DOCTORS AND NURSES

Multimorbidity may be stumbling block

Sadly, Sibbald is probably right. Primary care in England is being reduced to protocol based disease management and targets funded services that are increasingly privately outsourced. This is an entirely appropriate environment for nurse led management. General practitioners’ roles and responsibilities of the previously very successful model of general practice have been gradually eroded over the recent decades, whereas nurse specialist in chronic disease management and various other components of primary care has advanced.

The diagnostic work-up of patients by the GP is being prohibited by limited access to diagnostic tests and investigations, which are controlled by specialists and their teams. Discipline based consultant supervised practitioners such as radiographers, lab technicians, specialist triage teams, etc are sorting and gatekeeping, with a disease focus or target driven focus, armed with NICE protocols and guidelines.

In primary care, the practice managers, primary care nurses, pharmacists, and GPs are incentivised to deliver condition based care and protocol based prescribing that address the UK targets, with much effort spent entering data for performance monitoring. On top of this, GPs spend many hours per week signing repeat prescription forms.

Personal experiences in 2006-8 of working in urban general practice in Canada, the UK, and Australia in underserved areas have convinced me that the UK has the narrowest scope of practice for a GP of the three countries, and the least coordination of medical care. Although my account of the differences may be anecdotal (see bmj.com), health outcomes in terms of life expectancy, perceptions of care, and cost per head are better in Australia than in the UK.

Sadly, the adoption of US managed care practices around disease management to contain costs is possibly costing more, causing inconvenience and stress for the increasing number of patients with multimorbidity, as well as destroying generalism and an appropriate medical role for GPs in England.

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Competing interests: None declared.

1 Sibbald B. Should primary care be nurse led? Yes. BMJ 2008;337:a1157. (4 September.)

Cite this as: BMJ 2008;337:a1975

One clear remedy for nurses’ ambitions

The photograph accompanying Coombes’s article shows a nurse wearing a ring and watch on her ungloved hand, twisting awkwardly to “remove a mole” from the back of a sitting, not lying, patient. The article itself is replete with phrases about “nurses marching forward,” “nurses have made significant inroads,” but short of the one clear remedy for their ambitions: nurses who wish to practise medicine should qualify as doctors.

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Competing interests: None declared.

1 Coombes R. Dr Nurse will see you now. BMJ 2008;337:a1722. (18 September.)

Cite this as: BMJ 2008;337:a1976

Skills are very different

There is a big difference between the knowledge, skills, and abilities of doctors and nurses.

I trained as a state registered nurse/registered sick children’s nurse (SRN/RSCN) for four years and worked as staff nurse, research nurse, and ward sister for the following seven years. This gave me considerable clinical experience and knowledge of nursing and some medical knowledge. I then went to medical school and found I knew about 10% of the course already. The only exemption I was given was not to attend the one week’s nursing experience. My clinical interest enhanced my training and I got distinctions in physiology and pharmacology. However anatomy, pathology, and diagnostics were completely new.

As a GP I still believe that the knowledge and diagnostic skills I have now are not possessed by nurses. I rarely agree with the diagnoses made by nurses in the walk-in centre in patients who then come to me. I am concerned when a forearm wound is dressed at home for a week by district nurses with the angulation sign of a Colles’ fracture going unnoticed. I think that the overall clinical assessment of patients by clinical specialist nurses is too influenced by the nurses’ single disease protocol.

I think that nurses realise that they have not got this ability. This is shown by the number of nurses who undergo clinician or prescribing training and then don’t use it. Prescribing figures show that nurses don’t prescribe much except over the counter medication, and there is a large proportion who move to a management only role after training (all the nurse clinicians in our primary care trust).

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Competing interests: I am a general practitioner, a state registered nurse, a sick children’s nurse, and a chronic patient.

1 Godlee F. What skills do doctors and nurses need? BMJ 2008;337:a1722. (18 September.)

Cite this as: BMJ 2008;337:a1974

BABIES’ ETHNIC DIVERSITY

Data on births by ethnic group now available for England and Wales

Raleigh says that ethnic origin is not known for sentinel outcomes—such as the 636 000 births and 470 000 deaths annually in England. However, we have just published data by ethnic group on all births in England and Wales in 2005. Like the data recently published by the Office for National Statistics on infant mortality by ethnic origin that are mentioned by Raleigh, this uses ethnic group information collected in the NHS Numbers for Babies dataset.

