led' also marks a departure from the terms used by nurses themselves, such as 'nursing specialist' or 'nurse practitioner', to demarcate boundaries and areas of work in primary care (Blackie, 1998). The term connotes one of the many ways in which professional identities and boundaries are being renegotiated in the context of change in the nature of service provision and skill mix within primary care (e.g., between GPs and practice nurses).

The establishment of professional roles

Some sociologists have suggested that professional roles are established and affirmed as the outcome of negotiation between and within professions and in dialogue with government policymakers (Palmer and Short, 1989; Dingwall and Robinson, 1990). There is currently divided opinion about the role that nurse practitioners (NPs) should be playing. While some nurses are clearly keen that the role should be recognized (Mayes, 1998), others are less enthusiastic. Bryar (1994), for example, argues that instead of appointing nurse practitioners it might be better to develop the skills of current members of the primary health care teams, and Buck (1998: 3) notes that practice nurses feel anxious that 'their traditional role in disease management and health promotion will become the role of the NP and that they will be left with tasks'.

The Royal College of Nursing has recognized the role of nurse practitioner. However, whilst there has been a proliferation of graduate courses for nurses who wish to embrace certain medical tasks, while at the same time expanding their nursing knowledge and skill base, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) has not recognized the role of the nurse practitioner, and claims that the title is ambiguous and misleading (Torn and McNichol, 1996).

When considering factors that influence changing professional boundaries, relatively little attention has been given to the patient's perspective. Patients' perceptions of new roles also affect whether or not changes are accepted, and the extent to which new roles gain legitimacy. Annandale (1996) points out that nurses currently feel uncertain about their new roles, particularly in the context of increasing consumerism. Patients are seen as 'monitoring' nurses and as having the potential to become litigious. In some circumstances nurses may reject redefinitions of their role, and they may resist being pressured by doctors and managers to undertake certain tasks, either because they do not feel competent to do the work or because they are not certified to carry it out, and they fear legal action on the part of patients. Notwithstanding the last example, the influence of patients on the shaping of professional identity and nursing practice has rarely been acknowledged. Thus, as Pearson (1997) points out, it is important that we examine patients' perspectives on new roles within nursing, as well as looking at professionals' views of changing boundaries.

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Background to the study

Both the King's Fund Development Centre and the National Primary Care Research and Development Centre (NPCRDC) are supporting the evaluation of PMS pilot schemes. The practice described in this study is one of eight NPCRDC demonstration sites (Wilkin *et al*., 1997), and is situated in a socially deprived area of Salford (part of Greater Manchester). Salford has a Jarman Underprivileged Area Score of 27.8. This measure of health and social care needs can be compared with the average for England and Wales, which has a score of 0. In 1991, approximately 50% of Salford residents did not have access to a car, and about one-third of the population rented housing from the Local Authority. In 1991, according to census data, 14% of males and 6% of females of working age were registered as unemployed (Hill *et al*., 1996).

The practice where the study took place was once run by a GP who had worked in the area for over 25 years. Just before he died in June 1997, he was working as a single-handed GP. After this GP died the practice was run by a number of locums and other doctors who only stayed with the practice for a short time. The practice became 'nurse-led' in April 1998. The nurse who now manages the practice is an independent contractor, and employs a GP who works 20 hours a week at the surgery. The practice team also includes a practice manager, health visitor, practice nurse, midwife, and district nurses and receptionists.

This paper examines the way in which the role of the nurse was understood, configured and constructed in the context of the patients' experience of changing primary care services in Salford.

Method

A case-study approach was adopted for this evaluation, in order to 'capture all salient aspects' of the intervention (Keen and Packwood, 1995: 444). Having obtained local ethics committee approval, questionnaires were posted to patients who left the practice, and nine in-depth interviews were conducted with some of these patients. In-depth interviews were also conducted by one of the authors (A.C.) with patients who remained with the practice. These interviews, which took place in 31 households, sometimes included more than one member of the family, so 42 adults were included in this sample (one teenager also took part in an interview). The data used for this particular paper are drawn mainly from these interviews. Another of the authors (W.M.) conducted very short interviews and asked 200 patients to complete short questionnaires while they were waiting to consult the nurse or the part-time GP. This researcher also spent many hours observing in the waiting-room.

