Family physicians and nurse practitioners: guidelines, not battlelines

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Résumé : Dans les pages 29 à 34 de ce numéro, le D[r] Daniel O. Way et M[me] Linda M. Jones décrivent une démarche de collaboration entre un médecin de famille et une infirmière de première ligne. Cette démarche mérite des louanges à de nombreux égards. Tout d'abord, elle démontre que les professionnels de la santé peuvent collaborer et n'ont pas à rivaliser pour défendre leur «territoire» comme certains ont craint de devoir le faire et d'autres ont cherché à le faire. Deuxièmement, elle démontre qu'elle est possible si l'on suit des lignes directrices. Il reste toutefois à déterminer si la collaboration entre les médecins de famille et les infirmières de première ligne peut aider à contenir des coûts et si elle peut être mise en oeuvre de façon efficace dans une pratique rémunérée à l'acte.

In this issue (see pages 29 to 34) Dr. Daniel O. Way and Ms. Linda M. Jones provide a model for collaboration between a nurse practitioner and a family physician delivering primary care services. They also offer practice guidelines for the collaboration and the delegation of medical functions. They are to be commended for their diligence in producing guidelines for this type of service delivery.

A cost-containment strategy?

Way and Jones believe that family physician–nurse practitioner collaboration, with a shared patient population, is a more efficient and effective strategy than having nurse practitioners function as independent health care providers. In an independent role nurse practitioners could be paid on a fee-for-service basis and enter into direct competition with physicians and other fee-for-service providers.

The authors suggest that containment of health care costs will require reductions in physician numbers or availability and reform of the primary care system. However, their article provides little evidence to support this assumption. It does show how a family physician and a nurse practitioner can work collaboratively in an Ontario Community Health Centre (CHC); such centres bring together various health care professionals, all of whom are salaried and have full-time administrative support. Although Way and Jones state that the catchment area of their centre is 80 000 people, they do not state the number of patients actually served by the centre. Hence, the cost-efficiency of family physician–nurse practitioner collaboration cannot be determined.

Collaboration versus competition

In addressing the issue of collaboration Way and Jones state that the professional partnership is based on respect for each other's expertise, knowledge and skills. This view is in contrast with that expressed in a document from the Ontario Ministry of Health, which proposes the introduction of a training program for nurse practitioners in Ontario.[1] The document states that nurses and physicians possess the same knowledge and skills, a view that appears to justify and promote a competitive model.

In the practice Way and Jones describe, patients move readily between the nurse practitioner and the physician and are familiar with both providers. This is a particular strength of the model: it provides continuity of care when one of the providers is absent because of illness, holidays or involvement in other activities. A few

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cases illustrate both independent and collaborative care by the nurse practitioner and the family physician. How such care is undertaken and shared may differ from one primary care setting to another, but this example seems to have proven very effective for those involved.

Family physicians will be relieved to find that Way and Jones do not suggest that family physicians are interested only in curing patients. Many others who favour increasing the role of other health care professionals in primary care have suggested relegating physicians to this narrow role. On the contrary, the foundation of family medicine is a holistic approach that spans the spectrum from prevention through all types of caregiving. This is not to suggest that family physicians can do all of these things without support. However, many family physicians are troubled by such "boundary issues" and by the preconceived ideas of uninformed critics.

In a group practice with several family physicians and nurse practitioners programs for groups with special needs, in addition to care for individual patients, can be provided. The authors mention two such programs in their centre: smoking cessation and outreach. The programs will vary in different communities depending on the needs of the population served.

If such collaboration provides the support physicians need, particularly if it is extended to group practice, family physicians could also assume some of the tasks now referred to secondary care. Group practice provides not only an opportunity to share responsibilities but also economies of scale and shared special equipment or facilities that are not feasible in solo practices.

A model for fee-for-service practice?

I do not share the authors' opinion that the collaborative model can be used to any significant extent in the fee-for-service system. However, it could be introduced outside of CHCs in alternative payment systems based on capitation alone or on capitation with incentives for collaboration with other health care providers or for attainment of outcome measures related to prevention. Such payment systems are now being established in the British health care system.

There is a conspicuous lack of opportunity for Canadian physicians to enter into agreements with provincial governments for alternative payment systems. It is unclear whether this stems from overt or covert resistance from provincial medical associations or whether governments simply lack the will or expertise to implement alternative payment schemes. Certainly governments have enough information through provincial health plans to entertain realistic proposals.

I have worked in both fee-for-service and capitation systems in private practice and an academic setting; like me, most family physicians who have practised within an alternative payment system find the idea of providing primary care in a fee-for-service system repugnant and retrogressive. I believe that most of my colleagues who are trapped in the fee-for-service system will agree.

However, the number of CHCs will not increase enough to have a significant effect on the delivery of primary care. Therefore, if family physicians are to work collaboratively with other health care professionals in primary care services, governments must respond by offering other methods of payment for these services.

Valuable guidelines

Way and Jones have established practice guidelines for the management of short, episodic illnesses commonly seen in primary care and for the early detection and management of stable, chronic illnesses. According to the guidelines, conditions that require the nurse practitioner to consult with or refer the patient to the family practice colleague include an atypical presentation or unusual response to treatment of a common problem, a problem uncommon in primary care, initial diagnosis and management of a chronic illness, and multiple interactive problems. The authors have wisely chosen to create guidelines that set limits rather than a "cookbook" or "how to" manual.

