The 2005 RNZCGP Oration

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Exactly half my life ago, I came to New Zealand to get married. Neither my wife nor I planned to settle into general practice, but we were attracted to Winton in Southland by the offer of a locum. We were quite unprepared but, with the support of our colleagues and a forgiving community, we soon found ourselves enjoying the full gamut of rural practice.

What charmed me about New Zealand general practice was the high value it was given as the key point for patient contact with the health system. I was impressed that the things we did that produced the most benefit were the things that were most funded. In particular, I include maternity, child, and accident care but also the free hospital service. Accessed through the filter of general practice, these were all available at little cost to our patients. Both the structure and the funding of the health system seemed to provide tangible and logical affirmation of the value of general practice.

We have been subjected to constant change since then and the perceived value of general practice seems to have diminished.

Our key position in the health system has changed

Several events of the last few years stand out as redefining this:

- Midwifery capturing the market for maternity care.
- The rise of after-hours and walk-in clinics separating much acute and chronic care.
- The decision of the Medical Council to recognise 'Accident & Medical' and general practice as separate primary care branches.
- Legislation to enable nurses to become independent prescribers.
- And the loss of general practice as the gateway to ACC funding.

This begs a few questions:

Is maternity care better for having lost general practitioners?

Is primary care flourishing because the Medical Council now provides two qualification routes?

Will competition or cooperation between doctors and nurses lead to better care?

Is accident care more cost-effective without general practice at the gateway?

Why are these alternatives perceived to provide a value that we did not?

The role of the generalist has changed

Much of the past value of general practice lay within our capacity to be all things to all patients but, given the growth of medicine, this is now impossible. Some of us cope by taking comfort in the narrow expertise of a special interest, where it is easier to provide a sense of value. Perhaps many of us feel that we are now flying by the seat of our pants and start to doubt our value as generalists.

How do we realise the unrecognised value of the expert generalist?

Being a professional has changed

A doctor's internal drive for excellence is no longer sufficient to assume competence. We are expected to have more qualifications and competence must be periodically reassured through increasingly complex reporting processes. Our patients are now urged to be consumers. Good quality care is viewed as a right not a bonus. The threshold for complaint is lower and when there is an action against us, we are judged by our records.

Can our professional value really be measured with pieces of paper?

Our patients have changed

People are much better informed but more anxious about illness. They often seek our attention before we can find anything to treat, except their fears. Families are more varied, and most people have less support in a crisis. People are generally more mobile and more stressed.

How can we prove our value to patients when their problems are so often not really medical?

The rewards of being a doctor have changed

It is harder to make a good income in New Zealand. Power, trust and respect are no longer automatic, so the non-financial rewards of being a doctor are also less certain. Post-modern values, enlivened by access to the Internet, mean that power can no longer be retained through the capture of knowledge. Respect is as much a trick of publicity as it is a reward for service. Trust has to be personally earned and is easily lost.

How do we now help doctors to feel adequately rewarded for what they do?

Our funding has changed

The move to capitation is changing our business in ways that few yet understand. Our IPAs had a decade of success in rescuing excess profits to provide new services and support our practices. But they are currently on the wane, and PHOs do not provide the same sense of shelter.

Does this new funding provide enough value to compensate us for the new risks?

The nature of our work has changed

Our patients are living with increasingly complex health problems. As the possibilities for treatment and the promises of cure grow so does the gap between what is expected and what we can deliver. The time it takes to keep our patients and ourselves properly informed to enable good decisions is multiplied by the options available. Now both patients and doctors are trying to cram far too much into the short time available in a consultation. Yet our whole business tends to feed off this one activity for a standard fee. Too much of the supporting work is unfelt by the patient and therefore undervalued. Most of us are doing far too much paperwork and we provide too much service in our unpaid time.

To make matters worse, few of us feel comfortable with charging for our full value. This may in part be due to the 'compassion dilemma' – the problem of knowing and caring for our patients and then having to pervert this relationship by charging a fee. But, I am sure that it also reflects a discomfort with the uncertain value of much of what we do, where benefit is so often measured in reduced probabilities of future illness, not by immediate gain in health.

How do we deliver the best value for our patients with our limited time?

Technology has changed

Technology has now become relatively cheap and what we can do with it is limited only by our imagination. Yet, apart from computers, most of us are still using much the same tools as when we started out.

How do we bring value to general practice with new technology?

