International Perspectives

The Allied Health Professional in New Zealand General Practice

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For many years it has been usual for general practitioners to have the assistance of someone designated "nurse." Usually such people had been through formal nursing training but sometimes they acquired the necessary skills under the guidance of the general practitioner. These nurses were usually responsible for such things as injections, dressings, antenatal checks, and certain well-baby examinations—all routine procedures requiring only a modicum of medical knowledge. Sometimes such a nurse doubled as a receptionist, taking the responsibility of making appointments and organizing the physician's day.

More recently we have seen the evolution of the "practice nurse" concept embodying a somewhat new philosophy not universally accepted.[1] Ideally, the nurse is seen much more as a colleague and partner than as a handmaiden. The practice nurse should, in theory at least, complement the general practitioner, so that between the two of them the best possible care is afforded the patient. The work should approximate more closely the role of the nurse practitioner in North American practices.

Practice nurses are employed by many practices and there is some reason to believe that they have helped to alleviate the shortage of medical manpower in some parts of the country. Whether the concept will remain popular when there are adequate numbers of physicians remains to be seen.

Initially, practice nurse salaries were subsidized by the state, through the Health Department, but only in rural districts where the shortage of physicians seemed greatest. Recently, the scheme has been extended to urban areas also. There are two methods of paying the practice nurse:

1. *The 100-Percent Salary Subsidy.* The total salary is paid by the Health Department but the general practitioner can supplement it, if he feels that it is inadequate for the amount of work done. If a patient is seen by the practice nurse, independently of the physician, whether it be in his office or the patient's home, no item for service claim may be made on the Social Security System (General Medical Services Benefit) (see previous article "Paying for Medical Care: The New Zealand System"[2]). Similarly, no charge can be made to the patient.
2. *The 50-Percent Salary Subsidy.* With this ar-

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rangement half the salary is paid by the Health Department and the other half is paid by the general practitioner himself. The item for service social security subsidy may be claimed from the Health Department for services provided outside of the office and it is possible to make a charge to the patient as well, although this is discouraged.

If the practice nurse spends some of her time as a receptionist, or on administrative matters, the proportion of time must be calculated and the Health Department subsidy reduced accordingly.

This scheme has proved very popular as it has the effect of reducing practice expenses, but it has created a certain amount of anxiety with some physicians who feel threatened by a health professional who is capable of doing many of the tasks which the physician formerly did and who often seeks to expand her role even further. Consequently, some practice nurses find themselves left with trivial routine tasks which give little satisfaction and no intellectual stimulation.

Attempts are being made to establish formal training programs for persons wishing to make a career as a practice nurse. All, of course, are required to have completed basic nursing training.

For many years, New Zealand has had a District Nursing Service. This is really an outreach of the hospital services into the community, but despite the fact that the New Zealand general practitioner seldom has hospital privileges, this nursing service is available to him and his patients.

District nurses are responsible for providing nursing services to patients in their own home. This encourages earlier discharge from the hospital and may help to prevent hospital admission. The physician, recognizing that his patient needs wound dressings, injections, an enema, or various other nursing procedures, is able to request these from a central bureau, which in Auckland is known as "The Extramural Hospital." This is something of a misnomer as it is not a hospital in the usual sense of the word—it is a service and a very good one. Not only are district nurses available on the request of a physician, but also social workers, physical therapists, (physiotherapists, as they are known in New Zealand), speech therapists, home aids to assist with domestic chores, and occupational therapists to aid rehabilitation and advise on potential hazards in the home. In addition, an oxygen service is provided and wheelchairs, crutches, and sundry other aids to daily living are available. Where required, a linen service and Meals on Wheels can be organized. These services are all free to the patient and seem to relieve the pressure on hospital beds, thus helping to keep down the costs of health care.

It is obvious that there is a possibility of a conflict of roles between the practice nurse who does domiciliary visits and the district nurse. Until now this does not appear to have presented problems insofar as the practice nurse has usually been involved primarily with medical tasks and the district nurse has concentrated primarily on nursing tasks. Many general practitioners have urged the development of closer ties with the District Nursing Service and have suggested that such nurses should have an attachment to specific practices rather than a defined territory. Sometimes this has been engineered successfully, although the district nurse still retains a first loyalty to the Extramural Hospital. If practice nurses, with the approval of general practitioners, were to extend their role somewhat, it might ultimately prove possible to dispense with the District Nursing Service entirely, thus eliminating the tendency to centralization which this system encourages.

