Letters

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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[1] 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

1. Heath I. The medical care practitioner: Newspeak and the duping of the public. *Br J Gen Pract* 2004; **54**, 891.

For the first time in a while I picked up the *BJGP* with some excitement. Two of my favourite authors were headlining. And they didn't disappoint. Both Julian Tudor Hart[1] and Iona Heath[2] struck right at the core of the value system that brought me into medicine and general practice in particular. How wonderful to see the politicisation of the journal in this way. I don't mean in the way the magazines do it, full of GPs moaning about how hard done by they are, but in a way that challenges the philosophy and consequences of current political approaches to the health service. Now let us start a proper debate about the direction we are being taken in by the new contract, the choice agenda, payment by results, etc. What will be their effect on inequalities? How will they influence GP behaviour? Will they make us more patient-centred or less? Should I speak out about the erosion of the GP–patient relationship, or continue to propound the government line? Should I fight from within the system or from the outside? Thank you for a more challenging and subversive journal. Well done.

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REFERENCES

1. Hart JT. Inverse and positive care laws. *Br J Gen Pract* 2004; **54**: 890.
2. Heath I. The medical care practitioner: Newspeak and the duping of the public. *Br J Gen Pract* 2004; **54:** 891.

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

of patients. You will find that I have frequently voiced my concern about the direction of the Change Workforce Programme's (CWP's) pilot programme for the development of a medical care practitioner grade. Fortunately, I believe there has been a major change in the direction of that programme, driven by our experience with American physician assistants. Originally, the CWP's intention was for pilot sites to train nurses, and allied professionals while in post, to do front-line work. There is huge pressure from chief executives and the government for this model of 'training on the job', because of the workforce crisis and the current demand for front-line workers. Like Dr Heath, I believe that the best front-line workers are doctors, but when there are insufficient of these, we can bury our heads in the sand and let practices — particularly those serving the most needy — go to the wall; or we can look for alternative solutions. The RCGP seems to be taking the former route, whilst the Royal College of Physicians has taken the view that if the only way out of the crisis is to have a mid-practitioner grade, then we need to properly define the grade — so that everyone, including the patient, knows what they are getting. Work is being completed by the Royal College of Physicians in conjunction with our physician assistants and a medical school to define what those competencies should be. Unfortunately, by taking the stance it has, the RCGP will not be able to influence these.

I would be less concerned about the RCGP's stance on medical care practitioners, and in particular their view on American physician assistants, if they had actually come to see what they are achieving in Sandwell. It is all well and good maligning a profession from one's ivory tower. I, too, was cynical until I met and started to work with physician assistants, but I challenge Dr Heath and members of the RCGP Council to come and see and meet physician assistants at work and talk to the patients they are dealing with, before they make their minds up. The evaluation of their work in the UK is on the website of the Birmingham University Health[2] Services Management Centre and makes very positive reading. There are more than 50 000 physician assistants in the US and much evidence base to support the role, including the fact that litigation rates are lower in establishments that employ them.

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REFERENCES

1. Heath I. The medical care practitioner: Newspeak and the duping of the public. *Br J Gen Pract* 2004; **54:** 891.
2. Woodin J, McLeod H, McManus R. The introduction of US-trained Physician Assistants to primary care in Tipton: first impressions. http://www.hsmc.bham.ac.uk/publications/pdf-reports/Physician%20Assistant%20interim%20report.pdf (accessed 11 Feb 2005.)

We were saddened to read Iona Heath's editorial 'The medical care practitioner: Newspeak and the duping of the public'.[1]

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

1. Heath I. The medical care practitioner: Newspeak and the duping of the public. *Br J Gen Pract* 2004; **54:** 891.
2. Powe ML, Hughes N. The role of physician assistants in the delivery of medical care. *J Med Pract Manage* 1999; **15(2):** 73–76.
3. Roblin DW, Becker ER, Adams EK, *et al.* Patient satisfaction with primary care: does type of practitioner matter? *Med Care* 2004; **42(6):** 579–590

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,