The Social World of Australian Practice Nurses and the Influence of Medical Dominance: An analysis of the literature

Abstract

In Australia, the number of practice nurses is growing at a rapid rate. On the nursing landscape, this group of nurses stand out because of their relationship with the Australian Government who both fund them, and concern themself with their continuing professional development. This paper provides a construction of the social world of Australian practice nurses, identifying stakeholders in the business of practice nursing. Literature produced by the various social world segments is analysed for the influence of medical dominance on the role, image, power and politics of practice nurses.

Key Words

Australia, family practice, general practice, nursing staff

Introduction

As the health care system struggles with workforce shortages and a significant increase in the prevalence of chronic diseases, access to affordable, effective and timely primary care is fundamental to improving Australia's mortality and morbidity rates, while reducing the burden of disease [1]. To enable population health needs to be met an improvement in the coordination of care in general practice, streamlined access to community health services, a focus on preventative measures and the use of planned proactive management strategies for clients living with a chronic disease are required. Since 2001 one of the strategies employed by the Australian Government to meet the demand for primary care services has been targeted funding to support the employment of nurses in general practice [2]. These nurses are traditionally referred to as practice nurses which relates to the context of their employment as opposed to their level of skill [3].

Along with an increase in Australian Government and private sector investment is a concomitant growth of individuals and organisations that identify as stakeholders in

the business of practice nursing. This paper will conceptualise the social world of Australian practice nurses and identify the influence of medical dominance in the development of this burgeoning speciality group.

Method

A search of the literature was undertaken regarding Australian nursing in general practice between 2001 and 2008, limited to English. Search engines used were Medline, Pubmed, Search Gov and the Cumulative Index to Nursing & Allied Health Literature. Search terms used were: nurse, general practice, Australia, medical dominance and division of general practice a combination of which returned 56 articles. As well, the *Nursing Review*, *APNA Newsletter, APNA e-news*, and the *AGPN Nursing News* were searched by hand. Division of General Practice websites were also accessed and electronically searched. Literature retrieved was reviewed for the influence of medical dominance on the role, image, politics and power of practice nurses.

Results

Social Worlds Theory

The concept of a social world being a mechanism by which individuals or actors organise their lives, stems from the Chicago School of Interactionism and the thinking of Mead and Blumer [4-6]. Strauss [7] went on to develop this early work postulating that social worlds are formed when segments define themselves, while building a legitimate core activity that differentiates them from each other. Core activities of different segments promote their ability to compete for resources, power and the creation of history. Social world theory makes an assumption that actors possess the agency to interpret interactions and create change[8]. Examples of social world segments that are easily identified are those constituted by institutions or organisations.

Two other characteristics of social worlds that are considered analytically important are intersection and legitimation. Intersection between segments can result in ‘arenas’ or sites of contestation about key issues ‘where actions concerning these [key issues] are being debated, fought out, negotiated, manipulated, and even coerced within and

among the social world' [7, p.226].

Legitimation provides the cause for each segment's actions, their raison d'être. Some of the processes used in legitimation by different segments of a social world are discovering and claiming worth, distancing from others, developing theory, setting standards while also embodying and evaluating these, and defining and challenging boundaries [7].

Medical dominance is integral to the processes employed by different segments of the social world of Australian practice nurses to legitimise various positions taken. The following analysis of the literature will focus on medical dominance as a mechanism that shapes the role, image, power and politics of Australian practice nurses.

The Social World of Australian Practice Nurses

As a beginning point in the construction of a conceptual social world of Australian practice nurses it is important, as the authors of this paper, that we identify our own personal place and voice in this world, as a way of indicating to the reader and ourselves how this contributes to the intent of our analysis [9]. Both of us are registered nurses who currently work in university schools of nursing and midwifery and have an interest in researching the field. As well, we have previously been employed by Divisions of General Practice to work with practice nurses in both teaching and support roles. In this way we are intrinsically connected to and are currently actors in this social world.

The following diagram illustrates our conceptualisation of the social world of Australian practice nurses and includes the following segments: Royal College of Nursing *Australia*, Royal Australian College of General Practitioners, Australian Practice Nurses Association, Australian Nursing Federation, Australian Medical Association, Australian General Practice Network, State Based Organisations of Divisions and local Divisions of General Practice, Practice Nurses, General Practitioners, Consumers, Academics and the Australian Government.

