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VIEWS AND REVIEWS

NO HOLDS BARRED

Margaret McCartney: Passing the patient

OPEN ACCESS

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Epilepsy services managed by nurses. Heart failure services run by pharmacists. General practices staffed by nurses who do almost everything, save for a GP here and there. Have expensive doctors outlived our usefulness in some (or many) quarters?

What happens to a patient who gets intermittent mild breathlessness and chest ache sometimes, but not always, on exertion? History, examination: a little bit of ankle swelling indicates several possibilities. Some basic tests, and a process of exclusion.

A chest pain clinic offers to diagnose cardiac chest pain. A low risk exercise test suggests a low probability of angina. I still don't know why this person is breathless.

A heart failure clinic offers to diagnose heart failure. It takes another few weeks, and then heart failure is excluded. I still don't know why this person is breathless.

There is outpatient spirometry. And so on.

The staff at these clinics are often not doctors. They work to protocol ("Test serum B-natriuretic peptide; if raised, do an echocardiogram"). This is part of a broader enterprise to streamline medicine: the care many people receive from the nurse or pharmacist they see will be excellent and entirely what they need.

But this approach risks deskilling generalist doctors who may feel compelled to involve more staff, thus disrupting continuity, for what used to be regarded as bread and butter medicine.

A general adult psychiatry service may decline to see patients if they're being seen by the addictions team—even though the addictions team member is not a specialist in addiction or general adult psychiatry. This has a knock-on effect on GPs. If a secondary care service that was delivered by a doctor who could prescribe, refer, interpret results, and place symptoms in context is now staffed with people who don't do some or all of these things, the work is often transferred back to primary care.

Sometimes it feels as if we're playing "pass the patient," with parameters for referral set so narrow as to be restrictive. Additionally, general practice is shifting to a model in which GPs retain clinical responsibility by leading teams of people. This will mean fewer GPs carrying more risk, for more staff doing new work. Is this wise? Is it what we trained for? And is it primarily about meeting waiting list targets or saving money?

With potentially worrying symptoms and no clear diagnosis despite initial testing in primary care, I often refer for assistance. Yet this wander through the NHS can end up being diagnosis centred, rather than patient centred. An evidently old fashioned thing—a clinical opinion from a specialist who has broad based training and will make a clinical judgment—is something I value. But does the modern NHS?

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