

Life & Times

The ACP–GP relationship

The advanced clinical practitioner (ACP) role has been somewhat controversial since its initial inception, with a delightful array of fairly derogatory opinions aired and nicknames used, my personal favourite being 'noctor' — not a doctor. I entirely understand how and why this has happened. GPs spend a decade training to do an incredibly complex job, and many of them also have to be able to run a business with dwindling financial support and ever more hoops to jump through to get whatever money is available, while frequently feeling condescended to by hospital consultants who expect them to act as a house officer or a medical secretary. Then the Department of Health appears to announce that a load of paramedics, nurses, physiotherapists, and pharmacists will be trained in 2 or 3 years to do their job for a fraction of the cost.

I'd be pretty miffed too!

But ACPs are not here to do a GP's job, we are not a cost-cutting exercise, and, unfortunately, we are not a panacea for all the challenges that primary care faces at present. What we *can* do is free up GP time to allow them to focus on the more complex medical needs of some of their patients and the business needs of their practice.

HOW DO ACPS HELP GPs?

ACPs are able to order and interpret blood tests, request and read ECGs, request X-rays and ultrasound scans, refer on to secondary care routinely, urgently, as a 2-week wait cancer referral, and as direct admission, arrange follow-up appointments in primary care, and safety net each patient appropriately. Physiotherapist ACPs can run musculoskeletal and joint injection clinics, and ACPs can be trained to carry out minor operations. An ACP team can carry out care home ward rounds, and including an ACP with a pharmacy background would allow many of the consultations to include medication optimisation. This would help ensure the best quality of life possible for

patients while reducing costs to the NHS.

The ACP role is allowing GPs to move from 10- to 15-minute appointments. We are all well aware of the increasing complexity and expectation that patients have, so a 50% increase in face-to-face time is fantastic. Patients feel they are listened to better and have a sense of empowerment because clinicians have the time to explain their illness. We know that GPs experience less burnout when they have longer appointment slots.¹

As I mentioned earlier, there has been a lot of negative opinion spouted about ACPs by, what I believe to be, a very vocal minority, especially on social media. For a while I was a member of the 'Resilient GP' Facebook group until I realised that some other GPs' methods of resilience had a severe impact on mine! I read the phrase 'jumped up ambulance driver' more than once, alongside statements such as 'I don't drive with blue lights so don't you try to be a doctor'.

WORKING TOGETHER TO COMBAT THE UNCERTAINTY AHEAD

We are all, rightly, proud of our knowledge, experience, and achievements, and I am frequently in awe at the depth of knowledge the GPs hold on an incredible range of subjects. When I started I couldn't tell an intertrigo from a dermatitis, an SCC from a BCC, or a pitted keratolysis from a crumplet! But, after 8 years as a qualified paramedic, I was able to take a thorough history, show compassion and empathy to the patient, cope with not knowing what condition was going to present next, and tackle the steep learning curve involved in moving from emergency to primary care.

The uncertainty associated with this relatively new role affects both sides of the debate. Fellow ACPs talk about how varied and flexible the role can be, and in the next breath refer to an identity crisis because the role is, by its very nature, not rigidly defined. But this variance is a great strength: each

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profession bringing its own knowledge and skillset in much the same way as individual GPs may have specific experience in dermatology, surgery, or cardiology.

We are all at risk of giving in to a pervasive and destructive paranoia, GPs bitter and resentful that they are being cast aside in favour of a cheaper alternative and ACPs feeling used and that they are viewed as nothing more than trained monkeys there to deal with the drudgery. Both sides ultimately end up feeling disrespected.

That, I believe, is the biggest threat to primary care: disrespect between medical professionals. The next few years promise an unsurpassed degree of political uncertainty with Brexit, infighting in the two major political parties, and escalating global tensions threatening public spending and the future of the NHS like nothing before.

For us to take primary care forward and for it to not just survive but thrive, all clinicians must work together, play to each other's strengths, and have mutual respect.

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"For a while I was a member of the 'Resilient GP' Facebook group until I realised that some other GPs' methods of resilience had a severe impact on mine!"

REFERENCE

1. Bower E. 10-minute GP consultations are a 'disaster', says RCGP vice chair. *GP Online* 2018; **2 May**: <https://www.gponline.com/10-minute-gp-consultations-disaster-says-rcgp-vice-chair/article/1463627> [accessed 3 May 2019].