

should be that one system applies to all, with variation only where necessary. It would clarify how everyone today, irrespective of background, needs new skills. It would stimulate overdue reform of hidebound institutions, whether regulatory bodies or royal colleges.

Perhaps most importantly, it would refocus the debate about what doctors and nurses do. Instead of boundary disputes and substitution squabbles effort could be directed towards capitalising on the wealth of skills that all professionals can bring to bear on

solving health problems. This fresh approach to the division of labour puts the patient at the centre for the first time.

Jane Salvage *nursing director*

Emap Healthcare, *Nursing Times*, London NW1 7EJ

Richard Smith *editor BMJ*

This editorial is very close to one being published simultaneously in *Nursing Times*.

- 1 Prime Minister. *House of Commons official report (Hansard) 2000 March 22*:cols 981-4. (www.publications.parliament.uk/pa/cm/199900/cmhansrd/cm000322/debtext/00322-04.htm#00322-04_spm)
- 2 Beecham L. UK health secretary wants to liberate nurses' talents. *BMJ* 2000;320:1025.
- 3 Beecham L. NHS workforce planning must be integrated. *BMJ* 2000;320:1025.
- 4 Doyal L. Reshaping the NHS workforce. *BMJ* 2000;320:1023-4.
- 5 Shum CM, Humphreys A, Wheeler D, Cochrane MA, Skoda S, Clement S. Practice nurse-led management of patients with minor medical conditions: a randomised controlled trial. *BMJ* 2000;320:1038-43.
- 6 Kinnersley P, Anderson E, Parry K, Clement J, Archard L, Turton P, et al. Who should see the extras? A randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting "same

- day" consultations in primary care: process and outcomes. *BMJ* 2000;320:1043-8.
- 7 Venning P, Durie A, Roland M, Roberts C, Leese B. Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *BMJ* 2000;320:1048-53.
- 8 Iliffe S. Nursing and the future of primary care. *BMJ* 2000;320:1021-1.
- 9 Lattimer V, Sassi F, George S, Moore M, Turnbull J, Mullee M, et al. Cost analysis of nurse telephone consultation in out of hours primary care: evidence from a randomised controlled trial. *BMJ* 2000;320:1053-7.
- 10 O' Cathain A, Munro JF, Nicholl JP, Knowles E. How helpful is NHS Direct? Postal survey of callers. *BMJ* 2000;320:1035.
- 11 Davies C. Getting health professionals to work together. *BMJ* 2000;320:1021-2.
- 12 Davies C, Salvage J, Smith R. Doctors and nurses: changing family values? *BMJ* 1999;319:463-4.

Nursing and the future of primary care

Handmaidens or agents for managed care?

Set against what we already know about nurses working alongside general practitioners,¹ the four trials of nursing in primary care in this week's *BMJ* give us a better idea of what the future of primary care might look like.²⁻⁵ Most people seeking a rapid response to their symptoms or concerns accept practice nurses or nurse practitioners in front line roles, although a substantial minority continue to prefer a doctor's opinion after experiencing nursing attention.²

On average, nurses have longer consultations, arrange more investigations and follow up, provide more information, and give more satisfaction than general practitioners. Primary care nurses are not cheaper than general practitioners,³ but they are as safe in managing self limiting illnesses.

Nurses undertaking triage assessments by telephone with computer decision support may reduce the number of visits to general practitioners, hospital use, and costs.⁵ The trials do not tell us anything about the medicalisation of discomfort that might follow from increased investigation and follow up, but one study suggests no reduction in patients' intended help seeking behaviour after seeing a nurse.⁴ When it comes to coughs, cystitis, earache, sore throats, and other common acute conditions seen in general practice, nurses are a safe but less productive alternative to doctors. When working in triage roles on the boundary between community and hospital care, they may avert some inappropriate short stay admissions.

Proving the obvious?

Apart from the economic evaluation of nurses working in a triage role out of hours,⁵ none of these

findings is very surprising and none contradicts conventional wisdom on nurses' safety, acceptability to patients, and costs.¹ A general practitioner who has worked alongside nurse practitioners or practice nurses in extended mode for a decade or so without anxieties about their safety and acceptability might even wonder why so much time and money has been spent on proving the obvious. From this sceptical standpoint, the trials may seem to be closer to the trailing edge of knowledge than to its leading edge, with perhaps more emphasis on the elegance of the research design than on the relevance of the research question. Such a view may be reinforced by the clinical focus on self limiting minor illnesses, the small sample sizes, and the short follow up of two weeks in three of the studies. If nurses are as safe as doctors they will miss no more of the uncommon major illnesses with minor presentations than their general practitioner colleagues, but these small, short trials cannot detect this.

An opposite opinion would accept the validity of the trial results but discount their generalisability. The studies conducted in practices used experienced nurses, but their usual working relationships may have been altered to fit professional activity into an experimental design, potentially biasing performance in various ways. The variation in performance between practices, shown more clearly in the local research network study⁴ than in a conventional national trial,³ hints at the powerful human factors shaping clinical activity and patient satisfaction.

