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

Iona Heath’s leading article ‘The medical care practitioner: Newspeak and the duping of the public’ has real merit in its defence of the role of the well trained, experienced general medical practitioner. However, it is deficient in that it is unclear whether she is taking offence at Newspeak itself or the planned development of a new tier of clinician by the Modernisation Agency. If it is the latter then she should think again.

General practice has changed out of all recognition in the last 50 years, partly as a result of medical education and partly out of the public’s increasing critical awareness and access to primary care. Marshall Marinker used to speak of the ritual, the routine and the drama of general practice. Most experienced and certainly most inner-city GPs would recognise that much (not 60%, but a lot) of the ritual and routine of surgery consultations can be screened and often handled by clinicians less qualified than highly-trained doctors. How much of our working days are repeatedly interrupted and frustrated by currently legitimate demands on us to deal with the trivial, the self-limiting and, sadly, the incompetent?

Recruitment into general practice is at a low. In part this is because some sections of everyday clinical practice are unattractive to highly-trained, bright medical graduates. If this dull, repetitive routine and ritual is at least shared by other less trained clinicians, then this will release the new generation of GPs to actively become involved in further higher professional training, including specialist medicine, education, management, medical journalism and politics.

The role of the GP needs to be underpinned by two significant principles. Referral rights should largely be confined to GPs. Younger colleagues appear too easily to concede their role to other clinicians in the name of equity and modern practice. This diminishes the role of the GP and increases health spending. Rather, non-medical clinicians should be required to refer to GPs for second opinions and advice as to how to further manage and/or investigate a problem. With time, trust will grow so that boundaries will become blurred, but the principle will remain. Secondly, patients should be able to continue to choose the type of clinician with whom they wish to consult. Here, Dr Heath’s point about choice having to be informed and not misled is well made. Experience suggests that patients are very good at choosing ‘horses for courses’ once they understand what is on offer.

In these ways Iona Heath’s concerns for public safety will be alleviated, the role of the GP enhanced, the health economy protected and the patients’ needs met.

The agenda around physician assistants or medical care practitioners need not be resisted — it should be shaped — by us general practitioners.

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REFERENCES

As the GP lead for the organisation employing the longest serving American physician assistant in this country, you may be surprised that I am in agreement with your editorial writer Iona Heath,1 that our patients need and deserve highly trained and skilled professionals on the front line, to ensure the welfare and safety

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We were saddened to read Iona Heath’s editorial ‘The medical care practitioner: Newspeak and the duping of the public’.2 Iona has failed to look at the evidence base concerning the physician assistant (PA) role both in the US and the UK. If she had done so she would have found that PAs are both clinically safe, and positively received by patients.2,3 She would have also discovered that the PA role is not particularly a primary care practitioner role. PAs are generic medical practitioners working to assist physicians in all areas of medical practice, not independently of them. Rowley Regis & Tipton PCT was the first primary care organisation (PCO) in the UK to employ PAs trained in the US to undertake clinical work, after the first of our two nurse-led PMS practices appointed one and suggested the role might be generalisable within the UK. Now we know of at least six other trusts (PCOs and NHS hospital trusts) that employ them in a number of diverse roles. Before recruiting we carried out extensive research, including visits to US universities delivering PA educational programmes. Two of us who went on these visits both felt that the level of skills, knowledge and experience of the US trained PAs was similar to that which we had had as GP registrars. We now have almost 2 years experience of PAs in general practice and plenty of data, both quantitative and qualitative, on all aspects of care provided by PAs and patients’ experiences of them. We have also recruited PAs to work in our local A&E departments and our GP co-op out-of-hours service. One of us is an RCGP member (as are many of our doctors who have PAs working alongside them) and the lead director for the PA project for the PCO, the other is the PCO Professional Executive Committee (PEC) chair. Both of us are practising GPs.

Iona has failed to be critical of her sources. There are a number of so-called mid-level practitioner projects being developed in the UK at the present time involving various medical specialties and the professions allied to medicine. The Changing Workforce Programme (CWP) has, indeed, led some of these projects, but others have arisen spontaneously in advance of the CWP’s project in response to local need, as ours has. I wonder whether Iona has really thought about whether there is no role for a mid-level practitioner in general practice at all, or whether it is just the CWP’s model she doesn’t like.

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REFERENCES

Author’s response
A number of correspondents appear to have misunderstood the nature of my objection to the training and deployment of medical care practitioners. I welcome unequivocally the extension of skill-mix and team working within primary care,