Medical generalism

Why expertise in whole person medicine matters

June 2012

RCGP Royal College of General Practitioners

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Foreword

Health services have always had to adapt to meet the changing needs of patients. At the moment our own healthcare systems across the UK have a really tough challenge ahead of them: to deliver kinder, safer, more efficient care with increasingly stretched financial resources to patients who are more and more likely to have complex care needs, and to be living with multiple health problems.

This Royal College of General Practitioners (RCGP) report on medical generalism – which responds to and takes forward the excellent work undertaken by the independent Commission on Generalism last year – makes a compelling case as to why generalist medical practice has a vital role to play if we are going to meet this challenge successfully in the coming years.

Those who work as medical generalists – and I am hugely proud to be one of them – see the positive results that generalism delivers for patients day in, day out. At a time when expectations are rising, GPs and other generalists provide care that is focused on the patient as a whole and his or her wellbeing. They can help patients and their carers make judgements that are right for them, because they see the whole picture – the person, his or her life and views, and the clinical issues they need to address. In the context of an ageing population and rising levels of co-morbidity, they work across professional and organisational boundaries to help patients navigate the system. Generalists already help to ensure that the NHS remains one of the most cost-effective systems of care in the world. Their role in our health system needs fresh consideration, given the massive financial challenge we have ahead.

This report is the result of months of consultation, debate and research. It draws on input from our members, who as GPs have the greatest breadth and scope of generalist clinical practice. It describes how generalism can continue to evolve to meet patient needs and sets out a programme of work to make it happen, including the important links with patients, other members of the medical profession, and other healthcare workers, who also need to understand and use generalist skills to maximise patient benefit.

One of the central themes of this report is that the future of medical generalism relies on an outward-looking, inclusive approach to health care, with GPs willing to think creatively and engage with others. In this spirit, we look forward to hearing your thoughts on our findings and would encourage all those with an interest in delivering kinder, safer, more efficient care to get involved in the ongoing debate.

Prof. Clare Gerada MBE FRCGP
Chair of Council
Royal College of General Practitioners

Executive summary

The RCGP believes that the case set out here for why medical generalists matter to all healthcare systems is simple. Generalists are professionals who are committed to you as a person. They do not have to give up on or pass on your care because your problems do not fit their expertise; they can deal with many issues of prevention, diagnosis and problem management without referral; and they can recognise their own limits and yours, while orienting their service to your world views and character. A good generalist is trustworthy, therapeutic in relationship, and makes judgements that are safe for the individual and the system. This is key to patient needs being met quickly and effectively, and already makes a huge contribution to the NHS through the work of primary care teams. This report reviews how medical generalism can play an even greater role, to make the NHS a better service.

Ensuring that we understand medical generalism is important to achieving this vision. The debate about generalism needs to be outward looking and inclusive, engaging with all those who have a stake in the future of care – from patients and professionals working on the front line to policymakers involved in shaping the future of how services can produce the best outcomes most effectively.

This report starts that process. It outlines the College's overall position on the future of medical generalism, explores some of the challenges raised in the Commission's report, and proposes a programme of work to take these issues forward. It offers a definition of medical generalism as expertise in whole person medicine, which requires an approach to the delivery of health care that routinely applies a broad and holistic perspective to the patient's problems. Its principles will be needed wherever and whenever people receive care and advice about their health and wellbeing, and all healthcare professionals need to value and be able to draw on this approach when appropriate. The ability to practise as a generalist depends on one's training, and on the routine use of skills that helps people to understand and live with their illnesses and disabilities, as well as helping them to get the best out of the healthcare options that are available and appropriate for their needs.

The report also outlines how medical generalists are defined by their training, setting, scope of practice, and the retention of a broad skill set and ethos that routinely allow them to achieve these ends. It sees the ethos of a generalist as a specific professional orientation that makes different demands from those on a specialist, and needs different training and self-discipline to be effective. Different chapters explore this in more detail, including raising questions about where in the health system these skills are best used, and how different models for access and continuity of care impact on the outcomes of generalist care.

Later in the report, the RCGP specifies that effective general practice can deliver excellent generalist care, but to do this some preconditions are needed: longer training, a team of generalists, more time with patients, better access to additional near-patient or ambulatory diagnostics, and better communication with specialists. Finally, the proposed programme of work addresses all of the Commission on Generalism's recommendations, and invites others across the clinical and political spectrum to engage with the next steps – which will make medical generalism a real force for effective and efficient personalised health care in the twenty-first-century NHS. Please read and respond!

Acknowledgements

The conclusions of this report are based on a wealth of input from a wide range of participants who took part in both the RCGP's own consultation and the original gathering of evidence undertaken by the Commission on Generalism. The College would like to thank all the individuals and organisations who contributed ideas, opinions and evidence to the project.

The College is grateful, in particular, to the Commission for the excellent report it produced in October 2011. In particular we would like to thank the Commission's Chair, Baroness Finlay of Llandaff, the Secretary, Dr Susan Shepherd, and the commissioners themselves – Mr Harry Cayton, Ms Anna Dixon, Baroness Audrey Emerson, Prof. George Freeman, Prof. David Haslam, Baroness Hollins of Wimbledon and Grenoside, Prof. Finbarr Martin and Dr Clare Taylor – for all their work.

The Health Foundation has provided support throughout both the work of the Commission and the RCGP's follow-up consultation. This important and timely body of work would not have been possible without this support.

Following the RCGP's consultation, which included a number of face-to-face events facilitated by Dr Maureen Baker, the College's Honorary Secretary, Prof. Amanda Howe, led the writing of this report. Additional peer review input was provided by a number of experts across the College, including Dr Baker and the College's President, Dr Iona Heath. In addition to their role as commissioners Prof. George Freeman, Prof. David Haslam and Dr Clare Taylor also provided peer review input as the report progressed.

The RCGP's Policy and Public Affairs team managed the project, providing analysis of the data collected as well as drafting and logistical support. In particular, policy analyst Paul de Ponte ran the six consultation listening events around the country, collecting feedback from a wide range of stakeholders. The History of Generalism section (Annex B below) was written using information provided by Dr Chantal Simon in her article on this subject.

1 Introduction

1.1 Background: building on the work of the Commission on Generalism

In October 2011 the independent Commission on Generalism, chaired by Baroness Finlay, published its report *Guiding Patients through Complexity: modern medical generalism*.[1] The RCGP, in partnership with the Health Foundation, had initiated the Commission, which was conducted independently and drew on evidence from a wide range of stakeholders. The Commission's report raised important questions about the concept of generalism and the role of the GP in today's NHS; made recommendations for developing, strengthening and promoting medical generalism to deliver effective patient care in the NHS of the future; and added to the existing wealth of evidence[2,3] about the hugely important role that generalism should play in any effective healthcare system.

The Commission's report also outlined a set of key challenges facing generalism in the twenty-first century and made 11 specific recommendations aimed at ensuring that generalism continues to thrive in future years. The following RCGP report – produced with ongoing support from the Health Foundation – contains our formal response to the Commission's findings.

In formulating this response, the College has consulted widely and built on its own research, through debates, discussions and consultation within the College, and direct engagement with members. The College's response to the Commission draws on:

- a thorough analysis of the findings of the evidence submitted to the Commission, as well as the report and its recommendations (by Prof. Amanda Howe, the College's Honorary Secretary)
- a detailed review of the implications of the findings by the RCGP Chair, Prof. Clare Gerada, and Dr Maureen Baker, supported by the RCGP policy team)
- debate on the Commission's report within the College's Council and College Executive Committee (CEC)
- a planned consultation based on the iterated findings of the Commission – launched at the RCGP Annual Primary Care Conference in October 2011. This included six UK-wide listening events attended by almost 60 stakeholders, including GPs, members, academics, and other professions and organisations. The College also gathered written evidence from a range of stakeholders and launched an online survey of its members (see 'Appendix A: methodology' for further details)
- consideration by experts across the RCGP's working groups, committees, education and training departments, and Clinical Champions.

The purpose of this response is to:

- outline the College's overall position on the future of medical generalism
- explore some of the challenges raised in the Commission's report
- set out a programme of work to take forward these issues.

This report considers issues relating to generalists working in a range of settings. However, as the professional membership body for GPs, the College report largely focuses on areas affecting GPs and general practice specifically. We have, however, highlighted many areas where the same ideas can usefully be applied to other health and social care settings.

1.2
The wider context: a central role for medical generalism

Box 1: The UK's ageing population and long-term conditions

45% of all hospital in-patient treatments in 2009–10 were for people aged 60 or over.[4]

50% of GP appointments are with patients living with long-term conditions.[5]

The findings have important implications not only for medical generalism, but also for the design of health and social care services as a whole, which are facing a number of challenges in the coming years. The Commission's report highlighted two key issues in particular: the UK's ageing population and the increasing number of people living with more than one long-term, complex medical condition (Box 1). Furthermore, services across the UK are facing a squeeze in funding at a time when levels of demand for services, and patient expectations, are rising.[i] Meanwhile, inequalities in health status, health literacy and healthcare provision persist in communities throughout the UK. These are shared challenges for all healthcare professionals as well as for policymakers, and affect all parts of the UK.[6]

A clear message emerging from this report is that medical generalism provides some of the key tools that will be needed to overcome these problems. For example, the RCGP has been at the forefront of calls for a greater focus on integration of healthcare services.[ii] The significant experience of working across professional and organisational boundaries that generalists are able to draw on is a key asset that will help deliver more integrated care in future. Generalists also have a key role to play in meeting rising patient expectations, as they are able to take a person-centred, holistic approach that patients value greatly. Finally, there is no doubt that generalism and general practice help ensure that the wider healthcare system is cost-effective.[2]

However, in the context of a rapidly changing external environment, there is a need for a broader discussion – including but not limited to medical generalists – about how we deliver these benefits and maximise the potential of generalism in the coming years.

The RCGP appreciates the input of many into the Commission, but now needs more people to engage in a debate about the future of generalism – across a broad range of patients, specialists, other medical professionals, those involved in delivering social and community care, and policymakers at all levels of central, local and devolved governments.

Before we look in more detail at some of the challenges, it is important that we establish a clear definition of what we mean when we talk about medical generalism. The following chapter addresses the question of how we define generalist practice.

i These shared challenges are illustrated by common themes running through the following documents recently published in England, Scotland, Wales and Northern Ireland respectively: Department of Health, NHS Finance, Performance and Operations. *The Operating Framework for the NHS in England, 2012/13*. London: DH, 2011; NHSScotland. *NHSScotland Chief Executive's Annual Report 2010/11*. Edinburgh: Scottish Government, 2011; NHS Wales. *Together for Health: a five year vision for the NHS in Wales*. Cardiff: Welsh Government, 2011; and Department of Health, Social Services and Public Safety. *Transforming Your Care: a review of health and social care in Northern Ireland*. Belfast: DHSSPS, 2011.

ii www.rcgp.org.uk/integrationofcare (June 2012).

2

What is medical generalism?

The Commission's Report (sections 2.10 and 2.11) gave the definition and dimensions of medical generalism as:

> an approach to the delivery of health care, be it to individuals, families, groups or to communities. Its principles apply wherever and whenever people receive care and advice about their health and well-being. The generalist approach applies equally to individuals and to clinical teams. It is one facet of medical professionalism (p. 5).[1]

It involves (according to the Commission's definition):

a) Seeing the person as a whole and in the context of their family and wider social environment;

b) Being accessible and available to deal with undifferentiated illness and the widest range of patients and conditions;

c) Demonstrating concern not only for the needs of the presenting patient, but also for the wider group of patients or population;

d) Engaging in effective multi-professional working and co-learning;

e) Communicating freely and clearly with patients and professionals across health and social care;

f) In the context of general practice, taking continuity of responsibility across many disease episodes and over time; and

g) Also in general practice, co-ordinating care across organisations within and between health and social care (p. 5).[1]

This description was broadly accepted by many, but the RCGP thinks it can be made more useful by some refinement. Some of the main points of criticism from the College's consultees were that:

- the definition is still context dependent – the scope of practice depends on the setting
- we need to clarify how generalism can be a 'facet of medical professionalism' – as all doctors are meant to act professionally, but not all doctors are generalists
- the role of medical generalists in addressing population needs and case management is not yet agreed[iii]
- more emphasis is needed on the dimensions of holistic care and its essential features.

Professor Trisha Greenhalgh notes that: 'Generalist knowledge is characterised by a perspective on the whole rather than the parts, on relationships and processes rather than components and facts; and on judicious, context-specific decisions on how and at what level (individual, family, system) to consider a problem' (p. 115).[7] Key to this is the idea of interpretive medicine[8,9] – establishing a relationship that from the outset and by definition is focused on the individual and how he or she deals with the world. This is a 'biographical' perspective taken by a professional who is an expert in dealing with people. It involves establishing a rapport that can be therapeutic, in the sense of developing shared insights. It is enabling and developmental, in that it has the potential to move individuals on from where they are, whether this is in terms of understanding/knowledge, emotional capabilities, or in making decisions about undergoing investigations and treatment options. For general practice, this has always been a core component of good clinical practice. As Dr Peter Toon wrote in his original submission to the Commission:

> The interpretive function is and should be at the heart of general practice, because it is through this activity that people are helped to understand and live with their illnesses and disabilities, to integrate them into their life narratives, and within the confines of the options available to them to make this a narrative of flourishing.[iv]

iii In the RCGP's online survey, points c and g of the definition were most disputed by respondents as part of the core role of generalists *per se*.

iv Dr Peter Toon, submission to the Commission on Generalism.

So, for purposes of clarity, we suggest that the Commission's definition of the ethos[v] of medical generalism is important to our members, but that we clarify it for our future work programme with the following statements (Box 2):

Box 2: RCGP definition of the ethos of medical generalism

Medical generalism is an approach to the delivery of health care that routinely applies a broad and holistic perspective to the patient's problems. Its principles will be needed wherever and whenever people receive care and advice about their health and wellbeing, and all healthcare professionals need to value and be able to draw on this approach when appropriate. The ability to practise as a generalist depends on one's training, and on the routine use of skills that helps people to understand and live with their illnesses and disabilities, as well as helping them to get the best out of the healthcare options that are available and appropriate for their needs. It involves:

a) Seeing the person as a whole and in the context of his or her family and wider social environment

b) Using this perspective as part of one's clinical method and therapeutic approach to all clinical encounters

c) Being able to deal with undifferentiated illness and the widest range of patients and conditions

d) In the context of general practice, taking continuity of responsibility for people's care across many disease episodes and over time

e) Also in general practice, coordinating his or her care as needed across organisations within and between health and social care.

In the context of healthcare services, the RCGP also believes that:

- medical generalism is valuable at some point in most care pathways
- true generalists extend their perspective not only to the presenting patient, but also to the wider group of patients or population
- the generalist perspective needs to be available in, and inform the practice of, multi-professional teams across health and social care
- although general practice is the most generalist of all medical specialties, other medical professionals may also, depending on their training, scope and setting of practice, act as generalists within their own specialty for the benefit of patients.

While in the RCGP's view the above core definition applies to those who practise as medical generalists, particularly GPs, several of those who submitted evidence to the College also made the point that the capacity to adopt a generalist perspective is the responsibility of all doctors, and that the generalist approach could be tied into *Good Medical Practice*. One respondent[vi] stated that medical generalism should be an 'inclusive entity' with a flexible application that encourages specialists to understand and engage with the benefits of utilising generalist skills in their own practice. The RCGP concurs with this view, and suggests that most aspects of the above definition (with the exception of points 'c' to 'e' above) can be applied by specialists and other health professionals to enhance the care they provide to patients.

The following chapters develop these ideas, and end with the RCGP's response to the Commission's report and its own recommendations.

v Ethos is defined in the *Oxford Dictionary* as 'the characteristic spirit of a culture, era, or community as manifested in its attitudes and aspirations'.

vi Prof. Martin Marshall CBE, Professor of Healthcare Improvement, UCL.

3
Medical generalism
Impacts and limits

3.1
Who is a generalist?

Each healthcare system is different, and the use of generalists varies between countries. In practice, it is important to be able to identify which professionals are actually practising as medical generalists. One fairly narrow example of a generalist is someone who has a sufficient breadth of skills and competencies to handle undifferentiated symptoms safely, and to start initial assessment and treatment. Using this description in the UK, the first point of contact for any person seeking care for a new problem is nearly always with a 'generalist'. Our respondents supported the role of medical generalists as being important in the 'front line' where problem mapping and diagnosis is essential.

It was the view of many stakeholders from the Commission's work that medical generalism needs to be a core feature not only of GPs in the UK, but also of physicians working with the elderly (medicine for the elderly/MFE), consultants working in emergency care settings, and some working as surgeons, child health doctors, and mental health leads. GPs are doctors whose training specifically equips them to work in this way,[vii] and community teams, triage settings and walk-in clinics need to have medical generalists leading the team. Nurses working in primary care doing triage, health visitors (for family and child health), pharmacists (when interfacing with the public for self-care of acute illnesses and some preventive work), and paramedics doing urgent call-out also need to work across a broad range of new problems, but the scope of these roles is different from those of medical generalists.

Responses to the Commission suggested that medical generalist practice is defined by *training* ('Have you been trained to have this breadth of work?'), *retention of skills* ('I still do shifts leading the acute medical admissions unit, although my main out-patient work is in respiratory medicine'), *the scope* of the role within a specific profession (GPs have a broader scope of generalist practice than pharmacists, for example), and the *setting* (community settings with open access to patients from all different age ranges and backgrounds require a wider breadth of generalist practice than do hospital-based and age-specific services such as MFE and paediatrics).

The work of the Commission, and the College's own research and engagement with key stakeholders, suggests that other common characteristics shared by generalists include:

- working with patients who present new symptoms and do not yet have a diagnosis that relates to a specific body system or medical specialty
- providing a population-based service and accepting any patient
- working at the centre of a multidisciplinary team that together provides a generalist service to patients
- dealing with patients suffering from multiple morbidities
- assessing the individual patient in the context of his or her family and social setting
- having a key role in referring or signposting patients to specialist or other forms of care/support.

For some generalist services, there may be geographical, age- or condition-specific boundaries but the implication of being a generalist is that, within the specific service setting, the generalist will accept any patient with any problem without limits imposed by more specialised colleagues. For GPs, this would be any person of any age or gender with any problems.

