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Nurse Practitioners are Taking on an Increasing Role in General Practice. Is this a Good Idea?

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Introduction

The workload in primary care is rising for several reasons. There has been a transfer of work looking after chronic conditions such as Diabetes, increased demand stoked by health campaigns, NHS 111 ("you need to see your GP within 24 hours")', the ageing of the population, extra tasks to do with new initiatives such as preventing admissions, a huge increase in the number of immunizations administered etc. At the same time the GP workforce is only growing very slowly (around 2% annually), and the net income per practice has been falling steadily for the last few years.

So it is not surprising that patients are increasingly likely to be cared for by non-medically qualified staff, many of whom have not been formally trained in important subjects like pharmacology, or in consultation skills. Most often it will be nurses and nurse practitioners taking on these roles with a smattering of pharmacists as well. The idea is that they are more cost effective, and it has been shown that they are more consistent in following protocols and guidelines. Patient satisfaction, especially with the time spent on their care, is also generally very good.

What is not to like? It is a no brainer that nurses doing chronic care for example for diabetes or contraception is useful skill mix and frees up doctor time.

But many practices are going way beyond this, and a large number of patients with new problems are seen by Non Doctors (aka Noctors). These patients may have any of a bewildering variety of medical conditions.

The training of doctors who are able to deal with this situation involves the following. First of all students are chosen from the brightest and most hardworking of school pupils. Then they have five or six years at university, absorbing huge amounts of information as in pharmacology (about drugs), and skills (such as consulting with patients), with regular exams up to four times a year. Then they compete for the foundation program, and if successful they spend 2 years on the bottom rung of hospital doctors in a sort of apprentice role. Many follow this by getting 2 or 3 more years of experience all over the world before deciding to enter GP training. Then they have to pass a selection exam, and after that they have 3 years further training of which 18 months is in a highly supervised position in a practice. During the latter stages of these 3 years the doctors have a complex exam (costing them 1500 pounds each time)' which around 30 percent of them fail, and without which they cannot work in general practice at all. The whole system is intensively supervised by the General Medical Council, the Universities concerned and the Medical Royal Colleges. Once fully qualified as a GP, continuing to be allowed to work depends on compliance with Revalidation with compulsory postgraduate education, audit, and a review of complaints, all done at an annual appraisal.

This long and complex process is necessary, because although some of the work is trivially easy, the job is hugely variable, and the knowledge and skills needed to deal with the less common stuff are very considerable. The aphorism says that it is the easiest job to do badly, and the hardest job to do well. Noctors (nurse practitioners, practice pharmacists, physician associates, emergency care practitioners etc.) have a very much shorter period of training, for which there is no standard system of regulation, and no agreed curriculum. They lack the necessary knowledge and skills to a variable extent, and as a result errors are common, and patients are harmed. Typical mistakes in my experience are to assume that the patient has a common condition when it should be obvious that it does not fit, and similarly applying an inappropriate guideline when the patient really is not in that category. One would assume that in these cases it should be easy to consult with a doctor who could sort it out, but often this does not seem to happen. Perhaps the nurses are defending and justifying their position and perhaps the doctors are too busy with plenty of their own patients to deal with. Another common problem is that patients are taking large numbers of long term medication, with potential adverse effects. Nurses rarely have the detailed knowledge which would enable them to spot likely adverse effects, and also find it very difficult to interpret the huge number of warnings (many of which are trivial) that are issued by standard prescribing software, so they tend to just ignore them.

There is no requirement for revalidation of nurses or pharmacists or paramedics (although it is starting for nurses soon). There are also no rules whatsoever as to how many doctors are needed for a certain number of patients. It would be legal to have a practice with 100,000 patients and one doctor.

Aside from the harm done to individual patients, the NHS as a whole suffers as a result of excessive prescribing by non-doctors. For example, nurses who are trained in asthma care will tend to see a wheezy toddler and step up treatment in terms of inhalers, and if there is no response will increase treatment further according to the steps of the asthma guidelines. A doctor on the other hand might observe that if inhaled steroids do not work well, and if the child tends mainly to get wheezy with a cold, and if there is no clear story of eczema or other allergic diseases in the family, then maybe it isn't really asthma after all, and stopping the treatment will save money and possibly also save the child from stunted growth. Unwise referrals from Noctors may also be costing the NHS a large sum which is impossible to try to estimate.

Conclusion

So what can be done about it?

Obviously the clock should not be turned back to the days when doctors did their own ear syringing, but I wonder if we should not possibly utilize nurse practitioners more in hospitals and less in General Practice. They could be doing an aesthetics, routine operations, stenting heart arteries, scoping inside people's guts etc. These activities require the learning of skills to a high level, but not the massive breadth of knowledge and experience that is needed in General Practice.

Then we could regulate GP practices so that unselected patients have to be seen by a doctor, and nurses etc. only see patients for long term conditions. This would benefit individual patients and the NHS as a whole.