A number of other workers from time to time contribute to the primary care team and some practices now have social workers attached. In certain circumstances their salary may be subsidized by the Health Department. Such workers usually assist with counseling tasks and may help with the placement of patients among the various helping agencies in the community. Most physical therapy is provided by therapists who practice independently and who are not under the control of the Extramural Hospital. Their service is subsidized by the state in much the same way as the physician is subsidized. Like the physician, they also have the right to make a charge to the patient directly.

There is a well-established well-baby clinic service (the Plunket Society) which has been largely dependent for support on donations from well wishers and from the mothers who use the service. More recently, its income has been inadequate and the state has had to come to the rescue. The service is provided by nurses who have undergone some special training in infant and child growth and development. Infant feeding is commonly supervised by the Plunket Society which also monitors a variety of developmental

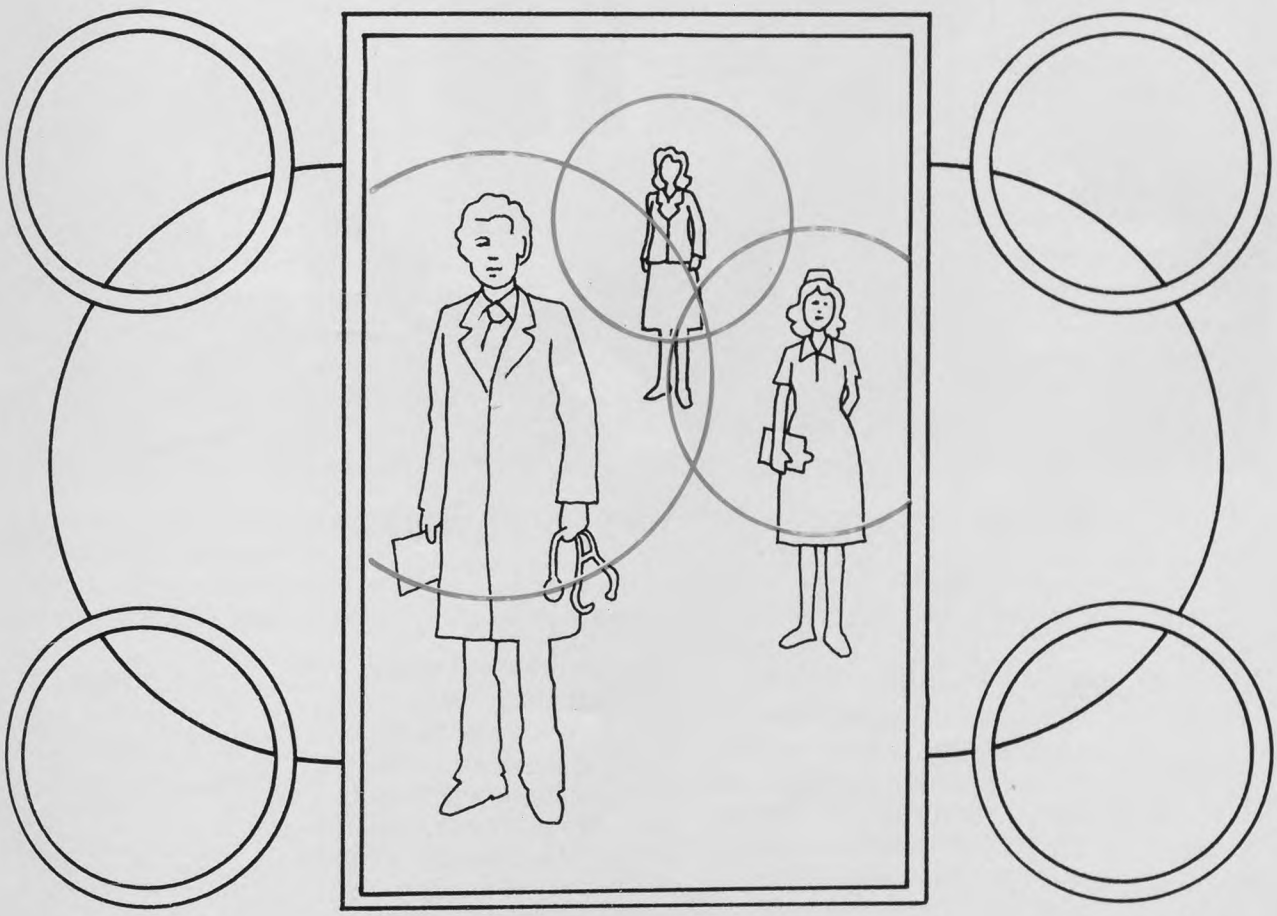
parameters. If deviations from normal are detected, the parent is usually advised to take the child to the general practitioner. While some physicians perceive this organization as a barrier between them and their patients, most welcome the assistance they can give, particularly in matters of infant feeding. In some areas this work is shared by yet another health professional, the public health nurse, who is employed directly by the Health Department. Her work involves the supervision of well babies who are not getting this care from the Plunket Society, together with follow-up of tuberculosis and other infectious disease contacts, the regular surveillance of school children for health problems, and other tasks of a preventive nature. Her relationship to the general practitioner is usually a rather tenuous one and there is a need for more collaboration and consultation.