Figure 1: The Social World of Australian Practice Nurses

Over the past seven years, the considerable injection of money into this branch of nursing practice has resulted a high degree of competition between some actors who

in other circumstances may have been grouped together and considered as one segment [10]. In Figure 1, close grouping indicates similarities between different segments. Note there is no overlap between some segments, representing the competitive nature of the social world at hand and the vested interests of the actors within the arena.

Considerable overlap is seen in the depiction of the general practice workplace where general practitioners, practice nurses and consumers form a tripartite. The structure of these workplace relationships is reflected in the hierarchy of Divisions of General Practice. Authoritative relationships exist within both the general practice workplace and the hierarchy of divisions that relate to clearly identified lines of authority and employment.

Funding for both the general practice workplace and the Divisions of General Practice is sourced from the Australian Government. The large amount of power that this confers is indicated in the diagram by the Government's position of ascendancy.

The most common communication style between professional organisations that constitute segments in this social world is negotiation, which is represented in the figure by a wavy line. There is a direct line between local Divisions of General Practice and practice nurses, representing their strong, mutual concern for quality assurance, education and training, and support.

A dotted line connects nurse academics to various segments of the social world as they communicate with a range of actors in relation to their work as researchers and teachers. The work of nurse academics is often conducted through segments within the social world, these provide a conduit to primary care clinicians be they practice nurses or general practitioners. The use of a conduit segment is neccesitated by Australia's stringent privacy legislation that limits opportunities for academics to initiate direct negotiations with clinicians.

All of the segments of the social world of Australian practice nurses are contained within a permeable circle. This permeability represents the potential of other transient segments, for example non-government organisations concerned with chronic disease management such as the National Heart Foundation of Australia, Arthritis Foundation of Australia and the National Asthma Council Australia, to influence actors through occasional projects, advice and support.

Medical Dominance and Nursing in General Practice

Nursing has long been conceptualised as an oppressed feminised group, while medicine is conceptualised as a dominant masculinised group [11]. Sullivan et al. argue that the division of labour played out by these two groups 'manifests in the clinical work done; in the involvement in and influence over decisions about patient care as well as the division of labour itself' [12, p.1545]. Medical dominance therefore, is a mechanisim used to control practice as exemplified by the low level of self-determination able to be exercised by nurses in general practice regardless of their legal scope of practice. The language of medical dominance is apparent in the literature relating to the social world of nursing in general practice, beginning with how role of the practice nurse is described and defined by various segments.

The Australian Practice Nurses Association, the peak body for practice nurses, promote a strong focus on the employment status of practice nurses in their definition of a practice nurse as 'a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a General Practice' [13]. The position of the nurse is clearly spelt out as being controlled by the general practitioner while at the same time identifying the requirement for licensure as either a registered or enrolled nurse. There are conflicting messages in APNA's definition about the role of the nurse and the scope of their practice, one of which can potentially constrain the other. This contrasts strongly with the Australian Nursing Federation who uses the broader and more sophisticated International Council of Nurses' definition of nursing to delineate the role of Australian practice nurses.

> Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings. Nursing includes the promotion of the health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environments, research, participation in shaping health policy and in patients and health systems management, and education are also key nursing roles ICN cited in [14].

Other segments postulate a far different and less autonomous role for practice nurses in the delivery of primary care services, firmly relegating these clinicians to being general practitioner's handmaidens. This is seen in the Australian Medical Association's (AMA) position that, practice nurses under the supervision of the doctor can enable patients to access services [15].

