



DR NURSE WILL SEE YOU NOW

Nurses are increasingly taking on doctors' roles but, as **Rebecca Coombes** reports, lack of regulation is making their acceptance more difficult



“Dr Nurse,” “Noctor”—just two of many slights used to describe senior nurses who take on some medical roles or, worse still, take a job previously carried out by a doctor.

But how far is this paranoia? In secondary care, nurses are doing endoscopy, minor surgery, and anaesthesia. The United Kingdom has between 3000 and 5000 advanced nurse practitioners, including those working at junior doctor level or higher. The number of registered nurse prescribers has grown 27% between 2004 and 2007 to over 45 000 nurses.¹

Former prime minister Tony Blair made a direct challenge to doctors by extending prescribing to nurses and pharmacists in the late 1990s. Health minister Ara Darzi, in his report on the NHS workforce in July, emphasised the need for increased investment in continuing professional development to allow existing staff to expand their roles. Health secretary Alan Johnson is said to be interested in using health centres run by companies such as Tesco and Virgin to swell the number of nurse-led practices.

Professional resistance

However, it is not a simple case of nurses marching forward unimpeded. There is a lack of good evidence to underpin nurse to doctor substitution. “There are studies

around, but they are not a good design,” says Alan Maynard, professor of health economics at University of York.

The drivers are clearly present to launch yet more nurses into quasimedical positions—for example, to cover for reduced doctor working hours caused by the European Working Time Directive and the pressure to meet clinical targets. But there are major impediments to a significant growth in Dr Nurses—including lack of professional regulation, low pay, and cultural objections by doctors.

Nurses have made significant inroads in the past 10 years. In anaesthetics, for example, there has been intense professional resistance to non-medically qualified practitioners—although nurses in the United States, Netherlands, and Sweden are already very active in this area. In the UK, so far about two thirds of the newly minted physician assistants in anaesthesia are nurses. It is a limited development—only 27 have so far entered a voluntary register at the Royal College of Anaesthetists. The UK model is not as flexible as the Dutch one, which has an anaesthetist supervising practitioners in parallel theatres. In fact, “a scope of practice” statement issued by the royal college is hugely restrictive. A consultant anaesthetist must be present during induction of anaesthesia, which raises the

question: what’s the point?

Robert Standfield, of the NHS national practitioner programme, is optimistic: “Consultant opposition is different in different trusts; some are more flexible with local governing arrangements in place. But as the relationship between the new roles and consultants grows that level of trust will grow—employers will want them to do more.”

There has also been a rise in nurse endoscopists—although the experience hasn’t been uniformly positive. David Sanders, consultant gastroenterologist at the Royal Hallamshire Hospital, Sheffield, talks about a pendulum swing away from nurse endoscopists.

“Nationally there was great enthusiasm for a few years for nurse endoscopists, which led to almost every trust employing them. A driving factor was the increasing demand for endoscopy, especially because of cancer surveillance. It was asked: how can we possibly cope with demand? Answer: train up nurses. Management were enormously interested in this—a quick and easy cure financially speaking. Why pay for a doctor when you can get two nurses for the same price? When this was suggested in the US there was enormous reluctance—doctors are paid extra for this so the medical fraternity was very keen not to use nurses.”

A nurse removes a mole from a patient's back



JOSH SHER/SCIENCE PHOTO LIBRARY

Clare Morran, an advanced nurse practitioner in acute medicine at Derbyshire Hospitals NHS Foundation Trust, says: “An advanced nurse practitioner can be any nurse from one who has done specialist care at diploma level—which I say is not enough—through to someone doing a PhD. I think your skills need to be at the same level as the person doing the job previously—a registrar or SHO [senior house officer] or HO [house officer]. For example, general anatomy is one of the weakest areas for nurses. Derby is looking to set up a course for advanced nurse practitioners, but the trainer was not sure at what level to pitch it. He was going to pitch it lower because we are nurses, but we said no, it needs to be at a level that would be expected of junior medical staff; this is right for patient safety.”