Enrolling nurse practitioners on a wide scale in general practice may not achieve the desired effects

General practice
pp 1038, 1043,
1048, 1053

BMJ 2000;320:1020-1

because the trials were conducted by experienced volunteers, not a wider range of variably skilled and motivated nurses. The division of labour, the rules and funding systems, the perceptions of local professional and lay communities, and the available resources all combine to produce or impede changes in practice,⁶ but trials only hint at the contents of these black boxes.

Expansion of primary care nursing

Whatever the implications of these studies for future research approaches, primary care nursing is likely to expand as a discipline, and these papers will be cited widely and correctly as evidence of its importance for modernising the health service. This may be good news for primary care nursing, vindicating the efforts of some nurses to use their skills fully and to extend their clinical roles. It may be good news for general practitioners, who will be able to delegate the demand for immediate care for minor illness to nurses and escape from a sense of being overworked but underemployed. And it may be good news for primary care groups and hospital trusts if unnecessary hospital admissions can be reduced and resources saved by nurse triage. The public may have more mixed feelings, however, and a few may continue to seek medical rather than nursing authority—the affluent with their credit cards and the rest by learning the new system's rules.

The issues for the NHS could be more complex. What roles should primary care nurses occupy? Is

demand management in general practice the best use of this skilled professional resource? Perhaps we might learn from north America, where nurse practitioners made up for the physician shortage of 40 years ago and now face managed care and competition. Their future may lie in substituting for doctors in aggressive case management of patients along care pathways and in organising and coordinating team care.⁷ Could this be our future too?

Steve Iliffe *reader in general practice*

Royal Free and University College London Medical School, London NW3 2PF
s.iliffe@ucl.ac.uk

- 1 Koperski M, Rogers S, Drennan V. Nurse practitioners in general practice—an inevitable progression? *Br J Gen Pract* 1997;47:696-7.
- 2 Kinnersley P, Anderson E, Parry K, Clement J, Archard L, Turton P, et al. Who should see the extras? A randomised controlled trial of nurse practitioner versus general practitioner care for patients requesting "same day" consultations in primary care: process and outcomes. *BMJ* 2000;320:1043-8.
- 3 Venning P, Durie A, Roland M, Roberts C, Leese B. Randomised controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care. *BMJ* 2000;320:1048-53.
- 4 Shum CM, Humphreys A, Wheeler D, Cochrane MA, Skoda S, Clement S. Practice nurse-led management of patients with minor medical conditions: a randomised controlled trial. *BMJ* 2000;320:1038-43.
- 5 Lattimer V, Sassi F, George S, Moore M, Turnbull J, Mullee M, et al. Cost analysis of nurse telephone consultation in out of hours primary care: evidence from a randomised controlled trial. *BMJ* 2000;320:1053-7.
- 6 Engström Y. Innovative organisational learning in medical and legal settings. In: Martin LMW, Nelson K, Tobach E, eds. *Sociocultural psychology: theory and practice of doing and knowing*. Cambridge: Cambridge University Press, 1995:326-56.
- 7 Coile RC Jr. Integration, capitation and managed care: transformation of nursing for 21st century health care. *Adv Pract Nurs Q* 1995;1:77-84.

Getting health professionals to work together

There's more to collaboration than simply working side by side

Doctors and nurses work together every day. But is there more to working together than making sure that the work of the one profession dovetails with that of the other? Is there really any content in the "co" words, so popular in government policy documents—coordination, collaboration, and cooperation?

Researchers are beginning to understand what working together can achieve. The settings are different—how work groups in the private sector can perform better,¹ how democracies can involve people more directly,²⁻⁴ how conflict can be resolved⁵—but the message is the same. Working "together" rather than working "alongside" can energise people and result in new ways of tackling old problems. We have had glimpses of this in patient participation in the NHS. We know much more than we did even five years ago about giving lay people the support and information they need to have a meaningful dialogue with managers and clinicians and to make an input into how services are run. We need to encourage real "conversations" at work—ones that start to create a dialogue between people who have not yet understood what they can achieve in common.⁶

It's the differences that matter

What characterises the new models of collaboration is the recognition that it is not what people have in common but their differences that make collaborative work more powerful than working separately. Working together means acknowledging that all participants bring equally valid knowledge and expertise from their professional and personal experience. Affirmations, acknowledgment, and recognition are important, but it is the questions and challenges that arise from the differences that are vital. A diverse group can arrive at a place no individual and no like-minded group would have reached. When, for example, a social services department decided to bring people with learning difficulties into the heart of its evaluation of quality, staff realised how inaccessible and unnecessary some of their jargon had become. The direct comments of those in residential care about what would help them in their day to day lives gave a simpler and more motivating starting point for change.⁷

The same kind of thinking is at work when theorists of leadership urge a move from transactional to transformational approaches. A transactional leader has a