Nurse and medical (general) practitioners

Whilst appreciative of the combative structure of the debate section of the *Journal of Primary Health Care* and the opportunity it provides for clear argument, it was disappointing to see the device used in yet another journal to present the issues around the role of doctors and nurses in primary health care. There is already too much misunderstanding and dichotomous thinking about this issue and the polarisation of attitudes invited by the confrontational style of 'Back to Back' is unhelpful.

The moot point in the June 2009 issue was 'The nurse practitioner provides a substantive opportunity for task substitution in primary care',[1] to which our response echoes Homer Simpson's—well, yes—DUH!

Mary Jane Gilmer and Des Gorman made valiant efforts to avoid it, but unfortunately fell into the trap of debating whether nurse practitioners can replace doctors; tragically for this debate, the nurse practitioner role is not one which is designed to substitute for doctors.

It is clear from the nurse practitioner assessment process, which emphasises the collaborative environment in which nurse practitioners work, that the role is supposed to be one which works autonomously but within the context of health care teams.

Nurses and doctors have always had a symbiotic relationship, if not an equal one in sociopolitical and economic terms, and just as medical training now involves a holistic approach to the patient and places illness within a social and spiritual context, advanced nurse training includes assessment, differential diagnosis and treatment to a much greater extent than 20 years ago. Nurses do not have a monopoly on 'caring' and doctors do not have a monopoly in 'curing.'

There are distinct skills that nurses and doctors bring to health care, but the roles and responsibilities overlap. The extent of these overlapping areas of care will vary from team to team depending on the experience and capability of team members, and the populations we serve are best cared for by teams that can make best use of all the skills available to them. It is also clear that nurse practitioners do not want to replace doctors, particularly if they are doing the same job on cheaper terms!

It is our contention that just as nurses will not be replaced by doctors, doctors will not be replaced by nurses; both will be needed to provide safe, effective, comprehensive care in the future, just as they have always been in the past, and the sooner medical and nursing hierarchies stop debating and get on with developing team approaches the better.

Dr J Scott-Jones and Ms Kirsty Murrel-Mc-Millan RN MN Rural and Remote

What then of the moot indeed asks Professor Des Gorman in reply to Mary Jane Gilmer nurse practitioner (NP) and Mark Smith's assertion that a NP provides a substantive opportunity for task substitution in primary care.[1] Although Gilmer and Smith give a strong and clear response, the question itself is ill-considered, in that it continues to give credence to an overused model of primary health care (PHC) that accepts current health care delivery is adequate. Different personnel delivering the same model will change very little, when what is needed is a radical revision of how and by whom PHC is delivered in New Zealand.

The underlying philosophy of PHC, not primary care, is to address health inequalities; to provide accessible, affordable and acceptable health care, and some sort of equity in an increasingly unequal world. Both NPs and doctors, alongside a myriad of other PHC health professionals, are well positioned to do just this, but not within the current PHC delivery model.

Gorman's unsubstantiated claim of strong support for the doctor of the future to lead PHC teams is somewhat out of step with global expectations when it comes to addressing health issues. Increasingly our knowledge and understanding points to the ways in which social, economic and political forces impact on peoples abilities to access appropriate healthcare. What people want is a range of health professionals they can relate to and engage with, when and as they need. Not this constant bickering amongst professional groups with what appears to be the aim of bolstering one's professional status.

A recent article in the *British Nursing Times* encapsulates well what a patient-focussed, nurse-led (two doctors employed) general practice has to offer.[2] High on the list of changes made in this practice were flexible policies and opening hours, appointments when needed, and a range of health professionals who listened. Over the last few years this general practice, with some high areas of deprivation, has moved to be ranked 3rd in England in the general practice patient survey. Key to this success is no staff hierarchy, with all staff encouraged and free to expand their area of expertise. I rest my case.

