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VIEWS AND REVIEWS

PROVOCATIONS

Doctors need to give up professional protectionism

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The need for the medical profession to protect its role was, until recently, deemed essential. The notion that others might take on some tasks traditionally thought of as being “doctors’ roles” was regarded as an existential risk to the medical profession.

Medical societies, colleges, unions, and regulators approached proposals of clinical practice by other health professionals with deep suspicion. Concerns were often couched hubristically in terms of patient safety. But the prime motive was a fear that the profession would be diminished in size and stature.

If there were a shortage of work for doctors to do, then such attitudes would be a rational response. But these protectionist attitudes persisted long after the workload per doctor had become excessive. They have continued even when doctors’ workloads have become impossible. New clinician roles have not arisen out of some grand plot to do doctors down but from the need to deal with the workload crisis.

A junior doctor is a pluripotential clinician, a creature of learning and skill who is not yet fully differentiated into whatever their career may deliver. Conversely the new roles of nurse specialists (for heart failure, epilepsy, Parkinson’s, and other conditions) and nurse practitioners (emergency nurse practitioners, advanced nurse practitioners, and advanced clinical practitioners) are differentiated and settled.

Doctors provide continuity for services and patients, while nurse specialists and nurse practitioners are an invaluable addition to the urgent and emergency care workforce. Medical associate professionals, critical care practitioners, and surgical and anaesthesia practitioners deliver procedure based expertise.

Not one of these practitioners has made a doctor redundant, nor diminished one single doctor or the profession as a whole. Over the past 10 years the number of doctors on the GMC specialist register has risen from 60 000 to 90 000. Medical unemployment is a conjecture.

Experience devalued

Recognition of the value of these new roles is, belatedly, a welcome reaffirmation of the benefit of experience. Since the introduction of Modernising Medical Careers in 2005, experience has been devalued in medical roles, albeit unintentionally. It has been sidelined by assessment, appraisal, and reflection. In contrast, most appointments to the new clinician roles are predicated on experience and encourage long term careers. The stable workforce that arises advantages patients and doctors.

Sadly, doctors have done little to support these new groups, which, however, have prospered despite the medical profession’s indifference and antipathy. Notable exceptions are the establishment of a Faculty of Physician Associates by the Royal College of Physicians (London) and the credentialing of advanced care practitioners by the Royal College of Emergency Medicine.

Demographic change is the biggest challenge we face in healthcare. The over 85s are increasing by around 2000 a month, of whom 25% are moderately to severely frail. Care of this cohort requires frailty nurse specialists, clinical pharmacists, occupational therapists, and physiotherapists. Enabling these professionals to start (and, perhaps more importantly, stop) medication, request plain radiographs, and determine safe discharge is the only way we can hope to meet the care needs of our grandparents, parents, and, in time, ourselves.

Changing boundaries of practice

One perfectly legitimate concern is the issue of scope of practice. This again has its roots in a notion of medical omnipotence and unbounded expertise that wasn’t credible even when the sum total of medical knowledge could be contained within a few large books on a very small shelf. All doctors have a clinical remit of varying radius and, in general, depth has supplanted breadth, of knowledge and of practice.

As the radius of practice has decreased, so more and more gaps have appeared in the fabric of healthcare. These gaps represent patients’ needs and employment opportunities. In filling these gaps—whether with more doctors or with new types of clinician—the boundaries of practice must be clearly defined.

> Pull quote: As the radius of doctors’ practice has decreased, so more and more gaps have appeared in the fabric of healthcare

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It remains the responsibility of the regulatory authorities to police and enforce these boundaries of practice. Regulation is therefore an important issue; medical associate professionals need a regulatory home. The GMC has proposed to undertake this role in response to a 2017 government consultation.

Now is the time for those of us who provide the GMC with its income to endorse, encourage, and expect our fellow practitioners to be overseen by our regulator.

Competing interests: I was president of the Royal College of Emergency Medicine from 2013 to 2016. I am seconded for two days a week to NHS England as national clinical advisor (accident and emergency) and for one day a week as national clinical co-lead (emergency medicine) to the GIRFT programme. I am employed by Taunton and Somerset NHS Foundation Trust as an emergency medicine consultant. Before 2013 I was training programme director and head of school (emergency medicine) in the Severn Deanery.

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