The last of these relates to a contrasting discussion about who is *not* a generalist. As one respondent explained, referring to the work of Marshall Marinker:[10]

- GPs exclude the presence of serious disease
- consultants confirm the presence of serious disease
- GPs accept and live with uncertainty, explore probability and marginalise danger
- consultants reduce uncertainty, explore possibility and marginalise error.

vii In the MRCGP curriculum, which details the RCGP's required minimum competencies to be a GP, this is defined as a 'specialist in family medicine'.

> GPs are risk managers and recognise that not all symptomatology requires investigation, referral or treatment but requires … the allaying of fears and explanations of the problem. GPs' generalism is also linked to their open accessibility to patients, which is not the case for specialists.[viii]

So, in summary, the core characteristic as shown in many pieces of evidence is that generalists are people who, within the training and setting of their work, retain the ability to do a clinical assessment and arrange appropriate next steps for a variety of conditions that present to them without previous vetting. This contrasts with a breast surgeon who has ceased to do emergency surgery except for the complications of his or her own specialty; or the practice nurse who deals mainly with planned contacts with asthma, diabetes and COPD patients for chronic disease monitoring.

While any member of a clinical team needs to be able to recognise when more is going on than his or her competency allows them to deal with, the specialist will hand this back to another team, where the generalist should be able to assess a broader range of problems and even deal with them without referral. *Each* specialty and setting therefore may benefit from defining what is the range of generalist skills needed to assist patients to get appropriate care efficiently, and where specialist skills centred on specific sets of tasks may be more effective. This is about skills/competencies, context and setting, and will influence training. Further discussions are needed with other clinical groups to define who is currently trained for generalist practice and how these skills are (or could be) utilised in health services.

3.2 The ethos of medical generalism

While those consulted for our report were unclear about the Commission's rationale for defining generalism as a 'facet of medical professionalism', there was a clear consensus that the person-focused orientation needed by generalists did denote a specific *ethos* whose core values, as one stakeholder put it, include:

- empathy – intelligent use of insight into the whole setting of the patient's plight
- engagement – a commitment to active involvement in every aspect of the patient's care
- an appreciation of limits – understanding and acknowledging the specialist aspects of … care
- professionalism – in clinical communication, interactions and behaviour.[ix]

In detailed study of the data, this clearly goes beyond being excellent at communicating with patients *per se*. Medical students learn about establishing a rapport, eliciting concerns and expectations, getting and giving appropriate information in a way that is useful, and making effective decisions about management that the patient understands and will take forward.[x] The evidence and literature from some of our witnesses[xi] attempt to describe something *different*. Their focus is on how doctors and patients as people achieve positive outcomes: not by their communicative skills alone, but by working to get the best therapeutic outcome while acting in the interests of both patient safety and autonomy.

viii This was referred to in the submission of the General Practitioners Committee (GPC) of the British Medical Association (BMA) to the Commission on Generalism, 24 June 2011.
ix British Thoracic Society, submission to the Commission on Generalism.
x E.g. 'the Cambridge–Calgary Communication Skills' method (Draper, Silverman, Kurtz) – taught widely in most medical schools and built on in the MRCGP.
xi This includes the oral evidence to the Commission on Generalism provided by Dr Roger Banks, Consultant in the Psychiatry of Learning Disability, Betsi Cadwaladr University Health Board; and Carolyn Chew-Graham, Professor of Primary Care, Health Sciences – Primary Care, University of Manchester and the work of Prof. Glyn Elwyn, Clinical Professor at the Institute of Primary Care & Public Health, Cardiff University, on shared decision making. See also Balint M. The other part of medicine. *Lancet* 1961; **1(7167)**: 40–2.

> **The way we handle the problems that patients bring to us is controlled by the values that we put into the system, and these in turn are constrained or enhanced by the context in which we work.**
>
> (Prof. John Howie)[xii]

This emotional effort was also operationalised as being 'person centred', which in the evidence provided by Dr Joanne Reeve to the Commission was defined as:

> decision-making which is person not disease focused, which is continuous and not episodic, which integrates the biographical and the biotechnical knowledge – it is an interpretive process that includes the patient's story, the scientific story, and the professional story which brings in professional 'tacit' knowledge – all with a view to supporting health as a resource for living and not an end in itself.[xiii]

The ethos of generalism is therefore a specific professional orientation that makes different demands and needs different training and self-discipline to be effective.

3.3 Medical generalism and healthcare systems: essential and desirable conditions

There were a number of health systems issues that were debated across different respondents: these need detailed consideration to maximise the effectiveness of generalist clinical practices. The key issues raised were as follows.

- Where in different healthcare settings and care pathways are generalist skills best made available?
- Does access to generalist skills need to be limited by registration or location for it to be maximally effective? That is, will these skills have maximum effect if patients can move around different care settings without restriction?
- Similarly, to what extent does continuity of care matter to the generalist function?
- Is the generalist function different/in tension when applied to population rather than individual health needs?
- What is the implication of the core medical generalist role for the modern GP's role within the NHS?

While many discussions acknowledged that different components were interdependent – for example appointment systems that encourage patients to return to the health professional seen previously may facilitate use of 'knowledge' of the patient and more accurate assessment – each raises issues that healthcare providers need to address in order to maximise the best outcomes of generalists within the system.

3.3.1 Access

In the UK a key role of general practice has been to provide patients with a community-based single point of access to comprehensive health care – a 'one-stop shop' across a full range of preventive, acute and chronic illness services that is free at the point of access to all. One consultee stakeholder stated that the GP 'has learned the value of holding the border between perception of illness and biomedical actuality'.[xiv] The role of the GP is to consider the totality of an individual's state and situation, including his or her history and social context, and to make decisions on the best course of action. This action may include treatment, health or lifestyle advice, referral to diagnostics or secondary care, referral to social services, or simply listening to the patient and reassuring the person by ruling out physical problems. One GP consulted by the College highlighted that one of his roles was to help patients manage their 'threshold' for seeking help,[xv] i.e. so that patients can accurately identify when they should take up preventive measures or when they need clinical attention. A ten-minute appointment could prevent months of ill health later in life.

xii John Howie, Emeritus Professor of General Practice, University of Edinburgh, oral evidence to the Commission on Generalism, 5 April 2011.
xiii Dr Joanne Reeve, National Institute for Health Research (NIHR) Clinical Scientist in Primary Care, University of Liverpool, written evidence submitted to the Commission on Generalism.
xiv Stakeholder, Portsmouth listening event, 14 November 2011.
xv Stakeholder, Portsmouth listening event, 14 November 2011.

The stakeholders and members that the College consulted as part of this report agreed with the commissioners that, at a time of significant change in the role of GPs and other medical generalists, the need for open access to a primary care team with medical generalists in lead roles should be supported: 'We are firmly of the view that, if generalism and general practice did not exist today in the UK, we would be recommending that such a broad and holistic way of working with patients would need to be invented' (p. 3).[1] It was repeatedly pointed out that, while patient choice should be respected, systems which allow multiple consultations with different providers are costly and often lead to the patient receiving duplicate tests and conflicting advice.

Enhanced access such as secondary registration for commuters near their workplace may disrupt the 'holding function' and sense of responsibility of teams who are currently gatekeepers for patients for the system as a whole. As one stakeholder put it,

> Generalism is attacked if the system means that patients no longer access care from a central point. This can mean that the generalist is no longer the expert in the patient and so may be unable to guide and support the patient to make appropriate decisions about their health and care. This leads to disjointed and inappropriate admissions or referrals and ultimately a waste of limited resources with the potential for iatrogenic morbidity.[xvi]

The Commission's recommendation for more primary research into the impacts of system reforms on costs and outcomes of generalism is relevant here.

There was also debate about the best term for this important function, which marries system and resource management with patient need and preference. The Commission's report introduced the term 'gate opener' as an alternative to 'gate keeper', which was supported by participants in our research. Other terms suggested were 'navigator' (a term used by the King's Fund)[11] but also 'health conductor'[xvii] and 'information finder and appraiser'.[xviii]

> The role [of the gate opener] includes the responsibility to steer the patient to the appropriate gate so that they are seen by the specialist service best placed to meet their needs, thereby avoiding multiple cross-referrals and unnecessary investigations (p. 10).[11]

3.3.2 Knowing the patient: the doctor–patient relationship

An important strength of the medical generalist identified by consultees is that they 'know' the patient. This 'knowing' had different dimensions. A health professional might:

- have a *longitudinal* relationship with a patient over many years, whether as a GP or in another setting
- know that person's *family and community*
- know the *practice areas and population*, and so have a general knowledge of the context of a person's life even if the GP has not met the patient often
- 'know' the *nature of their problems* in depth, even if the GP has not known the patient for very long – the intensity of sharing an acute serious diagnosis and its treatment often gives patients and their families a real sense of being 'known' by their professional carer at a profound level.

Respondents acknowledged that, while the medical disciplines that are explicitly generalist in the sense defined earlier, tend to have longer relationships with their patients, specialists might also come to know a patient in such a holistic fashion. Further, while the period of treatment by hospital-based specialists is often finite and task oriented (such as care of a heart attack or resolving a surgical problem with an operation), care of patients in other settings is also episodic. So the *knowledge of the patient* that typifies generalism appears to be related to the ability to be interpretive, to contextualise, and (though this was little mentioned) be

xvi COPMED, written evidence submitted to the Commission on Generalism.
xvii British Thoracic Society, submission to the Commission on Generalism.
xviii Medical Women's Federation, submission to the Commission on Generalism.

> **What a generalist may lack on detailed technical expertise, (s)he can more than compensate with biography and context (epidemiological and psycho-social).**

known to the patient. Doctors working in a community for a long period become part of that community's folklore, and are visible in a way that hospital specialists are not.

Again this was seen as precious and system dependent. Thus generalist skills available from a stranger for only a single consultation are less effective than in a personal or community context:

> What a generalist may lack on detailed technical expertise, (s)he can more than compensate with biography and context (epidemiological and psycho-social). But without the relationship to amplify the context, a generalist may offer less.[xix]

Trust is another domain of the relationship between a patient and his or her doctor, and is an important part of achieving positive health outcomes. While this trust is not unique to medical generalists, evidence suggests that GPs and other medical generalists – due to the extensive scope, personal interaction, and typically longer-term nature of their contact with patients – should be able to develop particularly high levels of trust, enhancing the care they can provide. In the more recently published British Social Attitudes Survey, satisfaction with GPs was at 80%, an all-time high.[12]

It is therefore the College's view – shared by consultees – that the ability to form strong interpersonal bonds within professionally appropriate limits (i.e. not collusive or dependent/abusive) is an increasingly important aspect of the role of the medical generalist within the wider health system, particularly in the context of and the need to develop an approach to health care that is more person centred and focused increasingly on prevention.

Medical generalists who are experts in interpersonal interactions are also well placed to deal with health issues that require delicate discussions about emotional vulnerability, lifestyle and behavioural choice, for example when exploring mental and sexual health issues, or substance misuse. Systems that disrupt or ignore the potential of such relationships will reduce the positive impacts of generalist skills.

The next chapter examines the changing context, which also raises the vexed question of 'continuity' of care.

3.3.3
Continuity and coordination of care

There is a complex literature around continuity of care, including a respected body of work by one of the commissioners who is also an academic GP (Prof. George Freeman – see Appendix C). The Commission's report challenged the current context in their second recommendation:

> Commissioning of health care should take full account of the need for continuity of care, 24 hours a day and seven days a week, whatever the setting. The needs of patients are not confined to office hours. Novel arrangements for care by identifiable teams should be piloted and evaluated (p. 23).[1]

The new GMC *Good Medical Practice* draft for consultation[xx] also suggests that every patient should have a 'named doctor', so clearly the concern about loss of overall responsibility for patient care is widespread.

Three distinct aspects of continuity of care stood out in the College's discussions with consultees: longitudinal care, coordination (or integration) of care, and '24 hour' care.

i Longitudinal care

> Continuity of care is highly prized by patients. Seeing a doctor who knows the patient and remembers key events in the life of that patient and the family, who will be there subsequently when required and who takes a longer term view of care and its outcomes is an important feature of primary care (p. 9).[13]

xix George Freeman, commissioner, Emeritus Professor of General Practice, Imperial College London, evidence to the Commission on Generalism.
xx December 2011 – expected final version to be launched in autumn 2012.

> **Seeing a doctor who knows the patient and remembers key events in the life of that patient and the family, who will be there subsequently when required and who takes a longer term view of care and its outcomes is an important feature of primary care.**[13]

Consultees agreed that longitudinal care can be a key strength of medical generalism. It supports the development of the personal relationship, and the biosocial model of general practice that is most valued by patients and GPs. As one GP said, 'it is person orientated, and not disease orientated'.[xxi] One GP consulted by the College stated that taking a longitudinal approach allows for more proactive and preventive care to be delivered. One example was that of a GP who reviews elderly patients twice a year even though medical intervention is not known to be required, with the aims of helping them develop greater confidence to manage their own conditions, remain mobile, and prevent falls.

However, even among GP respondents, the idea of this much emphasis being placed on individual personal longitudinal continuity was contested. While some felt that 'in general practice, generalism makes little sense without continuity of relationship',[xxii] we know that patients may be advised to see others in the practice to access specific services, and same-day appointment systems frequently do not allow doctor-specific bookings, so patients 'trade off' speed of access for continuity. Continuity of care in UK general practice is preserved by the registration system at the level of the practice and the primary care team, who are able to provide continuous long-term care through regular discussions and information sharing about patients, shared electronic records, and other communication routes. There is, however, a need to look more closely at the gains and losses of the current system, and to ensure that patients have the choice to book for a specific GP if they wish to. As one consultee stated:

> Clearly 100 per cent contact with one doctor is not possible – but to be registered with one GP and expect to see them a high proportion of the time is not unreasonable and must surely make the GP's job easier, quicker and therefore more cost effective, as they will know the [patient's] history and family background.[xxiii]

ii Coordination across service boundaries

The Commission's report outlined the responsibility of generalists to coordinate care:

> The skills and experience of generalists enable them to operate at the many boundaries that exist within the health and social care system. This gives them a unique responsibility for promoting integration of care and support for people in need, and for achieving optimal cost-effective use of services (p. 9).[1]

One GP succinctly called this the 'hidden hand of generalism'.[xxiv]

Our stakeholders supported the role of the GP as a coordinator of care, navigating patients through the healthcare system and linking to appropriate teams. GPs can follow up any contacts with other services and ensure that they are able to provide advice to the individual as required. Seventy per cent of our members responding to the College's online consultation thought that GPs needed to play a role in the coordination of care, although the recent proposals for GPs to be 'case managers' is an approach that is not yet defined or evaluated.

Coordinated care is delivered by the primary care team and not just the GP. Staff who are co-located have greater opportunities to share information about patients, and some respondents remain concerned that health visitors no longer operate from the same premises as GP-employed staff. However, electronic communications can assist remote working, with the more complex issues around who sees the patient for what and when. An anecdotal example provided by the RCGP's Honorary Secretary is the following statement made by an elderly patient: 'It's brilliant that so many people want to help me but I'm spending every day doing appointments!' On discussion, this patient was attending a coronary rehabilitation physiotherapy group exercise service, having weekly bloods for anticoagulant control, being followed up by the incontinence service post-catheterisation, having

xxi Glasgow listening event, 9 November 2011.
xxii Prof. George Freeman. Practising Generalism in 2011 – Generalism Commission, presentation to the RCGP Annual Conference, October 2011.
xxiii Jenny Britten, Lay Member, Vale of Trent Faculty; written submission.
xxiv Stakeholder, Manchester listening event, 3 November 2011.

his leg ulcer dressed by the practice nurse, seeing the nurse practitioner for assessment of additional treatment for his COPD, and having BP monitoring on a monthly basis for his poorly controlled hypertension by the healthcare assistant – as well as various hospital appointments. None of these was unnecessary, but more coordination of appointments by the primary care team would have enabled the patient to have a life as well!

The World Health Organization describes integration from the perspective of the patients as follows:

> [It] means health care that is seamless, smooth and easy to navigate (p. 5).[14]

The RCGP has been a continual champion of integrated care and believes that it is central to the ethos of general practice and primary care. At the heart of the NHS, GPs already work across a spectrum of health and social care services to facilitate and coordinate the smooth transition for patients across organisational boundaries, and navigate their way around the system. In 2011 the RCGP undertook a review of models of integration and an extensive consultation of our members and key stakeholders on this subject,[xxv] and found that there is no one model of integrated care and integrated services. However, GPs are in a unique position to lead on and develop integrated care services, having a comprehensive knowledge of their patients' needs. Contractual and commissioning levels, as well as joint working agreements and federations, can all be utilised to deliver the best integrated care services for patients.

Coordination and integration may well mean one agency or individual professional doing a number of activities across the spectrum of the patient's needs. This again makes the case for generalist capacities rather than specific task-oriented staff, which tend to fragment care and mean multiple attendances for different aspects of service. This contrasts with the prediction of one witness from the Commission's consultation who stated that:

- The essential attribute of primary care is its 'generalist' approach providing first contact, ongoing, comprehensive and coordinated care to all members of the population.
- Primary care can be delivered more effectively and efficiently by a multi-professional team (general practice) than by a single type of professional (GP).
- The GP of the future will be a medical consultant dealing only with complex patients (e.g. those with multi-morbidity) providing back-up to frontline providers who are non-physicians.[xxvi]

In this context, the debate on *role substitution* is also relevant and its risks to continuity and integrated care also need consideration. The same witness cites that:

> Larger team size is a logical consequence of integrating non-physicians into primary care teams. As the number of staff in a team increases so too does the amount of time people need to spend in conferring with each other which then decreases the amount of time available for direct patient care. While good team working can improve performance, coordination of care remains more challenging in large as compared with small teams.[xxvii]

The view of the RCGP is that practices need to actively evaluate how to balance the value of expanded skill mix and expertise in their services against issues of continuity. One issue raised in the Commission's report and subsequently discussed amongst the stakeholders consulted by the RCGP is the question of who should be responsible for dealing with first presentation of illness. The RCGP would broadly agree with the Commission's view that:

> First presentation of illness and discussion with the patient of any treatment plan is the clear responsibility of a generalist health care professional. Although this professional is not always a doctor, he or she must be part of a team working to high clinical standards and common principles of audit and reflective practice (p. 23).[1]

xxv RCGP Consultation on Integration of Care (launched October 2011, due to report spring 2012).
xxvi Prof. Bonnie Sibbald, Health Services Research, Health Sciences Group – Primary Care, University of Manchester, evidence provided to the Commission on Generalism.
xxvii Sibbald, evidence provided to the Commission on Generalism.

