# The medical care practitioner: Newspeak and the duping of the public

FORTY years on, Orwell's Newspeak[1] is finding its apotheosis in New Labour's modernised National Health Service (NHS). However, whereas the original form of Newspeak restricted the range of words in order to limit the expression of dissent, the contemporary form deliberately distorts the meaning of words in order to mislead and manipulate.

The Changing Workforce Programme of the NHS Modernisation Agency is planning the development of a new category of health professional. Originally to be called a 'physician practitioner', the name has now been changed to 'medical care practitioner', though why this is felt to be less misleading is unclear. The idea is derived from the US model of physician assistants but has been given a new title. It is very difficult to understand the renaming other than as an attempt to deceive the public. Both proposed titles imply that the person is a doctor, a practising physician who will deliver medical care, whereas the proposal is that 'medical care practitioners' will be science graduates with only 2 years further training. Those in charge of this development anticipate that these new health professionals will be able to function at the level of a senior house officer (who has, at that stage had 8 years of dedicated medical training). Further, 'medical care practitioners' are described as having 'the skills and knowledge base to deliver 60% of the generalist treatment within ... [a] general practice team'.[2] Such statements appear to reveal a wilful ignorance of the extent and complexity of medical knowledge and skill. The Changing Workforce Programme's justification for the change of name is their intention to emphasise that the new medical care practitioner will function with a high degree of autonomy and will be expected to obtain full medical histories and perform appropriate physical examinations, diagnose, manage and treat illness, request diagnostic tests and interpret the results, provide patient education and preventative health care advice and decide on appropriate referral to other professionals[2] — and all this after just 2 years of dedicated education.

Over the last 40 years, general practitioners (GPs) have demonstrated, through their enthusiastic pursuit of the development of multiprofessional primary healthcare teams, that patient care is strengthened and enriched by different professional perspectives and that it is possible, and indeed desirable, to delegate a large range of healthcare tasks away from GPs themselves. However, the core GP task of providing a first-line medical diagnostic service, without recourse to excessive, unnecessary, and potentially harmful investigation and referral, is not one that can be delegated to anyone who does not have a full undergraduate medical and postgraduate GP education.

The sheer range of diagnostic possibility and the need to identify not only the common, but also the unusual and the dangerous, and to provide an appropriate and safe response to each successive situation, means that primary medical care demands the highest level of knowledge and skill. Each decision in the medical care of individual patients involves judgment as evidence from population science is applied to that individual. To the extent that each decision involves judgement, each decision also involves risk. No amount of exhaustive and stifling regulatory effort will change this fundamental truth. It is, therefore, essential that those who undertake roles that involve both judgment and risk in the face of situations that will always be uncertain and unclear, continue to have the benefit of the most extensive education and the highest possible levels of skill and knowledge. The classification of any clinical situation as straightforward is always retrospective rather than prospective; to place minimally trained professionals in the frontline of primary medical care and expect them to undertake 60% of the work of a GP is potentially extremely dangerous to the safety and welfare of patients.

There are further dangers. One of the stated benefits expected from the introduction of medical care practitioners is the alleviation of recruitment problems in areas experiencing staff shortages.[2] Recruitment is usually more difficult in areas of socioeconomic deprivation where relative poverty results in higher rates of illness, disease, and premature death.[3] This leads to the prospect of a systematic amplification of the Inverse Care Law with GPs replaced by medical care practitioners in deprived areas where the need for skilled medical care is greatest.

In his James Mackenzie Lecture in November 2003, Richard Baker argued persuasively for two key principles. Firstly, the person who is, or believes him or herself to be ill should be able to consult a medically qualified practitioner. Secondly, patients who so wish should be allowed to consult a medical practitioner with whom they have developed a trusting relationship.[4] Recent evidence shows that patients, especially when suffering more serious medical conditions, continue to value such personal relationships with their doctors.[5,6,7] The NHS was founded to allow patients to consult doctors without the impediment of cost. The modernised NHS seems in danger of abandoning that achievement and consigning many patients, particularly those in poorer areas to the care of poorly trained 'medical care practitioners' masquerading as doctors. That such far-reaching changes should be being planned and imminently implemented without any attempt to inform the public of what is proposed is very much in the spirit of Newspeak.

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