Doctors have changed

Both the young and old now want more freedom and leisure. Baby-boomers have unprecedented options to self-indulge (if we can find a locum!). Younger doctors have to factor large debts into their career decisions and most New Zealand general practice does not pay well enough. My conversations with young doctors alarm me – too many are leaving clinical practice altogether. They say that the risks and uncertainties of medicine now outweigh the rewards. The lack of recruits to general practice means that the average age of general practitioners is increasing rapidly. Two local colleagues committed suicide within weeks of each other this year. Perhaps they represent the tail of a distribution curve for happiness that has slipped a little for us all.

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What does this attrition tell us about how we value ourselves?

The way forward

Sentiment does indeed seem to have moved against us. We feel more vulnerable to complaint. Because we are so heavily invested in what we do, we tend to experience complaint as an attack on our integrity.[1,2,3] Yet complaint is a necessary consequence of an open society. It is not going to go away and we are going to have to harden up. Ideally, we should feel free to respond to it openly and honestly. This would help to keep expectations realistic, and protect us all from the huge wastage of defensive medicine. In fact our environment is a lot less hostile than we think. In New Zealand we have an excellent system for managing error. Our complaints process is groundbreaking and, thanks to Ron Paterson (the present Health and Disability Commissioner), it is respectful of our profession while still fulfilling its duty to our patients. ACC's new Treatment Injury process now complements this with blame-free compensation. As a consequence, I believe New Zealand is now one of the best and safest places in the world to practise medicine.

Much of our fear of error is a consequence of always having to work with such limited information. But to borrow from a recent Apple Corporation slogan, we need to 'Enjoy Uncertainty'. It is in the essence of general practice, as it is of life. The very uncertainty that plagues us in our daily work is the principle source of our utility within the health system. We act as filters forestalling unnecessary concern, and concentrating expensive, specialised intervention on those for whom it will yield the most return. General practitioners have a fine appreciation of risk, and managing uncertainty is what we do best. Full realisation of this value does depend on giving a gateway role to general practice. And it will not be achieved without rewarding the careful use of referred services, whether this is in prescribing, investigating or referral to specialised health care providers. It is only natural to avoid taking on any new risk unless it is balanced by something that justifies the effort.

Much of the change in our key position has come about through a belief that the competitive market is the best way to reveal value. Even though maximising health-care consumption should never be our goal, in the way it might be if health were a normal market, this belief is still likely to continue to shape policy. So we need to build a much clearer understanding of how we add value in the health system. We need to quantify this, differentiate ourselves from the competition and promote our value widely.

I believe that if we do this, New Zealand general practice has a rich future. Medicine is a growth industry, and most patients have a desperate need for a familiar shoulder to lean on in times of trouble. It is cer-

tainly not that we have become irrelevant or provide no promise of future dividend. Nor do I think our politicians have been forcing us to change for the sake of change. After all, their role is to identify and condense into policy the changing values of their communities as they try to precipitate votes. Our future will be determined by the needs and wants of our patients at least as much as it will be by our professional aspirations. And this is as it should be, if we are truly patient-centred.

With an ageing population, the generalist is needed more than ever to integrate whole person care, provide low level intervention and translate the work of the partialists into something that is balanced and meaningful for peoples' lives.

Survival of the generalist depends on being able to manage and value the deluge of information we now face. While there is a minimum knowledge that we must have immediately available to be competent, nowadays the generalist does not need to remember the detail to function well. A good answer to almost every question is only a Google away. Palm-held storage devices put a library in our pocket, and web-based diagnostic tools such as Isabel Healthcare,[4] promise accessible decision support. With the aid of the Internet and information that is structured in ways that are useful for general practice, the generalist can still thrive.

Nor should we underestimate the value of the retrievable information we now hold as a side-effect of our computerisation. We have barely explored the potential for this to create additional value. Though to realise this value, we will have to reliably separate it from personal identifiers, to avoid restrictive consent requirements for the use of pooled health information.

New technology could soon place enormous diagnostic power in the hands of general practitioners, if we want it. Safe, low cost, imaging ability with high definition, ultrasound scanners is already in the making.[5] Diagnostic mass-spectrometers and desk-top genetic mapping are probably not that far away. With the right assistance, we could have the capacity to resolve much more diagnostic uncertainty within primary care. In fact, our problem may soon be that we know more about our patients' problems than we have the capacity to treat. But accurate diagnosis has a high prognostic and perceived value, even if it does not change the outcome. Much of our value then will lie in our unique appreciation of the wide range of normality. Our challenge will be to provide advice about the variations that are important. IPAs would be obvious vehicle for introducing technology into general practice, allowing shared use and expertise, but this does depend on being able to be confident in their future.

