

Is there a GP in the hospital?

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Modern health care is increasingly complex with a progression to specialisation and super specialisation in the primary and tertiary settings. Traditional models of health such as the biomedical model are often inadequate. The value of a more holistic approach to patients' health problems has been long accepted by the medical profession. As health care becomes more fragmented we are overlooking the potential benefits of a generalist approach in improving the care of patients in our hospitals. This article examines the potential benefits of involving general practitioners in the tertiary care setting.

'Dr Munro, sir,' said he, 'I am a walking museum. You could fit what isn't the matter with me on to the back of a ** visiting card. If there's any complaint you want to make a special study of, just you come to me, sir, and see what I can do for you. It's not everyone that can say that he has had cholera three times, and cured himself by living on red pepper and brandy.'**

Sir Arthur Conan Doyle, *The Stark Munro Letters*

In some ways the modern doctor is not very different from his ancient counterparts in that they use the age old techniques of examination, diagnosis and treatment. But where our predecessors may have individualised their patient care, modern health care is increasingly specific and complex. If Dr Munro lived in 2006, he would have to enlist the help of several specialists, subspecialists and even super specialists to figure out this patient's illness.

The biomedical approach

The biomedical model of health care delivery has been the dominant model of western medicine for over 100 years. Its appeal lies in the ability to come to a quantifiable endpoint such as a blood pressure reading or cholesterol level. The utility of this model is limited by it being only a surrogate for human beings: their physiology, psychology and the environment they live in. If a doctor's only aim is to categorise a particular problem, dissect it further into smaller categories using investigations until a disease diagnosis is made, then this is an inefficient technique. In the area of psychiatry, the number of diagnostic categories in the *Diagnostic and statistical manual of mental disorders* has risen from 106 in 1952 to 357 in 2000.¹ This reductionistic approach can easily separate the patient from their illness and disease, thus creating the mind-body dualism (the mental and the somatic operating independently) that George Engel described when he proposed the biopsychosocial model as an alternate framework. He commented:

'The crippling flaw of the model is that it does not

include the patient and his attributes as a person, as a human being. The biomedical model can make provision neither for the person as a whole nor data of a psychological or social nature, for the reductionism and mind-body dualism on which this model is predicated requires that these must first be reduced to physicochemical terms before they have meaning. Hence the very essence of medical practice performe remains 'art' and beyond the reach of science.'²

Case study

The following case study illustrates limits of the traditional disease orientated medical model and why it is necessary to challenge this paradigm.

Mr Smith, 42 years of age, suffered chronic paranoid schizophrenia. His illness was characterised by somatic hallucinations. These somatic hallucinations were experienced by the patient as an abnormal sensation involving his jaw bone and an unpleasant feeling in his abdomen. A relapse in Mr Smith's psychotic symptoms resulted in admission to a tertiary hospital psychiatric unit. During the course of this admission, Mr Smith complained of central chest pain. This complaint was interpreted by the psychiatric team as a new somatic hallucination. It was only when one of the authors (a former GP doing a psychiatry rotation) recognised the patient's symptoms as typical of angina pectoris, that the patient was investigated and appropriately treated for ischaemic heart disease. Mr Smith required coronary bypass surgery 6 weeks later.

Discussion

A diagnosis does not need to be framed exclusively in terms of the biomedical model. By focusing on psychological symptoms, the patient is denied physiological explanations for their illness. It is not surprising then that studies have shown schizophrenia and other mental illnesses have high rates of physical comorbidity that are less efficiently detected.³ To be fair, no one model can explain all our patients' illnesses.⁴ But an adverse consequence of the biomedical model is that it encourages hospital staff to think

purely in terms of their specialty. It is not only in psychiatry where this 'tunnel vision' exists. A study published in 2001 highlighted the apparent neglect of women's health issues in a cohort of women undergoing regular haemodialysis in Victoria.⁵ The authors concluded that hospital based dialysis services should include a service that deals with women's health issues to ensure that this aspect of their routine health management is not neglected. It may be that few hospital specialists or their staff encounter the undifferentiated patient population that is the daily norm for the GP.

Hospitals are a complex mix of specialist teams, seemingly well informed patients, and expensive technology. What are the barriers to hospital based specialists dealing with patients' global health issues? Possible barriers may be rigid clinical pathways (many of which have been developed from studies on patients without other concurrent illness), the emphasis on evidence based medicine, and the preoccupation with quality, safety and accreditation at the expense of understanding the patient's reason for their presentation. This system almost failed Mr Smith because nursing and medical staff did not recognise that he could have something other than a mental illness. The system was designed to have the psychiatric patient treated for a psychiatric illness and not anything else. While individual specialties such as psychiatry and nephrology may deliver excellent care, they are not designed to manage the whole person. A possible consequence of this system failure is the estimated 10 000–14 000 possibly preventable deaths that occur in Australian hospitals each year.⁶

Some countries have encouraged the emergence of a 'hospitalist' who has a wide range of expertise. He/she would specialise in acute and serious illness; be familiar with medical comorbidities; and understand continuity and coordination of patient care, managing the patient's hospital stay, and arranging a smooth transition to a community setting. Single disease management is not an appropriate strategy for a patient's overall health care needs and the fragmentation of care can result in inefficiencies and higher costs.^{7,8} At the same time, momentum is gaining for workforce reform in Australia, with debate on innovative strategies such as task

substitution (eg. extending the role of existing health professionals such as nurses and allied health professionals). We believe one strategy that needs to be considered is the introduction of generalism to the hospital system – in the form of a GP – to achieve comprehensiveness and continuity of care.

Health care in Australia is being devolved back to the community at a rapid rate, as acute care hospitals attempt to decrease admission rates, reduce length of stay and facilitate early discharge.⁹ Results have been mixed, as seen with the Coordinated Care Trials and Hospital in the Home.^{10–12} The boundary between primary care and institutional care should be made common ground – not a line to be fought over. One way to achieve this 'seamless care' is to dissolve these 'silos' and provide multidisciplinary care.^{13,14} Studies have shown that integrated management involving GPs achieves outcomes similar to, and in some instances better than, hospital care.¹⁵ How this shared care will be arranged has not been established. Six possible models, according to their method of data transfer, have been proposed by Hickman et al¹⁶:

- community clinics – the specialist undertakes a clinic in general practice
- basic – communication comprises regular exchange of letters or standardised record sheets
- liaison – the hospital team and GP meet to discuss and agree the management of patients under shared care
- shared record cards – the exchange of information through a booklet or 'cooperation card' (commonly carried by the patient)
- computer assisted shared care – information is established between the GP and hospital based specialist based on data collected at each patient visit and mediated through computer generated summaries, and
- electronic mail.

Conclusion

Patients are multidimensional. Frequently the model of illness adopted will influence whether a person or health professional interprets a change in their state as indicating disease.¹⁷ Just as doctors must have an understanding of alternate models of disease to diagnose and manage patients appropriately, the medical community

must re-evaluate traditional notions and assumptions of the way health care is delivered. Patient centred care can be succinctly defined as 'sharing the management of an illness between a patient and doctor'.¹⁸ We would like to further elaborate on this definition by adding that better outcomes for patients occur when the generalist is involved in care.

Conflict of interest: none declared.

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