The role of the practice nurse therefore is an arena in the social world of Australian practice nurses with academics, Royal College of Nursing *Australia*, the Royal

Australian College of General Practitioners and the ANF intersecting with the AMA to challenge the construction of the general practitioner as an appropriate arbitrator of the scope of nursing practice [16-21]. Arguing that what practice nurses really want 'is genuine collaboration, not trench warfare [and that] it is arrogant for the AMA to suggest that the doctor is the most pivotal member of the health care team' [22]; the ANF developed a set of competencies for Australian practice nurses [23] which are supported by the RCNA's guidelines for the general practice team [24]. Both of these documents serve to legitimate each organisation's position as an advocate for recognising practice nurses' legislated scope of practice as opposed to nursing work being firstly defined, and then supervised and directed, by a general practitioner. Divisions of General Practice at all levels also argue that practice nurses are autonomous professionals in their own right. However, such a position is acknolwedged to be constrained by a funding arrangement that perpetrates a model of medical dominance [25]. For example, Medicare Benefit Schedule (MBS) remuneration for a task such as immunisation when undertaken by a practice nurse is significantly less for the same task when undertaken by a general practitioner [26].

Academics writing about practice nursing have also concentrated on the current role of the practice nurse, identifying cultural and historical barriers that prevent clinicians from delivering care that would normally fall within their scope of practice as a registered nurse [18, 21, 27]. Only one nursing research study was found that directly discussed the influence of power and the division of labour on the role of practice nurses [28]. Conducted before the 2001 general practice reforms, which saw the introduction of practice nurse MBS item number allocation, the researchers identified the same barriers to clinicians realising a full scope of practice that later studies would also find. These are 'the historical lack of multidisciplinary teamwork in general practice, current funding models and the culture of general practice' [29, p.125], each of which follow each other in a self perpetuating cycle of oppression that effectively results in reduced access to care, particularly for those clients living with a chronic disease [30].

Regardless of such arenas that clamour for a change in funding models to increase the autonomy of practice nurses, the culture of general practice with its patriarchal division of labour remains largely unchanged. 'In every team situation… it is the doctor who bears the final responsibility, and the doctor who is the natural and

appropriate leader of the team [31, p.28].

Discussion

Speed and Luker identify three key influences on the relationship between doctors and nurses in primary care, which perpetrate a division of labour influenced by medical dominance.

1. Doctors and nurses are trained in hospitals where nurses are socialised into a subordinate position from the start of their careers
2. General practitioners have a long history of operating as an independent practitioner that contracts the services of others such as practice nurses, and
3. Work relations in primary care are invariable influenced by the relative social positions of men and women in a patriarchal society. (McIntosh and Dingwall cited in [32])

Manojlovich offers a useful framework for an analysis of nursing and power, postulating that there are three nexuses where power can be negotiated. These are: control over the competence of nursing practice, the content of nursing practice, and the context of nursing practice [33].

In the social world of Australian practice nurses, legitimising strategies aimed at developing control over the competence of practice nursing have been used by segments that promote the professionalisation of nursing, namely the Australian Nurses Federation and Royal College of Nursing *Australia*. Interestingly work undertaken to develop practice nurse competencies was funded by the Australian Government, even though the project outcome is not consistent with its activity in the other nexuses of power: the content of practice nursing and the context of practice nursing. A contradiction such as this brings into question the value of a document such as a set of competency standards for nursing in general practice [23] if it is not used as the basis for further decision-making by policy makers.

The content of practice nursing is shaped by a designated set of MBS item numbers that includes: immunisation, wound care, pap smears, preventative health checks for women, antenatal services in regional, rural and remote areas and chronic disease checks. Most of these item numbers include a proviso that the practice nurse can undertake these tasks ‘under the supervision of a general practitioner’. In addition to nurse specific MBS item numbers, a range of general practitioner MBS item numbers include a potential practice nursing role, these are: supporting general practitioners with health assessments and care plans, delegation of some aspects of the care of

diabetics and asthmatics as well as clients requiring a 45 year old health check. Practice nurses can also assist general practitioners with Aboriginal and Torres Strait Island child health checks and health assessments for refugees and other humanitarian entrants [2]. In all of these MBS item numbers, the terms supervision, support, assist and delegate pepper the language used to describe the care to be provided.

General practitioners are small businesses that usually rent or own general practice workplaces. By virtue of employing practice nurses, therefore, general practitioners also control the context of their practice. A study currently examining the determinants of practice nursing has found that the control of space is key to the way that general practitioners interact with practice nurses and influence the content of their work. Findings demonstrated that practice nurses rarely have their own space in which to work, rather the context of their practice is in a central or a transitional space such as a treatment room or corridor. Working in such a space enables informal, frequent and usually unplanned interactions between the practice nurse, the general practitioner, other practice staff and clients that often lead to the practice nurse feeling unsatisfied with her job[34]. Not providing the practice nurse with his or her own space devalues the nurse's practice in comparison to general practitioners, as well as constraining the type of care that the nurse is able to provide.