Ms Judy Yarwood, RN

LETTERS may respond to published papers, briefly report original research or case reports, or raise matters of interest relevant to primary health care. The best letters are succinct and stimulating. Letters of no more than 400 words may be emailed to: **editor@rnzcgp.org.nz**. All letters are subject to editing and may be shortened.

The 'Back to Back' essays June 09[1] reflect several major problems with the assertion that nurse practitioners (NP) are the new future in primary care. The evidence from Mary Jane Gilmer on cost of production, length of training and cost of running an NP in practice is largely based on overseas data. In New Zealand (NZ) three years' nursing degree, two years' general nursing, five full-time years in the area of NP registration and a Master's degree amounts to at least 10–12 years and probably more to train a NP, as New Zealand NPs frequently practice part-time balancing life and work.

Many of the NPs in NZ appear to have come from a US background and training, often in areas where there is considerable deprivation and the provision of physician health care may be sparse. The US has 40 million people with no health insurance, NZ has four million all of whom are effectively insured by the state.

In *Kai Tiaki* June 09 a US NP, presently working in Wairarapa, writes that in her practice in the US, she has registered nurses (RNs) booking and clerking patients, doing vital signs, ECGs, spirometry and other routine office procedures, she orders MRI and CT and PET scans, labs and prescribes medications etc.

In a NZ training hospital it would be unreasonable to expect an RN to be solely responsible for 20 patients in an eight-hour shift. The training is not the same nor is the expectation of the numbers of patients to be seen or managed in a routine day the same. In primary care, experience is gained by practice and exposure to numbers. In specialised care such as neonatal paediatrics where there are three NZ-trained NPs, they are and will always be part of a team; it is unlikely they will ever practice in NZ as independent practitioners.

The Nursing Council does not list the primary degrees of any of the NPs in NZ, nor does it list the country of origin of their Master's and NP qualifications. No considered discussion can be made based on the true NZ situation because of this lack of information.

After nearly 10 years of NZ NPs it is still a very difficult qualification to achieve in NZ and the duration of training and personal costs as well as the financial costs to the employer of getting the nurse to NP status are considerable. At the completion of the training there is the expectation of pays which currently are almost double the top practice nurse scale ($90–$120,000 per annum vs $55,000).

If most primary care NPs are to be recruited from overseas and will be working in much the same capacity as a GP, there is no advantage to NZ to have a two-tier registration system providing practitioners to do the same job of primary medical care. The reality of recruiting, training and registering for what seem to be touted as equivalent qualifications by the Nursing and Medical Councils does not appear to be a realistic proposition .

Would NZ medical schools and Council recognise nursing skills and qualifications as contributing to a direct entry to the final two clinical years of a medical degree, instead of a Nursing Masters degree and thence to the GP training scheme to fast track the provision of more qualified and experienced people into general practice positions? With 14 primary care NPs in NZ the process to qualified, registered practitioner couldn't be any slower than the current system of training for NPs.

Dr Bill Douglas, GP

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Bring back the NZ Family Physician

Professor Murdoch's letter in the third *Journal of Primary Health Care* reads as either a warning or a cry for support. Since rural GPs are being called on for some sort of enlightenment, as one of that longserving breed, now thankfully retired, I offer a few comments. The new Journal is setting out the parameters for what seems to be a politically-inspired new subspeciality of general practice, members of which are those Multi-Disciplinary Health Workers employed in Integrated Family Health Units under the guidance of the PHOs—sorry for the capitals. Just how this hybrid came to be spawned by the RNZCGP is a mystery the explanation of which is yet to filter into the boondocks. Perhaps the new Journal will eventually be followed by yet another College—the NZCMDHW et alia. I wish its instigators well in their efforts, and its growth will be watched with interest. I can understand that new graduates in general practice, bearing a heavy load of debt, will be attracted to salaried employment in some version of a health organisation, rather than the perils and challenges of the old-fashioned business model. Meanwhile, to any influential members of our RNZCGP who may be reading this, may we have the *NZ Family Physician* back, please. It has been a great privilege to have been accepted as a GP to rural communities. I hope future GPs, whatever their working relationships, come to feel the same way at the end of the day. To Campbell Murdoch and his friends, keep the flame alive of that vision of General Practice that has been crafted over the past decades.

