Should GPs be involved in diabetes clinics?

Jill Rodgers and Gwen Hall

Introduction

Before 1990, structured diabetes clinics in primary care were the exception rather than the rule (BDA, 1996) and many people with diabetes were referred to hospital clinics for routine diabetes care. In 1990, payments for chronic disease management were introduced, as well as payment for other health promotion activities, through the revised GP contract and subsequent advice on its implementation (NHS Management Executive, 1993).

There was a corresponding increase in the number of practice nurses (PNs) employed to participate in many of these activities, including organising and running diabetes clinics. The organisation of these clinics varies — in many general practices, patients have appointments with both PNs and GPs in diabetes clinics, and in others the diabetes appointments are with the PN alone unless certain problems arise.

This article focuses on whether it is imperative for a GP to be involved in diabetes care. This was stimulated by a discussion between the co-authors at a recent diabetes conference. It is acknowledged that the input of other health professionals such as podiatrists and dietitians is often available and extremely valuable within surgeries, although this aspect will not be debated in detail here.

JR: Practice nursing offers an almost unique opportunity for nurses to shape their role within an individual practice, and develop systems of working to benefit their local population. Diabetes is no exception to this, and a nurse-run clinic can make use of these organisational skills, leaving patients feeling that they are cared for and not being made to wait between nurse and doctor appointments.

GH: I would argue, as would many, that it is imperative for a GP to be involved in diabetes care, and I would not like to see the level of commitment being eroded. Recent research on behalf of Primary Care Diabetes UK (Pierce et al, 2000) showed that the number of nurse-run clinics is increasing and my main concern, formed during many visits to clinics run in general practice, is that many do not have the training to take on an extended role but are being asked to do so anyway. A particular concern surrounds those who have had diabetes care foisted upon them, perhaps when the previous experienced nurse has resigned, and are expected to review patients alone. I favour a planned programme of care delivered as a team event!

JR: But nurses are able to work methodically within protocols, and in the majority of cases they will have devised their own protocols according to local or national guidance and available evidence of optimum practice. It therefore makes sense to tap into the nurses' expertise which lies within the majority of general practice; it is rare nowadays to come across a practice where no PN is employed.

GH: I feel less confident about nurse-run clinics, and feel a better model is diabetes care provided as a partnership between the GP, PN and patient in the primary care setting. I agree that nurses are very good at following protocols, although in my experience the quality of protocols can vary within primary care. In some cases the protocol may be nothing more than a checklist, reflecting a lack of insight into the depth of care required for people with diabetes. Unfortunately, patients rarely conform to standards and each person needs to be treated as an individual.

Training and experience count but I don't feel an algorithm of care or a flowchart gives the patient the best service. The patient needs to be involved in their own care and I feel that some may see diabetes as not very serious if delegated to 'only a nurse'. Of course I acknowledge that many have excellent systems in place for referral to a GP if they suspect something untoward, but I have seen considerable delay where there is no particular GP available with an interest in diabetes. Nurse prescribing of diabetes medications is still some way off — and not a single clinic goes by without the GP I work with and me, plus the patient, agreeing treatment changes. With more and more patients being discharged from hospital on insulin, nurses will be expected to become more involved in this aspect of care too.

JR: The idea of GPs being involved sounds good in principle, but not all practices have interested GPs, which is one (although not the only) reason that PNs have taken

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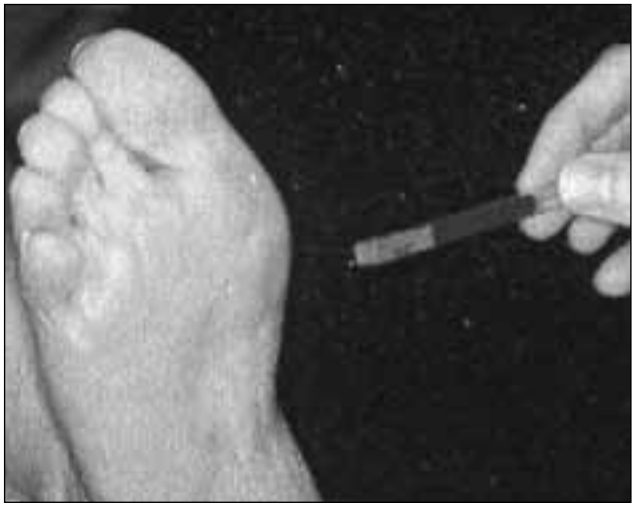
such a major role in running diabetes clinics. I also have some concerns about the perception that delegation to a nurse lessens the importance of care provision, although I acknowledge that this perception may still be in evidence. Nurses have been striving for many years to be recognised and valued for the role they play in healthcare delivery, and this comment only serves to perpetuate the myth of medical care being more important.

In my experience nurses can, through training and adherence to protocols, carry out most aspects of an annual review in diabetes. For example, a nurse can be trained (as can any other person) to carry out a foot examination, identify abnormalities and refer on as appropriate. Similarly, in hypertension, working to protocols can ensure that hypertension is detected, reported, and appropriate treatment initiated. Although these areas of work may be considered traditionally to be carried out by GPs, it can be argued that they are no different from other 'tasks' that now sit firmly in the nurse's domain.

