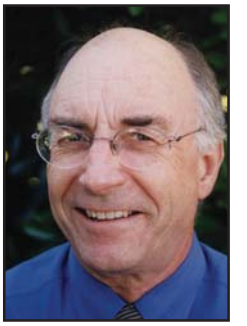
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

The changing face of general practice

Hippocrates has been credited with founding the science of medicine. It is said that he was born on the island of Kos in 460 BC. Recently, while visiting the Asklepion, which was originally built on Kos to honour Asklepios, the god of therapeutics, and which later became a medical centre, I took to thinking about what had remained constant in medicine for the last 2400 years. In the Hippocratic writings (not necessarily written by Hippocrates) the practice of clinical medicine is described.

'With regard to diseases, the circumstances from which we form a judgment of them are, by attending to the general nature of all, and the peculiar nature of each individual, to the disease, the patient, and the applications, to the person who applies them, as that makes a difference for better or for worse, to the whole constitution of the season, and particularly to the state of the heavens, and the nature of each country; to the patient's habits, regimen, and pursuits; to his conversation, manners, taciturnity, thoughts, sleep, or absence of sleep, and sometimes his dreams, what and when they occur; to his picking and scratching; to his tears; to the alvine discharges, urine, sputa, and vomitings; and to the changes of diseases from the one into the other; to the deposits, whether of a deadly or critical character; to the sweat, coldness, rigor, cough, sneezing, hiccup, respiration, eructation, flatulence, whether passed silently or with a noise; to haemorrhages and haemorrhoids; from these, and their consequences, we must form our judgment.'

Holistic, patient-centred, comprehensive, clinical medicine; not too much has changed about that. But, of course, there have been changes and it is some of the changes that have occurred in the last decade that have had, or will have, major implications for the way in which we function as general practitioners that are considered in this issue of *NZFP*.

On a recent visit to the Asklepion, which was originally built on Kos to honour Asklepios, the god of therapeutics, and which later became a medical centre

Philip Evans, a general practitioner with an interest in medical history, recently stated that the two discoveries that had made a major contribution to mankind since 1950 were the contraceptive pill and the Internet.[1] It is interesting that both of these have close associations with general practice, although the former had most impact prior to the last decade. The Internet specifically, and information technology (IT) generally, is continuing to have a major impact on everyday general practice from increasingly sophisticated Practice Management Systems to informing and misinforming patients.

My list, with a little help from my friends, of what else is contributing to the changing face of general practice includes, in no particular order:

1. **Patient-centredness**. Although the Greeks may have been onto this, sometime during the past two millennia it appears to have been forgotten and replaced with a strongly paternalistic approach. George Engel and others began to challenge this almost 40 years ago and *'Patient-centered Medicine'* was published in 1995;[2] this has had a major impact on the way in which we think about patient care.
2. **Increasing specialisation**. Many GPs are narrowing their scope of practice. Some have become managers;

others have become occupational medicine doctors, musculoskeletal medicine specialists, appearance medicine specialists, sports medicine specialists and family planning doctors. Other health care practitioners, such as midwives and counsellors, have taken over what was once part of general practice. Although this may have resulted in better care for patients with particular needs, it has also impacted on the content of general practice and fragmented primary care.

3. **The impact of primary care nursing**. Primary care nursing has evolved considerably in the last 10 years. We have generalist and specialist nurses who work with general practice and independently from general practice. Primary health care teams are now a reality in most communities. There is little doubt that this has enhanced primary care services but, in some instances, it has also contributed to fragmented care.
4. **The gender shift**. When I started in practice about 30 years ago, gynaecology was an important part of my daily general practice. I recall having a Registrar who had been to medical school overseas. We were astounded that he had never performed a vaginal examination during his training and considered that this was a major skills deficit. However, with the increasing competency of primary care nurses and the marked increase in the number of women GPs, I now do very little in the way of gynaecological examinations, smear tests, IUCD insertions or diaphragm fittings. I believe that I could still detect a positive Hegar's sign, but in the past decade this has not been put to the test!
5. **Evidence-based medicine**. The incorporation of EBM into primary care medicine, as well as an acknowledgement of its limitations, has changed the way we practise. Despite early reassurances that evidence-based guidelines will not be used as standards against which we are judged, this has not turned out to be the case.
6. **Recognition of the specialty status of general practice.** The New Zealand Medical Council's recognition of general practice as a specialty without *'becoming ensnared at the boundary between semantics and politics'*[3] is beginning to impact on our practice. An example of this is that Pharmac now allows vocationally registered GPs to make Special Authority applications for some drugs that could previously only be made by other specialists.
7. **System review processes**. Significant event management or harm reduction processes have been incorporated into primary care practices. These have altered the way in which we look at mistakes and complaints although they may not have had much impact on patients' perceptions.
8. **Accountability**. We are now required by law to show that we are involved in continuing professional development and self-audit. Although this may not have altered many GPs' involvement in endeavours to improve their skills and knowledge, it has the potential to change the focus of these activities.
9. **Changing values.** In my father's day general practice was a vocation, in my day it was a profession, but for many younger doctors it is a job. This change in the way we view the work that we do impacts on many areas of practice including practice ownership, involvement in practice management and the assumption that after hours care is part of the package.
10. **Changes in general practice management.** In the past decade a procession of reforms with consequent HMOs, IPAs, PHOs, contracts and evolving pay-for-performance agreements have influenced what we do and how we do it with little evidence, as yet, that the changes have resulted in better outcomes.
11. **Population focussed practice**. Partly as a result of the primary health care reforms, general practice has developed a focus on the care of populations in addition to the traditional focus on individual health care. This has had an impact on screening and preventive care that will continue to evolve.
12. **Academic/research**. Acknowledgement of general practice as an academic discipline and the establishment of a robust research base (including the acceptance of qualitative and other methodologies more appropriate to primary care practice) are beginning to happen.

No doubt readers will come up with other influences that I have not included or challenge the contention that some of those that I have listed have or will result in changes to general practice. The intention of this editorial is to encourage readers to think about what has happened to change the way in which we practise and to consider how we would like to see general practice develop during the next decade.

For the theme papers in this issue we have invited a few contributors to comment on some areas that reflect the changing face of our discipline; workforce issues, salaried general practice and primary care nursing. We are grateful for these contributions and welcome comment about how you see the future of general practice in the next decade.

References

1. Evans P. Past, present and future, an illusion? Keynote lecture. 11th Conference of the European Society of General Practice/ Family Medicine. Kos Island, Greece, September 3-7, 2005.
2. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam CL, Freeman TR. Patient-centered medicine – Transforming the clinical method. California: Sage Publications, 1995.
3. Heath I, Evans P, van Weel C. The specialist of the discipline of general practice. BMJ. 2005; 320:326-327.