In addition to providing guidance for practice, the guidelines set criteria for evaluating the quality of care given and communicating the role of the nurse practitioner. This clarifies expectations for the nurse, the physicians and other appropriate parties such as administrative and funding sources. As well, the guidelines help determine what in-service training programs are needed. The authors note the importance of keeping the guidelines up to date and sensitive to the setting in which they are used.

In time several prevention issues will need to be added to the guidelines. There is no reason to think that nurses are better versed than physicians on some lifestyle issues, such as exercise and diet (including supplementation), or on screening protocols, such as screening for prostatism with the prostate-specific antigen test and the digital rectal examination, mammography and measurement of blood cholesterol levels. Without up-to-date evidence-based information on the efficacy of these manoeuvres, care will not be cost-effective or of high quality regardless of who provides it.

The way of the future

Way and Jones have presented a model that they feel is effective in their practice, and they encourage others to adopt it in other settings. I agree that collaboration among health care professionals is the way of the future. Family physicians who ignore this model will find it increasingly futile to try to meet changing patient expectations with diminishing resources and insufficient support. CHCs, such as the one in which Way and Jones

practise, will not proliferate enough to meet the primary care needs of the future. However, alternative payment systems would allow family physicians to practise in collaboration with nurse practitioners and other health care professionals. The authors' practice guidelines are an excellent first step in developing a more comprehensive set of guidelines for collaboration between family physicians and nurse practitioners or other health care professionals in the care of their patients. I believe that family physicians and nurse practitioners who are already working together will find the guidelines useful and will expand on them. In addition, as Way and Jones suggest, the guidelines could be used for many other purposes.

The cost-effectiveness of collaborative practice and its effect on outcome measures have yet to be determined. However, collaborative models will not await the results of research into their value. They are at our doorstep.

Reference

1. *Nurse Practitioners in Ontario: a New Beginning*, Ontario Ministry of Health, Toronto, 1994

Conferences

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Aug. 7–12, 1994: 10th International Conference on AIDS and International Conference on STD — the Global Challenge of AIDS: Together for the Future
Yokohama, Japan
Secretariat, c/o Congress Corporation, Namiki Building, 5-3 Kamiyama-cho, Shibuya-ku, Tokyo 150, Japan; tel 011-81-3-3466-5812, fax 011-81-3-3466-5929

Aug. 8–12, 1994: European Bioethics Seminar — Health Care Issues in Pluralistic Societies (organized by the International Program in Bioethics Education and Research)
Nijmegen, the Netherlands
Official language: English
Ms. I.G. van der Heide, Department of Ethics, Philosophy and History of Medicine, School of Medical Sciences, Catholic University of Nijmegen, PO Box 9101, 6500 HB, Nijmegen, The Netherlands; tel 011-31-80-615320, fax 011-31-80-540254

Aug. 12–13, 1994: Accuracy and Accountability in Scholarly Information: a Symposium — the Quality of Information in the Electronic Age (cosponsored by the Natural Sciences and Engineering Research Council)
Montreal
Symposium Secretariat, National Research Council of Canada, Ottawa, ON K1A 0R6; tel (613) 993-9009, fax (613) 957-9828

Les 12 et 13 août 1994 : L'exactitude et la responsabilité en matière de diffusion du savoir : un symposium — La qualité de l'information à l'ère de l'électronique (cocommandité par le Conseil de recherches en sciences naturelles et en génie)
Montréal
Secretariat du symposium, Conseil national de recherches Canada, Ottawa, ON K1A 0R6; tél (613) 993-9009, fax (613) 957-9828

Aug. 17–19, 1994: Cellular and Molecular Biology of Adipose Cell Development and Growth (satellite symposium of the 7th International Congress on Obesity)
Ottawa
Dr. David Lau or Dr. Gillian Shillabeer, Division of Endocrinology and Metabolism, Ottawa Civic Hospital, 1053 Carling Ave., Ottawa, ON K1Y 4E9; tel (613) 761-4657, fax (613) 761-5358

Aug. 17–19, 1994: Exercise and Obesity: Morphological, Metabolic and Clinical Implications (satellite symposium of the 7th International Congress on Obesity)
Quebec
Dr. Angelo Tremblay, Physical Activity Sciences Laboratory, PEPS, Laval University, Sainte-Foy, PQ G1K 7P4; tel (418) 656-7294, fax (418) 656-3044

Aug. 18–19, 1994: Pharmacologic Treatment of Obesity (satellite symposium of the 7th International Congress on Obesity)
Saint-Adèle, Que.
Dr. George A. Bray, Pennington Biomedical Research Center, 6400 Perkins Rd., Baton Rouge, LA 70808; tel (504) 765-2513, fax (504) 765-2525

Aug. 20–25, 1994: 7th International Congress on Obesity
Toronto
Study credits available.
7th ICO, c/o Faculty of Medicine, University of Toronto, 121–150 College St., Toronto, ON M5S 1A8; tel (416) 978-2719, fax (416) 971-2200

Aug. 21–24, 1994: Schizophrenia 1994: Exploring the Spectrum of Psychosis — 3rd International Conference (organized by the British Columbia Ministry of Health, the British Columbia Mental Health Society and the Department of Psychiatry of the University of British Columbia)
Vancouver
Secretariat, Schizophrenia 1994, c/o Venue West Ltd., 645–375 Water St., Vancouver, BC V6B 5C6; tel (604) 681-5226, fax (604) 681-2503

Sept. 9–10, 1994: Health Law Seminar: Legal Challenges for Today's Health Professional (with the assistance of the Greater Victoria Hospital Society)
Victoria
Coastal Conferences Ltd., 1459 Jamaica Rd., Victoria, BC V8N 2C9; tel (604) 477-7559, fax (604) 595-9594

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