

**GUIDING PATIENTS THROUGH COMPLEXITY:  
MODERN MEDICAL GENERALISM**

**REPORT OF AN INDEPENDENT COMMISSION  
FOR  
THE ROYAL COLLEGE OF GENERAL PRACTITIONERS  
AND  
THE HEALTH FOUNDATION**

**October 2011**

# GUIDING PATIENTS THROUGH COMPLEXITY: MODERN MEDICAL GENERALISM

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## Members of the Commission

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## Foreword

The Royal College of General Practitioners (RCGP) and the Health Foundation are to be congratulated for taking the initiative on behalf of the whole of medicine in this debate about medical generalism. It was a privilege to be asked to chair this commission of inquiry. My fellow commissioners worked tirelessly to explore the issues facing medical generalism, with particular reference to, but not confined to, general practice.

Overall we concluded that a generalist approach is widely applicable across health care, from general practice at one end of the spectrum, through to the highly specialised services found in secondary or tertiary care at the other.

Within the current political climate of seismic change in the NHS, we felt our inquiry must move beyond the confines of patterns of service organisation, planning and contracting. We, therefore, explored the subject beyond current political rhetoric.

Patients lie at the heart of health care delivery – they are its *'raison d'être'*. People become ill, or more ill, at all times of the day and night. They present with undifferentiated conditions, sometimes with conditions that progress very rapidly. Central to their care is effective and accurate diagnosis in the context of other conditions they may have, and the lifestyle they lead. Effective management of people whose health is jeopardised for whatever reason requires excellent communication between all involved at every level. The appropriate clinical response may be to support the person in self-management, to provide care and treatment from the generalist, or for the generalist to be the gate-opener to other clinical services. It is the ubiquity of these needs that makes the delivery of high standard generalist care essential round the clock.

Some patients are at particularly high risk of not getting adequate levels of care at any time. This group includes those with mental health conditions, learning disabilities, those with multiple chronic co-morbidities, and those whose condition is rare. Not infrequently, children are seen by GPs with insufficient training in paediatrics. End of life care remains patchy, despite recent improvements. Those with learning disabilities may be unable to communicate their needs to someone who could understand them. And some in nursing homes languish without dedicated medical attention.

General practice can take pride in much of the care delivered overall – but not all. We have recommended expanding the training time for new recruits to the discipline, to put them on an equal footing with those who train as specialists. We also recommend that training in generalism, including experience of general practice, be a core training requirement for specialists. We want GPs and hospital consultants to learn together and from each other, and from patients; to communicate directly person-to-person with each other for the benefit of patients and their families, and to jointly use the revolution in electronic communication tools to deliver the information and support which patients need to look after themselves. Such integration and continuity across the primary/secondary care divide is essential if the benefits of generalism are to be realised for the good of patients and their families.

The RCGP could lead the integration of care provision across both mental and physical health care and coordinate research into conditions that can and should be managed across a range of settings. We hope that political changes will not detract from the urgent need to be ever more patient focused, while having regard to the population within which a person lives. 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.

Ilora Finlay  
Commission Chair

## Acknowledgements

The content of this report has been greatly enriched and influenced by a background seminar at the start of the work and by a series of formal oral evidence-gathering sessions, together with informal visits to two inner London general practices, and a teleconference with Francois Schellevis, professor at the General Practice Medicine department of the Free University Medical Centre, Amsterdam, and head of the Netherlands Institute for Health Services Research, Utrecht (see Appendix A). The Commission wishes to thank all those who gave their time in providing the evidence on which much of the thinking behind this report is based. The questions that witness were asked to consider are listed at Appendix B.

The Commission wishes to thank all those listed at Appendix C who sent in written responses to the questions, and officers of the Royal College of General Practitioners for organising the written consultation and collating written responses.

The Commission is particularly grateful to the Health Foundation who had the vision to commission and fund this timely piece of work, and who respected the independent nature of the Commission's work.

The Commission also wishes to thank the Royal College of General Practitioners for additional financial support; and Dr Clare Gerada, who chaired preliminary meetings in March, 2011, before handing over the chair to Baroness Finlay, thus preserving the commission's independence.

The report was written by David Brindle and revised by him in discussion with commissioners. The final document is an agreed consensus of the Commission.

## Gathering the evidence

In order to gather material to write this report, the Commission adopted a comprehensive method of consultation, beginning with a background seminar in April 2011, following which Professor Freeman agreed to join the group as commissioner. Commission meetings finished in July 2011. Between April and July the Commission took oral evidence from 38 witnesses and additional soundings through a process of written submissions from a broad range of medical and lay opinion. Many of those who gave evidence provided documents and quoted references to support their statements. The Commission considered this material along with other reference documents when formulating its conclusions.

Throughout the text of this report, the Commission has selected quotations from its witnesses to illustrate and amplify points made and conclusions drawn. The Commission believes, therefore, that this report is informed by the evidence it received as well as by debate and deliberation among its members.

## Commission terms of reference

- Define medical generalism, with particular reference to general practice;
- Explore the intrinsic values of medical generalism;
- Define the role and value of medical generalism in contemporary clinical practice. Please see below for further explanation\*
- Formulate a description of the medical generalist that:
  - Is widely recognised
  - Defines what patients and the public should be able to expect
  - Clarifies how the medical generalist interfaces with other health care professionals
- Make recommendations about the future development of medical generalism.

\*In order to understand the benefit to patients and the public of generalist care, the commissioners recognise they need to investigate the role and value of medical generalism in contemporary clinical practice in a variety of settings and in a number of different environments. These include, but are not restricted to, the following areas:

- The care of patients of all ages;
- Patients with multiple co-morbidities;
- An aging population demographic;
- Health inequalities;
- Mental health and learning disabilities;
- Delivering cost-effective care to individual patients and across a population;
- Providing equitable health care services;
- Health promotion;
- Public health information and data.

# 1 INTRODUCTION

*'The first essential is to curb the incentive for specialisation, which has been encouraged to an unreasonable degree .....*

- 1.1 The declaration above was made by a speaker at the first annual general meeting of the Royal College of General Practitioners, in 1952<sup>1</sup>. There is nothing new in concern for the standing of medical generalism: although general practice has been the cornerstone of medical care in Britain for at least 200 years, and is admired and envied across the globe, there have been recurrent questions of confidence in generalism's future. But the present questioning goes particularly deep.
- 1.2 Three challenges stand out. First, does the scale and pace of development of health care, and the growing complexity of its basis in science, make possible a generalist overview that is sufficiently accurate, comprehensive and safe? The global electronic MEDLINE database indexes some 900,000 additional clinical articles every 12 months<sup>2</sup>, so keeping abreast of latest developments can be challenging. Second, have public expectations of swift, and possibly direct, access to specialist treatment – expectations heightened enormously by the information revolution delivered by the internet – overtaken the generalist approach? Such expectations may reflect both assumptions of greater patient autonomy and a lower tolerance of uncertainty in modern life. And third, has the role of the generalist doctor been squeezed beyond any sustainable residual form by pressure, on one side, from other professions taking on additional tasks and responsibilities, and, on the other, from an increasing dependence on protocols in medicine in order to deliver care in a systematic way? Current training requirements have compounded this by locking in doctors early to either a general practice or a specialist career path.
- 1.3 These are important tests, and the Commission has taken evidence on all three fronts that might be seen to call the future of generalism into question. Yet other factors work very much in favour of generalism. And the Commission considers these of far greater significance.
- 1.4 First, the UK's ageing population is having a profound impact on the nature of health care demanded of, and delivered by, the NHS. Almost 45% of all hospital in-patient treatments (finished consultant episodes) in 2009-10 were of people aged 60 or over, an increase from an average of just over 39% on the preceding decade (1999-2000)<sup>3</sup>. Patients aged 60-74 stayed an average seven days in hospital in 2009-10 and those aged 75 or over an average 11 days, compared to an overall average of 5.6 days. Thus the majority of hospital beds are at any one time occupied by older patients<sup>3</sup>.
- 1.5 Second, and what makes this demographic trend of particular relevance, six in 10 older people are thought to be living with at least one long-term condition, most of whom have two or more<sup>4</sup>. It marks the overall success of medicine that many of them are living with diseases that until recently were rapidly fatal; some of them are living with secondary, long-term complications of treatment. The constant emergence of new treatments and interventions means that the course of some illness is rapidly and unpredictably altered. For example HIV and much breast cancer have become chronic conditions rather than rapidly fatal ones. According to the Department of

Health, people living with long-term conditions account for 50% of all GP appointments, 64% of all outpatient attendances, and 77% of all hospital bed days<sup>4</sup>. In 2009-10, an estimated £70bn of total health and social care expenditure was on people with long-term conditions<sup>4</sup>. Added to this is the growing toll of dementia. Professor Alistair Burns, national director for older people and dementia at the Department of Health, said in evidence to the Commission that 25% of NHS hospital beds are occupied by people with dementia and *‘that up to 40% have ambulatory conditions which may not need to be admitted to hospital’*. So responding more effectively, and more cost-effectively, to this rapidly changing agenda has become the principal challenge facing the NHS.

