Skill-mix in primary care: sharing clinical workload and understanding professional roles

IF there is to be a 'primary care led' National Health Service (NHS), it is inevitable that health care professions based in the community will face many added responsibilities.[1] There seems little doubt that the past 10 years have seen many activities transferred from secondary to primary care without a corresponding, significant re-allocation of resources. In addition, the concept of 'care in the community' inevitably means that the care of the elderly, the infirm, the mentally ill and the physically and mentally handicapped is now undertaken in carers' homes, residential homes, hostels and nursing homes.[2] The changes do not stop there. Over the same period, an increasing number of patients have been discharged from hospital much earlier than in the past. Whereas many chronic diseases were once the province of hospital consultants, today the great majority of patients with conditions such as asthma, diabetes, hypertension and depression are almost exclusively looked after by general practitioners (GPs) and their teams. The imposition of a 'new contract' for general practice in 1990 resulted in most child health services, immunization and family planning services being taken into general practice, with a corresponding increase in GP workload as the number of community clinical medical officers was reduced.[3]

Given these changes, it is hardly surprising that stress among GPs is high.[4] A sense of being overwhelmed by change and by work has inevitably manifested itself, in particular when there is a perceived mismatch between resources and workload. These are just some of the facts which may be contributing towards low morale and an impending recruitment crisis in the profession.[2]

Can general practice absorb such an enormous workload without sharing responsibilities with other health care professionals, particularly nurses working in the community? If we are truly to share our workload, can this be done against a background of tightly defined territorial professional boundaries? In particular, we need to ask if nurses might undertake some tasks currently carried out by GPs and what the implications are for such a transition.

There appears to be considerable confusion among GPs, nurses and managers in the NHS with respect to the various terms used for nursing in general practice. The titles 'practice nurse' and 'nurse practitioner' should not be used interchangeably as they represent different levels of education, skills and responsibility. For example, a practice nurse is someone who works with a GP and who is responsible for implementing prescribed programmes of care, working under the supervision of a GP. A nurse practitioner, on the other hand, is usually qualified to degree level and works autonomously alongside a GP colleague.[5]

Central to the nurse practitioner role is that the nurse should be responsible for all aspects of nursing care for an individual, rather than undertaking specific tasks prescribed by a doctor or senior nurse. This is supported in *The Scope of Professional Practice,* a document produced by the United Kingdom Central Council (UKCC)[6] that emphasized the need for nurses to recognize the limits of their own competence and be accountable for their own practice and learning needs. The document also approved the removal of statutory restrictions on nursing practice and made possible the acceptance of an advanced nurse role.

Stillwell identified five areas of work relating to her role as a nurse practitioner in the general practice context:[7]

- Acting as an alternative consultant for the patient
- Detecting serious disease by physical examination
- Managing minor and chronic ailments and injuries
- Providing health education, and
- Counselling.

Similarly, Salisbury and Tettersel[8] compared the work of a nurse practitioner and a GP and concluded that the nurse practitioner was a valuable extra resource for the development of new areas of care, rather than a cheaper role substitute for the GP.

Skill-mix is an increasingly important area of concern for both GPs and nurses and is closely linked to the concept of cost-effectiveness in health care. Re-profiling and skill-mix reorganizations in NHS Community Trusts (for example, nursing auxiliaries carrying out tasks previously performed by qualified nurses) have been a direct result of the introduction of an internal market with a continuing drive for cost-containment. Eventually, if performance-related pay is introduced to a greater degree in general practice, skill-mix will impact directly on the doctor/labour market. Maynard and Walker have commented that is inappropriate to protect doctors from the effect of NHS reforms, technological change and substitution possibilities.[9] On the contrary, it is suggested that if delegation occurs it may be possible to work with a higher GP population ratio (up to 1:3000 or 1:4000).[10] This argument has recently been repeated even more provocatively by Eric Lilley,[11] who suggested that GPs could be almost entirely replaced by nurse practitioners. Such a simplistic solution would be acceptable neither to the nursing profession nor to general practice; however, this is an indication of the importance of the skill-mix issue on the health policy agenda.