> **First presentation of illness and discussion with the patient of any treatment plan is the clear responsibility of a generalist health care professional.**

However, the College would stress that in our view the GP is best placed to see most patients, most of the time, with nurses having more clearly defined roles.

iii '24-hour care'

Eighty-five per cent of members completing the College's online survey said that patients need access to generalists around the clock, and 73% said that they should have access to GPs. Having the 'right care, at the right time, in the right place' was seen as a core feature of generalist practice. However, out-of-hours (OOH) primary care was raised as a serious concern by the Commission, and this was echoed by consultees. While there has been some negative press about these commissioned services,[xxvii] we also heard of some very good examples of continuous 24-hour care being provided through primary care.

3.4 A comprehensive service to all: a response to the Commission's challenges

Although the Commission strongly supported general practice and generalism, it raised several questions, echoed by witness submissions from a variety of other disciplines, about how to ensure that it remains safe and effective to expect GPs to do 'cradle to grave' care. These included effective diagnostics, managing multi-morbidity, specific challenges around care of children and people in nursing homes, and our role in community care. In the sections here we highlight relevant evidence from the RCGP's consultation relating to these challenges. The Commission's recommendations 3 (new models of community care) and 9 (nursing home care) need further consideration with a range of stakeholders, and will be put forward for consideration for further work.

3.4.1 Effective diagnostics

Accurate diagnosis and appropriate management of the risks in uncertainty are challenges to generalists. In the primary care setting, where many symptoms do not denote serious pathology, and where people are seen early in the course of disease development, the risk is of missing an emerging problem. Our respondents emphasised that dealing with diagnostic uncertainty is a core part of GP training, and noted recent reports such as the RCGP's National Cancer Audit,[15] which demonstrated that in most cases GPs ensure that early action is taken. They wanted better access to new technologies to allow early exclusion of pathology, and pointed out that most hospital-based specialists have the advantage of additional access to test facilities. Although it was noted that all tests are proportionately less discerning in low-prevalence settings such as general practice as compared with high-prevalence specialist settings, in the RCGP's view focused, evidence-based improvements in access to diagnostic tools could help enhance diagnosis in areas such as dementia.[16]

Many respondents talked about having adequate time to do really good diagnostic practice, especially in the context of more complex patients, more investigative and management options to explore, and the value of empowering patients with additional self-care information and communication options. The College points to recurrent studies of the need for longer consultations[17,18] and agrees with the views of both patient and medical respondents that ten minutes is now very short to combine a patient-centred approach to information gathering, do a proper examination (an important part of diagnostics mentioned by many), and make an effective shared management plan. From the broader responses on the needs of medical generalism this can be summarised as: *effective training in excellent clinical method for generalist practice; retention of those skills through appropriate breadth of case mix and continuing professional development (CPD); access to best near-patient and ambulatory diagnostic testing; and enough time with patients to manage their needs and preferences appropriately.*

xxvii For example, the Care Quality Commission concerns about the quality of OOH care being provided to patients in Cornwall. See www.guardian.co.uk/society/2012/may/25/serco-investigated-claims-unsafe-hours-gp [accessed May 2012].

3.4.2
Managing multi-morbidities and chronic illnesses

Most patients with complex multisystem problems – for example rheumatology patients, people with learning disabilities, palliative care patients and most people above the age of 70 – need generalists to care for them, so that all issues can be addressed and the pros and cons of treating each problem fully understood. This is particularly true of UK GPs in the context of an ageing population. As stated in the Commission's report, on average 60% of older patients have more than one condition, and this increases with age.[5] The Commission's conclusions on the needs of generalists for effective diagnostics are similar for patients with complex problems, as these will need regular review, test interpretation, and shared decision making. In some situations such as palliative care and serious mental health problems, the consultation may need to include medico-legal considerations such as advance care planning that allow important personal choices but need sensitive, well-informed clinicians with time and emotional availability to people and their carers.[19]

The College recognises that medical generalists can reduce both financial and personal costs of age-related diseases by preventing, delaying and minimising the impacts of complex diseases. This requires action at a population as well as individual level. There was, however, a body of criticism of the current models of evidence-based practice, which tends to treat each illness as separate. A patient with multi-morbidities may be receiving a package of different treatments and medications, some of which may interact negatively with one another, and (as above) be in receipt of multiple disconnected services. There is a need for more evidence of the best outcomes for patients who have more than one condition, but they are frequently excluded from clinical trials.[20] The College advocates for more primary care-based research in this area, and for a public debate on the appropriate societal approach to medical options in later life, as there is need for an acknowledgement of the serious consequences of the medicalisation of old age.[21,22]

Another challenge from the Commission's report focused on patients with serious long-term clinical problems in learning disability, palliative care and frailty requiring nursing care. The RCGP has Clinical Champions and expertise in all these (including work conducted by Dr Matt Hoghton, Clinical Champion for Learning Disabilities[23] and Prof. Louise Robinson, Clinical Champion for Dementia[24]), and has endeavoured to spread good practice, but acknowledges that more needs to be done to disseminate these to *all* clinicians to meet a good enough standard of care in the relevant area. The role of GPs with Special Interests (GPwSIs) may be valuable here, but all primary care teams need to retain the expertise and professional commitment to underpin the general care of patients with complex needs.

3.4.3
Working within a multidisciplinary primary care team

Primary care teams must continue to be underpinned by generalist skills, with the ability to draw on community-based specialist knowledge (e.g. GPwSIs and specialist nurses) as required. Those consulted by the College consistently reported that medical generalism was most cost-effective when surrounded by a multidisciplinary primary care team, albeit mindful of the unintended consequences on continuity and holistic practice.

We heard about the essential roles of district nurses, practice nurses, health visitors and community and specialist nurses. The RCGP has highlighted that traditional roles of nurses in providing care and support are essential to NHS services, and specialism of nurses must not diminish this caring role.[xxix] District and community nurses play a valued role in supporting the care of patients in, or close to, home, while

xxix See the work of the General Practice Foundation at: www.rcgp-foundation.org.uk/rightmenu/nurses/the_role_of_a_practice_nurse.aspx.

> **Being a GP requires leadership skills, political vision, and a clear sense of purpose if they are to steer a primary care-led NHS towards achieving the worthy goals of its founders.**

health visitors have a broad public health-oriented role that has 'immense social consequences',[xxx] following children and families throughout their early years. A stakeholder mentioned how health visitors are able to oversee all aspects of the health of children in the early years. One GP consulted said that health visitors 'immunise (children) against life's problems'.[xxxi] Historically, health visitors had significant input to community-level interventions, and were also involved with other age groups, and the current proposal to increase their numbers[25] may lead to new opportunities to re-engage with primary care teams and assist their role in population health. The RCGP has also worked with the Royal Pharmaceutical Society on a joint statement[26] on improving the working relationships between pharmacists and GPs, and to consider the best interface between GPs and community pharmacists, which is an area of continuing research.[27]

The introduction of specialist and nurse practitioners who can prescribe is an important development to make best use of GP time, but respondents disputed the cost-effectiveness of extensive role substitution: 'Flexibility of roles must take into account core competencies, the most appropriate care and efficiency.'[13] GPs are trained and gain experience in a unique setting, providing clinical-based diagnostics in primary care for a case mix across all populations. Witnesses to the Commission did provide one example where nurse practitioners have been trained to do a similar role, but it is more common to be working with a more limited case mix. The role of the GP is also to lead the team and develop services. While this has always been true for running a practice, the potential of GPs to act as clinical leaders across practice boundaries has become clearer recently. Being a GP in the UK requires:

> leadership skills, political vision, and a clear sense of purpose if they are to steer a primary care-led NHS towards achieving the worthy goals of its founders (p. 171).[28]

The capacity and training of GPs to do this is discussed later.

3.4.4

Providing care close to home and reducing the need for secondary care

Patients, policymakers and professionals agree that people do not want to be in hospital unless it is essential. Even when achieving the best standards of care and service, hospitals are costly institutions, and can add risks such as cross-infection to the patient's pre-existing problems. General practice by definition reduces the need for specialist care, identifying those who can be managed without referral from those who require specialist input. Generalists and specialists are therefore 'interdependent',[xxxii] and part of the value of generalists is to ensure that specialists' time is most effectively used.

This interface is constantly shifting: more of the care that formerly was provided by secondary care services can now be provided by primary care services. This care relies on multidisciplinary teams, including generalist as well as GPwSIs and specialist nurses, but can be in tension with proposals from other specialties to increase their community outreach. The College feels strongly that new models of care currently being developed – delivered in a primary care setting and based on generalist principles – represent the way forward for generalist care in the coming years. The Commission's report echoed the importance of these initiatives:

> New models of care need to be developed for patients in the community who live with episodic or deteriorating conditions and often require more intensive or specialist interventions than primary care can offer. These models need to draw on specialist expertise, but retain a generalist underpinning. They should be co-designed by primary and secondary care clinicians (p. 23).[1]

xxx Stakeholder, Belfast listening event, 16 November 2011.
xxxi Stakeholder, Belfast listening event, 16 November 2011.
xxxii Stakeholder, Portsmouth listening event, 14 November 2011.

> **the role of the wider primary care team can have a great impact on community-level health inequalities, both by identifying individuals who may need health care or medical input and by undertaking community interventions.**

The Commission's report also highlighted the value of 'home assessment and treatment of patients whose access to services is limited, for whatever reason (p. 23).[1] Ninety-one per cent of RCGP members responding to the College's online survey agreed that home assessment is important in the care of some patients, and that home visiting remains an important part of primary clinical care. Although increased access to transport and newer approaches such as telemedicine may reduce the home visit as a proportion of all consultations, many stakeholders supported this as a core service provided by GPs and potentially as part of other forms of medical assessment. Further consideration needs to be given to any unforeseen consequences of a culture of practice that assumes little home visiting is needed.

3.4.5
Providing a community health service and reducing health inequalities

Many consultees identified the role of the generalist as looking after a whole community and not just individuals. An area that our consultees thought should be further explored was the potential of general practice and generalism to reduce health inequalities. There were important examples of excellent community care by primary care teams as flagged in the Commission's report:

> [the] understanding of, and responsibility for, a wider community is a key quality of general practice, but it is also evident on the part of generalist specialists – especially those, such as paediatricians, geriatricians and psychiatrists, with a brief for a particular cohort of the population (p. 7).[1]

In the College's online survey, 85% of GP participants said that ensuring equitable care (i.e. according to need rather than demand) was an important aspect of general practice. However, there were also concerns expressed by our consultees. Two of the causes of health inequalities – people not seeking care when they need it, and the social determinants of health – cannot be solved by improved access and excellent care alone. Further, any service providing unconditional care for patients on request is in tension with the need to ensure people who are undemanding but with significant healthcare needs get appropriate attention.[29] General practice services have increased their commitment to proactive preventive services and chronic disease management, but public education and enabling services such as translation and community support remain important to ensure disadvantaged groups take up health services according to need. The impacts of unemployment and poverty on health are devastating, and the College will continue to argue for additional resources for practices who have additional demand and need to run more costly services (this applies both to rural and remote practices, and to some inner-city practices). Further research is needed to ensure resource allocation is appropriate where there are large variations within a small area.[30]

Responsibility for reducing health inequalities was seen to lie with the whole health system, including those who commission services. As discussed above, the role of the wider primary care team can have a great impact on community-level health inequalities, both by identifying individuals who may need health care or medical input and by undertaking community interventions. The RCGP will consider a more detailed proposal on how GPs can best provide input into this aspect of work, which also has implications for training.

3.5
Summary

It was the view of our respondents that general practice, as a discipline, is delivering genuine generalist-based health care and medicine in the NHS, but that practices and commissioners need to ensure that reforms and developments maximise its effectiveness. This will depend on the opportunities for those doctors working in general practice (as above) to have:

1) Effective training in excellent clinical method for generalist practice
2) Retention of those skills through appropriate breadth of case mix and CPD
3) Access to best near-patient and ambulatory diagnostic testing
4) Enough time with patients to manage their needs and preferences appropriately.

In terms of the health system for generalists in primary care to be effective, they need: *appropriate access* (allowing patients choices but still avoiding overuse or duplication of service use); *stability of contact,* which allows knowledge of context and continuity; an *orientation to the 'hidden needs' of patients and populations;* and the existence of a *coordinated multidisciplinary team who work together to provide services close to and within the patient's home*.

The political environment of marketisation and the economic stringencies facing public services across the board present a huge challenge to continue to provide access to universal and comprehensive care that is free at the point of use based on the individual's needs and social and historical context. During its history, general practice has adapted to developments in NHS structures and policy in order to provide comprehensive health care for all. Services that once were provided in primary care, and then moved to specialist teams in secondary care, are increasingly being delivered in primary care again.

However, the role of the GP in the twenty-first century is changing even faster and we are now at a critical point for health services in the UK, with rising levels of expectation, financial challenges, and increased demand. Clearly all disciplines have an economic stake to protect – this becomes more pronounced and often less cost-effective in 'fee for service'/insurance-based health systems, where generalists and specialists may both derive a fee for an action. Costs of extending services are offset against staff investment and income for the self-employed (GPs and pharmacists). Generalism will only work if all aspects of its clinical provision are rewarded without undue threat to professional income. It would be easy to lose a generalist approach if this becomes 'too expensive' – the current debate about putting the most experienced people at the front line of service pertains.

The following chapter explores these challenges further.

4
Challenges facing GPs and medical generalism

The Commission on Generalism and our own consultation identified a number of challenges to generalism, today and in the future.

4.1
Out-of-hours services

The Commission's report highlighted major concern about access to OOH care and the impact on continuity of care when OOH services are not provided by members of the same extended team as has primary responsibility for the patient. Overwhelmingly, participants at our listening events were as concerned about OOH care as the Commission, and there was much discussion about how this could best be provided. As one GP said: 'GPs may have opted out of OOH care but they have not opted out of caring'[xxxiii] and examples were given of where safe technical care might not fully take into account patients' preferences. It is thought that 10–15% of GPs provide OOH services, and the BMA reported this is increasing.[31]

Many members believed that OOH services were very risk averse, and were more likely to refer patients to emergency services.[xxxiv] For example, an elderly patient was visited by OOH services. The OOH GP correctly identified the level of urgency of the problem, but focused on maintaining the safety of the patient. The patient's GP felt the action taken was not appropriate for that patient.

The question of whether the requirement on GPs to have overall responsibility for their patients 24/7 should be reinstated was seen as a key issue with major contractual and political implications. Extended teams, cross-consortia provision and shared electronic records are all possible solutions, and some primary care services are already making progress to resolve this. GPs also thought that there was a lack of understanding from the media, politicians and the general public about the distinction between planned/non-urgent care and urgent care, and what is required in each setting. A clearer perspective of what is required when, and who needs to deliver this, should be taken.

4.2
Within hours

The role and expectations of modern health provision are very different from the time when GPs could rely on low demand from a small list of patients with whom they shared a community base. Being a doctor, whether generalist or specialist, usually involves commitment to teaching others, audit and quality improvement, team support and service development – as well as providing high-calibre clinical services and maintaining professional development for appraisal and revalidation.

Many doctors, especially women with pre-school children and those in the last five years of working life, will seek part-time work opportunities, and there is a clear trend to this in workforce data over the last ten years. Respondents were clear that they did not think doing long shifts on call was good for professional performance or safety, and also talked about the increasing loss of boundaries between work and leisure because of electronic communication.

Working in partnership with other GPs and pairing GPs have allowed many practices to be able to provide some continuity of care for patients, and previous discussions about team continuity and managed continuity also apply here. In line with good practice in employment policies and laws, the ideal is for flexible opportunities that maximise input and support skill retention across the workforce, but general practice has historically been challenged by its self-employed status and diverse workforce. The RCGP is already participating in a Department of Health-funded project on sessional GP input in the new context of commissioning, and is championing consideration of effective workforce management by input to workforce planning, including recent commentaries on the new English Local Education and Training Boards (LETBs), and input to fact finding on the GP workforce by the Centre for Workforce Intelligence.

In summary, four factors – greater professional and clinical demand, part-time working and 'out of practice' working within the career life cycle, different expectations about work–life boundaries, and the '24-hour access culture' – mean

xxxiii Belfast listening event, 16 November 2011.
xxxiv Evidence from listening events and online survey.

that respondents felt we needed to find new ways to marry retaining responsibility for patients with inevitable limits on personal continuity of care, particularly when working part-time. This is a complex area that requires further work.

4.3 Remote and rural generalism

The College also heard that, in some parts of the UK, generalism has a more extreme role to play in remote and sparsely populated environments.[xxxv] Some island communities – for example Arran, Islay and Mull in Scotland – rely entirely on GPs to cover all medical presentations, including A&E, pre-hospital and community hospital or intermediate care. These duties can extend further to roles such as police surgeon, OOH dentist and, in some cases, helicopter transfers.

Maintaining competencies for this type of general practice is particularly challenging. The hallmark of safe practice is the adoption of the generalist approach, to the extent that confidence and competency in the initial stabilisation and management can be demonstrated no matter what condition is presenting. Practitioners in these areas accept that their work is likely to extend well beyond the realms of core general practice; however, significant challenges remain to ensure access to suitable training.

4.4 Communication between specialists and GPs

Many GPs and consultees agreed with the Commission that the relationship between specialists and GPs is often distant and that levels of communication between the two are decreasing. As one GP said, 'the failure of the NHS is the relationship between specialists and GPs'.[xxxvi] Some common reasons offered as to why communication and relationships between the disciplines have deteriorated included:

- a lack of understanding and respect between GPs and specialists for each other's roles and the value of their respective disciplines
- decreasing frequency of shared events and meetings
- lack of known communication routes – some hospitals had more than 100 specialists and GPs do not always know which specialist has lead responsibility for a patient
- reciprocally, the fact that specialists are likely to deal with a large number of GPs was seen to act as a barrier to establishing close working relationships with individual practitioners
- new incentives such as payment by results (PBR) and the current commissioner/provider split in England have introduced additional barriers between GPs and other doctors.

Importantly, accurate information about patients needs to be shared in a timely fashion, which currently does not always happen. In particular, delays in discharge letters and also the quality of referral and discharge summaries were identified as problematic.

4.5 Increasing demand for health care and reducing resources

The NHS as a whole is going through an intensely difficult period, being required to make substantial cost efficiencies, while caring for an ageing population, combined with rising lifestyle-related health problems and increasing number of patients suffering from multi-morbidities.

GP respondents believed that the pressure for cost savings in secondary care would have a knock-on effect by increasing demand on primary care services at a time of diminishing

xxxv Evidence submitted by RCGP Scotland Council Member Dr David Hogg.
xxxvi Glasgow listening event, 9 November 2011.