- 1.6 Third, the purpose and mission of all health care is today seen as much more about sustaining the overall wellbeing of the individual, over time, than about episodic clinical interventions, The World Health Organisation’s definition of health, drawn up 75 years ago, seems today more relevant than ever: *‘Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.’*<sup>5</sup> Rapid and effective management of acute conditions remains essential, not least to avoid the onset of chronic diseases, but it must be done as part of an holistic approach and with an eye to the long term.
- 1.7 It was in this context that the Commission was established by the Royal College of General Practitioners with the support of the Health Foundation. This was in line with the college’s policy priorities, but also in part a response to a recommendation of a working party convened by the Royal College of Physicians, which had called on the Academy of Medical Royal Colleges *‘to review the role of generalism in medicine and how it can be enhanced alongside the development of specialism’*<sup>6</sup>.
- 1.8 The Commission has deliberated at a time when the policy and fiscal climate has been unstable: in particular, the proposed introduction of clinically-led commissioning of health services in England places great expectations upon general practice. The Commission has not taken specific evidence on this issue, nor on the implications for generalism of current constraints on health care spending, but it was mindful throughout of the pressures being brought to bear.
- 1.9 In setting about their task, and throughout the course of their deliberations, commission members have been clear on three things that medical generalism **is not**:
  - It is not a synonym for general practice: although generalism is the essence of good general practice, the approach is needed also in secondary care;
  - It is not simply first-contact care: although many medical generalists are the first health care professionals to see a presenting patient for the purposes of diagnosis, other professionals can and do fulfil this role; and
  - It is not purely good doctoring: although the generic attributes and attitudes associated with good professional practice are an intrinsic part of generalism, the generalist has specific clinical qualities that go significantly beyond this.
- 1.10 The Commission believes that true generalism is one of the hardest things in medicine to do well. This does not mean that generalists need to know how to do everything, but they do need to know what they cannot do. And they need routinely to draw on the knowledge, skills and experience of others.

## 2 MEDICAL GENERALISM - A WAY OF LOOKING AT THE WORLD

- 2.1 The Commission has sought to approach the issue of medical generalism from the perspective of the patient. Our starting point has been that unless the patient benefits demonstrably from generalism, there is no justification for it. However, that does not mean that the patient will necessarily know that they are being attended by a generalist.

*'My mum couldn't care less about the specialist/generalist categorisation. What she wants is the right care at the right time'. David Behan, Director General for Social Care, Department of Health*

- 2.2 By definition, a generalist takes a general interest in all parts of the body and mind. This enables the proficient generalist to act, where required, as the first point of medical contact for the patient, to deal with both acute and chronic health problems and, critically, to manage illness that presents in an undifferentiated way at an early stage of development. Thus a generalist needs to be competent in the provision and co-ordination of care for individuals of all ages and to have an understanding of the variable impact of illness through the life course.

- 2.3 In specific reference to general practice, the European Definition of General Practice/Family Medicine goes further, specifying characteristics that demand a deeper and richer interpretation of the generalist's role. These include: an approach orientated to the individual, their family and their community; provision and co-ordination of care from birth to death; and promotion of health and wellbeing<sup>7</sup>. So in addition to 'general' interest in the body and mind, there must in these circumstances be an overriding interest in the person rather than the illness, a commitment to continuity of care through the life term, an ability to manage the boundaries of different forms of care and support, and an understanding of the health needs of the wider community.

*'Generalist practice is decision-making which is person-, not disease-focused, which is continuous and not episodic, which integrates the biographical and the biotechnical knowledge ... all with a view to supporting health as a resource for living and not an end in itself.' Joanne Reeve, NIHR Clinical Scientist in Primary Care, University of Liverpool*

- 2.4 What distinguishes generalism from specialism? The most obvious contrast is that where specialism is about depth, generalism is about breadth: the greater the depth of expertise in a branch of medicine, the more specialist the doctor; the greater the breadth of expertise, the more generalist. At the extreme, and to accentuate the distinction, this can be portrayed as a cultural divide.

*'The difference between generalists and specialists is important because it depends which lens is in front: the disease lens or the patient's lens. Young doctors need to decide (and both decisions are legitimate) whether they are more interested in the science of disease or the way in which disease affects individual people.' Iona Heath, President, Royal College of General Practitioners*

- 2.5 But there is another factor, equally significant, pertaining to the way in which doctors reach diagnoses. Whereas the specialist relies heavily on scientific evidence to arrive

at a precise explanation of an illness within a limited range of possibilities, the generalist (especially the GP) takes a far broader approach to arrive at one or more probabilities and decide whether or not action is needed.

- 2.6 The European definition puts it thus: *‘[General practice/family medicine] requires a specific, probability-based decision-making process which is informed by a knowledge of patients and the community. The predictive value, positive or negative, of a clinical sign or of a diagnostic test has a different weight in family medicine compared to the hospital setting.’*<sup>7</sup>

*‘... the defining skill [of generalism] is the different weight generalists and specialists give to biomedical and social-science based evidence in making management decisions.’ John Howie, Emeritus Professor of General Practice, University of Edinburgh*

*‘To be a good generalist ... the doctor has to have an intellectual grasp of the situation ... necessary to understand and interpret the evidence, but also needs to use imagination and an appropriate degree of emotional engagement. Neither of these is privileged over the other – both are necessary.’ John Gillies, Chair, Royal College of General Practitioners, Scotland*

- 2.7 The Commission believes it misleading and unhelpful to label all doctors either generalist or specialist. Rather, it believes it more appropriate to see all doctors as being on a continuum from pure generalism to pure specialism, with the overwhelming majority at points in between.
- 2.8 Moreover, it may be more accurate in the context of modern health care to think of generalism as a characteristic of a service, department or team, rather than of an individual. While there are professionals other than doctors who are generalists, the focus here is on medical generalism. There is potential for substitution of some of the roles of the generalist doctor by other professionals - but the unique training in diagnosis and managing probability and risk in the context of changing knowledge that medicine provides, means that for this aspect of generalist care the doctor is essential.

## Defining generalism

- 2.9 Overall, the Commission considers that medical generalism is, at root, a way of thinking and acting as a health professional and, more than that, a way of looking at the world. It is possible to be a generalist in any speciality or profession and, equally, it is possible to work as a GP without being a true generalist. The essential quality is that the generalist sees health and ill-health in the context of people’s wider lives, recognising and accepting wide variation in the way those lives are lived, and in the context of the whole person.

*‘To me and the people I have spoken to, the generalist has the big picture with all its nuances, connections and complexities, and considers the whole patient rather than just the condition’ Andrew Vallance Owen, Group Medical Director, Bupa*

2.10 With these factors in mind the Commission defines medical generalism as follows:

*Medical generalism is 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.*

*Those adopting a generalist approach to the provision of care will need to recognise the limitations of their skills and experience and know when and where to enlist the most appropriate help, support and advice from colleagues – working across inter-professional boundaries and recognising the interdependency of professional skills.*

2.11 The underlying principles of generalism are:

- *Seeing the person as a whole and in the context of their family and wider social environment;*
- *Being accessible and available to deal with undifferentiated illness and the widest range of patients and conditions;*
- *Demonstrating concern not only for the needs of the presenting patient, but also for the wider group of patients or population;*
- *Engaging in effective multi-professional working and co-learning;*
- *Communicating freely and clearly with patients and professionals across health and social care;*
- *In the context of general practice, taking continuity of responsibility across many disease episodes and over time; and*
- *Also in general practice, co-ordinating care across organisations within and between health and social care.*

2.12 A patient's view of a generalist is a doctor who:

- *Sees me in the context of my situation;*
- *Helps me to stay healthy and develops with me a plan for me to manage as much of my care as is possible myself, or with support from a carer;*
- *Understands and is able to identify the causes of any illness I have;*
- *Helps me to get the care I want and need;*
- *Gives me care, but knows when to refer me to someone else;*
- *Helps me access appropriate care, advice and support to cope from a variety of sources and helps me co-ordinate my care; and*
- *Arranges for someone appropriate, with key details of my condition, to be available when I need care, advice and support.*

## 3 STRENGTHS

### Seeing the whole

- 3.1 It is often held that the core strength of the generalist is their ‘patient-centredness’. This may be sub-divided into continuity of care of the individual, which we turn to later, and the holistic view of that individual as a whole person rather than as the embodiment of a single presenting illness.
- 3.2 To say that patient-centredness is an attribute peculiar to generalists is inaccurate and unfair, however. A specialist may very well be patient-centred, particularly in circumstances where they have long-term contact with someone living with a chronic condition. ‘Comprehensiveness’ may be a somewhat better term for this core quality of the generalist, though that has its own limitations.
- 3.3 The issue was illustrated graphically in evidence presented to the Commission by a witness who recounted the experience of a friend diagnosed recently with inoperable oesophageal cancer. The diagnosis had come five weeks after investigations had started, during which time the patient had been to four hospitals, as well as their GP surgery, and had been assessed by two GPs, three consultants, a consultant nurse and a health visitor.