It was not easy to recruit people for the interviews, partly because many individuals were not on the telephone, and some had moved house. It was particularly difficult to find people who were working and who were prepared to be interviewed in depth. We were keen to interview those who had experienced the new service at least a few times, so most respondents were selected from a list of frequent attenders that was provided by the practice manager. However, about one-third of the respondents were selected via the questionnaires that were given to patients in the surgery. This was partly because we wanted to interview some people who had not been selected by the practice manager, and partly because we were trying to find more respondents who were employed outside the home. A few respondents were selected via the 'snowball method' and via a health visitor.

In total, 26 women and 16 men who were still registered with the practice were interviewed. Of these, 18 individuals were aged 20–44 years, 17 respondents were aged 45–64 years and 7 respondents were 65 years of age or more. Only 14 of the 42 respondents reported that they were employed, and almost all of them had manual occupations. Five women were unemployed and stayed at home caring for young children. One man was unemployed while he waited for a hernia operation. A total of 13 people had retired early or were not working because of ill health. Seven others were not working because they were over 65 years of age. The occupations of two adult children who contributed to one of the interviews are not known.

The research took place between May 1998 and January 1999. Interviews lasted from 30–60 minutes, and were tape-recorded (with the patients' written consent) and later transcribed in full. The analysis of interview data using Microsoft Word computer software, which involved coding and constant comparison of phenomena, started soon after the first interviews had been conducted (Tesch, 1990). Observations were recorded in the surgery and were expanded upon as soon as the

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researcher had departed. Notes were made of patterns of interactions, and of frequency and direction of communications. The data were examined for themes which illustrated the way in which the surgery operated. Comparison of the findings from the in-depth interviews and the observations provided support and validation for certain specific comments made by patients during the interviews. The questionnaires were analysed using the Statistical Package for the Social Sciences.

The research was informed by theories and concepts drawn from symbolic interactionism and social constructivism (Blumer, 1969; Schwandt, 1994). Symbolic interactionism and Blumer's (1969) three premises were particularly useful for the interpretation of the data. Blumer's (1969: 2) first premise is that 'human beings act toward things [including people] on the basis of the meanings that the things have for them'. The second premise is that 'the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows', and the third is that 'these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.'

Findings

During the interviews, patients were asked about their perceptions of the role of the nurse leading the practice (who will hereafter be referred to as 'the nurse' or N), compared with the role of the part-time GP and the practice nurse. Patients' perceptions of the role of the nurse and the service were influenced by many factors. These included letters sent to each household from the nurse via the health authority before the nurse-led service started, comments made by the receptionists before and after the nurse started work, articles in the local newspapers about the new scheme, the practice information leaflet, contact with other nurse practitioners, the patients' own experiences, and the experiences of other patients.

Patients were confident that they would receive good care

The patients appeared to construct the role of the nurse who was leading the new service by comparing the service with two previous phases of primary care. When patients spoke about the new nurse-led service, they regularly compared it to the service that they had experienced when their previous GP was working single-handedly. They described their old GP as a friend, someone who had helped them when they had social as well as medical problems. For example, as patients commented:

> He was a very caring doctor. He really put himself out . . . nothing was too much trouble, time, he'd listen to you.
> (Interview 5)

> You could sit there and tell him all your troubles, . . . and laugh and joke with him. He weren't one of those in and out doctors.
> (Interview 13)

> He was a best friend as well as a doctor.
> (Interview 10)

After the GP died in 1997, there was a series of locum GPs, and the patients missed the continuity and care that their old GP had provided. One patient compared the old GP with the locums:

> He [Dr D] was brilliant. He cared about you. He used to listen to you. These others [the locums] don't give a toss. They just want you in and out. (Interview 8)

The practice became nurse-led in April 1998, and the results from our questionnaires and the in-depth interviews showed that patients were almost always satisfied with the advice and treatment that they received when they consulted the nurse. They clearly saw the nurse as knowledgeable, highly qualified and competent (see details presented below), and they appreciated the time that the nurse spent with them. For example, a patient who grumbled about the locum GPs said that the nurse who led the new service provided care similar to that provided by the previous GP [Dr D] who had died:

> Whereas N. [the nurse], N in his own way, was like Dr D, cos he was sort of like, wouldn't rush you out, he'd listen to you and then he'd talk to you about what he thought it could be. (Interview 17)

While observing, the researcher (W.M.) noticed that the nurse seemed to know many of the patients who were waiting in the waiting-room, and unlike the locums, always made eye contact with the

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patients. He joked and seemed at ease with everyone. During the interviews patients said that they felt the nurse was always approachable, and as one patient commented:

> I don't see him as a nurse, I just see him as someone I can talk to. (Interview 29)

The nurse perceived as 'more qualified than an ordinary nurse'

Having experienced the new nurse-led service for a few months, some of the patients thought of the nurse as a highly qualified member of the nursing profession. This may have been partly because the letter that was sent to each household stated that the nurse was 'specially trained' and 'able to diagnose and treat diseases and illnesses in general practice'. One elderly respondent commented:

> I always thought that perhaps he was more qualified than just an ordinary nurse. (Interview 2)

Another patient thought that the nurse was more 'like a sister in nursing' (Interview 1), and someone else suggested that 'he's probably a bit more clued up, like a nurse in casualty' (Interview 29). One man had recently been in hospital as a cardiac patient, and had been nursed by a nurse practitioner. While on the ward he had observed that if anyone had a problem they consulted the nurse practitioner and not the doctors. As a result he had a high respect for nurse practitioners. While reading the local newspaper he had seen that a 'nurse practitioner' would be leading his practice. He commented:

> R: I've heard of nurse practitioners before. . . . It's been in the paper twice. It was in the paper before he took over, and it was in the paper afterwards.
> I: What did it say? Do you remember?
> R: Well, it just said that this was a new thing that had come into being, and that he'd been practising for five years in Stockport. Now I mean, he's got plenty of experience, and he could do seventy per cent of the things that a doctor could do. (Interview 19)

As mentioned above, interaction with practice staff also affected patients' perceptions of the new nurse-led service and the role of the nurse, as is evident in this transcript of an interview with an elderly man:

> I: So what did you think, you and your wife, when you had the letter saying a nurse was going to be running the practice?
> R: We was quite happy, we was quite happy because X [a member of the practice team] had explained to me that he wasn't just an ordinary nurse, he was a nurse practitioner, you know, anyway, so we was quite happy.
> I: Did she tell you, when she explained, what did she say? Do you remember?
> R: She just said, 'He's not an ordinary nurse, you know, he can write prescriptions out and . . . and he can examine us and stuff like that, he's just very, very good'.
> I: So, I'm interested in what X told you. She said that he wasn't an ordinary nurse, you said?
> R: Yeah, and N said to me, he says he's not an ordinary nurse, he's similar to a doctor but he's not got a doctor's title, something like that. (Interview 28)

The nurse regarded as a 'doctor'

During the interviews many of the patients spoke of the nurse as though he were a doctor. Most of them 'knew' he was a nurse, if reminded, but they thought of him much more in terms of a doctor. A few patients thought that the nurse had also been *trained* as a doctor:

> R: I think, I don't know if someone's mentioned he's had doctor training. I don't know. I've heard something like that. (Interview 27)

One woman thought that the nurse had both professional qualifications, and suggested that this was particularly useful if the practice nurse was not available. She thought that the nurse must have trained as a doctor for him to take on an extended role:

> R: I think he's had training as a doctor and a nurse.
> I: Right . . .[meaning mmm]
> R: Because I don't think he could take on

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the surgery if he hadn't, like I say, ER [emergency room] trained as a doctor . . . so he's capable of doing like I say, the two jobs. Where a doctor, he's got to learn, you know, be trained at say . . . what to feel for in your stomach if you've got owt wrong with your bowels or anything like that, but like I say, with being a nurse, if anyone's scalded or burnt they just need the surgery, he'll know what to do, you know like, if the nurse isn't there at the time.
(Interview 13)

Another 37-year-old patient was quite confident that the nurse was well qualified to take care of her needs:

R: A doctor's seen as higher than a nurse, but you can't say that that doctor's got more knowledge than that nurse. Well, I think she's just as, nurses are just as . . . intelligent as 'em, sort of thing. Sometimes they might know better than a doctor, you know.
I: But you said they might have a different sort of knowledge, is that what you said?
R: No. They might have been taught different, but at the end of the day, I think a nurse is just as good as a doctor, even though they've had different teachings on it. Cos it all points to the same direction at the end of the day, doesn't it?
(Interview 17)

A woman who had three young children commented:

R: He's more doctory [than the practice nurse]. . . . He's more like a doctor than . . . I wouldn't call him a nurse. I don't even, if you say, 'What's the name of your doctor?', I don't say he's a practice nurse, or whatever, I just say, 'He's my doctor.' You know, I don't see him as anything different.
I: Do you think that's because he's a man, or because of what he does?
R: It's what he does. (Interview 9)

An elderly woman, aged 72 years, had clearly forgotten that the practice was nurse-led. She said:

R: I didn't know they had a nurse running the practice. I thought N was running it.
I: Well, he's a nurse. Did you know he was a nurse?
R: Oh, I knew he was a nurse. Yes . . . but I don't class him as a nurse.
I: You don't class him as a nurse?
R: No, no, no . . . He seems a bit too professional to be a nurse. He's got a lot more experience as far as I'm concerned, and I just don't think of him as a nurse.
I: Do you think that's because he's a man?
R: Oh no. (Interview 22)

On another occasion, an elderly woman (W) and her 40-year-old daughter (D) made similar comments:

I: Do you think N does different things from what another nurse might do?
W: I like N. I think he's alright.
D: To be perfectly honest, I look on him as a doctor.
I: Do you? Why is that?
D: Well, I just do. He seems to know everything.
I: You think it's because of what he knows, you see him as a doctor? Do you think it's because he is a man, or because of what he knows?
D What he knows.
I: So it's not because he's a man?
D: No.
W: No. (Interview 15)

One woman suggested that people thought of the nurse as a doctor because he was 'in charge':

R: I see N as a doctor, not as a nurse. I know that's wrong, but I go to him as a doctor, and to P [practice nurse] as a nurse. . . . I don't look at him as a male nurse. Probably because he is sort of in charge. (Interview 10)

A young couple pointed out that the nurse seemed more like a doctor, partly because he was able to diagnose, and partly because he dressed casually, without any uniform.

R1: He doesn't wear, like, I mean there is a male nurse's outfit, isn't there, that

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they wear in the hospital, the male nurses, the pants and the white . . . He just wears normal clothes . . . casual clothes.

I: Ah, that's interesting. So you think also the clothes?

R2: Yeah, that throws you. You don't look at him, at him as a nurse. If you, I mean, yeah.

R1: Like you say, all the other nurses that are there have the nurse's, like wear, like, nurse's uniform. (Interview 24)

When looking for 'deviant' cases (Silverman, 1994), only one patient said that he thought of the nurse as a doctor primarily because he was male. A 41-year-old window-cleaner expressed this view when asked what he made of the letter that he had received from the nurse via the health authority:

I: Did he say he was a nurse in that letter, do you remember?

