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Nurse practitioners

Sir,

The editorial by Koperski *et al* (November *Journal*)[1] represents a comprehensive review of the many issues that need to be resolved in order that nurse practitioners (NPs) can be integrated into general practice. It is a positive contribution to the debate at a time when the United Kingdom Central Council for Nursing, Midwifery, and Health Visiting is about to decide whether the specialist practice framework[2] can embrace NPs.

Since 1993, we have been researching the role of NPs in general practice via the EROS (extended role of staff) project, which was jointly funded by Northumberland Health Authority and the Northern Regional Health Authority. Our report is available (Bond S *et al*, Evaluation of nurse practitioners in general practice in Northumberland, Centre for Health Services Research, University of Newcastle upon Tyne) and addresses a number of the issues raised in Koperski *et al*'s editorial. In particular, it describes the educational programme that proved of fundamental importance in enabling the nurses to develop the higher level clinical skills necessary to diagnose and manage patients presenting in general practice with undifferentiated illness (a summary can be found at www.btinternet.com/~corbridge.health).

This programme was based in four training practices and consisted of the following elements: enthusiastic learners, a GP mentor identified for each nurse, funded protected teaching time, and strong clinical back-up for the nurse when working in the new role, with increasing responsibility for patient care taken as skills developed. Other factors that assisted the process included a clear agreement at the beginning by all partners about the development of the role, good planning, information given to patients and staff about the role, and a supportive primary health care team.

The number of academic courses that currently aim to develop NPs is mushrooming. Unfortunately, it is our experience that clinical skills training represents the weakest link in the educational chain, depending as it does on the goodwill of GPs to provide mentorship and teaching for nurses in the practice. As a result, the time allocated by practices for these essential tasks ranges from negligible to substantial. We feel, therefore, that there is a need to forge greater links between academic institutions providing such courses and local training practices that have the expertise to deliver clinical skills training at a consistent and appropriate level. These periods of training should be funded and of reproducible high quality, with nurses being regarded as trainees.

Practice placements of this type will ensure that the education and training of NPs move in parallel with the development of the role rather than lagging behind it (as happened with practice nurses).[3]

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Sir,

The information about nurse practitioners in general practice given by Koperski *et al* (November *Journal*)[1] is useful for the development of the role of the nurse in primary care. There is sound advice about avoiding problems by planning role responsibilities, job descriptions, protocols, supervision, and much else. If this is followed, it will help to avoid the prolonged gap between the validation of the role in Ontario in 1974[2] and its revival there and in Britain around about 1995. Much of the USA is further down the road with still unresolved problems.[3]

Yet is it all too tentative? The question in the title, 'an inevitable progression?', suggests some reluctance, and there are GPs who 'defend their territory'. It is time to progress. The way forward will be found by sharing overlapping work. Patients know what is needed: time to tell their story, air their worries, and ask their questions. Prescribing is less important. There are plenty of doctors doing that instead of listening carefully and advising wisely.

The way to do this can be found by working with nurses. Nurses may be better with some problems than doctors, and their lack of ready access to drugs may be an advantage. We need to repeat the work of Marsh and Dowes[4] in different settings to confirm their findings and answer some of these questions:

How does the special relationship of nurses with patients differ from that of doctors and how can it be used best? Many consultations require reassurance and education rather than medication. Can nurses do this better than doctors? Will nurse practitioners doing this allow doctors time to listen to patients more themselves and to use their skills for the complex medical problems now being treated at home?

Finally, many disabled people at home need more attention from doctors, which is best given in partnership with nurses, therapists, and other members of the primary care team.[5,6] Some specialized nursing skills may be needed here. Various types of nurse practitioners and specialist nurses are emerging. Their roles overlap with one another and with doctors. None of this is reason for delay. 'Come, my friends, 'tis not too late to seek a newer world'.[7] But it *is* getting rather late.

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Prescribing formularies

Sir,

Following their study, Avery *et al* (December *Journal*)[1] suggest that prescribing formularies in general practice may favourably alter prescribing patterns.

An alternative explanation may be that, over time, case practices (with 34% of the partners from dispensing practices and 62% from fundholders) were simply less likely to stick to a static range of NSAIDs than control practices (with 50% of the partners from dispensing practices and 41% from fundholders).