*‘What she actually needed was to feel that somebody actually understood her, her case, the trauma for her, the prognosis for her, and to know that somebody had got hold of that and was delivering it,’ the witness said. ‘That seems to me to be about individualism; whether we want to put that under generalism or specialism is a further point.’ Anonymous witness*

- 3.4 A similar point was made by Kirstine Knox, chief executive of the Motor Neurone Association, who pointed out that although motor neurone disease was a rare and terminal condition – a GP will on average see only one or two cases in the course of their career – the generalist played a critical role in ensuring that the patient’s wider needs, including non-clinical social and welfare needs, were met. *‘For those whose care has been very good, what they will say about their GP is that the GP was there for me from beginning to end and was on the journey with me.’* Kirstine Knox
- 3.5 The ability to capture the bigger picture of the patient’s life is not confined to general practitioners, however. The Commission was impressed by evidence it heard of specialist hospital doctors coming to appreciate the importance of a more generalist approach to their patients. This in part reflects awareness that individuals are increasingly likely to have multiple conditions, and that living with a debilitating long-term illness can cause mental distress, but also reflects an understanding that treatment will rarely comprise a single intervention.

*‘I am a kidney doctor in my day job, which is traditionally thought of as quite a specialist area, although latterly we have recognised in the kidney world that it is the patients with the kidneys, or the transplants or the dialysis, rather than the kidney per se that is the big issue, and for most people with kidney disease they do not need to darken the door of a kidney specialist. So I think there has been quite a change in the kidney world in the last five or 10 years that recognises more*

*the importance of generalism than when I was in training’ Donal O’Donoghue, National Director vascular and kidney care*

- 3.6 Generalists in both primary and secondary care settings, then, are trying to look at the patient’s health or ill-health from the patients’ perspective, through the ‘patient’s lens’. This has been termed a biopsychosocial approach, as distinct from biomedical, in that it is accepted that illness may have its causes in, or be aggravated by, psychological or social factors as well as biological. An emerging refinement of this, however, is the biology of biography, which takes a whole-life view of the patient and can trace much illness and disease to childhood and even to pre-natal experience, enhancing perspective and informing clinical management strategy. This seems to offer a more complete approach.

*‘There is so much more evidence now about how biographical events damage biology; they damage genes, they damage physiology. And so one example might be the way that if you have a severely disabled child, your telomeres [the protective zone at the end of each chromosome] are shorter so you are actually ageing faster than your peers.’ Iona Heath, President, Royal College of General Practitioners*

- 3.7 In many ways, such a biographical approach brings medicine alongside social work and behavioural therapy in analysis of individual dysfunction. The Commission was struck by the observation in evidence of David Behan, director general for social care at the Department of Health, that ‘*people are messy and they live their lives in messy ways*’ and that adopting an overly specialist focus as a professional fails to reflect life in the 21<sup>st</sup> century.
- 3.8 Commissioners were struck, too, by evidence from carers’ groups that a biographical generalist approach is essential to understanding the health issues that may arise in a household where one or more family members has a disability or severe long-term illness. Any individual health condition is likely to have far wider ramifications in such circumstances.

*‘From my experience as the disability rights commissioner who led the formal investigation into health inequalities for people with learning disabilities and mental health conditions, we felt that it was absolutely vital for patients and their families to have somebody who was interested in the generality of their health and well-being irrespective of particular diseases.’ Dame Philippa Russell, Chair of the Standing Commission on Carers*

### **Knowing the community**

- 3.9 The true generalist ‘looks beyond the surgery door’, as the King’s Fund put it in the report of its two-year inquiry into care quality in general practice<sup>8</sup>. This 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.
- 3.10 One of the most well-known examples of such ‘population doctoring’ was the long-term proactive work of Dr Julian Tudor Hart and colleagues in a South Wales mining community, leading to a claimed 28% reduction in age-standardised mortality under

age 65 against a control group. But as Tudor-Hart himself acknowledged in evidence to the Commission, even some two decades of such work was insufficient to develop a complete local picture.

*'Because all this was done by a small, stable staff team, dealing with an intimately-known population within which all staff themselves lived, over many years and with our high-quality structured records frequently referred to, we were constantly reminded of our continued dependence on imagination and judgment, and of the incompleteness and fallibility of our local knowledge, even though this was far richer than data available even to the best GPs working in traditional, demand-led ways.'* Julian Tudor Hart in written evidence

- 3.11 Making health needs assessments, addressing health inequalities and commissioning services accordingly are key components of this kind of approach. But so, too, is being known in the community (whether a physical community or a patient cohort), the obverse of the patient being known to the doctor. In some ways, therefore, the generalist can be seen as fulfilling for many people the type of role that a local priest would have occupied for them in former years: a respected figure who could be turned to for non-judgmental advice on a range of issues including, but not limited to, health care.
- 3.12 This is not to hark back to a romantic vision of the generalist as Dr Finlay, but rather to argue that a generalist service can offer a modern recourse for people who do not know where else to take problems and who need signposting to other agencies. Members of the Commission visited the Bromley by Bow Centre in Tower Hamlets, east London, which excels in such signposting and which accommodates various non-clinical services on site.

*'Never build a GP surgery in isolation.'* Sam Everington, General Practitioner, London

- 3.13 Taking a population focus it is essential to provide for deprived communities and groups whom professionals find hard to reach, such as Travellers, asylum-seekers or homeless people, who may not be registered with a general practice.

*'The [homeless people's] model at UCL is extraordinary because they have a very talented GP working as a specialist in the hospital alongside the other specialists. When a patient is admitted, the whole of the professional team, which includes social workers, housing, do a multi-disciplinary team meeting on that patient.'* Steve Field, Immediate-past chair, Royal College of General Practitioners; Chair, NHS Future Forum; Chair, National Inclusion Health Board

- 3.14 A population focus is important also for promotion of health and wellbeing. Evidence from New Zealand showed how the Pegasus Health charitable group, a collective of 390 GPs covering most of the city of Christchurch, has developed a number of preventative health initiatives and secured on-going contracts to continue them, and has achieved significant health gains for the community. At the centre of the group's approach are the twin disciplines of dynamic audit and reflective practice, very much as Tudor Hart applied in the Welsh valleys, and as the Commission observed in Tower Hamlets.

*'What we have done for the last 17 years is to approach this from a professional, bottom-up paradigm rather than the traditional top-down paradigm and look at variation, encouraging*

*healthy variation from which innovation is spawned, and then try and reduce the unhealthy variation thereby simultaneously reducing both under- and over-treatment. This we have achieved using an innovative evidence and feedback informed peer led small group education programme for both doctors and nurses.’ Les Toop, Professor of General Practice, University of Otago, New Zealand*

- 3.15 At the heart of all good practice in community medicine lies proactivity. Those generalists who have achieved most for their local populations or cohort groups have been those who have seized the initiative and reached out to them. While the Commission sees this is a great strength of generalism, it believes it is one that is some way from delivering its full potential.

*‘When I first arrived as professor in London from Southampton, the professor of medicine came to me and said: ‘Surely you would like to have your practice in the hospital?’ I said no - effectively that would be behind a wall. I wanted to be outside on the street.’ George Freeman, Commissioner; Professor of General Practice (emeritus), Imperial College, London*

### **Working the boundaries**

- 3.16 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.
- 3.17 The first and most important boundary is that the generalist sits at the point at which the person becomes, or may become, the patient. This is the case self-evidently in general practice, but also in hospital Emergency Departments where, according to evidence from John Heyworth, president of the College of Emergency Medicine, emergency medicine doctors deal with up to 20 million walk-in or ambulance patients a year in England, many being children and older people.