Ghislaine Young, a nurse, is a partner in general practice in North Bradford and clinical lead for nurse practitioners in Bradford and Airedale Primary Care Trust. She is also a clinical tutor to foundation year 2 doctors. She isn't surprised at the degree of medical scepticism, and even has some sympathy.

“There is a plethora of titles, and you might have nurses taking on responsibility without being properly trained. This may be why some nurse practitioners

have got a bad press from doctors—they may not have been actually qualified to work at that level. Separate registration would make a

big difference to how we are received. It would make advanced nurse practitioner a meaningful title, it would show you have reached a certain level. A medical professional could see someone like me who doesn't have medical qualifications but is doing some similar roles and think—what gives them the right?

“Legally, if a person comes to see me instead of the GP we must provide a similar level of care. The patient's safety must not be compromised by seeing a nurse practitioner rather than a GP—so the standard of care I give must be to a similar high standard.”

Jim Buchan, professor in health science

Limitations

Dr Saunders has mixed feelings about the development, having had positive experience with some nurse endoscopists in his own trust. “To work nurse endoscopists need clarity, support, and to feel a member of the medical team—have lunch with us, for example.

“Nurse endoscopists have changed the market, but we have hyped them up and they were never going to achieve all that was expected of them.”

One anonymous consultant was concerned that nurses are not trained to work as autonomously as doctors. “There is a big difference in what nurses do if they see something. For example, if doctors see a stomach ulcer, they will decide on treatment and treat the patient. But nurse endoscopists will refer back to the consulting physician. Once you have the technical skills you have to apply them. Just sending patients back to the consultant is not helpful. As soon as these nurses leave we won't be replacing them,” the consultant said.

In some areas nurses are being held back erroneously by management because of litigation fears. Chris Cox, director of legal affairs at the Royal College of Nursing, says it is “rubbish” to suggest that the law prevents nurses doing most medical tasks. “There is widespread ignorance around the legal issues

in relation to health care. The law doesn't prescribe who may perform the majority of healthcare tasks. There are a handful of things, such as abortion, areas of medication, certifying death, and certain things under the mental health act. But the law doesn't prevent a nurse performing surgery, for example. People see professional status as being some mark of their competence. But there

is just one issue from the point of view of concern from a legal point of view of risk management—has that person got the knowledge and skill to perform the task?” he said.

Accreditation

One major road block to better acceptance of nurses operating at higher levels is that advanced nurse practitioners have no nationally agreed standards and therefore lack credibility. Large numbers of advanced nurse practitioners in the UK have a master's degree, but it is still possible to do a week's course and use the same title. In New Zealand, advanced nurse practitioner is a registered trade title, something the Royal College of Nursing in the UK, supported by the BMA, is lobbying for.

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at Queen Margaret University, Edinburgh, agrees on the need for advanced nurse practitioners to be properly regulated. “It’s a factor in blurring their status and constrains levels of pay. In the NHS, there is one pay system for everyone except doctors. There is a disconnect there between doctors and nurses that contributes to difficulties.”

Clare Morran is an example of the lack of financial rewards to nurses working at her level. She does assessments, clerks patients, inserts chest drains and pleural taps, refers for investigations, and is part of the medical team. She earns around £32 000 (£39 000; \$58 000), but unlike her junior doctor peers doesn’t have the expectation of earning significantly more in later years. Ms Morran has been in nursing 22 years, including a decade in intensive therapy nursing and three years rotating in different areas of medicine. She has a master’s degree in critical care.

“I didn’t do a block of five years at medical school but I have got experience in ‘pockets.’ Obviously I don’t have the depth of biochemistry knowledge that doctors do. I would say I have medical insight to a certain level. But I would never, ever, say that I would want to work without a medic. The patients benefit most from a team approach; we all have strengths.

“The advanced nurse practitioner (ANP) role in secondary care is about acting as a bridge between the medics and nurses—I almost feel like a negotiator sometimes. I’m not trying to be a junior doctor but a senior nurse with additional skills. There are three level 1 specialist trainees and a consultant around on floor. I provide the stable part of the workforce—a senior focus when every four months juniors are rotating. I try to work in harmony and not antagonise. Medics come to me if they are not sure, and I can usually help on most questions. If I am seeing and clerking patients there will be times when I need a senior opinion. I never step outside my competence.