R: I can't remember, I just remember thinking he was a doctor.

I: Oh, oh you did?

R: You don't actually class like, blokes as nurses a lot of the time. You just class them as doctors [laughs]

I: Oh, do you think that's because he's a bloke?

I: That's it. Yes. . . . I wouldn't dream of calling him a nurse if he was a nurse. (Interview 12)

Discussion

It was noted at the beginning of this paper that governments, professionals and patients may all play a part in the development and acceptance of any particular role within the NHS. Certainly, at a structural level, the government appears to be encouraging the development of nurse-led services. In July 1999, the Secretary of State for Health announced a tripling in the number of NHS Personal Medical Services Primary Care Act pilot schemes, and some of these new schemes will include nurse-led services (Department of Health, 1999a). It has also been announced that at least 30 million pounds will be available for NHS Walk-in Centres, many of which will be nurse-led. These new pilot schemes are intended to provide convenient, flexible services (Department of Health, 1999b). The government also intends to extend NHS Direct, the pioneering nurse-led 24-hour telephone helpline, so that the service is available in other parts of the country (Department of Health, 1999c).

It is in this context that it is particularly important to consider the views of the patients. Our research shows that in Salford the patients who had experienced the service appeared to have accepted and welcomed the nurse-led scheme. The patients constructed the nurse's identity partly as a result of interaction with other people, partly as a result of using the service, and partly from notions of medicine and nursing that they had gleaned elsewhere.

Attributing the status of doctor to the nurse reflects the way in which the professional dominance of medical practitioners still holds considerable sway among the lay populace. However, our study also suggests that the actual experience of using services, and the way in which services met people's needs, were important factors in the acceptance, legitimation and construction of new professional roles. The temporary loss of a highly valued primary care service was the immediate context within which the nurse-led service was introduced and experienced by patients. The re-establishment of social support and continuity of care by the nurse-led service provided the basis for high levels of satisfaction and confidence in the role of the nurse as the principal provider of primary care.

Social support and continuity of care are particularly important in the context of providing services in disadvantaged areas where the local environment is perceived to be deteriorating and where existing forms of support are seen to be under threat. Social support in primary care may take many forms. For example, the nurse backed the efforts of local boys to secure a football pitch because he believed that such sporting activities would help to reduce the factors that might affect their health, such as boredom and crime (Anon., 1999).

Whether or not nurse-led services will develop in other areas is still open to debate, and some might argue that this research cannot be generalized. However, as both Green (1999) and Morse (1999) point out, the use of a single site

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does not in itself threaten the validity or potential generalizability of a qualitative study. However, the criterion for determining generalizability, differs from a quantitative enquiry. If qualitative research has been conducted rigorously with, for example, a search for deviant cases, and if the social context has been described in detail, it is possible to make certain generalizations about findings.

We suggest that our results could be generalized to other socially deprived areas, with certain reservations. The social context has to be considered carefully. For example, there may be other socially deprived areas in which people are less dependent on primary care services for social support. In such circumstances these individuals may prefer a primary care service that is doctor-led, even if there is a relatively high turnover of GPs, rather than a nurse-led service.

The issue of gender also has to be considered. Although research has shown that both female physicians and male nurse practitioners can be routinely mistaken for members of the other profession (Horman *et al*., 1987), the nurse's gender did not appear to be an important factor influencing the construction of his role. Almost all of the patients denied that their perception of the nurse's role was due to his gender. However, we cannot be sure that a female nurse leading a practice would command the same level of support from all of the patients in different cultures. In the area studied, the service that the nurse-led practice delivered appeared to meet the patients' needs, and it would seem that it was this factor which most influenced the way in which the patients constructed the nurse's role and utilized primary health care services. While a number of factors will affect the development of the 'nurse-led' role, as this research has shown, patients' definitions and experience of using nurse-led services will in part influence the success or otherwise of such schemes.

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