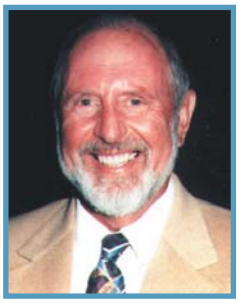
The tasks of general practice

A new kind of GP?

BACKGROUND The Department of Health and Aging is driving a reform of general practice to encompass primary care and population health. Although these new ideas are quite old they have rarely been comprehensively applied.
OBJECTIVE To develop an up-to-date conceptual framework of the comprehensive tasks of general practice.
DISCUSSION This framework can help the 'new kind of general practitioner' (and those in training) in deciding which elements of the 'new primary health care' they can, or will, encompass.



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Australian patients see the primary responsibility of a general practitioner as providing them with a medical diagnosis and treatment when they want it. Most GPs (and medically interested lawyers) would agree this is the core component of their role.

The funder of most of this core activity is the Commonwealth Department of Health and Aging (DHA). Its prime focus is on cost effective care that has the promise of improving the overall health of the nation. The DHA is currently the major driver in the reform of Australian general practice. Their health planners are exhorting and providing financial incentives to GPs to become involved in primary care and population health activities. The current working definition of population health from an Australian general practice perspective is: 'an extension in systematisation of general practice's existing role in preventive care for individual patients. As well, it is the provision of more comprehensive preventive care which addresses the needs of the practice's patients and local communities, including those not adequately accessing preventive care. It involves activities such as immunisation, risk assessment and management, patient education and screening, in which GPs are already engaged within their practice'. Since this is what many GPs already do, the current definition concludes with 'a population health approach means doing these things more effectively and consistently across a whole population'.[1]

Consequently, the DHA is encouraging the use of information technology, providing information on community health needs and what it believes are consumer (patient) needs. The Department of Health and Aging has taken the word 'partnerships' as both its mantra and password to the process by which GPs will contribute to improving the population's health through increased involvement with consumer associations, local communities and allied health professionals.

However, most of a GP's training, from undergraduate through to the end of vocational training, is concerned with the diagnosis and prescribing of treatment for an immediate or ongoing condition. For most GPs, learning the difference between treatment and the much more comprehensive and holistic skill of management, comes at a later stage when they are geographically settled and have ongoing responsibility for a stable practice population.

A different set of skills is required for preventive medicine and population health. This difference was outlined by Sir Donald Acheson, Chief Medical Officer of Health in England from 1983-1991, when he described general practice as a myopic view of medicine which is all about combat but with no strategy. He contrasted this with population health as being a bird's eye view of medicine, all strategy and no combat.

The unhappy GP

It is common knowledge that many GPs are unhappy with their lot and given their time over again would not choose general practice as their medical career. This dissatisfaction comes from feeling professionally and financially under valued, combined with a sense of powerlessness in the face of top down directives (and paperwork) from the DHA. This is exacerbated by the confusion and demoralisation created by the constant bickering of general practice's major organisations. Another underlying but less discussed cause of this dissatisfaction is the confusion of roles and tasks that arise from GPs' traditional role and training, and that being advocated by the government.

The tasks of general practice

The ideal task of a 21st century western GP is to develop a holistic and comprehensive view of an individual patient as well as care for an aggregate of human beings, over time. The two component thrusts of this holistic care are curative and preventive. In the model presented in Figure 1 each of these components is further divided into six subcomponents. The aim of this model is to provide a theoretical framework around which a GP can visualise and prioritise his or her chosen tasks. This model can also be used in the planning of teaching and training for present and future GPs. It is built on concepts extending from ancient Greece to the modern age.

Hippocratic generalists (460-370 BC) were clearly patient oriented.