*‘The case mix we see is unique and it is further along the serious pathology spectrum than is sometimes considered. So, for example, if you come along to an emergency department with headache, you are more likely to have significant intracranial pathology than if you go to a GP. That means that we have developed a unique pluripotential skill set in emergency medicine to be able to assess, diagnose, manage, dispose of this incredible number [of patients] and this incredible case mix’ John Heyworth, President, College of Emergency Medicine*

- 3.18 At this boundary, the onus is on the generalist to differentiate the undifferentiated. The doctor, or sometimes another first-contact professional, must assess the individual’s condition and arrive at a general diagnosis or arrange further investigation to do so. Central to this is an understanding of probabilities within the population in question. This can be both taught and refined through experience, though since most generalists begin and possibly continue with a whole-population epidemiology as their reference point, more work may be needed to embed this in training. The next stage is to prioritise any treatment. For the GP, this is often a dynamic process rather than a one-off, clear-cut decision: as Joanne Reeve, a Liverpool GP and NIHR clinical scientist in primary care at the University of Liverpool, put it in evidence: *‘We are saying: ‘This is the answer we are trying out and we are going forward with that’.*

- 3.19 The good generalist will be conscious that they should turn the person into the patient only when they judge that it will benefit them to do so. Similarly, and this addresses the second boundary, they will be scrupulous about referring the individual on to specialist care only when the evidence justifies doing so. The health care system in the UK, in both the NHS and the private sector, is based on the principle that access to secondary care is controlled by GPs; evidence taken by the Commission suggests that this remains a critical and valued role.

*'There is undoubtedly pressure from patients who are insured who feel that they are entitled to see a consultant and they are probably quite often demanding; it must be particularly difficult when you have got a short consultation period and you have got that going on. So we suspect that maybe not all GPs are as 'tough' in terms of being a gatekeeper with privately-insured patients, but I would have thought that most GPs would hold the line.'* Andrew Vallance Owen, Group Medical Director, Bupa

- 3.20 The Commission preferred to look at this role of the generalist as that of 'gate-opener' rather than gatekeeper. The role 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. To do so effectively, the GP needs to have a relationship of mutual respect with hospital consultants, including the facility of direct access to them by telephone and email. This is too rarely the case. The GP needs also to take advantage of the complementary expertise of their peers, cross-referring freely to other primary care practitioners who may have special interests.

*'The decision about who is needed for which problem is aided by a generalist perspective. Generalists have the best view from which to assess what specialties handle what problem.'* Gordon Moore, Harvard Medical School in written evidence

- 3.21 There is no denying, however, the responsibility that this gate-opening role places on the generalist to gauge and manage the risk of a patient referral, or non-referral, and the priority given to it. The Medical Defence Union reported a 20% rise in complaints against GPs in 2010, by far the most common of which related to alleged delayed or wrong diagnosis<sup>9</sup>. In the 12 months to July 2011, the number of referrals by GPs in England fell 4.7%, following a slightly smaller fall the year before<sup>3</sup>.

*'The generalists who are doing the gatekeeping are actually doing rationing, although they do not like to call it this. Doing this comfortably requires a shared vision between patients and professionals about what we can all afford, and getting this into line with our various expectations. And where that shared vision is absent, then gatekeeping can become controversial.'* George Freeman, Commissioner; Professor of General Practice (emeritus), Imperial College, London

- 3.22 Among other boundaries that the medical generalist operates at are those with other health care professions and with other sectors. This requires the generalist to be a skilled co-ordinator of others' input into the care and support of the patient. The Commission heard of rapid growth in the US in the appointment of 'hospitalists', usually physicians, who manage the (albeit episodic) care of patients in hospital in a similar way to GPs in the community. Studies indicate that use of hospitalists reduces

length of stay in hospital and average cost of stay.<sup>10, 11, 12</sup> Interest in this role is growing in the UK.

*'I just felt that everyone is dashing about – that is what I saw in my hospital when I was deputy medical director. Everyone is handing over, but not very efficiently. I was there looking at notes where things had gone wrong because that was my role as clinical governance lead – that is what you were seeing and you were seeing totally uncoordinated care.'* Margaret Helliwell, General Practitioner, Vice-chair and non-executive board member, National Institute for Health and Clinical Excellence; National Primary Care Consultant in general practice

3.23 The King's Fund's evidence to the Commission, reflecting the report of its inquiry into care quality in general practice<sup>8</sup>, called for GPs to see themselves increasingly as 'navigators', taking more responsibility for the pathway that their patients follow and for the care they receive from a variety of agencies. In this sense, the general practice becomes a hub of a much wider system of care and support, including input from social care agencies, pharmacies, therapists and nurses working independently or to protocols where appropriate.

3.24 This vision found echoes in many submissions to the Commission from patient and carers' groups and single disease charities. Dame Philippa Russell, chair of the Standing Commission on Carers, said: *'For carers, a key core value [of generalism] would be the ability to negotiate with a range of other agencies and to help in blurring the boundaries between health and social care.'* But it was evident to the commissioners that this navigating role was at present often lacking – to the cost of the patient.

*'[A person known to me] is going through her third lot of chemotherapy for ovarian cancer. She is 82. I don't see any coordination of her multiple conditions; I see her coordinating her multiple conditions. I don't quite buy that there is a GP in the middle of all this, spinning all these plates to make sure they don't fall to the floor.'* Anonymous witness

3.25 In response to the particular needs of people living in the community with episodic or deteriorating conditions, the Commission was persuaded of the case for forms of 'intensive generalism'. These new models of care draw on and develop specialist expertise but retain a generalist underpinning, and would sit between primary and secondary services. Analogous to a high-dependency unit of an acute hospital, these new forms of care likewise provide generalist care for patients with a range of different conditions, but provide a more intensive level of support in the community than would be found in typical general practice. One example is the 'virtual wards' programme pioneered in Croydon<sup>13</sup>, and since taken up elsewhere. This aims to provide intensive support and overview to patients in the community that is normally found only in hospital. Patients selected for such schemes may be identified by predictive risk modelling. The Commission believes that primary and secondary care clinicians should collaborate in co-design of such models, tailored to local needs.

*'I think in many ways it is almost like going back to the traditional model of good primary care, where you would have an attached social worker and a physiotherapist and a district nurse as part of the practice. I think the key thing is the new technology that allows us to work out who these very high-risk patients are so that we can afford to put this huge amount of investment into them potentially.'* Geraint Lewis, Senior Fellow, The Nuffield Trust; Consultant public health physician

## 4 CHALLENGES

### Continuity and access

*'Unless generalists have a serious think about going back to a model of comprehensive and continuous care that was the hallmark of the early definition, they are at serious risk of losing their standing and their ability to provide their patients with what they want.'* John Howie, Emeritus Professor of General Practice, University of Edinburgh

- 4.1 That such a figure as Professor Howie should have given this stark warning in evidence to the Commission says a great deal about the challenge posed to generalism by the perceived loss of continuity of care in general practice. Commissioners were clear that this presented the greatest threat to generalism's future.
- 4.2 Continuity of primary care services is widely seen as having been undermined by the 2004 GP contract<sup>14</sup>, allowing practitioners across the UK to opt out of responsibility for the provision of an 'out-of-hours' service in return for a reduction in payment. The great majority have chosen to do so. Local NHS agencies have made alternative arrangements for provision of emergency cover at night and at weekends, but that cover has proved seriously lacking in some highly-publicised cases. While many GPs still work in these services, they are not closely linked to their 'own' patients who know and trust them. As a result many patients have lost confidence in evening and weekend services and regret the loss of continuity of care.
- 4.3 The Commission agreed with witnesses who argued that 'out of hours' was a misnomer. Illness does not strike during office hours only and people's access to the services of their general practice should not be limited by a 'nine-to-five', Monday-to-Friday approach. Efforts to compensate for the lack of service by recruiting GPs to work in Emergency Departments, where patient numbers are rising by almost 5% a year<sup>3</sup>, have had mixed results.

*'Instead of trying to manage demand in a Canute-like fashion, we from the College of Emergency Medicine are keen to say to our primary care colleagues: there must be a better way of providing generalist care to the population. The axis between primary care and the emergency department is crucial in getting this right.'* John Heyworth, President, College of Emergency Medicine

- 4.4 Related to this loss of access to generalist care is a loss of contact with a named GP. Because people in full-time work find it difficult to attend surgery during office hours, they may go to walk-in treatment centres or may in future take advantage of the proposed opportunity to register with a practice near their workplace. Even if they are able to attend their home practice, they may have to see a different GP to their own if they want an early appointment.