> **Development of quality indicators to measure performance should take account of a broader range of patient outcomes than is currently the case.**

resources, for example via service closures, referral triage/refusal, longer waiting times and transfer of prescribing back to GPs – all of which are already experienced where there are cost pressures. Although GPs accepted the need to be as efficient as possible, there was concern that they would see an escalating loss of system capacity having an adverse effect on patient outcomes. One GP gave a recent example of a gastroenterologist prescribing a drug where there was no agreement for GP-led prescribing, leading to patient distress, personal conflict with a hitherto trusted GP, and a time-consuming dispute within the local healthcare system. Commissioning frameworks could improve this, but may act as a downwards pressure on both innovation and personalised care, as all parties are increasingly required to work to protocol and lowest cost.

On top of this, many are of the opinion that there is a shortage of GPs, and changes in public pensions raise a significant risk of more GPs retiring from the system in the next few years than were expected. This is of serious concern in a system that is already under pressure. Some GPs felt that they were 'firefighting' with all of these pressures, and that the breadth of demand could lead to burnout and demoralisation (though this was not seen as a consequence of medical generalism *per se*). The move into sub-specialisation was seen as a threat by some, and an interesting tension is raised in the response of the Faculty of Sports and Exercise Medicine, who foresaw that:

> The greatest threat to the medical generalist is the procurement of greater skills by allied medical staff, who may provide services in a more cost-effective manner. This, together with the changing population demography may require teams of generalists to evolve with different sub speciality skills as more care is transferred from hospitals to the community.[xxxvii]

This response shows clearly a way in which a lack of GPs might increasingly be seen as compensatable by a managed care pathway combining non-GP specialists with linked non-medical professionals. This vertical integration would be a completely different model of care from that suggested in the earlier definition of medical generalism, so increased capacity in the GP workforce to cover the patient population for comprehensive care is important for avoiding fragmentation of care. The need for more doctors entering general practice has been reiterated by the recent findings of the Centre for Workforce Intelligence as part of its ongoing work on 'the Shape of the Medical Workforce'.[32,33]

4.6
How to measure the quality of generalist practice

Stakeholders reflected on ways in which patient and quality outcomes could be measured and monitored in general practice. Many indicators are already in place and there are already a number of online tools and resources to monitor outcomes in general practice. For example, the Association of Public Health Observatories has developed Practice Profiles[xxxviii] based on currently collected data and indicators. However, our stakeholders concurred with the Commission's recommendation that:

> Development of quality indicators to measure performance should take account of a broader range of patient outcomes than is currently the case (p. 23).[1]

Furthermore, many stakeholders highlighted the difficulty in measuring the complex nature of the GP's work, such as doctor–patient interaction. The academic general practice community has refined a number of tools to measure dimensions of person-centred care, such as empathic relating,[34] patient empowerment,[35] and shared decision making.[36] Some suggestions for other indicators included quality of life, general wellbeing and Patient-Reported Outcomes Measures (PROMS), which are appropriate and valid in primary care team settings. It was also noted that outputs-oriented medicine incentivises the measurable outcome, and this often favours the specialists who offer definitive treatments.

xxxvii Faculty of Sports and Exercise Medicine, evidence submission to the original Commission.
xxxviii Available at www.apho.org.uk/pracprof/.

> **As telemedicine improves, easier communications between patients and specialists and increased capability for remote monitoring may also threaten the role of the generalist.**

Participants accepted that utilising patient feedback on experience and satisfaction was an important part of high-quality care, and this is recognised in the College's Practice Accreditation award. The RCGP has already contributed to this debate by its recent work for the Department of Health on 'Transparency in Outcomes'[37].

4.7
Challenges facing all medical generalists

There were some major areas of concern:

4.7.1
Making good decisions about how to train doctors in generalist skills, and how to utilise these in different medical specialties

The College heard that, apart from departments of emergency care and medicine for the elderly, hospital-based generalists have almost disappeared. Examples were given of lack of general medical cover for OOH shifts, and disadvantages because teams could not consult people who had retained generalist skills within their discipline. Evidence provided to the Commission reported that 'barely one in three' paediatricians now consider themselves to be generalists, highlighting the need for a more generalist approach to paediatrics in the community.[xxxix] Further to this, the Commission noted the growing specialisation of nurses, which is another 'drift' that raised concern among our respondents – again, that the general skills of nurses in giving care and support might be lost in a shift to technical and protocol-based specialisation. This led people to say that all medical specialties and general practice need to review how generalist skills are developed and embedded in their trainees.

4.7.2
Balancing the demands of empowered consumers with retention of the input of generalists

Generalists will need to remain involved to provide the most cost-effective and person-centred care. One witness suggested that:

> Social and technological change are both potential threats. A more informed and connected consumer may demand more specialist care and diminish the role of the generalist. As telemedicine improves, easier communications between patients and specialists and increased capability for remote monitoring may also threaten the role of the generalist.[xl]

4.7.3
Ensuring that GPs retain sufficient input into patients needing specialist involvement

GPs were challenged to ensure this, so as to be able to play what is regarded by specialists as a 'pivotal role'. For example, the British Thoracic Society said:

> An effective Generalist GP has an unrivalled contribution to lung cancer care. In what is usually an incurable disease the clinical course is characterised by rapidly changing clinical needs, multi-agency

xxxix Prof. Terence Stephenson, President, Royal College of Paediatrics and Child Health, oral evidence to the Commission on Generalism, 17 May 2011.
xl Arthritis UK, evidence submission, 2011.

involvement and family distress – the exact set of circumstances where the presence of a true overview is of paramount importance. There is a perception that this type of input has become less common – if so, causes which need to be addressed may include:

- Pressure of time/work
- Being excluded from the process by poor communication from secondary care
- Improved secondary care teams replacing primary care in-put
- A failure to appreciate their own pivotal role in lung cancer management.[xli]

This quote sympathetically shows the risks of 'ceding' a role in care, and the potential loss to all concerned.

4.7.4
Issues around the social and professional perception of the lower status of generalists

The Commission noted this perception. Ways to improve this were seen to include: reviewing the training of all medical practitioners to ensure that doctors understand the importance of generalist skills (and to prioritise this learning – 'generalists first and specialists afterwards'[xlii]); ensuring that the role of medical generalists is clearly part of the commissioning process; demonstrating confidence to manage all areas, e.g. child health;[38] and 'acting up a level' – commissioning, public health and community-level action.

4.7.5
Filling the evidence gap

A need to fill the evidence gap was identified by the Commission, who found a 'relative dearth of robust and recent research into the quality and cost-effectiveness of generalist medical care' (p. 16).[1] The Commission's report concludes that: 'generalists would have an easier task to make their case if they had a stronger evidence base. A priority for research should be an evaluation of a generalist approach to patients living with multiple conditions' (p. 16).[1] The College supports this goal, while recognising that a rich body of evidence – particularly drawing on the work of Barbara Starfield – does exist to be built on here.

Those consulted by the College agreed with the need for further research and evidence on how best to manage and treat patients with multi-morbidities. Most pharmaceutical research is drug specific, aimed at licensing of new treatments, and there is less evidence on which treatments might best/most safely be omitted, as the ethics of omitting treatments in studies is very complex. Others wanted to see more research into GP consultation and how GPs manage complexity: the 'intellectual rigour' of generalism, which reflects practice-based experience and clinical judgement. Such research does not utilise typical medical research methods such as randomised controlled trials (RCTs), but requires ethnological and other qualitative approaches.

There was also support for the Commission's recommendation that key priorities for primary care research programmes should be 'the relative cost-effectiveness of a generalist approach to patients with multiple conditions; the role of non-medics in the generalist team; (and) a full evaluation of the different models of first contact care' (p. 24).[1]

Finally, it was noted that the short training time for general practice does not allow many junior doctors to undertake primary care research, and academic GP placements are still relatively scarce. Furthermore, while considerable primary care research does exist, it is not clear how the

xli British Thoracic Society, evidence submission to the original Commission
xlii Association for the Study of Medical Education, evidence submission to the original Commission.

> **A placement in general practice should be compulsory during the two-year foundation programme for medical graduates.**

current financial context will impact on research funding in the near future, which tends still to follow biomedical industries. This is taken up in proposal 8 (p. 31).

4.7.6 The importance of early and accurate diagnosis

The Commission noted the importance of this, stating that it 'cannot be over-emphasised. Such skills are unique to clinical medicine and as such should be a cornerstone of medical education and training, and of revalidation' (p. 23).[1] This goes beyond ensuring that the right diagnostic tools are available (itself a highly important goal) and about ensuring that consistently high standards of diagnostic accuracy are maintained by front-line generalist clinicians and that there is consistent performance in practice. This needs more and better research to feed into more and better education, and extended and enhancing generalist postgraduate training is crucial to this. This is also covered in proposal 8.

4.8 The modern generalist and the need for changes in medical training

The Commission recommended that:

> The medical royal colleges should review career paths and reward systems to ensure that there are sufficient sources of advice and incentives in place to encourage talented doctors to pursue a career in generalism (p. 23).
>
> Medical training needs to become much more generalist in content, with more of it taking place in primary care settings. A placement in general practice should be compulsory during the two-year foundation programme for medical graduates (p. 24).[1]

The College has specifically consulted with our own members for this report, but welcomes the call made by the Commission to *all* those involved in medical training.

There has been a concerted shift in undergraduate medical education in the last 15 years, with increasing use of community placements to allow students a greater understanding of patients' lives with illness, the social determinants of health, the range of diseases and their natural course. These are elements of generalism that our members highlighted should be emphasised throughout medical training, and all medical schools should ensure all graduates are competent in using an understanding of the biopsychosocial aspects of ill health and the skills of the clinical consultation in which generalists excel. GPs see primary care as an experience that all students need.

Our consultation also showed support for the idea[xliii] that all Foundation Programme doctors should have a GP placement so that those who do not become GPs attain a better understanding of the complexity of the work of the GP, thus improving respect and status of the discipline. It was also felt that such measures would help tackle the perceived problem of 'specialism in isolation' and encourage greater integration of care in future. This links to the idea that medical generalism should be an 'inclusive entity' with which specialists are encouraged to engage (see discussion in Chapter 2 on defining generalism).

In terms of career choice, it is clear that newer medical schools that utilise general practice as an integrated base for learning medicine have more graduates choosing generalist disciplines such as general practice

xliii Professor Sir John Tooke, Independent Inquiry into Modernising Medical Careers lead, Commission on Generalism witness, 26 May 2011.

as a career.[39] We heard many times of students who have a 'light bulb moment' during a GP placement, when they understand the importance of general practice, and this may influence career choice.

However, our members and stakeholders reported that undergraduates continue to report that they are exposed to derogatory views on generalism and generalist careers, thus creating a perception that generalists are of lower status than specialists. It was thought that financial advantages through specialist private practice may also influence career choices, and that there was a need to ensure that generalist careers receive the same recognition and rewards at national level to ensure equity for candidates.

Our members stated strongly that a more proactive approach should be taken to promote the benefits and excitement of working as a generalist to medical students, and the RCGP is already able to show activity in this regard through its Student Forum and recent support to medical school GP departments to ensure GP careers are promoted. Medical students should be exposed to enthusiastic GP trainers and practices to provide good GP role models, and other disciplines should also identify and promote their generalist aspects to students as important career options for the future.

Finally, the extension of the length of training for GPs as recommended by the Commission was fully supported by all of our stakeholders as a key mechanism for improving the status of general practice. The complexity of the GP role, especially for developing skills of service improvement and population health, is difficult to embed in a training of only three years, and makes the status of this career look weak – 'If you can learn it in three years it's not very difficult!' The RCGP has repeatedly called for extended and enhanced GP training:[xliv] the first stage of acceptance of a four-year programme was agreed at the Medical Programme Board in April 2012, and the imperative to advance this to implementation is included in our recommendations set out in the next chapter.

xliv In January 2010 the RCGP submitted a business case to the Department of Health for extending GP specialty training to five years. At this time it was rejected by the Department of Health. In April 2012 a second business case was submitted for extending the GP training to four years. At the time of this report the proposal is being considered by the Medical Programme Board.

5
Next steps

The Commission's report published at the beginning of October 2011 ends with 11 recommendations. The responses and views gathered from RCGP members and some other stakeholders between October and December 2011 showed support for its recommendations as areas of legitimate concern and needing further consideration. There was also alignment with current programmes of RCGP work, and identification of some good practice already being advanced both via the RCGP and by local and regional practice groupings.

Following the publication of this RCGP report, the College will take forward a programme of work that builds on the conclusions emerging from both the Commission and the College's work. The programme of work set out below has been signed off by the RCGP's Council, and has been discussed with the members of the original Commission.

Part of the RCGP work programme in 2012 will be to ensure others such as the Academy of Medical Royal Colleges and the Department of Health are actively aware of and giving detailed consideration to the Commission on Generalism and RCGP reports. As we stated in our bid to the Health Foundation in 2011, 'this report is the beginning of an effort by the RCGP to facilitate a public debate about the role of generalism in creating a healthier society'.[40]

Those areas that explicitly need involvement from generalists who are not based in primary care will need further debate by policymakers and other professions. One area (outcomes development) has no specific linked proposal, as the College has recently undertaken work for the Department of Health in England on exactly this issue, and will keep it under review. The College hopes that many new initiatives will occur as we take forward these learning conversations across the wider community.

The RCGP Council in February 2012 agreed the following areas for a programme of work that will enrich medical generalism for the sake of patients.

5.1
Patient involvement in delivery and planning

The Commission recommended that 'generalists should incorporate dynamic and on-going patient feedback into their work as a matter of routine' (p. 23).[1]

The College's members, stakeholders and patients agreed with this. However, only a minority of participants in our online survey said that there was good use of patient feedback in general practice. There was a concern that, even when patient feedback was collected, it was not fully acted on, because solutions were complex and interventions did not always result in better feedback. The College needs to work with its Patient Partnership Group (PPG) to review the reasons for this apparent gulf between intention and outcome, and continue to develop and disseminate good practice in this area.

Proposal 1: the RCGP, through its Patient Partnership Group and its quality practice work, should, over 2012–13, develop and disseminate a position paper that supports good practice in using patient feedback for service improvement. This will also be used to update the MRCGP curriculum as required, focusing on effective ways of obtaining, evaluating and applying patient views to service development and quality improvement.

5.2
Improving access to, and continuity of, primary care

Despite the complex concerns expressed by our members and the Commission, we heard of many excellent examples of continuity of care being provided in the UK. It is essential that systems and networks be in place to share these examples and promote peer learning and evaluation to ensure that the whole of the UK provides the best primary care around the clock. These need to be fully evaluated to ensure that they retain the generalist principles of GPs and other generalists.

Areas for consideration include in hours, OOH, triage, principles for commissioning of 24-hour care, and supporting use of e-communications. The RCGP has already undertaken some work on best practice in this area[41] but accepts that more work needs to be done to resolve some of the tensions highlighted by the work of the College and the Commission.

Proposal 2: the RCGP will update policy on good practice in relation to 'round the clock' lead responsibility for patient populations. We will aim to do this in partnership with our relevant clinical experts, through the expertise of our members, and with the General Practitioners Committee (GPC) of the British Medical Association (BMA). Outputs by the end of 2012 will inform commissioning guidelines.

5.3 Developing generalist models of care for complex and chronic conditions in the community

We wholly support the Commission's recommendations that models of providing this care retain a generalist underpinning to ensure that patients are treated as a whole, rather than 'shoe-horned' into services that do not meet their needs. We expect that the current model of general practice with an extended team of doctors, nurses and managers will remain core to an integrated approach.

However, there are many opportunities for developing innovative care services, bringing in specialist support, including nursing and other health and social care professionals as required. These care pathways should be developed in collaboration between generalists and specialists. GPs as medical generalists, working with specialists, are best placed to design these systems. This will be one of the biggest challenges to the NHS in the twenty-first century, and the RCGP's work on integrated care and the 'Year of Care'[42,43], needs to be widely known and further developed to underpin this.

Proposal 3: examples of innovations in integrated/complex care will be collated, disseminated and debated with RCGP members, medical royal colleges and others to develop thinking in this area. A specific policy priority for 2012 will focus on this area.

5.4 Improving communication between GPs and specialists

The Commission recommended that: 'To speed and improve communication among doctors, GPs and hospital consultants should liaise directly and personally' (p. 23).[1]

Our members and stakeholders agreed that this is a priority for improvement. While some GPs reported that they still maintained very good links with specialists, more often than not there was not enough communication between the two. Our members and stakeholders particularly wanted direct email and telephone communication: virtual rounds, case conferences, community-based team meetings, and using e-communication have all been suggested. All of our members wanted quicker and more accurate referral and discharge summaries via email. There is a need for better incentives and/or commissioning arrangements to improve the flow of information between GPs and specialists.

However, communication was not just about discussing patients. It also referred to the relationship between GPs and specialists that, for many, was eroding. Historic tensions and issues around the status of different disciplines – as well as more recent changes such as those contained in the English Health and Social Care Act 2012 – have sometimes drawn GPs apart from medical specialists. Some of this may be improved by commissioning contracts, but further dialogue on this and related training issues for generalists need to be discussed nationally.

Proposal 4: that the Commission of Generalism's report, and this RCGP response, be formally debated and receive a response from the Academy of Medical Royal Colleges.

5.5
Changing education and training to improve understanding of generalism and make it more attractive to medical students

Based on the challenges and issues outlined in section 4.7, and building on the body of evidence collected by the College since the publication of the Commission's report, we have adapted the Commission's recommendations into our own proposals:

Proposal 5: the RCGP will:

- continue to campaign for enhanced training for GPs, and will work through the Academy of Medical Royal Colleges to develop a clear cross-College understanding of generalist career paths and reward systems
- endeavour to ensure that the GMC and the Medical Schools Council highlight and monitor student understanding of generalism, and explain how they benchmark the appropriate use of primary care as a learning setting for generalist skills
- commit to working through faculties and academic general practice to ensure full geographical coverage of GP career advice to those in medical schools and Foundation training
- request a full update from the Conference of Postgraduate Medical Deans of the United Kingdom (COPMeD) and the Committee of General Practice Education Directors (COGPED) as to progress towards 100% of Foundation Year doctors having a placement in general practice during the two-year Foundation Programme for medical graduates, and use this to inform Department of Health and regional funding.