The social world of Australian practice nurses has many different segments, each of which have their own agenda in relation to the promotion of practice nursing as an emerging speciality group. The influx of money into this developing speciality is a reflection of the concern that the Australian Government has for funding primary care services that have escaped the devolution of responsibility to a State or Territory level of government. A culture of medical dominance in Australian general practice influences the content and context of practice nursing, underpinned by a task based model of primary care funding that focuses on the concerns of the dominant group. Professional nursing bodies have attempted to assert their power through the formulation of a set of competencies for practice nurses; however, on balance this has been less than influential. As we move into the next three year term of a new Australian Government, there is the potential for a radical rethink of the way in which primary care services are funded which may lead to a greater recognition of the potential of practice nurses to contribute to improved access to health care, particularly in the area of chronic disease, health promotion and the prevention of

disease.

Acknowledgments

An Australian Government National Health and Medical Research Council Primary Health Care Fellowship Awarded to the Primary Author funded this study. NHMRC Grant ID: 431532.

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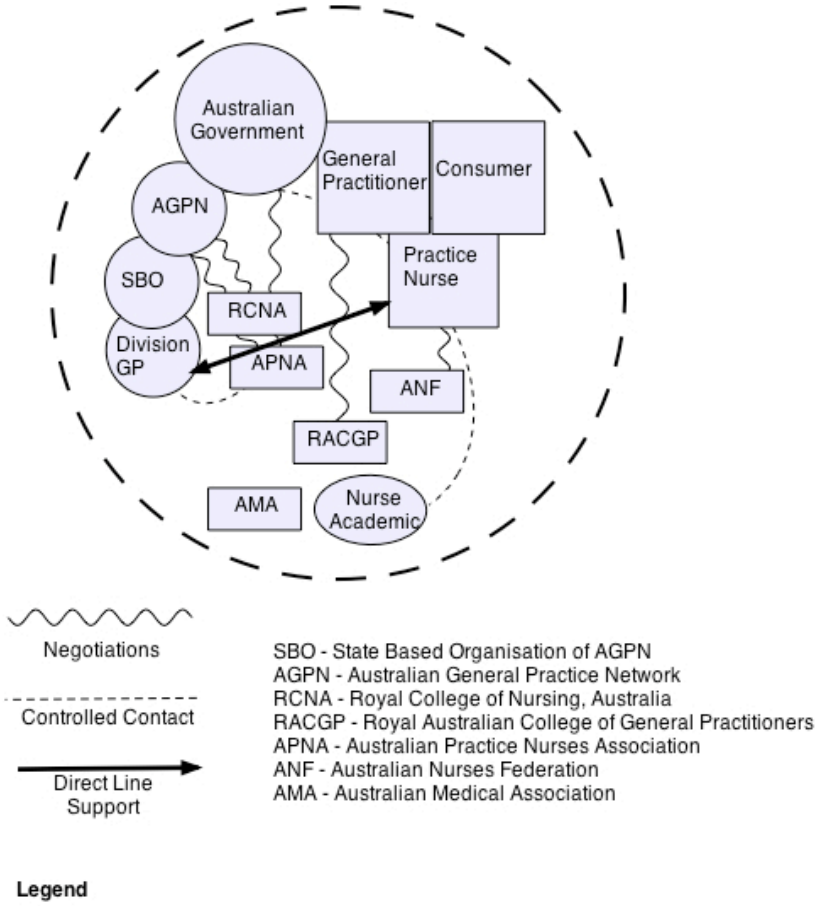

Figure 1: The Social World of Australian Practice Nurses

AGPN, Australian General Practice Network; AMA, Australian Medical Association; ANF, Australian Nursing Federation; APNA, Australian Practice Nurses Association; RACGP, Royal Australian College of General Practitioners; RCNA, Royal College of Nursing Australia; SBO, State Based Organisations of AGPN