*'From birth to 18 years it is true that I saw one of only two GPs every time I was ill, day or night, and the same two GPs who saw the rest of my family. Since the age of 18, I have lived in several major English conurbations and I have rarely seen the same GP twice – and I have rarely seen the same GP as members of my immediate family. Certainly out-of-hours I see someone who knows nothing about me and my family at all'* Terence Stephenson, Nuffield Professor of Child Health, Institute of Child Health, University College London; President, Royal College of Paediatrics and Child Health

- 4.5 When health care professionals and non-clinical staff are familiar with patients, they are better able to recognise significant change. When combined with training to identify ‘red flags’ this can lead to earlier diagnosis. For example, the response at the front end of the general practice setting may be improved: ‘I have picked up a couple of meningitises and a couple of heart diseases’ (Gwen Sawyer, Practice Manager, East London). However such serendipity cannot be relied on.
- 4.6 Some witnesses said in evidence that they felt it inevitable, given time and workload pressures that GPs would have to surrender relations with most patients without complex co-morbidity profiles. Work with patients with single or straightforward long-term conditions would need to be devolved to nurses. Some doctors, it was argued, would welcome this.

*‘My research suggests that not all doctors value the longitudinal doctor-patient relationship nor do they think it is an important thing to maintain. Some we have spoken to have suggested that they want to be able to ‘discharge’ people and to challenge them, without worrying about maintaining an on-going relationship. Carolyn Chew-Graham, Professor of Primary Care, Health Sciences-Primary Care, University of Manchester*

- 4.7 But what is patently undermined by the loss of continuity in the doctor-patient relationship is the generalist’s crucial understanding of the patient’s biography. Without home visits – something which Lynn Young told us is being reduced also by community nurses – it is difficult to build a picture of often complex family structures that impact on an individual’s health and wellbeing. Without face-to-face consultations in surgery, it is difficult to build any kind of biographical picture at all - or to acquire the skills that enable the generalist, when called upon to do so, to act in the absence of a biography.

*‘I would [sometimes] meet a patient once in their life and in my life, and I think I did some good consultations in this situation as a generalist. But could I have done so if there was no continuity and there was never going to be? Or could I only do that because I had been trained for several years with patients whom I have followed through, and could see a snapshot as part of a movie?’ John Gillies, Chair, Royal College of General Practitioners, Scotland*

- 4.8 It may be impractical to wish for a return to GPs’ personal patient lists, as opposed to practice or group lists, and to round-the-clock access to ‘your’ doctor. But there is a clear case for taking steps to restore a discipline of continuity of responsibility for registered patients, seven days a week, on the part of a named team. The Commission is calling for piloting and evaluation of different ways of achieving this, including the model operated in the Netherlands whereby part-time GPs are required to ‘pair up’ to offer patients continuity<sup>15</sup>.

*‘I think we could achieve real continuity within teams. It would mean a lot of communication both verbally and through IT, but in the long run is much safer than relying on the info stored in my brain, which works to a point but is actually a false reassurance for the patient as no one person can ever be there all the time.’ Margaret Helliwell, General Practitioner, Vice-chair and non-executive board member National Institute for Health and Clinical Excellence; National Primary Care Consultant in general practice*

- 4.9 What is inescapable, however, is that there is a clear conflict between the importance of access to medical advice and care 24 hours a day, and patients' preference for continuity of that advice and care. For people living with long-term conditions, the circle can be squared to some extent by proactive planning including preparation of a crisis plan. Both for them, and for people needing more episodic interventions, more could be offered without face-to-face consultations. Generalists need to make much better use of new information and communications technologies, not to say the telephone.

### Status and pride

- 4.10 With medical generalism under pressure, not least in terms of its perceived failure to sustain continuity of service to patients, it needs to be able to demonstrate its value and take pride in its professionalism. Yet for many young doctors, it does not appear to offer a clear and rewarding career path.
- 4.11 Generalism in the hospital sector is seen to be most at risk. The British Medical Association's General Practitioners Committee put it in evidence to the Commission that emergency physicians working in emergency departments were *'the only group left in hospital practice with a generalist outlook'*. Even they, the committee added, were generalist only for the purposes of immediate treatment and were more likely than GPs to call on specialist advice.

*'I think generalism in hospital has largely disappeared – and I am not suggesting that this is a good thing – but I think that the era of the general physician with an interest in something has largely gone. I think that is not necessarily in the best interests of patients, but it is so.'* Laurence Buckman, General Practitioner; Chairman, General Practitioners Committee, British Medical Association

- 4.12 In written evidence the Association of Surgeons stated that *'the term generalist is now pejorative'*. This would not change, it added, unless the general surgeon, general physician and GP were rewarded for their holistic approach to medical care.
- 4.13 Why should this be so? Giving joint evidence to the Commission, medical education and workforce experts Patricia Hamilton and Simon Plint said they detected *'a specialist drift in patient expectations that goes along with the specialist drift that we see in career aspirations and opportunities, and one feeds the other'*. Undoubtedly, specialism is viewed within the medical profession as the route to acclaim, prominence and the richest rewards in terms of esteem. According to Dr Hamilton, the problem starts in medical school: *'I think some of the messages are that if you are bright you become a professor in a specialty.'*

*'When you go to medical school, particularly in London, students are often taught by specialists working in a rarefied and super-specialised environment, detached from the patient's social environment and surrounded by GPs who are judged by their specialist colleagues to be doing an inadequate job. So it is not surprising that [students] get a bad impression of general practice and the view is encouraged and promoted among the juniors and it gets passed on.'* Martin Marshall, Director of Clinical Quality, Health Foundation

- 4.14 Other professions appear to be suffering from the same prejudice. Dr Catherine Duggan, director of professional development and support at the Royal Pharmaceutical Society, said in evidence that a *'flat career structure in the community'* did not encourage cross sector working, with many feeling hospital colleagues had more opportunities to develop and advance in a supported way. And Lynn Young, primary care adviser to the Royal College of Nursing, appearing in an independent capacity, observed that *'in my view we may have over-specialised nursing which could be one of the reasons for some of the poor care that we know about which takes place in general medical and surgical wards'*.
- 4.15 At the same time as many of the best and brightest young doctors have been lured into specialisms, other professions have been taking on significant parts of the generalist's traditional role. This can be traced back to the 1990 GP contract<sup>16</sup> under which general practices were paid for delivering services such as health promotion and chronic disease management, prompting GPs to take on practice nurses to deliver such services. According to Bonnie Sibbald, professor, Health Services Research at the University of Manchester, typically, nurses and healthcare assistants now handle almost all health promotion activity and, working to protocols post-diagnosis, services such as routine monitoring of heart disease. Some studies have indicated that such substitution may have no adverse impact on outcomes in the context of a medically-led and accountable primary care service<sup>17</sup>. However, contrasting evidence to the Commission demonstrates the controversy inherent in taking this further:

*'Research suggests that primary care nurse practitioners and primary care physician assistants who have far less training [than GPs] are none the less equally good at making first-contact diagnoses in as much as they recognise the limitations on their ability to decide what is wrong with that patient.'* Bonnie Sibbald, Professor, Health Services Research, Health Sciences Group-Primary Care, University of Manchester

*'In an evening surgery, a well-educated parent rang saying he was uneasy about his little boy who had pain in his testicle. He was advised to come in immediately. He did. It transpired he had attended the surgery earlier that day, seen a practice nurse with 15 years' experience and been told to give the child a warm bath. On examination, torsion was diagnosed and immediate admission to hospital arranged. The testis was saved. In the ensuing discussion, the nurse said nothing in her training had prepared her for the problem and she had never seen torsion before.'* Professor Sir Denis Pereira Gray

- 4.16 Strict working to protocols may facilitate a physician-free environment in some first-contact settings, particularly those dealing with discrete patient groups such as homeless people. Commissioners visited such a nurse-led setting in east London, where the role of the doctor was described as little more than *'issuing sick notes and prescribing methadone'*. But extending this idea further has its critics.

*'There is an interesting contrast for me between what happens in hospital as opposed to general practice: in hospital practice there is a recognition now that you put the most experienced person at the front of the queue in terms of sorting out the undifferentiated problem (it is customary now for the skilled acute physician to see people very quickly, to make critical early decisions) and in some aspects of general practice that model is inverted so that you might be seen with your presenting problem by a practice nurse depending on the nature of the problem. But I think it almost diminishes the importance of that first encounter and a capacity to open the mind and ask*

*what else [the problem] could be.’ Professor Sir John Tooke, Vice Provost (Health), University College, London*

- 4.17 One other factor which is seen by some to undermine the self-worth of GP generalists is the broad thrust of performance assessment and reward systems, emphasising as it does the achievement of treatment and prevention targets. Although supporters of the approach say it has had a positive effect overall on patient care, opponents argue that it imposes a straitjacket on the operation of general practices and that it is focused overly on process as opposed to more meaningful patient outcomes, neglecting the perspective of the whole person. The Commission certainly believes that performance measures and reward systems, notably the Quality and Outcomes Framework (QOF), should take account of a broader range of outcomes than is currently the case.

