Rethinking general practice for the 21st century

The patient counts!

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BACKGROUND Increasingly, reforms to health care systems appear to interfere with the traditional (healer) role of the general practitioner, and are perceived to disrupt patient care and the therapeutic relationship.
OBJECTIVE To outline measures for the survival and future development of the discipline of general practice in Australia.
DISCUSSION In order to preserve longitudinal relationship centred care and high level primary care clinical expertise, health bureaucracies and general practice itself, must re-focus care on the individual and community, integrating new developments rather than allowing 'new ideas and system pressures' to continually distort functional general practice.

General practice aims to provide comprehensive patient centred, community orientated, longitudinal and clinically expert primary care. This 'British' model that emerged post World War II was adapted by many other countries and has been recognised as a notable success in delivering such holistic care.[1] However, worldwide, the survival and future development of the discipline of general practice is under threat despite its impressive benefits to patients and communities. In Australia,[2,3] as in Canada[4,5] and the United Kingdom,[6,7] there are ongoing efforts to reform general practice. However, evidence indicates considerable dissatisfaction among general practitioners with these reforms.

And why are these reforms often perceived as interference and disruption to the task of patient care? Australian GPs feel they are doing a good job; and at the same time feel disillusioned. They are distracted from what they love to do – care for their patients – by such diverse issues as increasing bureaucracy (accreditation, red tape in delivering fee-for-service care, practice incentive payments, substitution for their care), demands of the National Prescribing Service, medicolegal threats and the indemnity crisis, demand for evidence based practice where that evidence is generally not available for the primary care setting, lack of government and specialist colleague recognition, poor remuneration, and top-down governmental changes without prior meaningful consultation.[1]

What are the problems with general practice care that are leading to increasing calls for reform? Criticisms about general practice are centred on four areas[8]:

- general practice is time and skill inefficient – highly trained, expensive medical professionals treat trivial conditions; they are individualistic and do not share care due to outdated notions about the doctor-patient relationship, thus blocking care access[9]
- general practice has an ill defined approach to disease management. Much of its care content is nonspecific and could be provided more cheaply by those with less training
- care appears reactive, rather than proactive, and
- goals of management are poorly

defined and general practice outcomes are difficult to classify and measure.

Hence, governments and bureaucrats struggle when applying their usual accountability principles, which are based on easily quantifiable – but largely clinically irrelevant – measures.

The bureaucratic approach to general practice

We argue that governments and private health organisations do not necessarily understand the nature of our discipline and what it has to offer. Indeed, there has been a lack of systematic and synthesised thinking about general practice in health service planning and development. In the guise of progress, successive 'reforms' have progressively and often unintentionally eroded the clinical, academic and financial base of the discipline.

Since medicine at large, and general practice in particular, is not an exact science, clinical decision making occurs in an environment of uncertainty. Experienced GPs are skilled and feel comfortable when dealing with uncertainty, whereas bureaucrats feel anxious and threatened by it. Creating protocols, insisting on evidence and demanding quantifiable outcomes are their ways to overcome the psychological void.

General practitioners, through initially attractive looking funding arrangements, have been enticed into the generally unproven arena of managed care type organisational structures,[10] promoting 'integrated delivery systems' through the use of practice guidelines, preventive care interventions and disease management programs. Despite good intentions, they have contributed to the fragmentation of holistic personal care because managed care implicitly forces the focus on to particular diseases, or bureaucratic rules, rather than the whole person with their complex bio-psycho-social needs.

Equally, research funding based upon discrete disease and narrow service interventions has pushed general practice academics into adopting reductionism, thus reducing patient care into discrete components and leading to the loss of the overall picture in minutiae.

Is it self inflicted?

Green[11], in a light hearted vein, argues that the discipline itself is responsible for the decline of general practice. The 'near worship of their independence, their lack of curiosity and solid contributions to better medicine, their focus on payment systems and their preoccupation with administrative methods has left them being 'out competed' by others in the best execution of specific tasks'. There has been on the one hand, an abdication of the core generalist role by GPs, allowing key tasks of patient care to be fragmented and delegated to other professionals. On the other hand, general practice has wrongly focussed on narrow clinical tasks rather than on individual and community needs, which has led to the erosion of holistic care.

The power of medicine – in a healing sense – lies in the doctor-patient relationship and this is most evident in primary care. Nonmedical practitioners, particularly policy makers and bureaucrats, as well as some public health specialists and epidemiologists, have a psychological envy of the primacy and privacy of this unique relationship. Knowing little about clinical decision making, these groups attack clinicians on the grounds of lack of evidence. Such attacks are appealing to governments because it provides them with tools for ascendancy and control over clinicians, ie. a power shift from clinicians to public health officials and managers that supposedly enables them to exercise greater financial control.[12]

Such an economically rationalist shift further undermines the value of the consultation and trust and confidence in the doctor-patient relationship. As a consequence, more value (prestige as well as money) is placed on procedures, and this process adds even more weight to the notion that the mechanistic and objective have more worth that the emotional and ephemeral.

Why is holistic care so important?

People are individuals who, over a life course, usually have many problems and more than one disease to respond to with different capacities and support structures to self manage. Health care needs are determined by age, gender, culture and community, as much as by diagnosis. Patient centred care with better communication and continuity leads to better health outcomes.[13] Such care can reduce health care costs such as avoidable hospital admissions and complications.[1,14] Prevention and health promotion, while apparently discrete activities, are centred on common risk factors and local cultural norms for a wide range of conditions. Attempts to constrain medical time and resources in consultations forces doctors to ignore complex health, disease and social processes in their clinical decision making[15] and thus increase flow-on costs of care.