Two current issues that are contrary to such a radical solution are the small number of nurse practitioners actually trained and the problem of GP recruitment. With a reduction in the number of GP registrars entering practice, there is a clear need to promote a positive future for the work. In addition, the nurse practitioner diploma/degree pioneered in the United Kingdom by the RCN Institute of Advanced Nursing Education (in London) is producing some 75 practitioners a year; although further sites are being developed in Swansea, Lancaster, Dundee, Dublin, Bournemouth and Exeter, the number of graduates is unlikely to exceed 400 a year for some time to come. Furthermore, there is a crisis in nurse recruitment.[12]

From a general practice perspective, there is no doubt that many GPs will have difficulty with the concept of a nurse practitioner, whom they may perceive as attempting to deprive them of a livelihood. The arguments used are that nurse practitioner training is not comparable to medical training. Nurses cannot prescribe and, even where pilots are taking place on nurse prescribing, the scope is severely limited.[13] Would nurse practitioners be entitled to the same level of personal liability in cases of litigation? In addition, we need to ask whether nurses will accept 24-hour responsibility for patients (although the concept of 24-hour care is something that GPs now have difficulty with). It has been argued that if nurses see patients at 20-minute rather than 10-minute intervals, they may not be cost-effective.[14] Nor can we ignore the professional territorial difficulties encountered between family physicians and nurse practitioners in the United States.

There are, however, positive models of nurses and GPs working together in primary care. Many asthma, diabetic and hypertension, and minor illness clinics are run by nurses alone,

working to protocols devised and agreed jointly with GPs, so that both perspectives are recognized.

There is a dearth of research relating to skill-mix in primary care. It is essential that this issue is addressed urgently to produce high-quality, reproducible information and to establish whether, for example, increased teamwork and delegation are changing the context of consultations, or are the most effective ways in which we can achieve the benefits of delegation without exposing patients to undue risk. Great care has to be exercised when designating the combination of skills that provide, at the least cost, both high-quality care and the desired outcomes for patients.[15]

The nurse practitioner role has now been systematically evaluated in the United Kingdom through the South East Thames Regional Health Authority (SETRHA) project;[16] it was found to be most effective and efficient when associated with a general practice setting. Studies have found nurses who felt they were already practising within the nurse practitioner role,[17] but what marks nurse practitioners apart from other nurses in the GP setting is their specific educational basis for practice.

It could be argued that by the time doctors have undergone professional training their vies are so entrenched that they are unwilling to develop a true appreciation of each other's roles, which hampers a 'team' approach to the care of patients. Perhaps doctors and nurses receiving education together (at the undergraduate level and while training as community nurses and GP registrars) will allow some of these barriers to be removed through improved communication, for the benefit of patients.

General practitioner now have a massive workload. In reviewing this issue it is essential that we do not simply discuss our professional territories but instead take the opportunity to look at our tasks and redefine our roles, to enable us to work together for the best for those we serve — our patients.

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Repeat prescribing — still our Achilles' heel?

GIVEN the considerable clinical and economic importance of repeat prescribing, it is surprising that there has been so little recent study of the subject. We correct this in the current issue of the *Journal* by publishing two complementary studies.

Harris and Dajda[1,2] give the grand picture, analysing what literature there is about the subject and providing the best data currently available on repeat prescribing in England in 1993, derived from data on over three-quarters of a million patients in the MediPlus database. The headline figures are that repeat prescribing accounted for 75% of items and 81% of the cost of all prescribing, and that 48.4% of all patients (and practically all patients over 75 years) were receiving a repeat prescription.

Zermansky's study[2] fills in the detail. Although he studied only 427 patients taking a total of 556 drugs, his data are drawn from randomly selected samples from a total of 50 general practices in Leeds; these themselves had volunteered from a randomly selected sampling frame. It is likely that his findings have relevance for UK general practice as a whole, and it is therefore worrying that his report is quite critical of the quality of repeat prescribing.

There is no longer any dispute that repeat prescribing is a necessary and entirely justifiable part of general medical practice. The desirable intervals for prescribing and for clinical review do not often coincide. It is usually undesirable to give a patient much more than a month's supply of a drug at any one time, but someone with mild and stable hypertension does not need clinical review at such frequent intervals. As Zermansky states, however, 'Periodic review and tight control are necessary to ensure effective treatment, minimize therapeutic misadventure and limit waste.' He examines the process of repeat prescribing according to a very useful model, which covers three tasks:

- Production: usually the responsibility of a receptionist