5.6
Ensuring that GPs have sufficient knowledge of paediatric care, learning disabilities, mental health, palliative and end-of-life care

The Commission recommended that:

> [education] must include specific provision for training in disciplines particularly relevant in general practice, including paediatric care, learning disability, mental health, care of people with life-limiting conditions, and end-of-life care for patients and their families. In the short term, general practices should ensure they are able to draw on the expertise of doctors with special interests in these groups (p. 24).[1]

Our members and stakeholders all agreed that these should be mandatory components of basic medical training, and that they should be retained in the GP curriculum as part of generalist primary medical care commitments. The RCGP has had frequent debates about the extent to which the current hospital placements offered to GP trainees really fulfil the needs of primary care generalist training, and have been working with other Colleges and the deaneries to enhance training in these areas both in hospital and community settings.

The College has also developed policy on the roles and accreditation of GPwSIs. GPwSIs may exist within practices, with a doctor taking a lead role for example in teaching, training, research or a clinical interest. They may also act across a consortium as a resource for other GPs, or actually be working in a non-GP specialist service. Having access to GPwSIs in primary care networks is beneficial and supports the RCGP Practice Federations model.[44] This report makes no specific proposal in relation to this Commission

recommendation, other than that the College will continue the discussions already in place. The College will debate the value of considering access for GPs to the specialist register, which currently gives an odd message about whether a GP is a specialty in its own right, as we would claim, and where the law currently presents barriers to GPs with highly developed special interests being registered to practise under a specialty licence.

Proposal 6: RCGP Council will debate whether there is any professional will or policy driver for the RCGP to seek a change in the law to accommodate GP registration as specialists.

5.7
GP-led commissioning and service planning

The input of GPs into commissioning varies between the countries. However, GPs should take whatever opportunities are available to influence commissioning and service planning decisions in order to advocate for the needs of their patients and communities. Commissioning is one mechanism that can help GPs to implement many of the service improvements that are needed by their patients. As noted above, commissioning can help to open doors for accessing specialist advice, developing new models of care in the community, and for improving inter-agency communications and OOH services. The RCGP has been actively supporting GPs in service development leadership, and has hosted a Centre for Commissioning to underpin these activities since late 2010.

Proposal 7: the College will continue to support GP leadership in service development for UK primary care through College-specific training and activities, and also through our general leadership strategy.

5.8
More research on both multi-morbidities and early, accurate diagnosis – and better use of this research

The RCGP has an active Clinical Innovation and Research Centre (CIRC), whose role is specifically to champion primary care-based research and its translation into clinical practice.

Proposal 8: the College will ask CIRC to consider both the key topics and capacity issues on research outlined in section 4.7 of this report – that is, that more research into multiple morbidities and early, accurate diagnosis in primary care are needed. CIRC will report back as part of its annual strategic review as to whether these are already areas of active research funded by grants, and will comment on the issues raised and ways to improve research activity and capacity in primary care teams.

5.9
IT systems

The Commission said that:

> generalists need to make more and better use of new information and communication technologies to improve communication between them and their patients, and with other clinical professionals. Effective use of information and communication technologies will improve the quality and coordination of patient care, enable efficiencies, and enhance clinical audit and research (p. 23).[1]

Our members fully supported many of these sentiments. There is already good use of IT systems, which lays the foundations for future development. The BMA reported that 'general practice has the highest level of computer use and literacy in the NHS, and is at least as good as in any other country's primary care system (for example less than a third of US primary care is computerised)' (p. 21).[32] The RCGP has an active output of good-practice guidance for GPs from the excellent work of its Health Informatics Group, and we therefore propose to ask it to comment in detail on how to take these issues forward from our consultation.

Proposal 9: the Health Informatics Group of the RCGP should consider the evidence submitted to the Commission and the RCGP's consultation, and will be asked to consider undertaking a survey to identify safe and effective practices in data sharing and inter-agency e-communications.

5.10
Nursing home care

The specific challenge of the role of generalists in nursing home care is again one in which the College has already made major investment.[xlv]

Proposal 10: the College will ask the RCGP clinical leads in Older People's Care to consider the best way to advance the idea of a 'community of interest' and dissemination of good practice in this area.

xlv The RCGP has two eminent Clinical Champions in dementia, Prof. Louise Robinson and Dr Jill Rasmussen, who lead on RCGP policy and responses to external policy and strategy. Further, the RCGP has launched specific GPwSI training in nursing home care. Our CIRC Clinical Priority Programmes between 2008–11 included End-of-Life Care (EoLC) and Ageing and Older People's Health and Wellbeing. CIRC launched an EoLC strategy in 2009 and an EoLC Patient Charter in 2011.

Conclusion
The future of generalism

The title of this report refers to expertise in whole person medicine. This is an aspiration, and should be supported by many health and social care practitioners regardless of their specific training and scope.

The RCGP believes that the case set out here for why generalists matter in the healthcare system is simple. A professional who is committed to you as a person – who does not have to give up or pass on your care because your problems do not fit their expertise; who can deal with many issues across the preventive health, acute diagnostic, and problem management setting without referral; and who can recognise their own limits and yours, while orienting their service to your world views and character – is key to ensuring that patient needs are met quickly and effectively. A good generalist is trustworthy, therapeutic in relationship, and makes judgements that are safe for the individual and the system. We need to know better how to provide this in practice in a modern health service that has been the best in the world, and can be even better. This should be an ongoing discussion to be had across the healthcare community.

Ensuring that we recognise the role of medical generalism will be important to achieving this vision. The future of generalism should be outward looking and inclusive, engaging with all those who have a stake in the future of care – from patients and professionals working on the front line to policymakers involved in shaping the future of how services can produce the best outcomes most effectively.

With this in mind, we look forward to hearing the thoughts and ideas of those who read this report as the programme of work outlined above gets underway.

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Appendix A Methodology

1 Background: Commission on Generalism

The Commission on Generalism was formally launched by the RCGP and the Health Foundation in March 2011. The Commission represented a major undertaking that overall took evidence from a wide range of UK and international stakeholders in 2011. A full list of those who provided evidence can be found in the Commission's report.[1]

The panel, chaired by Baroness Ilora Finlay, and Dr Susan Shepherd as Secretary, included seven other commissioners, who in their multiple roles included three peers, four doctors, one chief executive, three directors and one president.

The evidence collected by the Commission was extensive. It consisted of: a literature review; a seminar with experts in medical generalism; eight oral evidence sessions where 38 high-calibre witnesses gave evidence; an on-site visit to an East London medical centre; a teleconference with a similar project in the Netherlands; and 65 in-depth written responses from key national organisations and experts in the field.

The Commission spent considerable time in distilling this information, with analytical support from the RCGP, into one report, written by David Brindle (Public Services Editor, the *Guardian*), which they published independently in October 2011.

In addition to the main report, the Commission brought together, into one place, a wealth of primary and secondary evidence and information on medical generalism.

2 The RCGP's report

Following the publication of the commissioners' report in October 2011 the RCGP worked on developing its response and overall position on medical generalism. This involved a substantial range of activities that included in-depth debates, discussions and consultation within the College and with its members.

Our findings on medical generalism and general practice drew on the following:

- a thorough analysis of the findings of the evidence submitted to the Commission, as well as the report and its recommendations (by the College's Honorary Secretary)
- a detailed review of the implications of the findings (by the Chair Prof. Clare Gerada and Dr Maureen Baker, supported by the RCGP policy team)
- debate on the Commission's report within the College's Council and College Executive Committee (CEC)
- a planned consultation based on the iterated findings of the Commission – launched at the RCGP Annual Primary Care Conference in October 2011. This included six UK-wide listening events attended by almost 60 stakeholders, including GPs, members, academics, and other professions and organisations
- written evidence that the College had gathered from a range of stakeholders and the results of an online survey of College members
- consideration of the expertise across the RCGP's working groups, committees, education and training departments, and Clinical Champions.

2.1 Consultation

The RCGP's consultation on the commissioners' report was launched at the RCGP Annual Primary Care Conference in 2011, welcoming comments from all members and attendees.

In October and November 2011 the RCGP held six listening events in the UK. These semi-structured events drew on established methodologies, particularly action research and applied policy framework analysis. The questions and discussion issues for each event were modified and developed throughout this process.

From the evidence collected during the listening events, the College identified several issues that our stakeholders did not have a consensus on. These fed into a largely quantitative

online survey, which we ran during December and which attracted over 100 participants. The findings of all this evidence are contained within this report.

The report has also been through a process of peer review, and was agreed by the CEC and Council in January and February 2012 respectively.

Further detailed analysis of the data can be carried out as part of the proposed work programme building from the RCGP report in 2012, as it is a rich repository and captures many views.

2.2 Listening event format

Prior to each listening event registered participants were sent a copy of the Commission's findings, together with details of the process. In the first three events, full nominal group technique was utilised.

The *nominal group* as used in Liverpool by Lloyd-Jones *et al.*[2] involves the following steps:

1) Facilitator provides prompts relevant to the issues being evaluated
2) Participants write their response individually to all questions, e.g. on Post-it notes
3) All potential responses are recorded for joint consideration by the group, and clarified for meaning
4) Items recorded are grouped together, e.g. by putting 'like with like' on to flipcharts until all overlap is avoided, and the grouped items all address separate issues
5) These groups may be retitled by the facilitator
6) Participants then individually record a 'rank' for each item in terms of its importance to them
7) The researcher summarises the items that receive the collective highest ranking, and takes note of all redundant items
8) The core list thus gained can be compiled into a questionnaire for testing with a different sample when further items can be disregarded if they receive little consensus.

2.3 Questionnaire

Consensus from findings in October 2011 was used as the basis for an online survey launched in December – a structured consultation using the online tool Survey Monkey. The quantitative and qualitative results from this survey were then used to further inform the conclusions made in the RCGP's report.

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Appendix B
A brief history of medical generalism in UK general practice

1
Introduction

This chapter aims to provide a brief record of the growth of UK general practice and to explain how it established its clinical practice, which did not evolve in some other countries. The context is relevant to the current analysis of where generalism may need to be revived or protected over the next era.

This chapter draws on Dr Chantal Simon's article 'From generalism to specialty: a short history of general practice' from the RCGP's journal developed to support Associates-in-Training, *InnovAiT*.[1] This article is recommended as a starting point for further reading for those interested in the history of generalism, and we are grateful to the author for her permission to use the material here.

2
Historical summary

The role of general practice in the community has a long history in the UK. In the nineteenth century, GPs (then known as apothecaries) were the face of community-based medicine, dealing with any health problem that a person brought to them, making diagnoses and treatment decisions, prescribing medications and health advice, and referring patients to hospital-based physicians and surgeons as required. Prior to this most doctors viewed themselves as generalists, partly to maximise income. However, during the nineteenth century surgeons and physicians increasingly became dissatisfied with not being recognised for their specialist skills and knowledge.

Physicians already had a membership college, the London College of Physicians. The Royal College of Surgeons in London was formed in 1800, became the Royal College of Surgeons of England in 1843, and introduced an entrance exam, the Membership of the Royal College of Surgeons (MRCS).

Unlike physicians, GPs did not have a medical degree; however, as of 1815, new GPs were required to acquire the Licence of the Society of Apothecaries (LSA) to practise, and the majority also took the MRCS. The forming of the General Council of Medical Education and Registration (now the General Medical Council) in 1858 provided a process of registration of suitable training institutions and qualifications. In 1884 one medical registry was formed, joining the MRCS with the Licence of the Royal College of Physicians (LRCP), and finally recognising the GPs as doctors alongside physicians and surgeons.

At this time practices were largely single handed or at most consisted of two GPs. Many worked from home and all worked on a fee-by-fee basis. Some workers joined workers' clubs or friendly societies that provided a range of health and social security services. Employees paid weekly subscriptions and GPs received a fee per head from the scheme. The 1911 National Insurance Act expanded the coverage of such schemes by providing health and social care service for those employees who earned less than £2 a week. This can be seen as the start of the GP list, the act requiring GPs to take on a 'panel' of patients from the scheme and keeping appropriate medical notes. However, the 1911 act did not cover dependants and many people remained without health care.

It is with the introduction of the NHS that the GP took on the responsibility for a whole population. Prior to the act there was already agreement between hospital doctors that patients will access services via a GP. However, the NHS Act (1946) formalised the role of GPs as gatekeepers to the health service. The health service was divided between primary, secondary and community care services, and the boundaries between GPs, who were placed in primary care, and consultants, in secondary care, was finally fixed.

As access to health care was limited for a considerable part of the population, it is not surprising that, within a month of the introduction of the NHS, 90% of the population had registered with a GP. Over time, the increased workload,

lack of modern facilities and accommodation, lack of peer support, and low pay in comparison with hospital doctors understandably impacted on morale and quality of care, and did not make general practice appealing to future GPs. After considerable growing concern about quality and variations in practice, the 1966 GP contract was introduced to rectify this situation, limiting the maximum list size to 2000, increasing funding that was relative to the size of the GP population, and provided incentives for forming partnerships. The number of new GPs and group practices rose immediately. Later, the RCGP published its Quality Initiative to further improve, and reduce variation in, the quality of GPs.

There was still no specific training for GPs at this stage, although all GPs had a medical degree. Formed in 1952, the College of General Practitioners argued for general practice to be recognised as a separate discipline, with its own postgraduate training, and in 1981 mandatory vocational training for GPs was finally introduced by the government. The CGP received royal accession in 1972. The programme consisted of three years of medical training with a year in general practice with a GP trainer. To qualify as a GP, a doctor passed the Joint Certificate of Postgraduate Training in General Practice (JCPTGP). While passing the MRCGP bestowed membership privileges to the RCGP, it was not necessary to become a GP. Since 2007 the new MRCGP (nMRCGP) is now the final exam for all GPs.

As well as introducing the responsibility for an entire population, the twentieth century saw GP services expand into prevention and health promotion. These concepts, emphasised through the 1978 Alma-Alta Declaration on primary care,[2] led to increased partnership working with other health professionals, and the beginning of primary healthcare teams who together could offer a broader range of services to people across the life cycle. Many GPs developed additional roles as teachers, researchers and in clinical services.

The 1990 GP contract gave GPs the opportunity to expand their roles further by taking on fundholder responsibility, purchasing health services for their patients. Performance-related pay was introduced at this time. The fundholder scheme was abolished in 1998.

Clinically, the skills and functions of GPs have continued to expand. The 2000 NHS plan[3] introduced GPs with Special Interests (GPwSIs). GPwSIs provide a clinical service beyond the normal scope of general practice, undertake advanced procedures, or develop services. Initially only six specialties were open to GPs for specialism. However, by September 2008 17 frameworks existed for GPs to achieve the title of GPwSI. The RCGP's vision for federations of practices includes a growing and valuable role for GPwSIs in providing leadership, advice, supervision and specialist input within GP networks.[4]

The development of the enhanced service under the 2004 GP contract also allowed GPs to provide a greater range of services, with the aim of moving services away from the hospital setting. For example, GP practices and groups could be commissioned by Primary Care Trusts to deliver minor injury services, minor surgery, and services for alcohol and drug misuses.

The 2004 contract also introduced performance-related pay through the Quality and Outcomes Framework (QOF). The QOF was based on evidence developed by the National Institute for Health and Clinical Excellence (NICE) and particularly was aimed at public health interventions, and lifestyle and long-term condition management.

As a result of all of these developments, the range of services that practices provides has grown immensely. Practices are now involved in health promotion, prevention, screening and immunisations, as well as many services and interventions that were currently provided in secondary care. This has led to an expansion of the skills and roles needed in primary care teams, with non-clinical staff taking on more and more routine tasks that were previously provided by GPs.[5] However, 90% of all patient consultations in the NHS are still through the GP,[5] and, although the primary care team and its capabilities have expanded considerably, the demand for GP appointments continues to increase.

While maintaining the gatekeeping role, there are many more access routes to primary care and NHS care as a whole than through face-to-face contact with GPs in practices or A&E services. Triage systems with nurses or doctors, telephone and email consultations, OOH services, walk-in centres, and NHS Direct have all changed the way in which health care is delivered and where GPs can provide their services.

In 2006 the (Labour) government reintroduced GP commissioning through practice-based commissioning. In 2010 the Conservative and Liberal Democrat coalition government introduced proposals (culminating in the 2012 Health and Social Care Act) aiming to place GPs at the centre of commissioning decisions through Clinical Commissioning Groups. The RCGP's Centre for Commissioning was set up (initially as a partnership between the RCGP and the NHS Institute for Innovation and Improvement, and from September 2011 as a wholly RCGP project) to provide training, guidance and support for GPs moving into commissioning roles, and to lead the agenda on commissioning issues.

Today the role of the GP therefore can encompass anything from day-to-day consultations with patients, providing a specialist role within practices and practice networks, making commissioning decisions for whole populations, undertaking minor surgery, providing training and supervision to medical students, leading on community-based disease management models, coordinating care across healthcare boundaries and developing care pathways, and managing and leading a diverse team of health professionals and support staff to deliver high-quality care for all practice-registered patients.

3
In summary

Primary care teams in the UK come from a diverse and highly trained group of professionals, with a range of skills and experience that is unrecognisable from the role of the individual GP at the start of the twentieth century. Patients are provided with generalist services free at the point of use in a setting near their home where they can develop relationships with staff over a period of time and get help with health care regardless of their age, need or problems. This is true generalism, and requires a set of core skills, principles and an appropriate ethos of generalist medical care. Further, at its most basic, the GP remains the front door and community face of the NHS, and principles of practice are still based on two key concepts – holistic care and patient-centred care. However, history can change things for the better or worse. It is essential that the essence of generalism is articulated, valued and preserved. That is the purpose of this report.

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Appendix C
Generalism in medical care: a review for the Health Foundation

January 2010

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1 Summary

Generalism is an attribute shared by generalists – people usually defined in terms of multiple interests and a wide overview. In medicine generalism is often seen as an antithesis of specialism. Generalism comes in two guises – spread widely and too thin, and as the expert on complexity, overview, prioritisation and integration – the latter making the 'expert generalist'.

While specialists originated long ago, they have steadily expanded over the past two centuries and now outnumber generalists in most Western countries. There is a wide international variation in the extent and scope of generalist medicine in Western nations with the USA exhibiting a minimum and the UK arguably its maximum extent.

Generalism in medicine is best seen in primary care and GPs form the largest body of medical generalists.