Dr Graham Milne FRNZCGP

Battlefield acupuncture

Dr John Welch criticises the 'absurd proposal' that ear acupuncture is to be used to alleviate the pain from injuries incurred in action by the forces deployed to Afghanistan and Iraq (Letters, *Journal of Primary Health Care,* Sept 2009.) To clarify the situation, this procedure is already being carried out very effectively, and safely, in the front line. My com-

munication this week with Colonel Richard Niemtzow MD, USAF, MC, FS (active duty), CAM Consultant for the USAF Surgeon General, confirms that the medics, paramedics and injured service women and men are impressed with this new clinical initiative, with good levels of analgesia being obtained.

On behalf of those College members and fellows who are also members of the Medical Acupuncture Society (NZ), I invite Dr Welch and his colleagues in the NZ Skeptics to forgo their discomfort in understanding the biophysics of ear acupuncture, and to join us in lending support to this bold US armed forces venture, in the sincere hope that it relieves the suffering of those who are injured while risking their lives for us all.

Dr Robin Kelly, Education Convener,
Medical Acupuncture Society (NZ)

Our medical training encourages a healthy degree of critical awareness and yet Dr Welch's criticism of acupuncture goes well beyond skeptical inquiry which has been defined as a 'practical, epistemological position in which one questions the veracity of claims lacking empirical evidence' and seems to have devolved into a derogatory version of pseudo-scientism.

A look at the meta-analyses published in the last year shows benefits of acupuncture in the treatment of chronic headaches (Sun 2008), migraine prophylaxis (Linde 2009), obesity (Cho 2009), post-operative nausea (Lee 2009), opiate withdrawal (Epstein 2009) and depression (Zang 2009). If Dr Welch wishes to accept that these meta-analyses are simply the effects of placebo then perhaps we should stop using RCTs as evidence in medicine.

Dr Welch also believes there is no scientific basis for acupuncture which again does not match the large volume of neurophysiological research on the subject including fMRI and mapping of meridians (Chae 2008, Kavoussi 2007, Li 2008, etc). Medical acupuncture is now taught in universities and medical schools, and the National Institute of Health concluded that 'there is sufficient evidence of acupuncture's value to expand its use into conventional medicine'.

Dr Tim Ewer

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Dr J Welch has acupuncture firmly in his sights again, and while he was at it he managed to fire a salvo at the intercessory prayer evidence as well. We are colleagues of John and he's actually not a bad bloke, but we think he's confusing science with paradigm inertia. There's nothing wrong with a bit of healthy skepticism, but openness to new ideas is one of the defining characteristics of true science. We, the undersigned, both run well-established successful family medical practices, and we routinely use acupuncture in our work. We don't believe that because we are also acupuncturists John seriously questions our competence to practise medicine. However we don't think any amount of science will convince him of the validity of acupuncture at this time, so we don't intend to try. Fortunately the same is not true of a large number of our colleagues, and we welcome inclusion of articles and correspondence relating to acupuncture in the *Journal of Primary Health Care.*

Dr Rod Bird, FRNZCGP and Dr Grant Johnston FRNZCGP

Some 20 years ago I wrote a position paper on acupuncture for the NZ Skeptics Society and came to pretty much the same conclusions as Quackwatch (www.quackwatch.com) and the US-based National Council Against Health Fraud www.ncahf.org/. The acupuncture literature shows an inverse law where the most absurd claims are made by the most poorly conducted trials. Meta-analysis of such trials is hardly likely to be illuminating. I also discovered that no less a body than the World Health Organization endorsed acupuncture for a number of conditions including myopia. I am short-sighted and the cause is a structural problem with the eye. No amount of acupuncture can change this. Clearly there are stupid and gullible people in the WHO as well as the US Army. I find it incredible that any registered medical practitioner can endorse auricular acupuncture and I stand by my comments that it ought to attract concerns over competency. Such dogged fanciful beliefs by doctors brings to mind H L Mencken's criticism 'How is it possible for a human brain to be divided into two insulated halves, one functioning normally, naturally, and, at times, brilliantly, and the other capable of the most ghastly balderdash.'