> The regimen I adopt shall be for the benefit of the sick.[2]

By the late middle age the Jewish philosopher and physician Moses Maimonides (1135-1204) saw his task as caring for any sick person who asked his advice without any distinction between rich and poor, friend and foe, good person and bad.[3] The mid 19th century saw advances in the understanding of epidemics of cholera, typhoid and smallpox as being related to unsanitary and crowded working and living conditions. In England many GPs became Medical Officers of Health (MOHs) responsible for researching local causes of ill health and implementing local government laws. Their triumphs were in environmental controls, health education and organising the vaccination of children against a host of previously lethal infectious diseases.[4] Although their role has been largely subsumed by the public health work of state departments of health, local governments in Australia still appoint MOHs, nearly all of whom are GPs. Parallel movements were occurring in Germany championed by the father of pathology, Rudolf Virchow (1821-1902) who wrote that physicians were the natural attorneys of the poor in their struggle to solve their social problems.[5]

Current thinking about the task of general practice began in earnest with the founding of the British College of General Practitioners in 1952. In 1974, a high level group of European GPs met in the Dutch town of Leeuwenhorst where they produced a well accepted definition of the modern GP as: 'a licensed medical graduate who gives personal, primary and continuing care to individuals, families and practice population, irrespective of

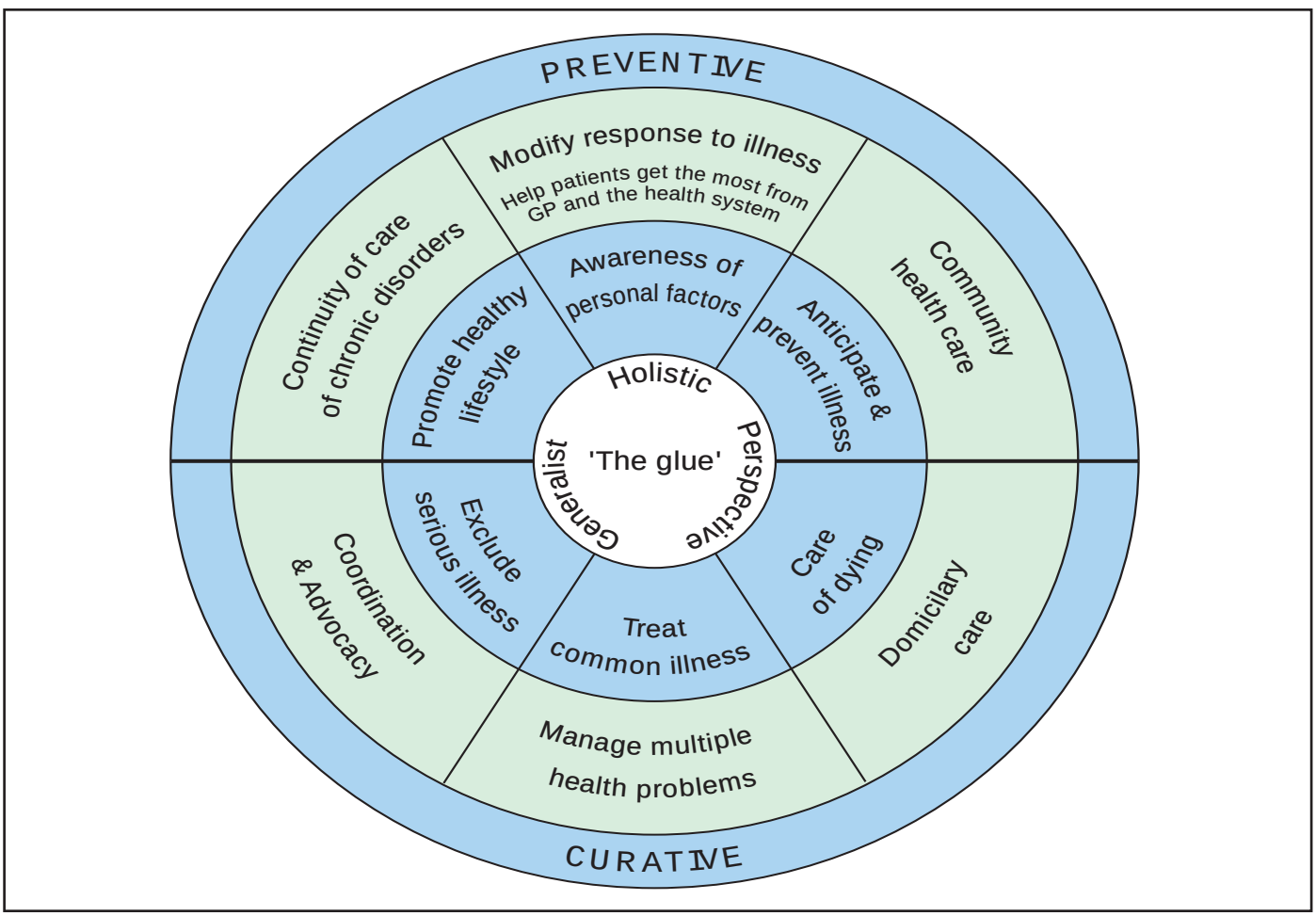

Figure 1. The tasks of general practice

age, sex and illness'. The working party stressed that: 'it is the synthesis of these functions which is unique'.[6]

However, little of this conceptual activity impinged upon the work of the busy GP. General practitioners continued to get through their day by focussing on the patient's presenting problem. The most academic of nonacademic GPs, Julian Tudor Hart, pointed out the problem with medicine at the general practice level, was that what was done was determined by the patient's expectation. 'If patients expect very little, very little is what they actually get'. He proposed the training of a 'new kind of doctor' who would use research based evidence to work within the context of individual and population based health care to improve the health care delivery, satisfaction and health status of patients in their catchment area.[7]

