Why generalists must be experts

RNZGP Conference for general practice 2013
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...this “holistic” approach is, in effect, code for “inexpert”!

David Aaronovitch on GPs versus polyclinics
The Times London 2008
is generalism redundant in the new millennium?
the Commission on Medical Generalism

modern medicine too complex?  No!
public too well informed?  No!
the clinical squeeze
  – non-medical clinicians too good and too cheap?
  – are we made redundant by guidelines?  No!
generalists and specialists

our task in primary care &

the expertise we need
1 generalists and specialists

the rise and rise of the specialist
generalist response evolves
international contrasts
status

what are we worth?

– are we a specialty?
– why do patients value us?

jack of all trades?

– the medical school experience
– vocational training - *deconditioning*
– patients’ reactions
– working with managers and politicians
modern medicine too complex?

a recurrent myth
based on a misunderstanding
of the generalist role

Ian McWhinney
London Ontario
As science advances, particular facts are comprehended within, and therefore, in a sense annihilated by, general statements of steadily increasing power and compass – whereupon the facts need no longer be known explicitly, that is spelled out and kept in mind.
generalists & specialists - distinct contributions

• generalists better at defining problems in context
• a generalist’s practice is an expanded one by virtue of synthesis or integration, not mere addition.
• specialists tend to frame a problem to fit their solutions

both have something to offer

‘neither will be of much help if their need for control is at odds with yours’

Fred Nickols
2 generalism and primary care - the task

the specialist explosion - a feature of modern life in all fields

*but, paradoxically*

makes generalism a priority for today’s patients

- diagnosis of unselected problems
- Multimorbidity
- working in context
  - crossing the mind/body fault line

this is all about judgment in complexity
**diagnosis**

- *first presentation of unsorted problems*

changes in UK primary care have led to increased admission without GP selection

• increasing focus on long term work squeezes out ‘emergencies’
  – loss of 24hr responsibility in UK

• many problems seem straightforward, so tempting to give the sorting job to the least experienced clinicians

too often ignored in both education and research
diagnostic expertise

• challenges from specialists
  – paediatrics

• research/urgent improvements needed
  fundamentally difficult – signal to noise ratio is weak
  – recent work on diagnosis of ovarian cancer
diagnosis – generalist style

1980: *Family trends in psychotropic and antibiotic prescribing in general practice*
challenge of **multimorbidity**

multimorbidity and EBM

information overload

the problem with guidelines

*scientific bureaucratic medicine*

personalised medicine

continuity of care and partnership
personalised medicine for multimorbidity

• 8/10 patients want their doctor to listen
• 6/10 say this happens
• 9/10 want their providers to work with them as a team
• 4/10 say this happens

treatment threshold for patients is higher than that of doctors

off-protocol decisions as a quality marker!

Kev Hopayian

11th July 2013 RNZCGP Wellington
Freeman - why generalists must be experts
**highlights of the primary care task**

- diagnosis of unsorted problems
- multimorbidity
- **working in context** (person not disease focus)
  - mind & body always together, helping interpretation of feelings
  - knowing patients helps appropriate diagnosis and management
  - again *relationship continuity of care* is vital and needs to be specifically encouraged

solutions are individual and negotiated
this means *partnership* with patients
and requires a ‘generalist with attitude’
Generalism describes a philosophy of practice which is person, not disease, centred; continuous, not episodic; integrates biotechnical and biographical perspectives; and views health as a resource for living and not an end in itself.

Reeve *Brit J Gen Pract* 2010; 60: 521
the expertise we need

crucial distinction is between

• multiple roles (merely)

and

• expert performance in a wide context
  - interpretation and prioritisation are key
generalist models for GPs

1a clinical all rounder providing multiple doses of specialist defined care

1b GP with a Special Interest - GPSI

2 value added clinical all rounder

the expert generalist
cost pressures
the challenge to GPs

leading to clinical squeeze between

• ‘scientific bureaucratic medicine’
  – the evidence based protocol is king

• nurse practitioners and other non-medical clinicians
  – seem cheaper
  – and equally good?
expert medical generalists?

need we be doctors? – what do we offer?
  defined by what we can do?
  or by how we’re trained?

how good can nurse practitioners be?

limitations of comparative studies

patient expectations
“By comparison with nurse or social worker, a doctor has more knowledge of the nature of disease, available therapy, its side effects & its dangers. Provided that he uses delegation in order to make use of special skills and devotes the time so created to increase knowledge of the patient and to communication, he can help patients to reach wise decisions as adult autonomous human beings.”
The condemnation of value judgments... is one of the devices by which scientific pretension maintains its misconceptions

- diagnosis always involves judgment and is always risky (Iona Heath)
- going ‘off protocol’ needs judgment
good clinical judgment includes

• toleration of uncertainty
  – time as diagnostic tool
• resisting temptation for premature or unwise labelling
• feeling good about not knowing everything
so the generalist also needs
• people management
• ability to defuse tension
value of generalist expertise

do expert generalists enable better and cheaper health care?

• key Starfield argument – but she was actually talking about primary care systems

• not provable – too much context!

• patient and professional stereotypes and expectations
  – see Gordon Moore ‘the disappearing generalist’
how to train experts?

clericians need opportunities to learn about

- diagnosis in primary care
- multimorbidity care
- in context, in partnership with patients

as undergraduates, vocational trainees, & in CPD

- complex skills needing the exercise of judgment
- professional learning
- in practice with feedback - supervision tailored to experience
making the case for expert generalism

patients are our most important advocates

personalised medicine is

a double hit for expert generalists

• more appropriate and professionally satisfying

• essential for keeping trust with patients

ultimately most cost-effective

• private funders have no doubts

  – the gatekeeper and the wizard

the value of a diagnostic test depends on the prevalence of
the condition in the population being tested
generalism is fun!

the answer lies with us - the challenge is there
we have to grasp it and run with it
in partnership with patients

chafe at guidelines or use them creatively?
run from the personal or welcome the richness?

ultimately the most stimulating and rewarding
job imaginable
real and rich lives of patients

we live with complexity

how simple we find the problems is partly about us ourselves
partnership

• involves negotiation
• harnessing patients’ own resources
• keeping professional perspective amidst emotional warmth
• helped by relationship continuity
• very challenging – patients vary so much!
  – can reduce guideline conformity
**McWhinney’s nine features of a GP**

*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/her practice as a ‘population at risk’ in public health terms
5. sees him/herself as part of a community-wide support network
6. ideally should share the same habitat as his/her patients
7. see 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”

Freeman - why generalists must be experts
the UK Generalism Commission 2011

*Generalism in medical care: a review for the Health Foundation*
Freeman GK. (January 2010).