*‘There is a real issue in my view with the business model of general practice, with quasi-autonomous contractors being driven excessively to focus on QOF, meaning that commonplace conditions such as dementia or osteoporosis or incontinence are less well-managed.’ David Oliver in written evidence.*

- 4.18 Finally, the Commission has been struck, and disappointed, by the relative dearth of robust and recent research into the quality and cost-effectiveness of generalist medical care. 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.

*‘Generalism cannot develop and thrive without its own evidence base. The Commission must call for an evidence base that informs the decisions made by generalists.’ Graham Watt in written evidence*

### **Pressures and gaps**

- 4.19 Generalist care is far from comprehensive, and the Commission was particularly concerned by evidence of shortcomings in provision for children, and explained in some detail by Terence Stephenson, president of the Royal College of Paediatrics and Child Health. Although children comprise up to a quarter of the typical GP’s workload, only an estimated 40%-50% of GPs have a placement in paediatrics during training. He told us that forthcoming research will show that barely one in three consultant paediatricians considers themselves a generalist, and community paediatricians, who are often taken to be generalists, are in fact tertiary specialists who see children only on referral.
- 4.20 Such deficits in paediatrics experience and expertise are compounded by the fact that children patently enjoy the least continuity of service of all patient groups. This is driven by the perceived short-term urgency of their needs, formalised in access targets, and exacerbated by professional underestimation of the advantages of knowing these patients well. As a result, GPs are often unable to deploy the contextual and biographical knowledge that is so central to good generalism.

*‘Whilst the general practitioner should be ideally placed - particularly as they should be familiar with other family members’ health issues - to take a lead in the care of children within the*

*community, increasingly GPs have had a very limited training in the care of children and there is research evidence to say that parents are increasingly attending other services, for example emergency departments, rather than seeking the advice of their GP.’ Sheila Shribman in written evidence*

- 4.21 This is especially worrying given rising numbers of children who live with a long-term condition or disability. An online, self-selecting survey by the Contact a Family charity, completed by more than 1,000 families with a disabled child, suggested that 76% felt there was no GP involvement in care of their child’s condition. As many as 13% said they had stopped consulting their GP on the child’s general health issues<sup>18</sup>.
- 4.22 Witnesses told the Commission that while, ideally, every child should be seen by a trained expert in primary care paediatrics, a realistic response in the current spending climate would be for steps to be taken to ensure that every general practice had access to such an expert who could advise and support the other doctors. Meanwhile training in relevant paediatrics should be made a mandatory part of expanded GP training. The Commission agrees.

*‘The UK gets a lot of criticism from Europe for not having primary care paediatricians. But I think that is creating a parallel workforce. I think that we should be looking more to the Swedish model - that is, enhancing the training of every GP.’ Patricia Hamilton, Director of Medical Education, Department of Health*

- 4.23 Two other patient groups seem to be getting an especially poor deal from generalism: people with a learning disability and older people resident in care homes. Steve Field, immediate past chair of the Royal College of General Practitioners, Chair of the NHS Future Forum, and Chair of the National Inclusion Health Board, acknowledged candidly in evidence to commissioners that *‘we are pretty hopeless in this country at managing people with learning disabilities’*. This was reflected in other evidence taken, including from practising GPs who admitted they did not know how many patients they had with a learning disability.

*‘If we think about the issues for people with learning disabilities that have come to the fore over the last few years ... we are looking towards specialism to try to correct some of the problems of a more generalist or generic approach which has said people should just get their health care in the same way as everybody else. Now we are realising that actually you need quite a bit more than the average to enable that to happen. Does that mean specialism, or does that mean individualism? Actually I think the discussion is more about individualism.’ Roger Banks, Consultant in the Psychiatry of Learning Disability, Betsi Cadwaladr University Health Board; Honorary Senior Lecturer, Bangor University*

- 4.24 Witnesses acknowledged also that people unable to attend primary care settings were often poorly served. The Commission believes that the value of home assessment and treatment, especially of the housebound, needs to be re-stated. It believes further that special provision should be made for the 400,000 residents of care homes. Dr Andrew Vallance Owen, group medical director of Bupa, which runs homes accommodating 19,000 people, said that in some homes there might be 20 different general practitioners looking after residents and *‘well, and although some are excellent, we do not get great support from a lot of GPs; we do not feel there is an expertise in managing patients in care homes’*.

- 4.25 Commissioners studied with interest the Netherlands model of a distinct generalist specialisation of nursing home medicine, existing parallel to general practice. While they understood that older people might wish to retain their GP when they moved into a care setting, subject to the GP's consent, they none the less concluded that there would be merit in examining the case for a dedicated generalist health care service for care homes, care villages or extra-care developments. The commissioners noted the similar recommendations of a report by a joint working party of the British Geriatrics Society<sup>19</sup>.
- 4.26 In terms of achieving overall improvement in generalist care, and making optimal use of limited available time for patient consultation, the Commission felt strongly that doctors could make much more, and better, use of modern information and communications technologies. Health services everywhere lag far behind other sectors in effective use of such technologies, and while GPs in the UK do generally have high-quality electronic patient record systems, these are not connected with clinical systems in hospitals. Following the government's recent announcement to dismantle the NHS National Programme for IT, it is essential that progress made already is built on, and that vital work continues to exploit the benefits of modern IT technology already realised in other sectors.
- 4.27 More important for improved patient care, however, will be the use of telephone, e-mail, texting, and web-based decision-support systems. There are obvious inefficiencies in current systems of face-to-face recall and repeat prescribing, which waste the time of both doctors and patients. Patient choice, self-management, and health education are all being supported by electronic means and generalists must embrace these technologies. They are no longer new, but the common currency of every sector except health care<sup>6</sup>.

*'We have got something called Renal Patient View<sup>20</sup> where, for £75,000, we have a 'kidney myhealth space' ... We have got 20,000 people, not just dialysis and transplant patients but all those who come to kidney services ... There is no reason why we cannot do the same for other conditions.'* Donal O'Donoghue, National Director vascular and kidney care

- 4.28 Although the issue was not specified in the Commission's terms of reference, the NHS reforms being planned in England in 2011 formed a constant backdrop to its deliberations<sup>21</sup>. Because these reforms propose to pass responsibility for upwards of 60% of the NHS budget to clinician-led commissioning groups, structured around primary care practices, they present both an opportunity for generalists and a risk that the new role will impact negatively on their core work with patients.
- 4.29 It is not the place of the Commission to comment on the merit of the reforms, other than to note that a number of individuals and organisations that submitted evidence did, unprompted, offer cautious views on the potential to set the planned system in a generalist mould.

*'While few at present would say that commissioning is a core activity of the generalist, the fact that the English government wants to give commissioning responsibility to GPs does depend in part on the characteristics of the generalist. Population responsibility goes along with providing 'comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness'. Indeed, it is precisely this mix of personal commitment and population (i.e.*

registered list) responsibility which means that GPs are suited to take on this challenging (if not always welcome) role.’ Martin Roland in written evidence

- 4.30 Nene Commissioning, a consortium of 71 practices covering 625,000 patients in Northamptonshire, said in evidence that *‘our strategy will be to disinvest in secondary care and invest in primary care and community care closer to the patient’s home’*. But it warned that one of the main threats or challenges to generalism would be *‘the need to balance the needs of the individual patient versus the needs of the population within a fixed financial envelope’*.
- 4.31 Significantly, Nene identified another threat or challenge as *‘the impact of strong clinical leaders within a healthcare community/consortium reducing their clinical commitments in order to increase their commissioning sessions’*. And it further identified *‘the relative lack of effective clinical backfill to allow the clinical commissioning leads to reduce their clinical commitments’*. These issues do represent valid areas of concern for the Commission in the context of a current, pre-reform, health system in which some general practices are plainly struggling to deliver a fully holistic generalist service and to maintain continuity of care.

