

Doctor displacement: a political agenda or a health care imperative?

Martin B Van Der Weyden

Bring on the debate, but let's base it on evidence

Not long ago, I received an email describing two different health care experiences:

Two patients limp into two different medical clinics with the same complaint. Both have trouble walking and appear to require hip replacement.

The first patient is examined within the hour, x-rayed the same day, and has a time booked for surgery the following week.

The second sees his family doctor after waiting 3 weeks for an appointment, then waits 8 weeks to see a specialist, has an x-ray which isn't reviewed for another week, and is finally scheduled for surgery a month later.

Why the different treatment for the two patients?

The first is a golden retriever.

The second is a senior citizen.

This tale of two treatments may seem to trivialise the gravity of a human experience, but it does serve to highlight the community's prevailing unhappiness with our health service delivery: the untimeliness of access to doctors.

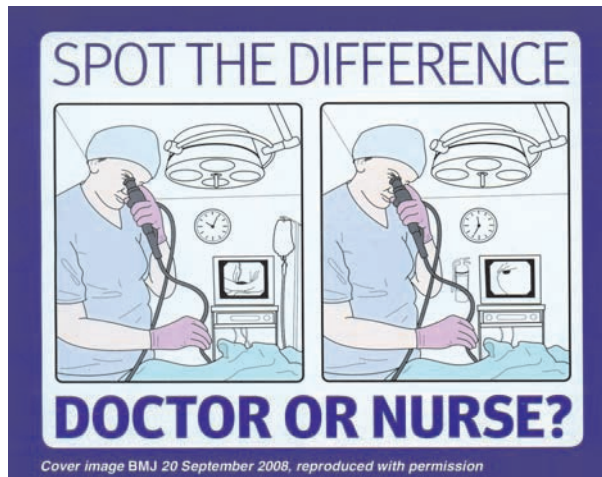
As David Weatherall, Emeritus Regius Professor of Medicine at the University of Oxford, recently noted:

... the work load of doctors today is such that good doctoring has become almost impossible, especially in an environment in which a medical supermarket mentality has been and continues to be generated by successive governments.¹

In the face of medical workforce shortages, governments are looking to displace doctors with alternative health care providers like nurse practitioners (NPs), physician assistants (PAs), and other health professionals such as psychologists and pharmacists to relieve bottlenecks in health care delivery. Displacing doctors in this way, or "role or task substitution" as it is also termed, has been actively pursued in the United Kingdom and United States.

In the UK, the number of NPs grew by 27% between 2004 and 2007 to over 47 000; NPs work in such diverse areas as general practice, emergency medicine, anaesthetics, surgery and endoscopy.² In the US, there were about 69 500 PAs in 2007 and 140 000 NPs in 2004.³ Different strands of the US education sector are delivering courses to train these practitioners. There are university-based PA programs, and nursing schools now provide doctorates of nursing, in which candidates are purportedly trained in skills equivalent to those of primary care doctors, and practise using the title "doctor".^{2,4,5}

In light of these developments, an obvious question requiring clarification is: "What defines the role of these alternative practi-



tioners?" One recent definition of NPs in an Australian context states:

A nurse practitioner is a registered nurse educated to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to the direct referral of patients to other health-care professionals, prescribing medications and ordering diagnostic investigations. The nurse practitioner role is grounded in the nursing

profession's values, knowledge, theories and practices and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practise.⁶

The Canadian definition of an NP is almost identical.⁷ These definitions and the ascendancy of NPs in the UK prompted the *BMJ* to run with a front cover (Box) questioning the difference between an NP and a doctor.

PAs are starting to appear in Australia. Queensland Health is exploring the use of PAs through pilot programs in the areas of primary and emergency care at Mount Isa Hospital and at Cooktown Multipurpose Health Service, in cardiology at both Prince Charles and Princess Alexandra hospitals in Brisbane and at Specialist Connect, Brisbane for ear, nose and throat. In these pilot programs, two experienced US-trained PAs will be employed at each site to explore whether PA roles are valid in our health system in terms of productivity, quality of care, patient satisfaction, cost-effectiveness, PAs' ability to work as part of a multidisciplinary team, and whether PAs provide a comfortable social and cultural fit within the Queensland health workforce. (Bronwyn Nardi, Senior Director of Workforce Planning and Coordination, Queensland Health, personal communication). A similar program is underway in South Australia, led by the state's Health Department. The program is to pilot PAs in major metropolitan hospitals in Adelaide in paediatrics, anaesthetics and surgery.⁸ More recently, two US-trained PAs were seconded to the Department of Surgery at Queen Elizabeth Hospital in Adelaide to perform designated tasks (Guy Maddern, Jepson Professor of Surgery, University of Adelaide, Queen Elizabeth Hospital, personal communication).

