New horizons

– celebrating the art of general practice

Dee Richards MBChB

***Dee Richards** is currently a senior lecturer in the Department of Public Health and General Practice at the Christchurch School of Medicine. She has both general practice and public health postgraduate training and her main focus in the department is clinical general practice research. She is the chair of the programme committee for this year's RNZCGP conference in Christchurch.*

The PHO environment provides opportunities to incorporate the best principles of general practice with population health and develop a unique model of primary care. In the enthusiasm for this new model it is vitally important that the best aspects of traditional general practice are carried forward – that the art and the value of general practice are recognised and celebrated. The themes for this year's RNZCGP conference include both the new and innovative directions GPs are moving in pushing the traditional boundaries of care, as well as the traditional skills so valued by patients – highly developed communication skills within the consultation which form the foundation for the closeness and consistency of the longitudinal relationship which is the core of general practice; a constant in an often fragmented world of health care.

A complex and specialised role

General practice is a highly complex and specialised discipline. No one is so skilled in managing and tolerating uncertainty, rapid triage, managing multiple complex conditions, coordinating chronic care, and integrating and recognising psychosocial context, while being responsive to patient preferences for varying levels of evidence-based patient choice. At another level is the skilful daily application of the Uncertainty Principle, incorporating perspectives that may be as mutually incompatible as quantum mechanics and relativistic theory. GPs have long been expert at using a variety of explanatory models in their clinical practice. There is a tension innate in trying to marry two core features of general practice – the evidence-based and patient-centred practice of medicine. Archie Cochrane's work, which led to the development in the 1990s of an evidence-based framework to sift information and inform clinical practice, has been enthusiastically adopted by New Zealand general practice. GPs and GP groups are now adept in the art of taking guidelines and evidence, often based on dissected-out micro chunks of objective research data obtained within the controlled environment of the protocol (and often not in the primary care environment), and integrating this with the richly complex, dynamic and unpredictable patient context. GPs have long been expert at using a variety of explanatory models in their clinical practice and, in parallel to this evidence-based approach, they have also demonstrably embraced the concept of a patient-centred approach to care. In a recent international survey under the auspices of the Commonwealth Fund, New Zealand GPs showed the highest level of patient-centred communication compared to primary care in the United States, Canada, Australia and the United Kingdom.[1]

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There are exciting new developments occurring in general practice. With the formation of Independent Practitioner Associations there have been new opportunities to implement more flexible funding and service provision structures. These have facilitated the development of more comprehensive and complex roles for primary care teams in caring for patients in the community whose acute and chronic conditions would have necessitated secondary care referral. Supporting general practitioners in these roles not only allows patients to remain at home but also increases the skills and experience of the GP workforce in managing acutely unwell patients in the community. This is a skill that doctors do not typically acquire during hospital training. Further developed, this model holds promise for responding to the predicted future burden on secondary care as the changing population de-

mographic and technological advances continue. Expansion of this model requires large shifts in public perception around where complex health care is provided (in particular the idea that aside from terminal care, hospital-sanctioned death is necessary to avoid suspicion that inadequate care has been delivered in the community).

There are other changes on the horizon that we must debate and respond to: changing models of ageing with our changing population structure, the appearance of social definitions of disease and medicalisation.

General practice and population health

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The traditional village GP was at the heart of the community – a powerful advocate for local 'population' as well as individual health, working in a team with other community leaders to ensure a healthy environment in areas not dissimilar to current public health issues – clean water, adequate housing... Who was and is better positioned to observe disease patterns and the effects of environmental changes? Even in those days GPs were able to effect much wider changes for population health by observing disease within the community. Edward Jenner was a West Country GP who literally changed the world by his keen observation of his practice population. Because of his observation that the milkmaids who had had cowpox did not develop the deadly smallpox, the world has been rid of a deadly scourge. He was also an evidence-based practitioner.

'To have admitted the truth of a doctrine at once so novel and so unlike anything that ever had appeared in the annals of medicine, without the test of the most rigid scrutiny, would have bordered upon temerity.'[2]

In the current context of population health in primary care, GPs perform a delicate balancing act in applying the principle of *'primum non nocere'* – assessing the risks and benefits of attending to the patient agenda of relief of suffering with population health needs, for which we would inflict upon them health promotion and preventive strategies that identify them as 'ill' when they feel well – integration of population health and traditional general practice.

Entanglement and advocacy

In the current context, GPs are well placed to observe the effects on communities of health policy and structural changes. The GP has also been respected as independent and an unbiased voice of advocacy for the community. In the modern configuration of general practice, GPs still represent a powerful voice when united. There is, however, a threat which may undermine this role. There has been a great deal of attention and discussion in medical journals overseas around the relationship between the pharmaceutical industry and the profession. The industry is motivated, quite appropriately, by their primary responsibility – to maximise profit for their shareholders. With recent examples such as the Seroxat (paroxetine) scandal in the UK and COX 2 inhibitors, there is an increasing trend in international lay media to expose the self-serving nature of the pharmaceutical industry and align with them physicians who have accepted largesse. In the United Kingdom a report of an enquiry into the influence of the pharmaceutical industry on the National Health Service has been damning in its conclusions. Claims of intellectual independence are undermined by examples of entanglement. A relationship between physicians and the pharmaceutical industry is essential and we need to explicitly and overtly reassess and determine the nature and boundaries of an appropriate relationship with industry, or we may find ourselves tarred with a self-serving brush at the risk of losing patient trust forever.

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The theme of this year's conference – *'New horizons – Celebrating the art of general practice'* – gives us the opportunity to explore the possibilities for the future, assess the new directions general practice is already taking and to celebrate the things that we have and will continue to do well. General practice has a tremendous opportunity to 'seize the day' and also a long tradition of interpreting complex situations, integrating competing demands and responding with innovative new approaches. These are exciting developments in primary care, but alongside this is the reality of the workforce trends – general practice is not seen as a specialty of choice – new graduates with student debt see it as a poor income earner, and there is still a perception that it is somehow an 'inferior' specialty. There are important trends in the GP workforce, which, if they continue, could threaten the laudable goals for the primary health care strategy, and place increasing burden on already overloaded secondary care. The workforce issues will only be addressed if the art of general practice, and GPs, are recognised and valued.

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Reference

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2. From: An inquiry into the cases and effects of the variolae vaccinae, or cow-pox. Dr Edward Jenner.