GH: This is the bit I have trouble with. A podiatrist takes years learning skills in foot examination. I would submit that there is inadequate training in many geographical areas on foot examination for PNs to take on this role, and general detection of neuropathy or vascular complications. How many use monofilaments? How many use Dopplers… or even simply remove shoes and socks? I was even told by one GP that it was appropriate for the nurse to examine the feet as 'she can feel a pulse as well as I can'. Yes, these are isolated cases, but it's the trend to nurse-only provision that concerns me. It's the recognition of the advance warning signs that highlights the difference of the experienced team working in diabetes and a reluctant nurse carrying out 'tasks'. Certainly the nurse can refer to the podiatrist, but she needs more than basic training to recognise the signs.

JR: This is certainly true, and I accept that appropriate training may not always be available. While nurses should not be carrying out any aspect of care if they are unsure of what they are doing or if they are unclear how to interpret their actions, it may be difficult for PNs to evaluate whether their local training programme is of high quality. However, using foot care as an example, I have had experience of systems where good local training has been available, and where nurses have welcomed this. I also suspect that many GPs do not currently use monofilaments. Certainly, they will not have started using them because they were taught in their medical training but because they have made sure they are up to date with current practice — can't the same be said of nurses?

GH: The trouble is, the most difficult thing to know is what you don't know. I've been running diabetes courses for years and monofilaments are new to many GPs and



Are practice nurses adequately trained to take on tasks such as foot examinations?

PNs alike. We need to be able to identify that the training undertaken is adequate to enable them to take on the role. Our chiropodist/podiatrist teaches on the course I run and demonstrates the complexity of the service. Of course I am in favour of all of us having the training and the time to take on this extended role but it takes more than just 'feeling the pulses'. Schemes such as the one you mention are not available everywhere.

Developing district services

JR: For those areas where it may be considered less appropriate for nurses to be involved, e.g. fundoscopy, other possible solutions include using local optometrist services, or developing district (possibly mobile) screening services. Indeed, if this is currently being carried out solely by GPs, this could be potentially dangerous in districts where there is no baseline training or regular updating of these skills. Also, in small practices, or practices where all partners examine the eyes of their own patients, it is doubtful whether the number of people with diabetes would provide adequate experience for the GPs to maintain their expertise. Optometrists, who examine people's eyes on a daily basis, would be the first to admit that even in their own circumstances they need to attend regular updates on diseases such as diabetic retinopathy.

GH: I agree that it is inappropriate for anyone to carry out retinal screening if they are untrained or lack ongoing experience in this area.

Whose responsibility?

JR: What about the situation mentioned earlier, where no GP in the practice has an interest in diabetes? I know of many practices where the partners rely heavily on the expertise of the PN, and are keen for that nurse to attend courses and updates on diabetes so that she can bring that expertise into the practice.

GH: While some practice nurses may be happy with that situation, many others feel that they are unsupported and are thrown in at the deep end. This is particularly evident when an experienced PN leaves and a new one is expected to run the same type of diabetes clinic. Also, the GP is still the prescriber, and as such takes legal responsibility for the medication, so it sounds to me as though the GP is an integral part of the process.

JR: You have a point, and until nurse prescribing is legal for diabetes medication, it may be more appropriate to try to generate the interest of the GPs and raise their awareness in the use of diabetes medication.

One of the biggest roles that PNs can play in patient care is an educational one. My worry about a joint GP and PN clinic is that it is often the PN who is left to carry out the screening 'tasks' within a limited time frame, and the GP then has the time to talk to the patient about their diabetes. To me, screening and education go hand in hand, and it does not make sense for labour to be divided in this way.

GH: I think the scenario you describe is the exception rather than the rule. Nurses are exceptionally good in an educational and supportive role, and in many joint clinics the GP and PN participate equally in both screening and education, and the patient goes away having received consistent messages rather than possibly conflicting advice. The GP and PN can work together to decide how best to provide continuing support for the person with diabetes, who may be followed up by the PN alone until the next joint review is due. If lack of time is an issue for the PN, then this should be tackled by lobbying for longer appointments for people with diabetes.

Conclusions

In summary, the argument for clinics run solely by PNs includes acknowledgement of the expertise they have undoubtedly developed, their organisational skills, their ability to work within protocols, and through developing skills in areas such as assessing the need for medication and in foot assessment.

POINTS OF AGREEMENT

- Diabetes care should not be undertaken by any health professional who does not have adequate training or understanding of diabetes, no matter what protocols are in place.
- It may be appropriate to use skills outside the practice for certain aspects of care, e.g. retinal screening.
- Adequate time needs to be put aside for both screening and education of people with diabetes, and the role of any health professionals involved should not be devalued.
- The particular expertise of nurses in patient education should be acknowledged.
- Diabetes care should always be based on the most up to date evidence available.

The argument for the GP and PN jointly caring for people with diabetes recognises that working within protocols does not take the individuality of each person with diabetes into account, that local education and training programmes for PNs are not always adequate, that GPs still retain responsibility for prescribing, and that a team approach should be used wherever possible.

Both sides of this debate have presented valid reasons for their arguments, and individual practices need to decide how best to organise their own services. However, both authors agree on certain aspects of care (see box above). ■

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