GPs bring special qualities to medicine, being expert in a wide range of problems including biomedical, psychological and social fields. They are experienced at making diagnoses in community settings where non-illness is common but where minor symptoms can herald more serious disease. They manage multiple problems that may be acute, chronic or at the level of risk factors. They operate close to the patient's context and help the patient interpret his or her symptoms and feelings in that light. They emphasise the person before the disease, in order that both diagnosis and management are as appropriate as possible for this patient at this time. This involves the best of evidence-based medicine; however, much of the 'fuzzy' symptom presentation in general practice lacks an evidence base. In any case the evidence is often derived from another context and requires interpretation. All this requires expert judgement.

In the UK more than elsewhere the GP has become the principal 'gatekeeper' to specialist services. This has assured a degree of continuing professional influence that is envied elsewhere. However, a number of recent developments have diluted some of the more 'holistic' features of general practice and it is timely to review and restate the value of medical generalism.

The evidence, largely assembled by Barbara Starfield in her longstanding academic advocacy of a comprehensive healthcare system in the USA, is broadly in favour of primary care generalism. The underlying mechanism is that primary care gatekeeping reduces demand for inappropriate specialist care; many would add that it protects patients from this. The result is that generalism is favoured in comprehensive, planned healthcare systems – such as either the NHS or an American HMO, but weak in the marketplace. Market-oriented reforms in the UK are therefore philosophically oriented against generalism and represent a threat.

It is not in fact self-evident that medical generalists have to be doctors. Nurses can act very effectively in the role of nurse practitioner (NP). In spite of the apparent success of general practice in the UK, the optimum training path for medical generalists has yet to be determined. Doctors need to be open minded about this; the public will not forgive us for being protectionist.

Generalism offers many other advantages to patients in terms of interpretation, coordination and advocacy. Older, iller and disadvantaged patients experience and value more of these benefits but are often politically weaker than younger, fitter people, who look more for technical solutions to problems they diagnose themselves. These latter people are likely to appreciate general practice as their lives progress, but we have to respond to them now in order that they don't wreck the system first.

It is to be hoped that GP leaders publicise the benefits of generalism more effectively than ever. But most GPs can probably improve the situation by being more proactive in their local communities.

2 What is generalism?

2.1 Dictionaries and non-medical approaches

Generalism is a relatively new word. It was not included in Dr Johnson's dictionary and a Google search for 'generalism' is almost immediately redirected to 'generalist'. Neither word appeared in my 1975 edition of the *Shorter Oxford English Dictionary*, nor in my 1959 *Chambers Twentieth Century Dictionary*. However, the root *general-* is old, recorded from the Middle English period (1150–1350) and is derived from the Latin genus, meaning class or large grouping.

On the world wide web we currently find the following: *generalist n* 1. a. a person who is knowledgeable in many fields of study; and generalist – a modern scholar who is in a position to acquire more than superficial knowledge about many different interests; 'a statistician has to be something of a generalist'.[i]

I take it that 'generalism' is the common attribute of a group of 'generalists'. This essay will treat the terms as closely linked and carrying similar meaning.

2.2 Generalism according to GPs

Recent British medical literature on generalism has focused on general practice. In a brief definition as part of an editorial, Gray *et al*. assert that the term generalist 'linguistically and professionally balances' specialist and involves 'getting to know patients as people, including their families and homes, and analysing how psyche and soma interact' (p. 486).[1] This is developed further by Heath and Sweeney in the context of market reforms in the NHS.[2] They describe the medical generalist as bridging the gap between the 'map of medical practice' and the 'territory of a patient's suffering'. They go on to explain how diagnostic tests are less precise in low-prevalence settings such as primary care and that diagnostic formulation 'always involves judgment and is always risky'. This has been put more colourfully by James Willis when he contrasted generalists working in low-lying swamps with specialists standing on higher, firmer ground with better visibility.[ii,3] In another editorial Heath *et al*. develop the expertise of the generalist, explaining 'general practice is special … in terms of … the complexity of healthcare in the patients' context'.[4] Generalism is also recognised in hospital specialties and a plea for continuing to value general pathologists is the subject of a millennial editorial in a specialist journal by Kirkham.[5] However, the author only defines generalism by implication as the absence of specialism.

2.3 Generalism as the essence of general practice

General practice has a long history, but its academic development is comparatively recent. In the UK the Royal College of General Practitioners (RCGP) was founded in

i For definitions, see: Johnson S. *A Dictionary of the English Language* [facsimile edn]. London: Times Books, 1983 [1755]; *The Shorter Oxford English Dictionary on Historical Principles*, rev. and ed. CT Onions. London: Oxford University Press, 1975. www.thefreedictionary.com/generalist.

ii Adapting an analogy used by Donald Schön to describe more and less rigorous aspects of professionalism. See Schön DA. *The Reflective Practitioner*. Aldershot, Hants: Academic Publishing Group, Avebury imprint, 1991 [first published 1983].

1952 and the first GP professor in the world was appointed in Edinburgh in 1963. As an emerging discipline much early endeavour was expended on defining its essentials. This was especially important in North America, where general practice had nearly vanished as a discipline under the onrush of specialist practice – in the USA it was 'refounded' as family practice in 1969. Two key figures were Edmund Pellegrino, a general physician in Yale, New Haven, Connecticut, and Ian McWhinney, an English GP who founded a world-famous department of family medicine in London, Ontario.

Pellegrino wrote 'it is the generalist function that constitutes what family medicine can bring to patient care'.[6] He listed three types of eligible patient: 1) those not yet classified into a specialty; 2) those so categorised who develop new symptoms that may or may not be related to that specialty; and 3) those with problems simultaneously in more than one system. He explained that all doctors must sometimes perform generalist functions, but 'only generalists do this across the whole range of clinical possibilities'.

The potential of such community-based generalists was fleshed out by McWhinney in his influential *A Textbook of Family Medicine*.[iii,7] He set out the basic characteristics of a family practitioner as one who:

1) Is committed to the patient as a person rather than to a disease or technique
2) Seeks to understand the context of illness
3) Sees every patient contact as an opportunity for health promotion
4) Views his or her practice as a 'population at risk' in public health terms
5) Sees him or herself as part of a community-wide support network
6) Ideally should share the same habitat as his or her patients
7) Sees patients in their homes
8) Attaches importance to subjective aspects of medicine (as well as traditional positivistic or objective ones)
9) Is a manager of resources – 'as generalists and first-contact physicians'.

McWhinney also emphasised that family medicine 'transcends the mind/body fault line' between physical and psychological disciplines. These nine principles are not at first sight synonymous with generalism but further examination reveals much agreement. The first implies that any medical problem can be addressed; numbers 3, 4, 5 and 9 give a wide remit beyond the individual and with the implication of long-term care; while 2, 6, 7 and 8 are intended to widen both the understanding of problems and the response to them. This exciting and coherent professional view, is not, of course, necessarily entirely shared or even understood by other doctors, patients or policymakers, but it remains almost unaltered as the policy of the RCGP.[8] We shall see how generalist primary care has been and remains seriously squeezed in the USA, and general practice challenged and managed in Britain.

A different approach was taken by Jane Gunn and her Melbourne-based colleagues in their detailed study about the future of generalism in the primary care team.[9] Their principal question was 'What are the essential elements of generalism?' They performed an extensive medical literature review, with 97 papers meeting their inclusion criteria: 74 commentaries, nine reviews and 14 empirical studies. None of these specifically addressed its subsidiary question about which dimensions of generalism might be essential for a cost-effective primary care system. This narrative literature review, supplemented by two rounds of stakeholder interviews, initially identified 133 themes; after an iterative process the research team arrived at a three-dimensional model of generalism, describing ways of *being*, of *knowing* and of *doing*.

iii This work originally appeared as 'An introduction to family medicine' in 1981 with the identical nine principles.

- *Ways of being* comprises *virtuous character, reflexive* attitude and an *interpretive* approach to patients in their own contexts.
- *Ways of knowing* includes both *biomedical* and *biographical* frameworks.
- *Ways of doing* includes access to primary care as first point of contact and to secondary care as professional gatekeeper; a culturally sensitive holistic *approach*; coordination; integration; continuity of relationship *'over the life cycle'* (necessarily excluding single disease focus); and *contextual* relevance.

While parts of these apply across the whole of medicine, this model was very firmly set in the context of primary care, with its emphasis on the patient as a person in context, primary access, gatekeeping to specialists, and care over the entire life cycle, regardless of disease or gender.

At the same time, Trish Greenhalgh was producing a new textbook of primary health care in London.[10] She discusses the generalist role with characteristic lucidity, acknowledging her debt to McWhinney on the way by updating his six fallacies about the nature of generalist knowledge (pp. 116–18). One of her supporting references is entitled 'feeling good about not knowing everything'; rather, generalists should know how to access knowledge and choose the right level at which to focus. In seeking an understanding of the whole rather than details of the parts he or she often focuses on linkages – relationships, interactions and patterns – rather than details.

Most recently, John Howie, a well-known British academic GP, has reflected on the central medical process of diagnosis in clinical general practice on the basis of three decades of his own research.[11] He writes 'the clear conclusion of this body of work is that the making of diagnostic and management decisions in general practice is influenced by many factors other than identification of the pathology of presenting symptoms and signs' and proposes a four-component model – three inputs and a single output.

1) *Diagnostic framework* – with acute, continuing, psychosocial and preventive sectors (after Stott and Davis).[12]
2) *Values* – derived from Balint[13] – patient-centeredness, continuity and empathy.
3) *Context* – of practice including time, stress and incentives.
4) *Output* – conventional (treatment, tests and referral), satisfaction and enablement.

The interpretation of this model is mine. I offer it as an elegant and simple résumé of the generalist approach in 2009.

Having considered the nature and philosophy of generalism – largely from within – it is time to turn to its place in medical practice, starting with its history. And this is completely bound up with its antithesis – specialism.

3
The evolution of generalism and its relationship to specialism

3.1
Specialism – a product of the Enlightenment, found in hospitals

Specialism goes back a long way. According to Porter,[14] specialisation in medicine was described by Herodotus in the fifth century BC in Egypt: 'one physician is confined to the study of one disease … some attend to the disorders of the eyes, others to those of the head, some take care of the teeth, others are conversant with all the diseases of the bowels' (p. 49).

Historically we can see a more recent evolution, from the multiskilled polymath generalist at the beginning of the Enlightenment, to increasing specialisation through the nineteenth and twentieth centuries. Porter describes how the process started with the founding of the London out-patient dispensary for sick children in 1769. By 1860 there were at least 66 special hospitals and dispensaries in London alone. Specialist hospital medicine began to threaten GPs. In 1900 the *General Practitioner* said of specialists: 'their minds are narrowed, judgement biased and unbalanced by disproportionate knowledge of one subject' and the specialist 'knows nothing of the constitutional idiosyncrasies of the individual, which are essential to correct diagnosis and treatment' (pp. 381–8, 683–8).[14] A century later Heath *et al*. regretted that general practice was not listed as a specialty in *Index Medicus*.[4] While they refrained from recommending that general practice actually be considered a specialty, they argued that 'ways must be found to ensure that the interdependence of specialist roles is reflected in mutual respect and equivalent status – professionally, in remuneration, and academically'. Any change in status after the passage of 100 years would appear to be minimal! Perception of status is considered further below in section 4.1.

3.2 The role of learning

Universities and medical schools have had a paradoxical role in the evolution of specialism. On one hand they started it. Weisz points to the emergence of a new kind of medical research community around the teaching institutions and hospitals of the city.[15] This happened first in Paris and Vienna from 1862 and soon afterwards in Berlin, but only slowly in London; then 'American doctors flocked to Europe to become specialists' (pp. xxi–iii). On the other hand, medical schools have always been required to train GPs, only some of whom might eventually specialise. Thus the undergraduate final examination remains a generalist exercise to this day. In recent years this has encouraged a growing role for academic general practice, which not only provides clinical teaching but also increasingly leads and coordinates the curriculum.

3.3 International contrasts

The emergence of specialism over the last three centuries is an international phenomenon, yet there are specific national patterns that are beautifully examined in Weisz's book *Divide and Conquer: a comparative history of medical specialization*.[15] Weisz studied four countries: France, Germany, Britain and the USA. The advance of specialism was based as much on scientific research and progress as on the growth of specialised medical practice – but this was subject to local, cultural and contextual variation. For example, science specialised early in France with the Paris Academy of Sciences, which was a public institution that was oriented to specialised expertise. In London, by contrast, the Royal Society was a private institution 'that long held on to "gentlemanly" notions of scientific work and resisted specialization in the name of polite learning'.[15]

This British tradition has proven very durable, with generalism being valued more highly than elsewhere. One factor behind this is the power of the royal colleges. These resisted fission into sub-specialties but their retention of the traditional division between medicine and surgery held up scientific progress. Even as specialisation advanced, all doctors still claimed to be generalists, merely 'performing particular tasks based on the requirements of their hospital appointment', or later 'with a special interest' (pp. 168, 201).[15] The British Medical Association successfully prevented the listing of doctors by their specialty in medical directories until the 1930s (pp. 174–5).[15] Even then circulation was restricted to the profession, which limited patients' ability to choose specialists for themselves and encouraged the referral system (which finally became absolute with the NHS in 1948). In

Britain the alignment of being a specialist with the status of consultant is more complete than elsewhere. This is inherent in the restriction of specialist access to GP referral and with consultants occupying leadership positions in hospitals. Consultant numbers have also been limited, raising their value (pp. 168, 233–7).[15]

The situation was quite different abroad, with public specialist registers appearing in France, Germany and the USA in the early 1900s. In America, uniquely, the classified national medical directory was published by the American Medical Association (AMA). In a healthcare market, it was essential that potential customers could select the right practitioner for their perceived needs.

3.4 Generalism in Western medicine – the USA as a special case

Specialism developed in the midst of generalism and at first specialists continued their own generalist practice in order to maintain their income. Over time, general practice has become restricted to doctors practising outside hospitals. Early manifestations included forbidding specialists to conduct home visits in Germany (pp. 109, 119).[15] Eventually most countries moved towards excluding specialists from general practice. The USA has stood aside from this process; in the new millennium there are no formal boundaries between general and specialist care, and the result according to Weisz (p. 249) is active promotion of the dominant role of specialisation.[15] The resulting pluralism in general medical care led to the emergence of the new terms primary, secondary and tertiary care in 1970 (p. 251).[15]

Thus, from the middle twentieth century onwards, there has been increasing divergence between the United States – the world's richest economy, which devotes the highest proportion of its Gross National Product (GNP) to medicine – and most other 'Western' countries.

It may be no coincidence that American primary care generalism has seen steep decline, specialisation squeezing out GPs early. Already by 1942, only half of US doctors were GPs and by 1989 the proportion of primary care doctors (now comprising a mix of family physicians, general adult internists and paediatricians) had fallen to one in eight (Porter, p. 684).[14] This was accompanied by a particular shortage of primary care in rural areas, with office-based physicians tending to concentrate in larger cities – a tendency noted as early as the 1920s, when rural health centres failed to develop against professional opposition (Starr, p. 195).[16] In the UK on the other hand the percentage of GPs in career NHS medical posts has fallen later and more slowly – 65% in 1980, 53% in 1997 and 44% in 2007 – with more even distribution between urban and rural settings.

The establishment of the NHS in 1948 indeed excluded British GPs from hospitals and at first allocated no new resources for primary care. But the restriction of access to specialists to referral by GPs made these the gatekeepers to secondary care. This was crucial for the survival of general practice, and arguably for the success of the NHS as a whole – as a cost-effective service funded largely from taxation and offering access to all free of direct charges and independent of ability to pay for care.[17]

The key argument is that generalists in primary care can offer accessible local care for most common conditions and refer appropriate patients to specialists – allowing them to actually specialise.[18] Limitation of specialist access in the NHS has been an important factor in enabling the UK to achieve a creditable position in international comparisons of health status indicators such as longevity and perinatal mortality while absorbing a smaller proportion of GNP than most other Western countries.[iv] Evidence for this view is well summarised by Moore[19] and updated by Starfield *et al*.[20] This is developed below in section 6.

iv However, this economy was possibly taken too far and resulted in rationing by waiting lists rather than costs for elective surgery. Since 1997, increasing public awareness of other health systems has forced the government to increase the proportion of GNP devoted to health, with a target of equalling the EU average.

But, even in the UK, the view that specialism may offer better care is recurrent. While primary care has been favoured by government as likely to lead to cost savings, reflected in a drive for 'secondary to primary care shift' over the last 20 years, the associated shift in resources has not all been allocated to generalist clinicians. Instead there has been great interest in 'intermediate' specialist facilities and the development of 'GPs with a special interest' has been encouraged.

4
The impact of culture and public expectations on this evolution

4.1
Patient power versus specialists and generalists

The status question underlies much of the argument in a stimulating essay on 'the emancipation of biographical medicine'. Armstrong describes a traditional state of bedside medicine, from the eighteenth century and earlier, as 'a product of the interaction between rich clients and their deferential medical attendants'.[21] We have seen how this was displaced later in the nineteenth century by hospital medicine where the patient was subjugated by the 'new mode of production of medical knowledge which in its abstraction of pathology-based disease from the patient brought about an increasing emphasis on colleague rather than client relationships'. Such mystique increased the social power of hospital doctors. At first GPs tended to respond by striving to gain hospital privileges and access to facilities. But GPs' increasing exclusion from hospitals became complete with the institution of the NHS in 1948. After a few years' hesitation the GPs changed tactics and in formulating their own discipline (see McWhinney above), rather than struggling to enter hospitals, have emphasised their commitment to a new style of biographical medicine that values the patient's story and context, and promotes a more equal relationship for the 'co-production of health'.[17]

Patients have always relatively felt more powerful with GPs, compared with specialists, because they are usually either ambulant or in their own homes, rather than effectively imprisoned in a hospital bed. This power is limited; studies of GP consultations have shown how completely doctors dominate the discourse (e.g. Barry *et al.*).[22] Thus the espousal of 'patient-centred medicine' implicit in McWhinney's nine principles and in subsequent teaching (Stewart *et al.*)[23] has sometimes been more lip-service than performance (Campion *et al.*).[24] Even so, focus on the patient as a person has been rewarded by remarkably high levels of trust in GPs (Grumbach *et al.*),[25] much of it necessarily based on the quality of interpersonal relationships (Mainous *et al.*).[26]

4.2
Generalism and professional status

To the British, public generalism is synonymous with general practice and this has implications of status. If I tell anyone I'm a doctor, their next question is almost invariably –'And what is your specialty?' Many are then satisfied with 'I'm a GP', but others perceive this as a failure to specialise. Of course the generalism/specialism divide also occurs within hospital medicine, but, in terms of social status, any hospital consultant can persuade a lay person that he or she is a 'specialist' and be respected accordingly. Tertiary specialisms such as neurosurgery ('he's a brain surgeon!') or transplantation rank even higher. The root word special has long implied prestige; one of Johnson's definitions (1755), quoting

> **The message is clear: the more varied your interests, the more diverse your talents, the less authority and expertise you can expect to have in those areas.**

Shakespeare's *Henry IV*, reads 'Chief in excellence – "The king hath drawn the special head of all the land together."'