It is interesting that sham acupuncture is just as effective as ordinary acupuncture, both working through the placebo effect. This is a similar situation to homeopathy trials which, like acupuncture trials, are essentially a trial of one placebo against another.

The recent trial of toothpicks versus conventional acupuncture (DC Cherkin et al. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Internal Med. 2009;169:858–866) will make it much easier for the military. Wounded soldiers

can poke themselves in the ear with a toothpick. Perhaps the skeptical ones can bite on a bullet.

John Welch, GP

REPLY: This correspondence is now closed—Editor.

Should we give aspirins and statins to the elderly?

In their survey of the use of aspirin and statins by patients in residential care, Hong et al. found that 54 % of patients with CVD were prescribed aspirin and 31% of those with CVD and/or dyslipidaemia were prescribed statins.[1] They consider these rates to be low and suggest that they may be explained by ageist attitudes towards preventive treatment in the elderly. They do not, however, give an expected rate of prescribing. Given that the patients studied were all in residential care, that almost half of them had consent to take part given by proxy and that the average number of medicines taken was 8.3, it is likely that this group included a large proportion of frail patients with multiple co-morbidities and diminished cognitive capacity.

It is the average number of medicines that is the key finding of this paper. Polypharmacy represents a great threat to the day-to-day quality of life of this population—a group with this average number of medicines is at greater risk from harm from their medicines if the suggestion of adding an extra two, for which evidence for real effect on overall quality of life is contested, is more widely adopted. It may therefore be that the observed prescribing rates are quite appropriate and reflect judicious use of medication in a frail population, many of whom may have a short life expectancy and for whom symptomatic treatment and the avoidance of polypharmacy are more important than the use of preventive treatment.

The authors make several references to the New Zealand cardiovascular guidelines and comment on the apparent departure from them by the prescribers responsible for the care of the patients in the study. They suggest that 'provider education may be worthwhile to bring the prescribing practices closer to the level suggested by the guidelines'. This, however, misses the point that guidelines are just that—they are not a standard to be measured against and found wanting, rather they are guidance to be taken into consideration along with individual patient circumstances and preferences before prescribing decisions are made. Guidelines are typically based on evidence derived from highly selected populations of younger, fitter patients, and have a single-disease focus. They are at their least helpful in guiding treatment in frail patients with multiple co-morbidities.[2]

Whilst clinical guidelines are often undoubtedly useful, they should not, and are not intended to, be a dogma from which we fear to depart. Using guideline adherence as a marker of good care is likely to have the effect of encouraging less thoughtful prescribing. Careful consideration of the needs and preferences of an individual patient and of the best available evidence should inform our decisions to prescribe or not. This is the true nature of evidence-based medicine, rather than a series of population 'oughts'. For some patients the best treatment will require us to ignore the advice of a clinical guideline and we should have the confidence to do this. Fear of a specious accusation of ageism should not influence our aim to provide the best care possible.

Dr Ben Hudson and Assoc. Prof. Dee Mangin

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I have major problems with the article on the use of aspirin and statins for cardiovascular risk.[1] Mangin[2] discusses many of the problems I have with the use of guidelines in the older population. This particular study does raise another important issue. This population is certainly not representative of the population on which the studies recommending the guidelines are based. I am not fully conversant with the literature but cannot imagine an ethics committee approving a study on prevention of CVD in people with dementia who would be incapable of giving consent.