The scope of general practice

A key feature of the discipline is that it defines itself in terms of the individual patient experience of illness and disease.[13,16] General practitioners, in the past very clearly, and now increasingly again, recognise they are dealing with individuals with problems such as tiredness, vague pains, and 'not coping', rather than narrowly defined subject matter such as myocardial infarct, psoriasis, duodenal ulcer, and cataract.[17] Many of these problems cut across the borders of narrowly defined disease entities.[17] Primary care based disease management in many instances works through its interactions with patients in their social environment rather than through specialised investigational, procedural or pharmacological interventions. The power of the therapeutic relationship between the patient (the sufferer) and his or her doctor (the healer) continues over the millennia.

In certain areas the therapeutic effec-

tiveness of the doctor-patient relationship has been enhanced, not supplanted, in the last century by many scientific discoveries and technological inventions. In the contemporary context one has to acknowledge Feinstein[18] who describes the role of today's doctor as: 'A clinician's privilege and power in clinical therapy is his ability to make both the therapeutic and the environmental decisions concomitantly'.

The dilemmas for medicine

The emergence of the science of medicine in the 18th century located disease in specific anatomical structures and explained diseases as the result of causal mechanistic processes.[19] We wholeheartedly agree with Rosenberg[20] that the bureaucratic process has reconfigured medical care around the narrow concepts of diagnosis and subtle disease entities and clearly defined interventions. Such a process sits comfortably with a perception of discharging bureaucratic responsibilities by managing costs based on 'hard' data.

Western medicine has become increasingly technical, specialised, fragmented and bureaucratised. As a result, medicine has been gripped by an accountability based, disease driven model that underpins policy, funding, organisation and practice. Terminologies describing those accessing health care have oscillated around 'patient', 'consumer', 'client', 'customer', creating role confusion among providers and receivers. Socially, the consumer movement has challenged medical paternalism and passive patienthood. Self management of disease linked to disease management programs across the continuum of care is the logical endpoint of care. Yet this requires a greater responsibility by GPs to empower and support the consumer or patient to manage and care for their conditions in a holistic way.[21]

One also needs to consider if 'health care' is seen narrowly as what doctors, nurses and allied health care workers provide, or broadly as all the interactions of societal activity of its members. The latter would require a systems approach to health care thinking[22] with governments, industry and society - together with the health, education and welfare sectors - assessing economic, education, employment, justice, capital works and other policies for their potential negative effects on health and our social capital.

The real production of medical care occurs in consultations[15] in contrast to the bureaucratic, top-down approaches of narrow disease management and other outputs. During consultations, decisions are made that determine whether people become patients, who consume investigations and surgical interventions, and who are prescribed medications. When consultations are not constrained, the major resource consumed is doctor time and expertise. However, less holistic and more narrowly focussed consultations may generate greater numbers of referrals, tests and hospitalisations. Thus longer 'production time' in consultations is the key to cost savings. Achieving understanding about the patient's concerns achieves the most cost effective health outcome.[15,23,24]

Meeting the challenges

The key question now is how to fund and organise medical care, especially general practice and primary health care. Challenges that must be addressed include changing social expectations of medical care, the impact of technological change on society at large, an aging population, less community cohesion and social support, greater expectations of scientific cure, advances in technology and pharmaceutical interventions, litigation and medical indemnity, shifting financing models including corporate ownership, private practice and fund holding, workforce changes and new roles for other health professionals such as nurse practitioners, pharmacists and complementary medicine practitioners.

To contain health costs, and at the same time achieve improved patient outcomes, medicine – and general practice in particular – must refocus on the patient. We therefore have to design models of patient care that allocate resources and personnel around patients rather than around specialised fragmented programs, bureaucratic processes and mechanistic interventions.

We need to reconstruct the disease model, integrating the emerging scientific and social knowledge of the 21st century, so that it fits the experiential reality of the individual sufferer. The development of the somato-psycho-socio-semiotic paradigm of health care by Pauli, White, McWhinney et al[25] is an important step in this direction. We need to appreciate the importance of the illness experience to our patients. As a discipline, we need to critically reflect and focus our research attention on the understanding of illness[27] as a fundamental element to the creation of medical knowledge.

General practice clinical care must not be organised or funded as the poor relation to disciplines that specialise in 'cure' through technical disease interventions. General practice research should and must have the courage to pursue its own models based around the complexities of the illness experience. There is a need to more carefully consider the process and impact on traditional general practice categorisation, social and economic pressures, and a burgeoning of other provider groups eager to take on new primary care roles.

Medical organisations, such as colleges and national medical associations, working with intellectual leaders and clinicians at the coalface, must unite to protect the discipline, promote it to medical students and plan what should be an exciting and expanded future. Patient organisations need to come on board to advocate for refocusing on the individual's illness experience. A concerted intellectual, cultural and clinical revival is needed; a regrouping of those with an understanding of the need to reinvigorate that branch of medicine that traditionally has provided personal, ongoing and community oriented care. Both decision makers and the

public must not allow one of the great successes of modern times – general practice – to disappear through the reductionist and economic rationalist obsessions about diseases and accountancy.[27]

We strongly believe that change is overdue to replace the cost management perspective with an illness experience perspective – after all, it's the patient who counts!

Conflict of interest: none declared.

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