4.3 Expertise and generalism

Even today, when the very existence of professionalism is questioned (Greenhalgh, pp. 267–8),[10] and the internet brings information at the touch of a key, patients are by definition in a disadvantaged position when seeking medical advice. Donaldson[27] argues that the value of continuity of care is to 'reduce agency loss by decreasing information asymmetry and increasing goal alignment'. Here the physician is the patient's agent, who has the knowledge and skills that the patient needs and lacks. Continuity of relationship means that the patients are better able to judge how far they can trust the physician to work for them – sharing the GP's goals. Nowadays patients can potentially get too much, rather than too little, information, but they need professional help in assessing its relevance for their problem in the particular context.

Generalists claim that this is precisely where their expertise lies, yet they fear belittlement as a 'jack of all trades and master of none'. This even applies to general pathologists. In mounting a defence Kirkham,[5] argues:

> One of the most important skills of the generalist is the ability to 'know when you do not know'. Most pathologists have an informal network of expert specialist pathologists whom they can call upon for the difficult case. Of course the chosen expert is probably only expert in a small area and will in turn need to call for help with problem cases outside that area. One definition, after all, of an expert is 'someone who knows more and more about less and less'.

He goes on to advocate collegiate working and the advantages of a panel of experts.

4.4 A counter-argument – expert generalism

Is generalism, as opposed to specialism, intrinsically of lower status? A non-medical internet discussion addresses this question:[28]

> *'Jack of all trades, master of none.' It rings in our heads like an accusation, or worse, a verdict. The message is clear: the more varied your interests, the more diverse your talents, the less authority and expertise you can expect to have in those areas. If you're a generalist, then clearly, you cannot be the expert we're looking for.*
>
> *But there are two kinds of 'generalists':*
>
> - *those who have acquired expertise or specialized in a wide variety of subjects*
> - *those who touch upon a wide variety of subjects because they only ever skim the surface.*
>
> *It is a fatal mistake to confuse the two of them. And maybe we need different names to distinguish between the two.*

This is helpful. The first kind can be termed an 'expert generalist' and is what many GPs now aspire to. The second echoes the oft-quoted denigration of general practice by an eminent specialist back in 1912: 'perfunctory work … of perfunctory men'.[29]

The expert generalist concept is supported from the world of American management by Nickols.[30] His summary reads:

> When considering the use of a consultant, it is important to know if you require the services of a generalist or a specialist. You might require both. Generalists are usually better at helping you define the problem. Specialists tend to frame the problem to fit their solutions. Either can be of help once the problem has been defined. Neither will be of much help if their

need for control is at odds with yours. Choose your consultant with care, and give thought to the difference between a generalist and a specialist.

The point about control nicely describes the contrasting relationships that specialists and primary care generalists have with their patients. Thus the concept of expert generalism is recognised outside medicine and potentially offers society advantages not available from specialists.

However, in a competitive market situation, these advantages may not seem overwhelming. Weisz argues that 'the growing faith of the general public in such concepts as "expertise" and "science" has been critical to the success of specialization. Specialists cannot survive unless patients believe that they provide care … better than … generalists' (p. 229).[15]

4.5
Generalism and national cultures – the gatekeeper role and other institutional factors

The decline of generalism in the USA has already been noted (section 3). Both public and professional opposition to any kind of managed care, and to many aspects of public health, go back to the nineteenth century (Starr, pp. 181–6).[16] The AMA opposed public health centres, then public programmes for care of the poor and then Health Maintenance Organizations (HMOs) in the 1960s and 1970s (Starr, pp. 363–405).[16] In his 1992 essay on generalism, Moore comments that 'the market place favours specialism … lacking a history of centralized manpower planning and regulation, America is unlikely to create such a system now' (i.e. any intervention 'to stimulate increases in primary care generalists').[19] If Moore is right then moves towards market-based reforms in England are likely to favour specialism over generalism. Generalists should be warned.

In other 'Western' countries general practice is stronger, but its degree of eminence is crucially linked to the presence or absence of control of access to specialists – the gatekeeper role. This is strongest in Britain, the Netherlands and Scandinavia, and noticeably weakest in Belgium, France and Germany, with other countries, including Canada and Australia, lying between. It may be relevant that this hierarchy is also reflected in the earnings of generalists relative to specialists, being at parity in most of the gatekeeping countries, but differing up to two-fold in the others (Starfield, pp. 337–49).[31]

In the Third World, primary care is often much weaker, with wide contrasts between rural areas almost devoid of medical care and prospering private specialists in capital cities. Indeed combating this inequality was the main aim of the Alma-Ata 'primary health care for all' declaration (1978).[32] The seventh of its ten provisions summarise the essentials of primary health care; these are in many respects close to McWhinney's principles adapted to suit Third World contexts.

In the USSR and other former communist countries, primary care has been relatively weak and was largely delivered by low-status physicians working in polyclinics and acting as 'signposts' to specialists. It was noteworthy that child health enjoyed higher status and paediatrics, both generalist and specialist, was completely separated from adult medicine, from medical school training onwards, thus the concept of a generalist doctor offering care to all family members was unknown there.[v] Since the break-up of the USSR and freeing of the former Warsaw Pact countries in 1989–91, variety has been increased, with many newly independent countries seeking to set up a system of universal primary care. Progress so far is mixed, though general practice is making noticeable progress in Poland, the Czech Republic and Slovenia.

v The author was personally involved as a 'mediatrician' in a GP 'age-specific care' experiment in Southampton in the 1970s. This divided a practice population into three age groups, split at 15 and 65 years. Each group had its own GP, the 'paediatrician' also offering maternity care. The experiment ran for three years before being abandoned thankfully. See Freeman GK. A Mediatrician Reflects. In EM Clark, JA Forbes. *Evaluating Primary Care: some experiments in quality measurement in an academic unit of primary medical care*. London: Croom Helm, 1979, pp. 167–71.

5
Primary care – the focus of modern medical generalism

Should we focus attention only on medical generalism (the GP), specialist medical generalists (general physician, surgeon, etc.), more generalist-oriented specialists (general geriatricians, paediatricians, etc.) or non-medical generalists (e.g. nurses etc.)? What are the pros and cons of a focused approach against an inclusive one?

This depends on why the question is put. Specialism is ubiquitous in modern life; medicine is not unique. Academic life, the law and industry all provide examples.[33] But organisations will tend to need generalists in senior management positions and transition to this role may be demanding.[34] The particular situation of medicine is expanded on by Weisz (pp. 231–56),[15] who locates the debate about specialisation in the domain of the struggle by national governments to rein in healthcare costs. Weisz cites Britain and France as favouring state regulation and the USA and Germany preferring professional self-regulation.[15] In Britain state regulation has particularly favoured primary care since the early 1990s, though not necessarily general practice as the best means of delivery for such care. This sociopolitical argument may underlie some of the differences between countries in the strength of their primary care systems already referred to.

My personal view is that primary care is where generalism either succeeds or fails and that trying to improve it is partly a matter of principle. But while principle generates motivation it is important to know how different systems work and why, so I propose to concentrate on the evidence for and against primary care generalism. But first a brief word about hospital generalism.

5.1
Generalism in hospitals

Generalism has also declined within hospitals and this brings challenges. Even when a patient is admitted with a relatively clear-cut diagnosis such as acute stroke, he or she is seldom immediately cared for by a neurologist, although this is thought to be desirable. Indeed a three-stage process is still common. Here the patient starts in Accident & Emergency (A&E), is admitted to an 'acute assessment unit' for 24–48 hours, and is finally transferred to the neurologist expert. However, the goal is clear – seeing the appropriate specialist. The situation is less straightforward for a patient with more than one significant problem – i.e. multiple morbidity – where several specialists may be needed simultaneously, and the need for an effective generalist can become pressing.

At first many NHS hospital consultants described themselves as general physicians or general surgeons and this was especially useful for the handling and sorting of emergency admissions. More recently specialisation has reached the point where few true generalists exist at a senior level in adult hospital medicine, although it is recognised for junior training grades. The lack of a generalist can lead to problems of prioritisation and coordination (see Kirkham (2000) on pathology[5]).

In the UK typically this is a specialist who cares for older people (also termed geriatrician). The elderly care specialty developed in the 1960s when it was realised that older people posed special problems of management, related partly to their slower adaptive ability but particularly because of their recognised multimorbidity. Geriatricians started as generalists. Their patients tended to be those too ill to be cared for at home by GPs, but who could expect little help from disease-based specialists. As the proportion

of older people has risen they have increasingly taken their place alongside organ-system specialists. In North America, also, it has been suggested that general internal medicine 'should become more closely focused on geriatric care, the newest growth field' (Weisz, pp. 203).[15]

In the USA this has led to the emergence of the 'hospitalist', a specialist with responsibility for first-line care of hospital patients and with special responsibility for coordination of any sub-specialists.[35] Hospitalists have been associated with cost savings, but, in an observational study of 45 hospitals, Lindenauer *et al*. found such savings to be less than previously reported.[36] Hospitalists' patients had shorter lengths of stay but no cost savings compared with those cared for by family physicians. The authors suggested that the 'family physicians … have a less resource-intensive practice style than their colleagues who are general internists or hospitalists'.

There is a considerable literature about the degree of specialisation (or sub-specialisation) in hospitals. The weight of evidence appears to favour high-volume specialist care for specific diagnoses but many comparative studies are observational and are liable to be confounding, especially by selection bias. (For discussion relating to acute stroke see Lindenauer.[37])

5.2 Primary care generalism attractive to some governments

Primary care appears to offer the chance to improve health outcomes in a cost-effective way and governments have been trying to effect 'secondary to primary care shift' in various ways. In the USA there was emphasis on HMOs, where patients sign up for a comprehensive health plan including both primary and secondary care. One of the largest US HMOs was compared very favourably with the British NHS in 2002.[38]

5.3 Developments in the UK

In the UK this is manifest by increasing funding and greatly increased direct management of primary care services. Primary care was almost entirely reactive to patient demand a generation ago. The British system was relatively simple. Most primary care was given by GPs in independent practice. GPs were starting to work with practice nurses but access to these was normally through the GP. All specialists were accessed through GPs. The only exceptions were 'emergencies', where patients presented themselves to a hospital's A&E department, and sexually transmitted diseases, where separate direct-access clinics had been set up by an alarmed government in 1916, during the First World War.

Successive reforms started in 1989 and have accelerated under the present government. New types of primary care are being developed, including the national telephone advice line NHS Direct, which is now the calling point for out-of-hours primary care. More controversial are direct-access Walk-In Centres, some linked with A&E units and some in busy city centre locations such as railway stations and shopping centres. So far their total capacity remains small, and evidence of benefit is limited,[39] but they certainly do offer a quicker alternative to general practice. Further larger new-style polyclinics or 'polycentres', again linked with A&E departments, are currently being developed. Staffed by a mix of nurses and doctors, patients can attend without prior registration, and indeed can transfer their registration without formality if already registered elsewhere.

More traditional general practices are increasingly focused on long-term and preventive care – for which they can earn target payments through the Quality and Outcomes Framework (QOF). This concentration on proactive care, combined with a wish to transfer simpler specialist diagnosis and treatment processes from expensive high-tech hospitals to the apparently cheaper primary care sector, has led to the encouragement of GPs with a Special Interest. Again, evidence of benefit is mixed.[40]

Policy leaders' interest in choice and competition has led to the potential involvement of private sector organisations in the provision of primary medical care. Practice vacancies may be put out for competitive tender and the private sector has successfully bid for a number of these. There is as yet no evidence of the effect of this policy.

Thus much money is going into primary care but only some of this is going to the practices where patients are registered and which are in a position to deliver both therapeutic relationships over time and coordination of care.[vi] One philosophy underlying these developments is belief in the efficacy of markets in health care; for further commentary see Jones.[41]

5.4 The importance of gatekeeping

For the present, British GPs have retained their gatekeeping role, controlling all access to specialists. This is now conceived as part of a wider system of primary care commissioning and budget holding. Primary Care Trusts (PCTs) contract with GPs and GPs make the referrals. There is no clear benchmarking for an appropriate rate of referrals, but there is considerable variation between GPs. In a climate of impending budget tightening there are inevitably moves to regulate GP referrals. Again, evidence is lacking about both the effects and the effectiveness of such a policy. For GPs it brings potential role conflict between that of advocate for the patient considering referral, and responsibility to the wider community of patients in the local health economy. In a thought-provoking back pages piece in the BJGP, Williamson points out that patients have not been consulted in this interference with the agency of their GP, and there are risks that equity of access to specialists may be compromised (see also section 7).[42]

In the next section I look at the consequences of moving away from generalist practice – best seen (and most studied) in the USA.

6 Generalism or specialism? Quality of care processes and outcomes (outcomes/ effectiveness, equity, cost, access)

6.1 Generalist primary care versus specialist care

The evidence for and against generalism has been considered in detail in the USA. In recent years there has been public and professional concern in the USA about the mounting costs of health care, combined with relatively poor ranking in international health indices. This is partly reflected in the current attempts for US healthcare reform.

6.2 Starfield's work comparing performance of different national healthcare systems

The USA is the richest country in the world and devotes the largest proportion of its GDP to health care, yet it ranks poorly in most international comparative health indices. Starfield has pointed out that this occurs in spite of low rates of smoking, drinking and road accidents. The USA only does well on the index of life expectancy at age 80. And she reminds us that it is older Americans who have universal coverage for health expenses and are most likely to have a close relationship with a primary care physician (Starfield, pp. 403–4.).[39] Some of

vi The main types of continuity of care – see Haggerty JL, Reid RJ, Freeman GK, *et al*. A synthesis of the concept of 'continuity of care' in the health and policy literature. *British Medical Journal* 2003; **327**: 1219–21.

> **The value of a diagnostic test depends on the prevalence of the condition in the population tested.**

this poor performance may be due to large inequalities in income distribution, combined with complete lack of access to health services for millions of poorer people. But the absence of a strong generalist primary healthcare sector is another very plausible factor. The evidence for this contention has been gathered by Starfield and co-workers over a number of years and collected together in the substantial monograph written with her colleagues Leiyu Shi and James Macinko in 2005.[20]

6.3 Availability of primary care physicians per 10,000 population – within the USA and elsewhere

Studies by Starfield's team showed that, in the USA, states with higher availability ratios had better outcomes, including lower mortality rates for all causes, heart disease, cancer, stroke and infants, as well as lower rates of low birth weight and poor self-reported health. This applied after correction for sociodemographic and lifestyle measures, and also income inequality (pp. 460–1).[20] When primary care physicians were separated into their US components of family physicians, general internists and paediatricians, only the supply of family physicians was linked with lower mortality.[43]

More detailed studies showed that these differences in favour of the supply of more primary care physicians held in comparisons by county in rural areas. However, in urban areas the situation was less clear cut, possibly due to the greater local variability of both population size and physician supply, and of racial differences.

Starfield *et al.* highlighted Jarman *et al.*'s British study.[44] Here lower in-hospital mortality was associated with larger numbers of hospital doctors (favouring teaching hospitals) but also, and three times more strongly, with the supply of local GPs.

Starfield *et al.* also pointed to studies comparing the health of people who do or do not have a primary care physician as their regular source of care. They found favourable associations with both mortality and current health status in the USA and also in Spain, Canada, Cuba and Costa Rica.

6.4 International comparisons

The core of Starfield *et al.*'s argument in favour of a generalist primary care system is based on international comparisons (pp. 466–8).[20] In successive studies the team classified countries according to the strength of their primary care and compared a range of health outcomes including all-cause mortality, and cause-specific mortality from asthma and bronchitis, emphysema and pneumonia, cardiovascular disease and heart disease. Primary care strength was assessed by the degree of *comprehensiveness* of primary care (i.e. the extent to which primary care practitioners provided a broader range of services rather than making referrals to specialists for those services) and a *family orientation* (the degree to which services were provided to all family members by the same practitioner). Studies mostly within the USA also showed that better primary care provision reduced inequalities in health even after controlling for income distribution (pp. 469).[20]

6.5 Generalist primary care costs less

These advantages for primary care were associated with lower costs, both within the USA and in international comparisons (p. 473).[20]

6.6
Proposed mechanisms for the advantages of generalist primary care

Starfield *et al*. propose six mechanisms to account for the beneficial impact of primary care on population health: 1) *better access* for relatively deprived population groups; 2) better quality of *care delivered by generalists*; 3) impact of primary care on *prevention*; 4) better *early management* of health problems in primary care; 5) the contribution of primary care characteristics to more appropriate care; and finally 6) the role of primary care in *reducing unnecessary or inappropriate specialist care* (pp. 474–83).[20]

Of these, the second (quality of generalist care), the fifth (special characteristics of primary care) and last (gatekeeping) are particular features of generalism.

Studies comparing generalist and specialist practice, when planned and executed by generalists[45,46] concluded that the quality of care was the same or that primary care was better. Starfield *et al*. comment that:

> these differences suggest differences in the conceptualization of appropriate 'outcomes' by the two types of physicians, with specialists more concerned with specific disease-related measures and adherence to guidelines for these diseases and primary care physicians more targeted to multiple aspects of health, that is, 'generic' health. Assessing generic outcomes, or quality of care *other* than for the particular conditions under study, is important because comorbidity is common and causes more visits to both generalists and specialists than do most specific conditions (Starfield *et al*. 2003, p. 476).[20,47]

Continuity of relationship over time, implying that patients use their primary source of care over time for most of their healthcare needs is associated with greater satisfaction, better compliance and lower hospitalisation and emergency room use (p. 481),[20] and also better recognition of their psychosocial problems.[48]

A key mechanism appears to be the role of a generalist as gatekeeper moderating access to specialists. Starfield *et al*. postulate a strong theoretical basis in the differences in diagnostic probabilities between generalist community and specialist hospital populations (Starfield 2005, p. 483,[20] Franks *et al*. 1992,[49] Sox 1996,[50] Hashem *et al*. 2003[51]). The argument is most elegantly stated in a memorable fairy story – 'The Gatekeeper and the Wizard'.[52] The crux of the story is this quotation from Vecchio:[53]

> *The value of a diagnostic test depends on the prevalence of the condition in the population tested.*

6.7
After Starfield

Starfield's body of work is impressive and persuasive, but it has not yet led to widespread US reforms in favour of generalist primary care. In fact Americans appear much attached to their specialist-oriented system and debate continues about its effectiveness.