In all areas, collaboration would probably be further facilitated if the medical students and allied health professionals were able to train shoulder-to-shoulder. Currently, any skills in teamwork have to be acquired by the physician and others after they have completed their basic professional training. In my view, the curriculum of each should be so organized that there are many opportunities for health workers to meet and share learning experiences so that each will become fully acquainted with the role of the others and the concepts of cooperation and coordination will become second nature rather than being appended as an afterthought.

References

1. Richards JG: The practice nurse. Aust Fam Physician 6:845, 1977

2. Richards JG: Paying for medical care: The New Zealand system. J Fam Pract 10:545, 1980



Self-Assessment in Family Practice

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This section of the Journal is designed to present clinical problems which focus on patient management, problem solving, and other elements integral to family medicine. The intent of this section is aimed more at teaching and learning than self-assessment as an evaluation or scoring device. Reinforcement of major teaching points is therefore included through the further discussion and supplemental references which appear on the following pages. Critical comments relating to these self-assessment materials are invited and should be submitted as Letters to the Editor.

Questions 1-5 each contain four suggested answers of which one or more is correct. Choose answer:

A. if 1, 2, and 3 only are correct
B. if 1 and 3 only are correct
C. if 2 and 4 only are correct
D. if 4 only is correct
E. if all are correct

Mr. H., aged 42 years, has come to your office complaining of intermittent left lower quadrant abdominal pain. He denies any change in bowel habits and describes the pain as "crampy." Following a negative sigmoidoscopy, a barium enema is done. Multiple diverticuli are noted in the descending and sigmoid colon.

1. What is (are) likely supposition(s) concerning the presence of the diverticuli?
   1. They were probably present since birth.
   2. There is often a history of irritable bowel syndrome.
   3. The diagnosis can always be made by clinical symptoms.
   4. They are more clearly seen on a follow-up roentgenogram done the following day.
2. Pathogenesis of diverticuli may include
   1. diets with decreased fiber
   2. pressure gradients between the colonic lumen and the serosa
   3. areas of weakness in the colonic wall
   4. frequent association with colonic cancer or previous appendectomy

Two days later, Mr. H. begins to notice diarrhea with occasional blood in the stool. The pain in the left lower quadrant has become more intense. The increase in the symptoms leads you to consider diverticulitis.

3. Confirming evaluations would include
   1. a stat survey film of the abdomen
   2. elevation of the white blood cell count
   3. the presence of sigmoid spasm on barium enema
   4. symptoms and signs of an inflammatory mass in the left lower quadrant
4. Treatment for Mr. H. would include:
   1. high fiber diet
   2. antibiotic coverage during this and all future attacks
   3. analgesics when needed
   4. strong consideration of surgery because of bleeding

Mr. H. is feeling better following his acute illness and returns to you to tell you that he has become a devout vegetarian because of your dietary instructions.

5. You should advise Mr. H. that
   1. milk products are needed to assure his intake of essential amino acids
   2. complete vegetarians should take Vitamin B_{12} supplements
   3. he should supplement the diet occasionally with meat or fish
   4. he cannot possibly get high quality protein comparable to animal protein

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