

## Nurse practitioners and physician attrition

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This brief note describes one possible solution to the problem of doctor shortages in urban Canada. It involves a family physician (B.M.) nearing the end of his career and wishing to reduce his overall workload in his final years of practice.

This family physician had hoped to pass on the care of his substantial practice in a medium-sized city of southern Ontario to a younger colleague. Unfortunately, dwindling numbers of family physicians in the 1990s were willing to take on an active practice, and B.M. was able to continue working beyond the age of 60 only with the help of a physician associate, who carried the practice for 2 days weekly on a locum tenens basis. In time, even the supply of part-time physician associates dried up. By 2002, B.M. was faced with three alternatives: return to full-time activity and simply keep working, close the practice and leave almost 3000 patients with no ongoing care, or look for creative alternatives.

Having worked with nurse practitioners in the past, B.M. began to explore having one as a colleague (designated RN[EC] under current Ontario legislation) join the practice as an independent associate to take on many of the responsibilities of locum physicians employed previously. The key was to have the associate practise independently but in conformity with collaborative guidelines outlined in provincial legislation. Such arrangements have worked well in isolated areas where physician supply has been minimal, but B.M. was unaware of similar collaborations in southern Ontario.

He was assisted in his endeavours by three positive factors. First, his was a capitation practice and could offer remuneration to the associate without fee-for-service support from

the provincial health plan. Second, electronic records, in place for several years, made it easier to ensure quality of care and consistency between two practitioners working from slightly different perspectives. Third, medical colleagues in the call group and the local community were, overall, highly receptive to the collaboration proposed. A search was made and C.L., who is an RN(EC) with a range of clinical, research, and teaching experience, joined the practice on a contractual basis. Once they had obtained clearance from professional bodies and medicolegal colleagues, B.M. and C.L. were free to begin their collaboration, and patients could be assured of a further period of stability.

### Medical directives

Incorporating an associate into the practice prompted creation of a set of medical directives relating to the principal medical issues facing a primary care practice: hypertension, diabetes, immunization, asthma, thyroid disease, and so on. This process has focused the two practitioners on quality-of-care issues and evidence-based guidelines; as a result, the overall consistency and efficiency of care have improved. Appointments have been tailored to the particular interests and skills of the two colleagues, and the volume of patients seen on a daily basis has not changed greatly. Office staff (a registered nurse and a registered practical nurse, both experienced and long-term employees of the practice) have adapted seamlessly and appear to enjoy the different perspectives offered by the two practitioners. Patients have welcomed the opportunity to choose between a physician and a nurse practitioner. Particular demographic and personality profiles self-select one way or the other.

## Coverage and consultation

From a practical point of view, B.M. runs the office 3 days weekly, while C.L. covers it 2 days weekly. On the days when B.M. is not physically present, he is available by telephone at all times, and consultation is frequently in the form of a 15-minute report at the end of the day. For emergencies, a medical colleague is a matter of feet away and is available for consultation, and the hospital's emergency room is across the street. Our medical colleague appears pleased with this arrangement, as when he needs coverage for vacation, C.L. is seconded to his office, and B.M. provides on-site consultation from across the hall.

While nurse practitioners are able to order a variety of tests under Ontario's current legislation and to prescribe a long list of medications independently, items that fall outside C.L.'s scope of practice (narcotics and specialized imaging, for example) can either be authorized after immediate consultation with a medical colleague or left for B.M. to authorize on his next day in the office. Referrals to specialists take place jointly, and specialists in the community have been generally cooperative.


At a professional level, B.M. is perhaps less free than he was in the past when another physician attended his patients 2 days weekly. On the other hand, he has benefited immensely from the input of an experienced nurse practitioner in his practice, and has learned from their daily telephone consultations. He believes that better decisions are made on behalf of his patients than would be the case if he were working alone,

full time. At the time of writing, B.M. was in the final months of professional activity; he retired in September. It is a tribute to the collaboration of the past 3 years that it has been relatively easy to find a family physician willing to take over the practice when B.M. leaves, despite the area's designation as underserved. There is no question that the practice is more vibrant and attractive as a result of C.L.'s work, and she continues to collaborate with the new physician. The greatest benefit, of course, is to the many patients who would otherwise be left without continuing medical services.

## Why it works well

From what we have learned, several prerequisites are needed for this model to flourish.

- Both partners need to be experienced and flexible and to have common goals in provision of primary care.
- Backup consultation must be clearly defined and accessible.
- Medical directives need to be agreed upon and easily applicable.
- An on-site physician should be available to support the nurse practitioner at times when the principal physician is not physically present.
- Emergency services should be close and accessible.
- Staff need to understand the rationale for such a collaboration and to be sympathetic to the needs of each practitioner.

We report this experience because it has provided one doctor (and the community in which he works) with a solution to the problem of attrition, both in the short and long term. Communities where recruitment of new physicians has been a fruitless exercise might wish to consider such a model. 

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