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I think that the 10 to 15 minute consultation, as the principle transaction for delivering our value might now be outdated. Only a few patients can or will pay the fees necessary to make it worthwhile for us to personally provide all the time they need. Many are happy with impersonal, convenient, low-cost delivery for their routine and acute care. We have tended to use the quick consultation to subsidise the complex, but patients are becoming more price-sensitive. They want the quick to be cheap but the long to be capped.

If we are to meet the changing market, we have to learn how to delegate. Both the diminishing pool of general practitioners and the move to capitation will precipitate this. To survive we need to turn the routine, predictable parts of general practice into processes that are clearly described and standardised so that staff can do them safely, reliably and well. Our skilled nurses can effectively deliver much of what we now provide personally. Our software needs to improve, as do our shared records. We will have to get used to using careplans for complex cases and we must avoid the indiscriminate collation of information that characterises the bulging hospital record. I think we also need a new type of lower-cost clerical assistant to perform the most basic tasks of record-keeping, recall, and form-filling. These require knowledge of the language and ethics of medicine, but not the clinical skill of a doctor or nurse. We also need clinically-directed managers to look after the cash flows and ensure proper pricing for every activity. Doctors do not do this well. We should focus on the high value and more difficult tasks that need our skill. And we need to start charging by units of time, as do most other professionals.

These days, much of the interface with the patient does not need to be in person. Nearly everyone has a personal communicator. Text messaging and email could already be used as the standard recall and reminder tools. Why not also use these to text careplans, test results and follow-up advice directly from our computers? Our world is changing very rapidly, but one thing is certain: the Internet will soon be such an integrated part of the lives of the young that we will have no choice but to provide some of our services this way. For patients that we know, Internet consultations can be a way to use time effectively. With tools like Paypal[6] it may soon be easier to charge for an Internet service than for a phone call. And be warned, it won't be long before the quality of our service will be publicly rated over the Internet, just like sellers on Trade-me.

I don't believe these changes will mean that we lose continuity or con-

nection with our patients. We don't need to personally see our patients every three months to be valued. I see my lawyer about every five years and my accountant once a year. Yet they are still my lawyer and my accountant, even though their staff provides most of the service. The bond comes from continuity of the organisation as well as from personal contact.

Continuity has a high intrinsic value. Working with patients we know helps us to focus on what is important for them and what has changed. In turn it rewards us with trust, approval and meaningful human connection. As extended families break down and fewer people can pin their identities to a lasting role in life, general practice provides an enduring and valuable connection for many people. Capitation based funding is an investment in this continuity. But it is only partial, and we need to be very clear about the limited value it currently purchases.

The tension for general practice will lie in balancing the new horizons of truly team-based care and complex technology with the art and joy of personal care. We celebrate our art in listening responsively, connecting warmly, making a clever diagnosis, and devising good solutions. Adding quality and value to human lives in this way will always be the greatest reward of general practice. We must never lose sight of this source of meaning, as teams and technology separate us a little more from our patients.

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I am a general practitioner because of a need to keep life's possibilities open, and this has been well served with the infinite variety of general practice. It has also provided me with all the necessities of life. I include in this: meaning, purpose, love and comfort. I am very proud to be a part of the community of general practitioners. I am overwhelmingly impressed by the goodness and commitment of the colleagues I am privileged to watch in my role as an assessor for College Fellowship. With so many good people and so much to offer, I am very confident that general practice has a vigorous future.

But a word of caution: many of those who have provided the vision and leadership to harvest new value during these recent years of change are now pondering retirement. The leaders of the next generation need to stand up and be counted. They may be amongst you new Fellows. Your task is to ensure a unified voice for general practice that will demonstrate and proclaim our value loudly and widely. We add far too much worth to the community to allow our purpose, skills and spirit to be lost.

Thank you.

Competing interests

None declared.

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Pandemic Influenza

'Recent experiences with highly pathogenic H5N1 avian influenza have given the world its first advance warning that another influenza pandemic may be imminent.

Given the serious consequences of past pandemics, this advance warning has stimulated a search for ways to prevent such an event from occurring…

No attempt has ever been made to alter the natural course of a pandemic near its start. Moreover, given the unpredictable behaviour of influenza viruses, no one can know in advance whether the start of a pandemic will begin gradually, following the emergence of a virus not yet fully adapted to humans, or be announced by a sudden explosion of cases, thereby precluding any attempt at containment.'

WHO pandemic influenza draft protocol for rapid response and containment. Updated draft 17 March 2006, page 2.