“Whoever works alongside us usually very quickly wants an ANP. We’ve had a couple of consultants in-fighting saying, why haven’t I got an ANP in my team? Some are fabulous and like working with you, and some are more resistant and not so welcoming.”

Financial incentive

Obviously the flip side of being lower paid than doctors is that nurses are an attractive alternative to doctors in employers’ eyes. Chair of the Royal College of Nursing’s nurse practitioner forum, Jenny Aston, is paid at band 8, which starts at about £37 000. She represents value for money for her employer considering her workload, which includes managing the nursing team. She says the difference in salary between a salaried general practitioner and an advanced nurse practitioner could be tempting for primary care practices looking to expand.

“GPs are hugely experienced and independent. I would never say we work at the same level, but nurse practitioners can do most things a GP can, including referral to the hospital. If you have a vacancy for a salaried GP and 25 apply but also an ANP, if you were top heavy with experienced GPs you might say—this nurse practitioner will be best for the overall practice—she will cost us £45 000 a year and has experience, for example, in family planning and sexual health.”

Status could soon be less of an issue in the United States, where more than 200 nursing schools have set up or plan to launch doctorate of nursing practice programmes. Nurses with doctorates should be equipped with skills that are equivalent to those of primary care doctors and will be able to use DrNP after their name and the title Dr.

However, many nurses bridle at being called “mini-doctors.” Ms Young says: “It is so complicated for the patients. I have a nurse colleague with a PhD, who has to continually remind patients she is a nurse not a doctor. I have a similar problem and have to say, “No, I’m a nurse” only to be told I’d make a good doctor. When I first started doing clinical examinations I did feel uneasy. Now 11 years on, I feel what I’m doing is more a nursing role. I’m not a mini-doctor, even though I do have a traditional doctors’ role. For me, the essence of nursing is the interpersonal relationship with the patient, relieving the experience of illness, helping the patient to feel better as well as get better—the care and the cure.”

In Ms Young’s experience patients don’t “really care” if they see a doctor or a nurse as

long as the professional is competent. “When I first started some did say, ‘I did want to see a doctor.’ But once they knew what a nurse practitioner was—that I was safe and competent—they were happy,” she says.

It’s impossible to know quite how many nurses are working in advanced roles in the United Kingdom. You can look at the numbers in the highest payment band, band 8, but the trouble is that lots of nurses in that band are in management and are not doing clinical work.

Professor Buchan says the advanced development of nurses has been “quite patchy,” but that government policy seems to be swinging back in favour of advancing nurses in the workplace after several years of inaction.

He said: “I think the pace of change was constrained after the modernising medical careers and Tooke report. It pushed preregistration medical training higher up the political agenda. The focus reverted back to improving medical career structure and it was drawn away from nurses in advanced roles.”

What will really get the ball moving, thinks Professor Buchan, is when nursing eventually becomes an all graduate profession, as it has in countries like Australia and will soon be in Wales. “The trend towards more use of nurses in advanced roles will be accelerated as you begin to see more cohorts of graduate nurses into the workforce.”

Many nurses simply don’t have a gung-ho attitude of robbing doctors of their jobs, says Ms Young. “I don’t feel like I’m depriving a doctor of a job, or deskilling others. We have a GP with a special interest in diabetes, so the rest of us are not so skilled in diabetes anymore. It’s no different from that. I feel I am complementing them. It’s all about effective team working.”

Ms Morran is diplomatic: “The medical and nursing professions are both dynamic and evolving. I don’t see us in separate clusters with ramparts but much more of a continuum. Doctors and nurses working together achieve much more than the sum of their parts.”

Rebecca Coombes freelance journalist, London
rcoombes@bmj.com

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¹ Nursing and Midwifery Council. *Statistical analysis of the register, April 2006-March 2007*. www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3600&Keyword=.

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