Editorial

The strength of the generalist

Professor Campbell Murdoch, Editor, MD PhD FRCGP FRNZCGP

One of the problems of being a generalist is that your contribution to the care of patients is always in danger of being overlooked.

We live in the age of the specialist, even with respect to Rugby Union where the day is coming, no doubt, when a specialist 'punt' will run on to the paddock to take the penalties and conversions. However we should remember that specialisation in medicine is hopefully reaching the limits of its bungy rope, and strive to emphasise and practise generalism.

We should always remember that general practice preceded the specialties. According to Stephens[1] the certifiable medical specialties 'sprang up like Topsy and exist by virtue of political, economic and technological factors that have little to do with a theory of knowledge.'

As a rural generalist I am extremely glad that they do exist as I see the marvellous results for my patients in oncology, paediatrics, surgery, cardiology, orthopaedics and the like.

However there is a great danger that the specialists, those who manage them and the public at large, forget the essential role of the generalist in the health care of our communities.

The medical professional whom children see most often is the general practitioner and not the paediatrician. In my practice I analysed two thousand consultations with children under the age of 15 and the referral rate was 3.4%, of which 1.3% were acute admissions to hospital.

Of these referrals only a third were to paediatricians, the others being most commonly to orthopaedic, ENT and general surgeons. So 96.6% of all childhood problems are dealt with in the general practice consultation.

The most common problems encountered are respiratory (35%), ear (18%), injuries (10%), infectious diseases (9%), and skin diseases (9%).

Aside from the consultation, our practice team coordinates WellChild health and is the focus for immunisation, WellChild checks.

A major omission from the arguments concerning the worth of well-subsidised care of under sixes is the opportunity this has given to provide a comprehensive service to children in our communities.

A major omission from the arguments concerning the worth of well-subsidised care of under sixes is the opportunity this has given to provide a comprehensive service to children in our communities.

The impact made by the demise of the GP obstetrician reported elsewhere in this journal (see *The strategic direction of maternity care in New Zealand*) has not yet been measured, but there is no doubt that GP obstetrics contributed a seamless introduction to child care with postnatal examination, immunisation and six-week check often occurring at the same time in the practice. It is to be hoped that any plans government make for paediatric care will not follow the same trend.

The lesson for us all, however, from the debacle of general practice obstetrics is that we have to make a case for the role of the general practitioner paediatrician, not simply assume that those who make government policy understand what our traditional role has been.

The erosion of the role of the general practitioner in obstetrics, accident and emergency care, mental health, elderly rest homes, tells us that the doctor 'who does everything' has a problem at the beginning of the 21st century.

The problem is that when budgets are being decided, they are based on the costs of delivering care in the different specialist areas and if we are to compete for these resources we have to do it in competition with hospital specialists and the nursing and paraclinical staff who claim expertise in that specialist area.

General practice is considered a rather outdated concept by those who make the policy, largely because they never meet us and because they do not see how efficient we can be.

With the devolution of budgets to District Health Boards and Primary Care Organisations we have the opportunity to persuade these policymakers that the important work that we do in these areas should be costed in a way that reflects the enormous contribution that we make to the total delivery of health services.

This will be good not only for us but for the services because, if done properly, it will make the services patient-centred, rather than the current service-centred approach, whereby both patients and their doctors are in danger of being ignored by the public health system.

For many difficult situations in our society we often have an outbreak of the 'GPs ought to do more about X' syndrome. We are often told by those in authority that we ought to immunise more, ought to report erring patients more, as if we were a statutory guardian of the state.

We are often told by those in authority that we ought to immunise more, ought to report erring patients more, as if we were a statutory guardian of the state

In this journal, Pat Tuohy has rightly drawn our attention to the need to keep an open mind to the possibility of child abuse in our patients. In particular he highlights the difficulties caused by poor information sharing within primary care and between primary and secondary care providers, the lack of health professional recognition of, and action on, risk factors for abuse, and the lack of recognition of patterns of family violence by health professionals.

The evidence is largely anecdotal, but it seems that no professional group can feel proud of their actions in these extremely difficult cases. General practitioners are no exception and we must all try to do better.

Studies from the UK,[2] Ireland[3] and Australia[4] all describe difficulty with the GP role in child protection, precisely because we are different from other professional groups in the way we work.

In the UK study GPs saw an average of 1.5 child protection cases per year and so it is not surprising that skills in identification and communication are difficult to maintain. Performance at the leading edge of these developing situations is difficult to assure and the key must lie in using our relationship with the patient to identify the early signs and then in deferring to the skills of others, either by using the valuable resource within general practice of groups such as Doctors for Sexual Abuse Care (DSAC,) or by liaising with professionals in Plunket, CYFS or at the base hospital.

The recent College guidelines on a recommended referral process (http://www.rnzcgp.org.nz/files/GP_Protocol.pdf) are extremely useful and should be discussed in all our practices.

However we should remember that our role may be an extremely important one, especially where we have a long relationship with an extended family. Also, most of the patients we see choose to come to see us, even when they do not pay.

This is the month in which we celebrate Christmas. Even for those who are not Christian, the nativity is a beautiful story, my interpretation of which is that God took a risk and must have, to use Tony Townsend's words, 'flown by the seat of his/her pants.' The saga includes an unplanned teenage pregnancy, a shotgun marriage, induction by donkey ride, delivery in a dung-filled outhouse, too many local and foreign visitors and the government wanting to include the baby in an age-based massacre – a weird form of a six-week check. They were there as the result of legislation and at the behest of the taxman. Nothing much has changed in two thousand years and, as yet, none of these human disasters can be legislated against, but each of us, in our own way, can surely vow to make things just a little better for the children that we meet as we consult.

The Nativity: "...an unplanned teenage pregnancy, a shotgun marriage, induction by donkey ride, delivery in a dung-filled outhouse, too many local and foreign visitors..."

References

1. Stephens GG. The intellectual basis of family practice. Winter Tucson 1982.
2. Lupton C, North N and Khan P. What role for the general practitioner in child protection? British Journal of General Practice 2000;50:977–981.
3. Payne D. GPs loth to report child abuse. BMJ 1999; 318:147.
4. Van Haeringen AR, Dadds M and Armstrong KL. The child abuse lottery – will the doctor suspect and report? Child Abuse Negl 1998;22:159–69.