These are the first statistics on ethnic differences in births and birth outcomes for England and Wales as a whole. They show considerable ethnic diversity in the sociodemographic characteristics of births, as well as in birth weight and gestational age (table). For example, compared with the white
Ethnic differences in births and birth outcomes, England and Wales 2005. Values are percentages unless otherwise indicated

<table>
<thead>
<tr>
<th>Ethnic origin</th>
<th>No (%)</th>
<th>Births to mothers aged &lt;30</th>
<th>Births in marriage</th>
<th>Births in fathers in managerial and professional occupations</th>
<th>Live singleton births</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Live singleton births</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Low birthweight babies (&lt;2500 g)</td>
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<tr>
<td>Asian, Asian British</td>
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<td></td>
<td></td>
<td></td>
<td>10.0</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>8241 (1)</td>
<td>71</td>
<td>97</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Indian</td>
<td>16 053 (3)</td>
<td>56</td>
<td>96</td>
<td>47</td>
<td>10.5</td>
</tr>
<tr>
<td>Pakistani</td>
<td>24 290 (4)</td>
<td>68</td>
<td>97</td>
<td>22</td>
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<tr>
<td>Black, Black British</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>African</td>
<td>19 756 (3)</td>
<td>50</td>
<td>63</td>
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<tr>
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<td>33</td>
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<td>10.9</td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White British</td>
<td>418 052 (64)</td>
<td>50</td>
<td>51</td>
<td>38</td>
<td>5.6</td>
</tr>
<tr>
<td>Other</td>
<td>33 462 (5)</td>
<td>46</td>
<td>67</td>
<td>44</td>
<td>4.9</td>
</tr>
<tr>
<td>All others*</td>
<td>50 747 (8)</td>
<td>53</td>
<td>63</td>
<td>33</td>
<td>7.0</td>
</tr>
<tr>
<td>Total†</td>
<td>649 371 (100)</td>
<td>51</td>
<td>57</td>
<td>37</td>
<td>6.1</td>
</tr>
</tbody>
</table>

*Chinese, other Asian, other Black, other, and all mixed groups. Includes not stated.

groups, the proportion of low birthweight live singletons was much higher in the Caribbean and all the Asian groups. Ethnic differences in preterm birth were also evident but were less pronounced than for low birth weight.

These new data start to fill an important gap in the routine birth data and add to what is already known about health inequalities in birth outcomes.

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MODERN APPROACHES TO TEACHING AND LEARNING ANATOMY

Modern models are already being applied

Collins may not be aware that progressive anatomy departments have already embraced most of the reforms he discusses. At the University of Otago, undergraduate medical students are taught clinically oriented anatomy within a curriculum centred around early clinical contact. Anatomy is taught in parallel to clinical cases, clinical skills (including surface anatomy), and radiology. Our teaching has included a highly successful body painting session and an abdominal anatomy ultrasound demonstration. Most anatomy is taught in practical classes with the aid of targeted dissections, prosections (plastinated and “wet” specimens), museum models, cross sectional slices, and radiological images. The few lectures on anatomy focus on concepts, difficult areas, and clinical application. Students have access to a wide range of multimedia resources for independent study. An active clinical anatomy research programme fosters and underpins a culture of research-informed teaching.

We have retained cadaveric dissection, which is extremely popular with most medical and dental students. It encourages teamwork, dialogue using medical language, ethical consideration, knowledge of human variation, and an introduction to common pathology. It may be emotionally disturbing for a few, but so are various other aspects of medicine—learning to cope with emotional upset in a supportive framework is an important part of becoming a doctor.

We are currently attempting to vertically integrate anatomy teaching into the more senior years of undergraduate medical training. We applaud the move of the colleges of surgery towards establishing a syllabus of generic anatomy with the addition of more detailed anatomy for subspecialty trainees, but assessments of trainees must be aligned with this as a matter of urgency. Testing surgical trainees by questioning their ability to remember irrelevent anatomical minutiae is no longer acceptable.

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Competing interests: None declared.


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PUBLISH AND BE DAMNED

An old story

With reference to the article by Patel, I would like to draw readers’ attention to a proposal by Marcia Angell, who was later to become interim editor of the New England Journal of Medicine: “I suggest that any institution or agency evaluating a researcher for promotion or for funding consider only, at most, the three articles the candidate considers to be his or her best in any given year, with a maximum of perhaps ten in any 5-year period. Other publications should not even be listed.”

As a librarian, I suffer greatly because of the syndrome. Had Angell’s proposal been adopted 20 years ago, things might look very different today.

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Competing interests: None declared.


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