## 5 LOOKING TO THE FUTURE

*'We still train people in a 20th Century paradigm. I think the media likes to see people dressed in green clothes and providing a cure, when most of the health care we are delivering is in chronic conditions, often multiple conditions'. Donal O'Donoghue, National Director vascular and kidney care*

- 5.1 If generalism has a future, which the Commission believes it does, then that future will depend on coming generations of doctors being trained in its skills and techniques. As the witness quoted above put it so succinctly, medical training will need to adapt to the realities of a system in which, already, more than 15 million people are living with a long-term condition. Within 20 years, that figure is forecast to be 18 million<sup>3</sup>.
- 5.2 This adaptation will eventually demand a fundamental reappraisal of how medical students are taught to think about illness and disease. In order to learn how to deal with far greater degrees of complexity and uncertainty than their predecessors would have faced, trainee doctors will need to dwell much less on narrow disease silos and to focus much more on the breadth of possible permutations of co-morbidity. They will need also to become much more fluent in the accessing of sources of rapid support in the diagnostic process and treatment planning. In the Netherlands, GPs are expected to be proficient in diagnosis and treatment of all diseases (some 400) occurring on average in two or more patients per 1,000<sup>15</sup>.

*'Part of the way of dealing with this is to stop trying to think of medical education as a series of systems or disciplines; it is really thinking of it as a more holistic process and series of care pathways which will involve a range of conditions which happen to present in different ways. It is re-thinking how you package the experience.' Professor Sir John Tooke, Vice Provost (Health), University College, London*

- 5.3 As a first step, however, there is evidently a pressing need to build more emphasis on generalist skills into the training regime. As evidence to the Commission said overwhelmingly, the existing three-year specialist training for GPs, comprising normally 18 months in hospital settings and 18 months in a training general practice, is patently inadequate. The Commission fully supports the case for an extension to five years<sup>22</sup>.

*'It is an extraordinary situation that 150 years after 1858 (the Medical Act), we are seriously saying that the generalist job needs a lot less training than the specialist job. Medicine is the only subject in the world where the study of the whole gets less attention than the study of the part.'* Professor Sir Denis Pereira Gray

- 5.4 Beyond this, a number of organisations that submitted evidence called for much more undergraduate medical training to take place in the primary care sector, with some arguing that all undergraduates should learn general medicine in such settings. This would raise serious questions about availability of placements, but the Commission does agree that experience of primary care should be made an essential part of the two-year Foundation Programme now undertaken by all trainee doctors on graduation

and prior to specialist training. At present, only 55% of trainees undertake such a placement.

*'General practitioners in primary care need to be better trained to undertake the functions previously offered by general surgeons and physicians in secondary care, by extending the length of their training. This means that more undergraduate training should take place in primary care, not limited to training needed for general practice, but involving teaching general medicine in primary care settings.'* Medical Schools Council in written evidence

- 5.5 Further to the earlier discussion of shortcomings in services for children in general practice there would seem a strong case for extending the undergraduate experience of paediatric care, currently ranging from five to eight weeks. There are serious shortcomings in care delivery also to those with learning disabilities or with mental illness, and to those with progressive life-threatening disease. There is need to improve the overall availability of good end-of-life care to support patients and their families at this difficult time. Some minority groups, such as asylum seekers and service personnel returning from a theatre of war, have particular needs that often fall out-with current general practice expertise.
- 5.6 In the interests of improved joint working and seamless support for the individual patient, opportunities should be sought for shared training across professions. The Commission was impressed by the development of compulsory shared learning modules across 13 different health and social care programmes, including medicine, at Southampton and Portsmouth universities<sup>23</sup>.
- 5.7 Ultimately, however, no amount of reform of training systems will have a lasting impact upon the numbers and calibre of generalist doctors if specialism is still considered the way to be more prestigious. The effect of such prejudice impacts, too, on hospital generalists. In evidence from medical education and workforce expert Patricia Hamilton there is no longer any training as such in general surgery. In written evidence from the British Medical Association's General Practitioners Committee, the Territorial Army has had to introduce broad, generalist courses for its war surgeons because, in their day jobs, they work only on one part of the body.
- 5.8 Well-trained staff are most effective in well-designed models of care. To capitalise on the skills and approach of the generalist in either community-based or hospital-based services, we need models of shared care so that the additional expertise of specialists can be embedded in a predictable and robust way. For the patient, it should not have to be generalist or specialist care: we can combine the strengths of each. Collaborative clinical governance across these current divides will strengthen this process.

## 6 CONCLUSIONS AND RECOMMENDATIONS

### Conclusions

- 6.1 Fifty years ago, psychoanalyst Michael Balint described the case of Mr B, who had seen 34 specialists in a six-year period without benefit to his condition<sup>24</sup>. When allowed to tell his story to a sympathetic practitioner with a world view beyond conventional biomedicine, he for the first time began to understand how his symptoms related to adverse life events. As this understanding grew, so his symptoms receded.
- 6.2 Half a century later, the value of medical generalism too often remains poorly recognised. Rapid advances in medical science and health technology have driven the growth of sub-specialisation and generalism has risked extinction in many hospitals, especially in larger conurbations. But it remains the cornerstone of the UK health care system, through general practice, and there are encouraging signs of a renaissance in hospitals in the UK and in the US. Certainly there seems to be a growing appreciation that the right balance of generalism and specialism will be key to sustaining round-the-clock, consultant-led secondary care.
- 6.3 This Commission believes that medical generalism has a strong and growing part to play in the way that health care must change, radically, to respond both to the needs of an ageing population living with widespread, often multiple, chronic conditions and to the growing imperative for patients to be in partnership with their doctors and to be able jointly to plan their care. This is important particularly for younger patients living with continuing health problems and struggling to stay in work. That is not to say that generalism should supplant specialism; rather, there needs to be a much more effective spectrum of medical care embracing a generalist perspective and specialist practice. Patients deserve nothing less.
- 6.4 To help achieve this, the Commission has set out a number of recommendations listed below. These are put forward for discussion in the hope that a broad and informed debate will lead to action for the change that commissioners feel is essential and urgent.
- 6.5 While the Commission strongly endorses high-quality generalism, it has not felt able to conclude that generalism as practised currently in the UK delivers as much for patients as it could. Significant numbers of people, especially those with learning disabilities, mental health conditions, children, and residents of care homes, do not receive the service they deserve and the service that could be provided within our current health care system. Generalists themselves need to be able to demonstrate the value of what they do and take pride in their professional and public profile. Above all, there is insufficient robust and up-to-date research to be able to evaluate and inform adequately all aspects of generalist practice and its relationship to specialist services.
- 6.6 None the less, the Commission believes that if steps are taken to: improve continuity in primary care; facilitate better and faster communication with patients and among health professionals; enhance the career prospects of generalists in all care settings;

broaden medical education and training; and expand the training of GPs, then the conditions will be in place for generalism to be pivotal to the realisation of a health and social care system fit for the 21<sup>st</sup> century.

## Recommendations

- 1 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. The importance of early and accurate diagnosis 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. Accurate diagnosis leads to the opening of the right gates to treatment at the right time.
- 2 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. The value of home assessment and treatment of patients whose access to services is limited, for whatever reason, must be recognised. Those with continuing health problems should be empowered to manage their own conditions as far as possible, including holding their own records if they wish to do so and having direct access to test results.
- 3 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.
- 4 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.
- 5 To speed and improve communication among doctors, GPs and hospital consultants should liaise directly and personally. 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.
- 6 Reward systems for institutions should similarly promote the concept of generalism. Payment for episodes of care risks promoting piecemeal treatment to the neglect of a perspective of the whole person. Appraisal systems should include assessment of the relationship between generalist and specialist services. Development of quality indicators to measure performance should take account of a broader range of patient outcomes than is currently the case.
- 7 Generalists should incorporate dynamic and on-going patient feedback into their work as a matter of routine. The Royal College of General Practitioners should, in

particular, ensure that patient audit is embedded in GPs' practice on a national basis. In adopting reflective practice, generalists should make provision to learn from each other, from specialists, and from patients.

- 8 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. There should be an immediate extension of the length of specialist training for GPs from three years to five. This 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. All medical undergraduates should have greater experience of these core disciplines, and opportunities for shared training modules across health and social care should be pursued.
- 9 Care homes should have dedicated GPs responsible for provision of medical services to their residents. This should be commissioned at local level, but the Royal College of General Practitioners should consider how best to foster a national expertise in this particular aspect of generalism and to host a community of interest with relevant specialists.
- 10 Greater investment is needed in academic general practice. The National School for Primary Care Research, established and funded by the National Institute for Health Research, is an important and welcome initiative, but funding of research into the quality and cost-effectiveness of generalist clinical care needs to be increased to address gaps in the existing evidence base. The Medical Research Council and other research funders should create a dedicated funding stream for clinical research in general practice, addressing GPs' current difficulties in securing research funding.  
  