One more recent, careful review comparing outcomes of care by generalists and specialists was published in a 'specialist' journal (*Archives of Internal Medicine*) in 2007,[54] albeit conducted by a team of generalist authors. Smetana *et al*. found 49 studies meeting their search criteria published in English between 1980 and 2005. They focused on 'single discrete medical conditions' and required comparisons between generalist and specialist care to include at least 50 subjects in each arm, to refer to an accepted optimal standard of care, and to have quantitative outcome measures. More than half of the studies (29/49) targeted coronary artery disease, diabetes or congestive heart failure. Their findings favoured specialty care as they expected and in an interesting discussion they advance a number of important reasons for why their findings appear to conflict with what they call Starfield's 'ecological' studies. These reasons included: failure

to adjust for case mix; failure to study the effects of the practice environment (accommodation, workload – especially time resources, record systems) on the comparisons. More seriously, they suggest they asked the wrong question. Instead of reviewing studies comparing discrete conditions, they should have focused on older patients and co-morbidity, pointing out that 95% of Medicare expenditures are for patients with two or more conditions.[vii]

A linked editorial[55] is more critical, both of validity and relevance. In only two of the 49 studies were subjects randomly assigned to specialist or generalist care, publication bias favouring specialist services is possible, and the outcomes do not measure 'the quality of care for the whole patient' of the subjects entered in the studies. They argue that such comparisons are unhelpful in the context of a system lacking universal access to primary care, with maldistribution of physicians and a lack of incentives for physicians to coordinate care.

Most recently, a 2009 review by Post *et al*. from the Netherlands included 22 articles comparing care for patients with chronic diseases from primary care generalists with that from specialised centres.[56] They concluded that outcomes for patients with rheumatoid arthritis, diabetes mellitus or cystic fibrosis were not superior in specialised centres or with sub-specialists. However, they remarked that it was difficult to draw firm conclusions from a heterogeneous set of articles; even so, restricting their comparisons to those studies with higher quality would not have altered their rather tentative conclusions. They concluded that in future it would be better to focus on the exact care process rather than on who was giving the care or in what setting.

It is noteworthy that none of these reviews included mental health problems, but one 2007 Canada-wide study by Wang and Patten reported that perceived effectiveness of mental health care provided by GPs or family doctors did not significantly differ from that provided by mental health specialists.[57]

6.8
So does generalist care give better outcomes?

Gordon Moore wrote:[19]

> For policy makers to take action to reverse the long-standing decline of generalism, they would have to be convinced that primary care, as delivered by generalists, is substantially better than the version offered by subspecialists. However, the arguments put forward by advocates for both generalist and specialist perspectives are inconclusive. The evidence is simply not available to provide a solid foundation for policy choice.

But we have much more evidence than was available to Moore and my reading of the evidence summarised above is, on balance, 'yes'.

The nature of the evidence is relevant. Even now, there are very few relevant randomised controlled trials (RCTs). Such a design is extremely difficult to apply to comparisons of generalist and specialist care. It is inherently difficult to compare a specialised system performing in a specific context with a generalist one operating across the board. It may be that only quite broad outcomes are appropriate. Yet the system of medical care can only be a relatively small contribution to such outcomes. It is naïve to expect that appropriate evidence from RCTs will ever be available. Starfield herself explained why in a JAMA commentary subtitled 'internal elegance and external relevance'.[58] She argued that RCTs are not capable of addressing issues of effectiveness, efficiency and equity of services that extend beyond comparisons of clinical interventions. This challenge has been widely recognised and the research community has responded by proposing a mix of qualitative and carefully planned studies to assess 'complex interventions'. While generalism is intrinsically a simple concept, the provision of either generalist or specialist care is surely a complex intervention!

vii Medicare is a Federal US programme for health care of older people.

6.9
Process measures are also appropriate

Another way of putting this is to see medicine as a stochastic art.[59] This reflects a view that 'a doctor might treat a patient conscientiously according to all learned precepts; yet the patient might deteriorate'. Thus looking at whether it was done properly (process), despite a possible sorry outcome, is how we must assess medical care of conditions that are not yet amenable to the best evidence-based regimens.

All systems show variation. This can reflect adaptation to local conditions and creative innovation. It can also mean being unaware of good practice and failing to optimise care processes according to local conditions. Early studies comparing generalist with specialist care of people with diabetes illustrate this point. Practices organising their own routines for their patients with diabetes were able to offer care comparable with hospital diabetic clinics, but patients looked after on a traditional opportunistic or *ad hoc* reactive basis had poorer diabetic outcomes.[60,61] Thus generalists can give good care to common specific conditions if they organise proactive care appropriately. Incentivising this process is the rationale for the QOF introduced in the UK in 2004, although the effect of the QOF on pre-existing trends may in fact be small.[62]

6.10
Patients' views

I'm not aware of any study where patients have been directly asked to choose between or comment about generalist- or specialist-oriented systems. But in the pluralist US setting the Family Medicine Specialty set up a significant national public investigation at the turn of the millennium. This was a national questionnaire-based study using initial qualitative interviews.[63] It asked patients what they wanted from family physicians. Its findings were summarised:

> Patients want their primary care physician to meet the following five basic criteria: to be in their insurance plan, to be in a location that is convenient, to be able to schedule an appointment within a reasonable period of time, to have good communication skills, and to have a reasonable amount of experience in practice.

Beyond the basic criteria, patients value the relationship with their physician above all else, including service. Patients value a physician who listens to them, who takes time to explain things to them, and who is able to coordinate effectively their overall care.

Green *et al.* added:[63]

> There is some skepticism regarding the concept of a comprehensive care provider who treats a broad range of health care problems. At least in part, this reaction is based on the belief that it is unrealistic to expect any one physician to be able to keep up with all of the advances in medicine.

This last would seem to echo Weisz's point that patients value expertise and science! (section 4). In a smaller study Main *et al.*[64] conducted 78 focus groups in the State of Colorado to investigate what patients expected from their ideal doctor (not specifying primary care or family practice). They report similar findings, with a strong focus on relationships and patient-centredness. Concerning generalism issues they say:

> Focus group participants … emphasized the importance of care coordination. Participants did not ask for a gatekeeper (in fact, this term was never mentioned) but wanted their doctor to help coordinate their care and medical information (specifically between primary care physicians and specialists).

In the UK Coulter and colleagues at the Picker Institute have led the field in ascertaining patients' views. However, since there has been no serious proposal to dismantle the system of generalist primary care, patients have not been asked to compare it with a specialist-led system. Coulter summarised

what patients looked for in primary care in 2005. Much of her discussion concerned issues of access and patient centredness. On direct specialist access she commented:[65]

> Some patients may want freer access to hospital based specialists, but tampering with the referral system risks undermining the important coordination role provided by general practitioners and other primary care staff. Greater provider choice will not be worth having if it undermines the foundations of a system that works reasonably well at present.

Evidence from patients offers broad support for care provided by generalists but does not decisively show that this is superior. But criticism can be trenchant – witness Aaronovitch in *The Times* (2008) at the height of the debate on polyclinics – 'this "holistic" approach, is, in fact, code for "inexpert"'!

7
A wider view – many unanswered questions!

So far I have discussed the meaning of generalism, how it evolved, cultural influences, its recent near-identification with primary care, and the medical evidence that primary care generalism is worth having. I have concluded that the evidence for primary care generalism is largely favourable, admitting the likelihood of some bias as a practising GP. However, as a self-professed generalist I must plead for a broader perspective.

The foregoing sections have illustrated some of the historical and cultural factors influencing generalism in medicine. These explain, to an extent, how we have arrived where we are. This does not mean that we are necessarily in the best situation.

7.1
If you didn't have generalism in medicine, would you have to invent it?

So a novice might ask.[viii] But alleged public interest in specialism might argue not. Moreover, those seeing the patient as a consumer might argue for direct access to specialists. But the high prevalence of symptoms that, while most often self-limiting, may occasionally be the first signs of more serious disease calls for special expertise. Skill is necessary to detect when an apparently innocent symptom may have greater significance. This is based on the varying predictive value and relevance of all diagnostic procedures (whether history items, examination signs or tests) according to the prevalence of the condition being sought (see the Gatekeeper and the Wizard story above). This is the gatekeeper function all over again, but emphasising appropriate care of less serious morbidity and the minimising medicalisation of symptoms.

Increasingly patients suffer from multiple morbidities, needing coordination between specialisms – a prime generalist function. Further, even as many patients act as informed consumers in control of all their problems and able to manage encounters with specialists and coordinate their care (and are very good at this), others, more vulnerable because of age, ill health or social disadvantage, find this difficult or impossible. They need help. GPs give this both by coordinating care and helping patients cross 'gaps' between specialties and systems. More generally they act as advocates, interpreting symptoms and treatments, and acting as sounding boards for patients wanting to understand what is happening to them.

Much distress is of complex origin based on interaction between a patient and his or her life circumstances. It is hard to improve on Balint's description of Mr B,[13] who had seen 34 specialists in a six-year period without benefit. Only

viii And apparently, according to one Martin Marshall, the famous American social historian Rosemary Stevens said yes!

when allowed to tell his story to a sympathetic practitioner with a world view beyond conventional biomedicine did Mr B understand how his symptoms related to adverse life events. With this understanding came resolution of his symptoms. Balint defined the necessary therapeutic skill as helping the patient to integrate his life. Integration is again an important feature of the generalist approach (see section 2).

Such advantages are most obvious to older, iller or otherwise disadvantaged people who have less influence on the provision of health care. It may be very difficult to 'sell' generalism in places where it is little known. People who have never known a personalised, local, accessible, friendly generalist service may not be able to imagine it.

I have personal experience of engaging with attempts to introduce general practice systems in Japan, Greece, Russia, Kazakhstan and Uzbekistan. The first two countries were relatively wealthy and the other three were suffering from the chaotic aftermath of the end of the USSR. In all five, the initiatives came from health planners hoping to save money. In all they were up against the combined opposition of the specialists already providing primary care and the patients fearful of losing their access to experts. The only way forward seemed to be well-funded systems staffed by well-trained GPs who needed both idealism and self-belief. Progress was bound to be slow!

Conversely, if we got rid of it, what would we miss?

This might get a more positive answer. Those with experience of good general practice would sorely miss the comprehensive, familiar, accessible features described above. They would not save money overall, but if they were well off, basically fit, and socially confident they would be able to access many of the services they thought they needed. If they were to fall seriously ill, they might get superb private treatment, but if things did not go well they might suffer severely for want of generalist overview. In Britain we would lose a strong force for reducing the effects of social inequalities. The disadvantaged would suffer immediately but eventually rising inequity might threaten all.

7.2 What sort of generalist?

While primary care generalism is almost synonymous with general practice in the UK, this is mainly a matter of evolution rather than any strictly rational plan. GPs have already come a long way up from the low level described by Collings at the start of the NHS.[66] Like a car marque, the GP has been constantly refined and enlarged with added extras, and is now better skilled, trained for longer and at greater expense, and working within an extensive team in costly purpose-built premises.

Nurses arrived in general practice very much as the servants of employing doctors. Access was largely via the doctor. In many practices the doctors were referred to by name, while 'the nurse' was called by her job title. This has changed a lot. With a short additional training period a practice nurse can become a nurse practitioner (NP). Some primary care practices are now led by NPs who employ one or two doctors to cover gaps in their expertise and where NHS routines require a medical qualification. Shortage of public funds is nothing new, and inevitably the rise of the NP, on a far lower pay scale, is attractive to care commissioners.

The work of NPs has been extensively studied overseas[67] and there is some British evidence[68,69]. NPs are popular with patients and no study has convincingly shown any poorer outcomes. However, evidence has so far focused on defined conditions, often relatively simple common conditions where management is arguably easier. Similarly, while appropriately trained NP prescribers can potentially use the entire *British National Formulary*, they usually stay well within their area of

competence.[70] Cost savings resulting from lower salaries have been limited by the longer consultations of NPs, so they can see fewer patients. However, this may not be intrinsic to their role and in any case there is pressure for GPs to lengthen their consultations.[71]

Anecdotal evidence is that NPs can deliver very high-quality primary care. Some very talented nurses have come forward, taken advantage of training opportunities and learned well on the job. Whether this can be extended to large numbers of NPs replacing many GPs is another question.

Can NPs replace GPs as primary care generalists?

What is the gap between a nurse and an NP? Is there an essential gap between an NP and a GP? Is it the training, the culture or the potential of individuals? It can be argued that delivery of generalist care by expensively trained doctors is an unaffordable luxury if our aim is to deliver the best primary care to all. Certainly it is far from self-evident that the years of strongly biomedical hospital-based medicine are the most appropriate way of training a primary care generalist. Indeed Pellegrino was suggesting alternative generalist tracks in medical school for aspiring GPs 44 years ago, when he delivered the keynote lecture to the first ever US Annual Association of GPs meeting.[72]

Surely the present system is a combination of the power of biomedical specialism and historical accident, even when in some UK medical schools community-based clinical teaching exceeds 25% of the clinical curriculum? It would be very hard for GPs as a professional group to give up the parity of status with specialists that derives from a shared education.[ix] It could be that, if GPs retain their strong biomedical training, they will increasingly 'specialise' in the more complex and difficult patients with multiple co-morbidities and leave the management of the border between illness and non-illness to generalist NPs. These would arguably need better focused training than at present.

Much of what I have argued about the nature of the primary care generalist in section 2 is at odds with this viewpoint. If we take the famous model of nested squares reproduced by McWhinney (p. 30)[7] to indicate the boundaries between self-care and primary care, and between primary care and hospital (secondary) care, then the primary care generalist needs to moderate both boundaries.[x] If the generalist doctor becomes restricted to complex medical problems then another boundary will be needed and his or her skills for the care of unselected patients risk atrophy.

7.3
Is general practice a specialty?

A related question is whether general medical practice should be classified as a specialty (see section 1, Heath *et al*. 2000[4]). At one level this is a nonsense – if generalism is the antithesis of specialism, then defining GPs as specialists is both meaningless and unhelpful. Underlying this question though is the sensitive one of status, with consequences for regulation and remuneration. I understand that differentiation between GPs and specialists has considerable relevance to regulation of free movement of doctors between European Union (EU) countries.[xi] There are also issues around shared levels of training for GPs and specialists. Traditionally, training a specialist took much longer in the UK – 12 years, rather than seven elsewhere in the EU. This difference has much reduced following the Calman reforms in the 1990s (Weisz, p. 235).[15] Clearly this is a political issue rather than a scientific one, and, as such, needs to be settled by persuasive advocacy more than by dry evidence. In my view we can certainly justify specialty status with dignity. If this were to happen it would strengthen the voice of expert generalism in negotiating primary care policy and this would bring benefits for patients.

ix Even the Gatekeeper in the fairy story was said to have gone to the same school for wizards as his Wizard colleague. See Mathers N, Hodgkin P. The Gatekeeper and the Wizard: a fairy tale. *British Medical Journal* 1989; **298**: 172–4.

x The model originated with John and Elizabeth Horder. See Horder J, Horder E. Illness in general practice. *Practitioner* 1954; **173**: 177.

xi Hill AP, personal communication.

7.4
Outstanding primary care policy issues

In 1998, Starfield ended her masterly book with a list of 'policy issues for primary care' (pp. 405–11).[31] All remain topical and several directly concern generalism.

Equity and gatekeeping

Starfield starts with an affirmation that cost-sharing leads to inequality of access, then reminds us that gatekeeping is empowering as a method of enhancing the use of specialists but a barrier to equity if it is used to restrict access. This is topical in today's NHS where efforts to rationalise specialist referral by PCTs needing to make the best use of public money include moderation of GP referrals by an intervening committee. Variation in GP referral rates is indeed large and only partly understood. Since referral can be so expensive, this aspect of generalist behaviour needs further examination. The English solution of so-called 'world-class commissioning' of specialist care by PCTs from independent Foundation Trusts is still being worked out but it appears to avoid the question of how generalists and specialists can best cooperate. It is another example of a reform based on belief in the supremacy of the market.

Teamwork

It is generally agreed that teamwork is essential in primary care (e.g. Greenhalgh, p. 118),[10] but the extent to which 'linkages between physicians and nurses … and other health professionals' bring benefits (Starfield, p. 408)[31] remains unclear.

Hospital- versus community-based specialists

This issue is most pertinent in mixed systems as in the USA, but it recurrently surfaces in the UK. It is attractive to bring specialists closer to patients but is expensive and ignores history about specialists' primary locus of relationships being with each other in hospitals (see section 3). As hospitals become fewer, larger and more specialised, it is logical to seek intermediate care facilities. As yet the evidence that these are economical in the British setting is hard to find, partly because of the involvement of private sector providers and difficulties about availability and comparability of performance data.

Variation between GPs

For me the outstanding issue is are GPs 'just gatekeepers' or are they truly expert? On the one hand Starfield's comparisons already imply that our GP-based primary care was doing well, albeit more than ten years ago. But looking more critically at her data, the UK, while ranking top of the scale of primary care attributes, came well down the list of outcome comparisons. Starfield excused this apparent anomaly in her argument by saying that the UK was relatively underfunded (p. 355).[31] Recent international comparisons of cancer diagnosis suggest that British primary care is at least partially implicated in delays in the pathway of recognition and referral. Possible reasons are being investigated.[73] It is noteworthy that research into clinical diagnosis and treatment has been relatively limited in primary care over its first 50 years as an academic discipline.[74] The evidence base underlying the different decision-making wisdom needed by gatekeepers and wizards is still far too small. There must be room for improvement.

Conclusion – the need to sell generalism

I have concluded that there is strong philosophical argument in favour of generalism and broadly favourable evidence for better outcomes and reduced cost, and also greater equity. Most modern generalists practise in primary care, and most medical generalists are GPs; the argument for designating general practice a 'specialty' in its own right is politically attractive. While most of the above evidence is based on the performance of medical generalists, the widespread acceptability of NPs must raise the question of the optimum selection, enculturation and training of generalists. This question merits further examination.

Meanwhile generalist medicine is threatened all over the world, not least in the UK. I hope GP leaders can exceed their previous efforts to influence the public and policymakers. But it may be even more important for GPs to reach out to persuade our own patients in our own communities, as suggested by Marshall.[75]

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