

Guest editorial

Who needs doctors in general practice?

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The great majority of clinical care in general practice consists of preventative healthcare for well people, treatment of minor illness and the routine management of chronic conditions such as diabetes, asthma and cardiovascular disease. Research suggests that all of this work can as effectively, or more effectively, be delivered by nurses. So who needs doctors?

Preventative healthcare is one of the principal areas of work for practice nurses in Britain. Nurses have lead responsibility in most practices for organising cervical cytology screening, childhood vaccinations and immunisations, and health check-ups for older people. This leadership role was largely brought about by the 1990 general practitioner (GP) contract, which paid doctors to meet population target rates for immunisations, vaccinations and cervical cytology screening. Many practices responded by employing nurses to provide these services, and those that did were better able to meet the new performance targets.^{1–3} Nurses performed well in these new roles and it is they, not doctors, who deserve most credit for the reductions seen over the 1990s in social inequalities in cervical cancer and childhood infectious diseases.^{4,5}

Nurses are equally effective in providing first-contact care for patients. A systematic review of worldwide research into doctor–nurse substitution showed that nurses can provide as high-quality care as doctors in the treatment of minor illness and the provision of primary care to unselected patients.⁶ The research included studies in which all general practice patients were managed by nurses instead of doctors, as well as a number of UK trials in which nurses substituted for doctors in first-contact care for patients needing urgent (same-day) treatment. No aspects of healthcare were identified in which doctors performed better than nurses. Indeed nurse-led care was superior in that nurses tended to give patients more information and patients were more likely to be satisfied.

Research suggests also that nurses are highly effective in the routine management of chronic diseases.^{7–9} The key element to effective care is service organisation. If care is well structured – i.e. there is a patient register and recall system with clinical reviews conducted in accordance with evidence-based guidelines – then health outcomes for patients are good. In

coronary heart care, nurse-led clinics appear to be as effective as doctor-led clinics, and more effective than care provided by doctors in routine consultations.^{10,11} In other words, nurse-led chronic disease clinics improve the quality of clinical care in general practice.

Patients' views and expectations of nurses are understandably influenced by their knowledge and experience of nurses working in extended roles. Although patients generally express high satisfaction with nurse-led care, this does not mean that patients inevitably prefer nurses to doctors. Patient preferences in most studies are mixed, with some patients preferring to see nurses while others prefer to see doctors.⁶ Preference may be partly related to the nature of the presenting problem. Nurses may be favoured when patients believe the problem to be 'minor' or 'routine', but doctors are preferred when the problem is thought to be 'serious' or 'difficult'.¹² Such preferences may evolve as nurses' roles evolve and with that, patients' knowledge and appreciation of what nurses can do.

If nurses are effectively able to deliver as much as 70% of all clinical care in general practice, why is it most care is still provided by doctors? Nurses have, in the past, been faced with a number of obstacles to achieving their full potential. But these obstacles are now steadily eroding. First has been the challenge of ensuring that nurses working in extended roles are appropriately trained and regulated. Here, the Royal College of Nursing together with higher education institutions have made good progress in defining the competencies needed by primary care nurses, and putting in place training programmes to equip them with the requisite skills.¹³

A second obstacle has been legislative restrictions on nurses' right to prescribe drugs. However, from spring 2006, suitably qualified nurses have been able to prescribe any licensed medicine for any medical condition with the exception of controlled drugs.¹⁴ What is needed now is considerable expansion in the numbers of qualified nurse prescribers in general practice.

Third has been the need to clarify legal liability. Here the barrier is more apparent than real. In England, each practitioner is liable for the quality of care he or she delivers. Employers wishing to substitute doctors for nurses have only to show that they have taken

appropriate steps to ensure that nurses are appropriately trained and supervised in their work.¹⁵

The fourth and most difficult obstacle to overcome is that the overwhelming majority of practices are owned by GPs who are understandably reluctant to hand control to nurses. It is likely however that economic self-interest will further accelerate the trend towards nurse-led care. Unlike earlier contracts, the new general practice contract of 2004 is held by the practice, not the individual GP, making it easier for practices to substitute nurses for doctors. Early indications are that practices have further increased their use of nurses working in extended roles.¹⁶ The small but increasing trend towards primary care trust or private sector ownership of general practices offers further scope for increasing nurse-led care.

So do we need doctors in general practice? The answer is probably 'yes' but far fewer than is presently the case. Nurses can effectively deliver most clinical care, leaving doctors to deal with that minority of patients who have complex medical problems beyond the competencies of nurses. The true frontline providers of general practice care in the future are most likely to be nurses, with general medical practitioners providing back-up at the invitation of nurses.

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