LETTER FROM NEW ENGLAND David Loxterkamp

What a doctor is good for

With growing numbers of physician assistants and nurse practitioners, what do doctors add?

Over the years I have served as a preceptor and colleague for more than a dozen physician assistants and nurse practitioners. All the while I wondered: are they as good as they seem, and are doctors as indispensable as we'd like to believe? When my daughter became a physician assistant I was forced to respond.

I share a small practice with six family physicians. Each of us works closely with a designated medical assistant. Around us, personal service representatives greet our patients and schedule their visits; billing associates ensure our financial survival. We also rely on a physical therapist, pharmacist, behavioural therapist, triage nurse, care manager, health coach, laboratory technician, medical records clerk, clinical coordinator, and practice director. Thus, you can forgive the doctor, let alone his or her patients, for sometimes getting lost in the shuffle.

Increasingly, advanced nurse practitioners and physician assistants will join the clinical team. One of each is now on our staff. In the United States more than 165 training programmes have educated the 95 000 certified physician assistants in practice today.[1] There are over 180 000 nurse practitioners trained in 92 programmes.[2] Numbers in the United Kingdom are less accessible, but at least six physician assistant schools are listed online. Like physicians, mid-level practitioners have gravitated toward the higher paying specialties, despite the design of their programmes and needs of society. In the US barely a quarter of physician assistants work in family medicine, general internal medicine, and paediatric settings.[1]

Our nurse practitioner and physician assistant are skilled communicators, detail oriented clinicians, and evidence based practitioners. They care for 90% of the problems I see routinely and are proficient in many of the procedures I perform. They have reached this level of proficiency in a quarter of the training time. Their metrics of clinical performance match or surpass the doctors who supervise them. That they command half our salary is surely not lost on those who employ us. Thus, it is not only justified but critical to ask: what is a doctor good for?

The doctor's basic role is to frame the clinical question. What are patients asking for? What do they actually need? The answers involve a sense of timing, an ordering of priorities, and a clear understanding of the social context. The most complex intellectual exercise in clinical medicine, it takes years to master. It cannot be assigned to a self completed survey, an assistant's checklist, or a computer algorithm. Whereas the specialist or technician is handed a clinical frame with a narrow list of options, the generalist must fashion an original and unique diagnosis from an infinite number of data points and possibilities.

Doctors, too, have a responsibility for the team they work with. This is not about being boss or captain. Rather, it falls to us, by example and through leadership, to create a workplace that fosters learning, mutual support, and compassionate care. No length of academic training can prepare or sustain us for the everyday demands of a doctor's life. That task is left for later. Can newly minted doctors create a work environment where we regularly review the team's efforts and learn from its collective mistakes? Will we insist on workflows that make the right choice the easiest choice? Do we provide emotional support for one another, especially in the wake of bad outcomes? Are there opportunities to discuss and reflect on the complexities of the doctor-patient relationship? Do we help each other avoid the most common diagnostic and therapeutic pitfalls—a yawning trap when we are hurried, distracted, or exhausted—our tendency to jump to conclusions, read less often and less carefully, discount the odds of doing harm, and overestimate the need and urgency to intervene.

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Our practice has, in small ways, responded to the shifting needs of the health professional. For two decades we have facilitated a weekly check-in session where clinicians can unload the personal joys and burdens that follow us to work. More recently, we have made efforts to integrate physical therapy, behavioural therapy, pharmacy, and care management into our clinical workflows and educational sessions. And once a week representatives from each area meet to discuss office-wide issues such as patient privacy, accuracy of our documentation, and common clinical goals.

If, in the new economy, physicians are required to justify their salaries, how will we compare to physician assistants, nurse practitioners, or any number of new health professionals who will participate in the practice of the future? First of all, doctors will need to improve their lacklustre record for adopting evidence based guidelines in the daily routine. We can no longer stake a claim on test scores or years of training unless they lead to improved clinical outcomes. And it is unwise and self interested of us to rely on licensure and hospital privileges to maintain the guild.

The only defensible answer is that we are committed to knowing and serving patients in the full context of their lives and to transforming our practices into "medical homes" that nurture not only patients but doctors and their teams. Increasingly, that team will include those with fewer years of formal training but who have every capacity to earn the title of "doctor" that their patients will gratefully bestow.

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References are in the version on thebmj.com.
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