In addition to these initiatives, the University of Queensland (UQ) will inaugurate Masters and Diploma graduate programs in PA studies, and James Cook University will be starting an under-

graduate program. All are scheduled to commence in 2009. The UQ program will provide broad generalised medical training with an emphasis on primary care, health maintenance and disease prevention, and medical, nursing and PA students will be taught together within the Faculty of Health Sciences to foster an ethos of team work (Peter Brooks, Executive Dean, Faculty of Health Sciences, UQ, personal communication).

Nurses also have a defined path to follow to become NPs, including pursuit of a Masters degree, a designated period of clinical work and a final assessment by a multidisciplinary team of examiners (Ged Kearney, Federal Secretary, Australian Nursing Federation, personal communication).

How should the medical profession react to these developments? Any discussions on doctor displacement will invariably raise the spectre of turf warfare.^{9,10} Be that as it may, there are questions that must be widely addressed and vigorously debated. It needs to be acknowledged upfront that the current medical workforce shortage is the outcome of successive past federal governments' policies to cap the number of medical graduates. Doctor displacement is a solution to the resulting predicament, but no solution should sacrifice quality and safety.

Becoming a doctor requires passage through an extremely competitive and rigorous selection process and indepth training in biomedical and clinical sciences to prepare for autonomous practice with its myriad clinical uncertainties. This is followed by a period of mandated, prevocational internship, followed by vocational training as prescribed by the clinical colleges. Doctors undergo 10–15 years of training to reach the stage of autonomous practice.

Such rigorous training for doctors surely raises the question as to whether NP or PA programs will inevitably evolve into a truncated alternative route to working as a doctor, especially if their graduates were to be remunerated as independent, stand-alone clinicians. Importantly, will the advent of independent NPs and PAs effectively result in a two-tiered medical system in which some patients have access to lesser medical care than others?

Most proponents of PAs and NPs stress the need for their obligatory involvement in teams focusing on multidisciplinary care, and this is commendable. But just how is this service delivery to be remunerated? Will remuneration be based on service provided by the team, or will individuals be remunerated for individual episodes of care? Who will decide what services can be provided by PAs and NPs and how they should be remunerated? Surely a bureaucratic and indemnity nightmare awaits! This approach will require the untangling of notions of parity — of cognitive and procedural services — and a political commitment to studies of the relative value of services provided by PAs and NPs and other members of multidisciplinary teams. Moreover, thorny problems such as these also touch on an overarching philosophical notion — that one of the primary roles of the doctor is to bring certainty to an undifferentiated illness, and to advise on and supervise an intervention or management plan.¹¹ If this is a unique role for which medical graduates have been specifically trained, how is it to be brought to bear under the proposed new arrangements? Will doctors become mere service supervisors, or will their role continue to stress competence in diagnosis and treatment of individual patients? In any event, it is imperative that doctors are the team leaders.

There is also an urgent need for consistent, reliable and agreed competency standards, as well as registered trade titles for PAs and

NPs, regulated and supervised by multidisciplinary bodies and transferable between various jurisdictions. Interestingly, the evidence underpinning the effectiveness and cost-effectiveness of doctor displacement schemes and protocols is not particularly rigorous.^{2,3} Furthermore, there are intrinsic cultural considerations in health care delivery. Any programs of doctor displacement in Australia need to be underpinned by contemporaneous research to provide answers as to their relative efficiency and effectiveness, as well as patient safety and satisfaction. It would be unethical and unconscionable to introduce and sustain programs of doctor displacement without evidence from local research.

Finally, the debate on whether we proceed with specific doctor-displacement programs will need to be cognisant of recent medical workforce developments. An impending "tsunami" of medical graduates from the recent expansion of our medical schools will soon flood our health care systems.¹² Their education and role in health care delivery should not be compromised by developments in doctor displacement. The Australian Government response of using doctor displacement to alleviate workforce shortages must also take into account current acute and future projected nursing shortages.^{13,14} Thus, it is absolutely imperative that this entire debate be based on community requirements, rather than on the pursuit of vested interests or ideology-driven political agendas.

So, bring on a wide-ranging debate about doctor displacement, but let us ensure that this is an evidence-laden debate — a debate that avoids the trenches of turf warfare. In this debate we need creative leadership from doctors.

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