A priority for research should be: the relative cost-effectiveness of a generalist approach to patients with multiple conditions; and the role of 'non-medics' in the generalist team, with a full evaluation of the different models of first contact care. Investment in academic general practice training posts is vital to developing academic evaluation by generalist clinical academics who will provide the evidence base to guide future strategic developments.
- 11 The Academy of Medical Royal Colleges should invite its constituent bodies to test and, if in agreement: endorse the Commission's definition of generalism; identify the principles of generalist practice; and incorporate them across postgraduate medical curricula.

## WHO SHOULD ACT ON THESE RECOMMENDATIONS?

Policy-makers and UK health departments: 1, 2, 4

Service commissioners and planners: 3, 6, 9

Medical Research Council and other research funders: 3, 10

Academy of Medical Royal Colleges and individual medical royal colleges and faculties: 3, 5, 11

Royal College of General Practitioners: 7, 9

Clinicians: 4, 8

Regulators: 4, 9

General Medical Council: 5, 7

Postgraduate deaneries: 5, 8

Medical Education England: 8

Private sector health providers: 9

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## **Appendix A Those who gave oral evidence to the commission in 2011**

### ***Tuesday 5 April***

Maureen Baker, Member of council, Royal College of General Practitioners  
Dinesh Bhugra, President, Royal College of Psychiatrists  
George Freeman, Commissioner; Professor of General Practice (emeritus), Imperial College London  
John Gillies, Chair, Royal College of General Practitioners, Scotland  
Iona Heath, President, Royal College of General Practitioners  
John Heyworth, President, College of Emergency Medicine  
John Howie, Emeritus Professor of general practice, University of Edinburgh  
Linda Patterson, Clinical Vice President, Royal College of Physicians  
Joanne Reeve, NIHR Clinical Scientist in Primary Care, University of Liverpool

### ***Monday 9 May***

Lynn Young, Primary Care Advisor, Royal College of Nursing, appearing in an independent capacity

David Behan, Director General for Social Care, Local Government and Care Partnerships, Department of Health

### ***Tuesday 17 May***

Patricia Hamilton, Director of Medical Education, Department of Health  
Simon Plint, Dean of Medical Commissioning Workforce, Education & Leadership, South Central SHA

Bonnie Sibbald, Professor, Health Services Research, Health Sciences Group-Primary Care University of Manchester

Terence Stephenson, Nuffield Professor of Child Health, Institute of Child Health, University College London; President, Royal College of Paediatrics and Child Health

### ***Wednesday 25 May***

Catherine Duggan, Director of Professional Development and Support, Royal Pharmaceutical Society of Great Britain

Jamie Rentoul, Director Workforce Development, Department of Health, London

Professor Sir John Tooke, Vice Provost (Health), University College, London

### ***Thursday 26 May***

Sam Everington, General Practitioner, Bromley by Bow Health Centre, St Leonards Street, London E3 3BT

Penny Louch, Clinical lead, Health E1 Homeless Medical Centre, 9-11 Brick Lane, London E1 6PU

### ***Thursday 2 June***

Darin Seiger, Chairman, Nene Commissioning, Northampton

Carolyn Chew-Graham, Professor of Primary Care, Health Sciences-Primary Care, University of Manchester

Roger Banks, Consultant in the Psychiatry of Learning Disability, Betsi Cadwaladr University Health Board; Honorary Senior Lecturer, Bangor University.

Donal O'Donoghue, National Director vascular and kidney care

### ***Friday 10 June***

Francois Schellevis, Professor at the General Practice Medicine department of the Free University Medical Centre, Amsterdam; Head of the Netherlands Institute for Health Services Research, Utrecht, by way of a teleconference

### ***Thursday 16 June***

Alistair Burns, National Director, Older People and Dementia

Andrew Vallance Owen, Group Medical Director, Bupa

Steve Field, Immediate past-chair, Royal College of General Practitioners; Chair, NHS Future Forum; Chair, National Inclusion Health Board

### ***Tuesday 28 June***

Gwen Sawyer, Practice Manager, Globe Town Surgery, Roman Road, London E2 0PJ

Margaret Helliwell, General Practitioner, Vice-chair and non-executive board member National Institute for Health and Clinical Excellence; National Primary Care Consultant in general practice

Kirstine Knox, Chief Executive, Motor Neurone Disease Association

Professor Sir Denis Pereira Gray, Former General Practitioner, Exeter; Former President, Royal College of General Practitioners

Martin Marshall, Director of Clinical Quality, Health Foundation

### ***Tuesday 5 July***

Laurence Buckman, General Practitioner; Chairman, General Practitioners Committee, British Medical Association

Dame Philippa Russell, Chair of the Standing Commission on Carers

Geraint Lewis, Senior Fellow, The Nuffield Trust; Consultant public health physician

Les Toop, Professor of General Practice; Head of Department of Public Health and General Practice, University of Otago, Christchurch, New Zealand; Clinical Leader for Education, Pegasus Health

### ***Tuesday 12 July***

Maureen Baker, Member of Council, Royal College of General Practitioners

Clare Gerada, Chair of Council, Royal College of General Practitioners

Amanda Howe, Honorary Secretary of Council, Royal College of General Practitioners

## Appendix B Commission questions

1. What do you understand by the term medical generalism? Where you can, please give examples of where you see it:
  - a. In general practice;
  - b. In other settings.
2. What are the core values of medical generalism?
3. How do the values you describe fit with what you recognise as generalism in practice (as you outlined in your response to question (1))?
4. Where do the boundaries of medical generalism lie? What are the challenges at the interface of medical generalism with other areas of practice?
5. Are there elements considered to be part of medical generalism that ought to be modified or abandoned? Does medical generalism need to adapt, and if so, how?
6. What threats and challenges do you think medical generalism faces today? What threats and challenges do you foresee in the next 10 to 15 years?
7. What can be done to strengthen medical generalism – particularly those aspects that you care about? How would you propose to go about doing this?
8. What recommendations would you make about the future development of medical generalism; are there particular aspects of this that relate solely to general practice?

## Appendix C Those who contributed to the written evidence

Arthritis Care  
Arthritis Research UK  
Association for the Study of Medical Education  
Association of Surgeons of Great Britain and Ireland  
British Dental Association  
British Geriatrics Society  
British Health Professionals in Rheumatology  
British Hypertension Society  
British Medical Association (General Practitioners Committee)  
British Orthopaedic Association  
British Thoracic Society  
Cancer Research UK  
Care Quality Commission  
Coeliac UK  
College of Emergency Medicine  
Committee of General Practice Education Doctors (Anonymous Director A)  
Committee of General Practice Education Doctors (Anonymous Director B)  
Conference of Postgraduate Medical Deans of the United Kingdom  
Dr Fiona Cornish (President-elect, Medical Women's Federation)  
Dr Joyce Williams  
Dr Julian Tudor Hart  
Dr Kamila Hawthorne  
Dr Mark Purvis  
Dr Mike Cheshire  
Dr Peter Toon  
Dr Rob Seddon-Smith  
Dr Roger Jones  
Dr Sheila Shribman  
Dr Stuart Carne  
Dr Will Warin  
Ethics of the Ordinary (of the Royal Society of Medicine)  
Faculty of Sport and Exercise Medicine  
Help the Hospices  
Institution of Occupational Safety and Health  
King's Fund  
Madeleine Gantly  
Medical Defence Union  
Medical Protection Society  
Medical Schools Council  
National Association for Patient Participation  
National Association of Primary Care Educators  
Optical Confederation  
Professor David Oliver, National Director for Older People  
Professor Gordon Moore  
Professor Graham C M Watt  
Professor Martin Roland  
Professor Mike Pringle  
Professor Michael Drury  
Professor Zorayda E Leopando  
RCGP Clinical Innovation and Research Centre and Society for Academic Primary Care (joint response)  
RCGP International Department  
RCGP Nursing Support  
RCGP Patient Partnership Group  
RCGP Quality Management and Training Standards Committee  
RCGP Rural Forum  
RCGP Scotland  
RCGP Wales  
Royal College of Midwives  
Royal College of Obstetricians and Gynaecologists  
Royal College of Physicians  
Royal College of Physicians Edinburgh  
Royal College of Radiologists  
Royal College of Surgeons of Edinburgh  
Royal College of Radiologists  
Royal New Zealand College of General Practitioners  
South West Strategic Health Authority  
UK Association of Programme Directors  
UK Conference of Postgraduate Education Advisers in General Practice