Given that this study did not attempt to determine the patients' views on taking this medication it is not properly designed to draw the conclusion that provider education is needed. If this is a study of provider behaviour then the question should have been whether the medications had been offered, not whether the treatment was prescribed. The obvious analogy is with immunisation rates. It is not fair to judge my immunisation rates by the number given without taking into account the numbers who despite my efforts have refused. I would suggest that those who were terminally ill or too ill to be involved should have been included in the analysis. If the question was whether residents were offered treatment according to the guidelines then not prescribing for this group was treatment offered according to the guidelines.

Finally there is an important ethical question here that is being skirted around. The presumption is that the values implicit behind the guidelines are universal and that non adherence to the guidelines is thus bad. In straitened economic times I could well argue the case that extending the life of a demented, abandoned by family, state-dependent rest-home resident is questionable. Are the patients allowed to have views on this that contradict the guidelines? The presumption is that the reason for prescribing that does not meet the guidelines is because of inadequate education on the part of the GPs. This study does not address the possibility that the reason for lower prescribing rates was because the residents chose not to (or were unable to choose).

Guidelines are great to inform decision making. If they are used as a substitute for decision making we risk great harm.

Ben Gray, GP

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IN A 100-WORD REPLY:*

We welcome Drs Gray, Hudson and A/P Mangin's comments and agree, an important finding is the high use of medications in this frail population.[1]

The main finding remains, however, that there is large variability in prescribing. Prevention in older age is about reducing morbidity rather than mortality. Management of CVD may prevent progression of vascular dementia,[2,3] and most cases of dementia are mixed. We pose the question 'Why should there be such variability in medication use?' Our study does not answer this question but rather gives evidence that it should be posed.

Please continue the debate.

Ngaire Kerse, GP, Professor, Department of General Practice and primary Health Care

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* Prerogative of the Editor; authors lobby for a longer right of rebuttal

Healthy Bastards

by Dave Baldwin

Reviewed by Dr Lannes Johnson, Clinical Director Harbour Health

My first impression from the title and skimming the illustrations and text, was, 'Oh dear!' However any negativity was rapidly dispelled and, although I am favourably biased towards any effort that improves men's health, I have to say now, that this book a great read and a 'must' for any family that contains, or intends to contain, human males of any age.

Baldwin, an experienced GP and pilot (Bulls Flying Doctor Service) has self-published the book as an 'accessible guide for the everyday Kiwi bloke'. His use of humour makes for an easy read and assists in getting pertinent points across; most GPs do use humour to ease communications, and in a way this book is no different although more outlandish. The blokish Gav McAvedy character, alias you the reader, by projection makes pertinent points personal. The illustrations contain more humour than anatomical detail but do give light relief and 'display' the body's organs under discussion.

The use of paragraph captions highlights important points, for example in chapter 2 on hypertension, 'high blood pressure will bugger your heart'; 'high blood pressure will bugger your brain' and 'high blood pressure will bugger lots of other things too'.

Each of the chapters begins with a half-page key points summary—excellent in itself. I found in general the clinical content is more than adequate for each subject, although I was disappointed that Baldwin did not enlighten blokes more on the main gender-specific cancer; prostate cancer was afforded only one page of 13 in the chapter, 'Gav's prostate gland, pecker failure and infections of the privates'. The concluding topic, Chapter 13, 'A section on sheilas', will be, I am sure, very useful for blokes of all descriptions, especially young blokes. Possibly a chapter on adolescent and young blokes' health will be included in the next edition?

The index and bibliography ('commonly used terms bandied around by brainy bastards') are basic but comprehensive for the general reader. An omission, important in this internet-based age, is the complete lack of useful reference websites. These could be included at the conclusion of each chapter.

There are several strong messages men and boys will gain from reading this book; the value of a healthy lifestyle, an understanding of important symptoms, and the invitation to see your GP before it is too late. All actions begin with a conversation and, if the conversation Dr Dave has begun results in more NZ men having comprehensive health checks and dealing with their health issues, the country will be improved in respect of both health and productivity. I would encourage GPs to recommend this book to their patients.

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