By end of the April–June period, approximately 25% of the NSAID defined daily doses originated from about 10 different NSAIDs for the cases, whereas, for the controls, approximately 30% of the ddds originated from 11 or 12 different NSAIDs. Though statistically this might appear quite exciting to the authors, surely there are other markers of NSAID use that reflect a favourable prescribing pattern: a difference between the cases and controls in the actual choice of NSAID used (e.g. low toxicity verus high toxicity), the use of simple analgesics rather than NSAIDs where appropriate (e.g. in osteoarthritis), and the appropriate use of gastroprotection in high-risk patients taking NSAIDs?

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Reference

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Summative assessment

Sir,

I write on behalf of an enthusiastic group of GP registrars who are fortunate to be part of the excellent Cleveland Vocational Training Scheme. While we all agree a compulsory form of assessment is needed, we believe summative assessment is not the answer.

Summative assessment comprises an multiple choice questionnaire in which our group obtained a 100% pass rate with little or no revision, and at that time there was a nationwide pass rate of 95%. Registrars also have to submit an audit — the concept of which the majority of us were already familiar with from our hospital training — and a video of consultations from which candidates can select their best consultations. It is clear to see that this is not going to raise standards. On the contrary, summative assessment may even lower standards; first because a number of my colleagues have now dropped out of the MRCGP examination because it is now compulsory to do summative assessment, and secondly, for registrars like ourselves who are taking both summative assessment and the MRCGP examination, so much time is spent involved with them that we lose time from the most important part of learning: patient contact and follow-through. Also, spare a thought for our GP tutors and their increased workload.

We need one form of assessment only. The MRCGP is the ideal exam for this purpose. It is one of the best postgraduate exams. It avoids the obscure, asks of us what we should know, has a very respectable pass rate, and leaves candidates with a good level of competence. Furthermore, as we have started to work for the exam, we have found not only that much of the work is interesting (especially the critical reading section), but that it is applicable to our everyday work.

General practice appears to becoming more popular again, with vocational training schemes once again staring to fill up. The introduction of cooperatives has significantly reduced out-of-hours work, and the new National Health Service (NHS) White Paper puts us very much as the driving force of the NHS. Making the MRCGP examination compulsory would not lesson GP recruitment, whereas we believe the current situation might. The two levels of assessment that currently exist are time-consuming and take away much of the enjoyment of GP training. Furthermore, general practice should not be seen as the easy option.

Change is for the good, not if we are just seen to be doing something, as we believe to be the case with the current summative assessment format, but only if that change leads to something better. We believe that with summative assessment we are selling ourselves short, and that it is time for those people who make the decisions to start listening to the growing body of people (in particular the registrars) who feel we should be setting ourselves higher standards, so that the new generation of registrars entering into the next millennium are of a high standard, joining the many excellent GPs already based in this country.

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Training in palliative care

Sir,

The questionnaire survey by Barclay *et al* (December *Journal*)[1] has shown that, although there has been an increase in training for palliative care, there are still deficiencies in the knowledge base of general practitioners.

A questionnaire study has been given to general practice registrars in the Medway and Swale area, who attend for a training afternoon at the Wisdom Hospice, looking at their training and knowledge in palliative care over an eight-year period.[2] Over this period, 40 GP registrars have visited the hospice and completed the questionnaire: 12 in 1988, 17 in 1991/92, and 11 in 1995/96. They had all been involved in the care of patients who were dying, but with different levels of training in different aspects of palliative care. Over the eight-year period, the proportion of trainees who felt that the training they had received was adequate had increased from 17% to 55%. However, the responses to the question on symptom control had not improved, and in many cases had deteriorated. Although a majority of the GP registrars knew of the frequency of administration of morphine, fewer trainees were aware that there was no maximum dose of morphine, and only 36% could correctly convert oral morphine to parenteral diamorphine.

This small study shows that, although there may be increased training in palliative care, this may not always lead to an increased knowledge of the principles of symptom control. There is a need to consider the training of GP registrars and other junior doctors, including the possibility of an attachment to a hospice unit,[3] and to ensure that all training is evaluated so that it is as effective as possible in increasing the knowledge of GPs in this important area of patient and family care.

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