Another conceptual milestone in defining the task of a GP was a paper from the Welsh National School of Medicine on 'the exceptional potential in each primary care consultation'. This could be achieved by a conscious focus on four major components of clinical practice, the management of presenting problems, continuing problems, opportunistic health promotion and the modification of a patient's health seeking behaviour.[8] The practical implication of this concept was that if it took only two minutes to diagnose a sore throat the GP then had 10 minutes left to focus on one or more of the other three components of the consultation.

Other concepts and tasks included in Figure 1 are coordination of care and community involvement,[9] whole person care requiring good medical records,[10] and the GP as the custodian of a population at risk and a participant in a community wide network of care.[11]

Barriers to change

Much of the pressure for change in general practice is coming from the DHA planners and bureaucrats rather than from patients or GPs themselves. Paradoxically this top down prioritising of health problems, as seen by the planners is the antithesis of the partnership approach they demand from grass root health professionals and academic GPs. WHO has reported the top down approach as a major reason for the partial failure of its primary health care programs.[12] So much is currently being asked of GPs that many will, for philosophical, practical or financial reasons, choose to stick with the core curative component of their role, the performance of which can already leave the conscientious doctor exhausted long before the end of his or her day.

Supports

Those who choose to be a new kind of GP will need organisational and hands-on help so they can concentrate on their areas of skill rather than on tasks which can be done equally well or better by differently trained health professionals. The most appropriate partners have long been shown to be practice nurses and nurse practitioners.[13,14] Australian initiatives to support their training and employment will add value to the effectiveness of these new kinds of GPs.

Conclusion

Anyone who has sat in a focus group with 10 GPs will know they have at least 11 opinions about any given topic. This also applies to something as fundamental as agreeing upon the tasks of general practice. Clearly, there is no right or wrong answer. And who is to say that the doctor who completes 20 multidisciplinary care plans per week, but occasionally misses important diagnoses, is any better or worse than the brilliant diagnostician who refuses to do health assessments or multidisciplinary care plans.

The important issue is for all GPs to carry an internalised model of the many tasks that make for the generalist holistic perspective advocated for the new kind of GP. However, whether doctors choose to be a new or an old kind of GP, the road map presented in Figure 1 will help them, and those training to be GPs, to decide which elements of the new task they can, or will, encompass.

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