Advanced nurse practitioners and physician assistants

Sir,

I read with great interest the article by Carol L Cox about advanced nurse practitioners (ANPs) and physicians assistants (PAs) (vol 62(3), 2001, p. 169). In this article, the author outlines the two possible roles which could be implemented to address the present and growing shortage of doctors in the UK. The author presents an excellent review of the ANP in UK and begins a much needed discussion about the delivery of health care in the UK today.

Referring to the PA concept as a 'mistake' the author writes: 'Too often the UK has followed in the footsteps of the USA in relation to health-care management and delivery of services, only to find that the lessons learned from mistakes made in the USA were not considered before implementation was taken in the UK.' The situation in the USA, however, could not be farther from the truth. The rapid growth and utilization of the PA in the USA is testimony to its incredible success and acceptance by both physicians and patients.

Additionally, Professor Cox points out that the educational curriculum of the PA is somehow less by its lack of standardization. Again, to the contrary, this flexibility allows for the graduate PA to enter the medical profession in any surgical or medical specialty, thus satisfying the 'needs' of any community, where they need the service most. Both the practice and the patient benefit from this broad, flexible educational perspective. The profession, however, is not without guidelines and the PA professional accreditation process ensures core standards for all accredited programmes.

I suggest that there are plenty of patients in need of services to go around for all physicians and non-physician clinicians. The ANP and PA can work harmoniously with physicians in any country if we keep that perspective in mind. The problems may lie less in the differences between the ANP and the PA than in the system and the regulatory environment in which we are forced to work. If, in fact, the focus is on providing competent and economical medical services to patients in need of those services, the PA, in conjunction with physicians and ANPs, may help to deliver such care. Might it be possible to come together on the behalf of those in need of our services?

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Sir,

I would like to thank Dr Cohen for his considered commentary regarding my article. The purpose of the article was to describe some of the background to the UK's present health-care situation in relation to the reduction in junior doctors' hours and fewer doctors being trained, which has led to a gap in appropriately trained clinicians to meet service delivery needs. The article also delineated two types of roles, the ANP and the PA, as alternatives to address the present and growing shortage and invited readers to consider these alternatives. Dr Cohen's interpretation that the article infers that the introduction of PAs in the USA is a mistake is in error. The PA fulfils an important role in the delivery of health care within the consultant's team. The issue that was raised in the article was about standardization of education and regulation.

With the advent of clinical governance in the UK, the NHS must reconsider how services are delivered as well as the importance of employing appropriately educated and licensed clinicians. Regulation and licensure goes hand in hand with clinical governance initiatives.

I could not agree with him more that the focus in the NHS today is on providing competent and economical medical services to patients in need of health care. That is why even health-care assistants must now undertake national vocational qualifications (NVQs) in the UK, and regulation of their practice is being considered by the UKCC. Indeed the PA and the ANP should work in collaboration with doctors to deliver the highest quality of care possible to patients. In order to ensure that the highest quality of care is delivered, as was stated in the article, 'if the answer is "yes" [to the introduction of PAs] then let us ensure we have the curricula and level of education and practice standardised throughout the UK, and finally, that licensure is mandatory.'

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Unusual cause of third nerve palsy

Sir,

Giant cell arteritis (GCA) was a notable absentee from the differential diagnosis of third nerve palsy listed by the authors of this case report (vol 62(2), 2001, p. 116), notwithstanding its previous documentation in association with partial, as well as complete oculomotor nerve paralysis (Dimant et al, 1980; Davies and Shakir, 1994), the mechanism being ischaemic neuritis of this nerve.

Although the final diagnosis in the case reported by the authors was myasthenia gravis, it is worth noting that, in the differential diagnosis of neurological manifestations of GCA, 'ptosis with ophthalmoplegia may suggest myasthenia gravis' (Reich et al, 1990). I believe that this diagnostic error is most likely to occur when ptosis is bilateral, and associated with non-dilated pupils, as in two of the cases reported in the account of opthalmoplegia, ptosis, and meiosis in temporal arteritis (Dimant et al, 1980).

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Davies GE, Shakir RA (1994) Giant cell arteritis presenting as oculomotor nerve palsy with pupillary dilatation. *Postgrad Med J* **70:** 298–9

Dimant J, Grob D, Brunner NG (1980) Opthalmoplegia, ptosis, and meiosis in temporal arteritis. *Neurology* **30:** 1054–8

Reich KA, Giansiracusa DF, Strongwater SL (1990) Neurologic manifestations of giant cell arteritis. *Am J Med* **89:** 67–71