The best of times and worst of times

SHORTLY after the inauguration of the National Health Service, the Collings Report described and decried the deplorable state of general practice in England.[1] As discussed in detail by Irvine Loudon elsewhere in this issue,[2] Dr Collings' observation of 55 general practices operated by 108 doctors led him to conclude that:

'The overall state of general practice is bad and still deteriorating. The deterioration will continue until such time as the province and function of the general practitioner is clearly defined, objective standards of practice are established, and steps are taken to see that these standards are attained and maintained'.[1]

Dr Collings' findings led to tremendous soul-searching by the discipline, and hastened the founding of the Royal College of General Practitioners.[3] Since its establishment, the RCGP has worked to define and maintain standards for general practice. This has included innovations in education, community-based training, and practice-based research as well as policy advocacy.[4]

Despite the College's efforts and many successes, there is once again a sense of crisis in the discipline of general practice. In a recent survey, 56% of general practitioners (GPs) said that they would consider resigning from the NHS if the British Medical Association was unable to secure new and acceptable contracts and negotiating rights for all GPs.[5] This majority opinion occurred despite an overall belief in the merit of the system by clinicians and the public alike. Doctors share a sense of overwork and inadequate support[6] for a role that is rapidly expanding with societal needs, and with emergent knowledge and technology.[7] The perception of crisis is not unique to the United Kingdom. It is paralleled by calls to renew and reform family practice[8] and the health care system[9,10] in the United States.

In June this year, I had the opportunity to spend two weeks observing five English general practices. Each practice was chosen from the four practice-based research networks in the London area that are funded by the NHS[11] and selected to represent a wide range of patient populations. I observed surgery visits and spoke with doctors, nurses, health visitors, administrators, patients, and others. Each evening, I dictated field notes of my observations and interviews, based on brief 'field jottings'. These field notes were later transcribed and analysed using an immersion crystallisation approach.[12] My observations were modest, and the small sample of practices unlikely to be representative of all British general practices. However, I was struck by the paradox that, despite the sense that general practice is in crisis, it is meeting fundamental needs and is vastly improved in comparison with Dr Collings' time.

The five practices that I observed were much better equipped for the full range of general practice than the sparse surgeries of Dr Collings' day. The general practitioners were all skilled clinicians. They were adept at the 'snap diagnosis' that Dr Collings observed, but were also able to focus on gathering complete information when it was needed for more difficult diagnoses and treatment. The 10-minute consultation was the norm, and often two or three problems were addressed in one visit, similar to family practice visits in the United States.[13,14] This limited time would have made visits seem superficial, except that in most cases this brief attention to multiple problems occurred as only one part of an ongoing relationship. As an observer, I frequently had the sense of coming into the middle of a long-running conversation in which brief consideration of multiple problems over time might be more effective than intensive scrutiny of a single problem at one moment in time.

Consultations that required urgent referral to a specialist all were readily accomplished with a telephone call to the hospital, except one that involved a two-hour delay. One patient who did not want to wait several months for an elective haemorrhoidectomy decided to seek a privately performed procedure outside the auspices of the NHS. These referrals were greatly aided by the personal advocacy of the GP and by the ease with which patient information was transferred from the electronic medical record into a referral letter. The electronic medical record also facilitated patient care with rapid access to patients' medications, laboratory findings, previous diagnoses, recent care provided by partners, and letters from consultants.

While Dr Collings observed only the most perfunctory staffing, the offices I saw had personnel serving patients in a multitude of roles with a high degree of autonomy, coordination, and knowledge of the patients and community. In several practices, nurses had advanced roles that included chronic disease management clinics for diabetes and asthma. Several practices also had sophisticated administrators who were essential to acquiring sufficient resources and managing personnel. In one practice, the roles of the NHS Trust health advocate and the health visitor were particularly well developed. This practice had a large population of patients who did not speak English and who were suffering the stresses of recent immigration and poverty. The advocates served as cultural and linguistic interpreters in guiding the patient through the health care system and in educating the system about the cultural context of the patient. The health visitor identified high-risk individuals and families during prenatal assessments, providing counselling and guided access to medical and mental health services while following the families through the postpartum period. The health visitor's insights were incorporated into care plans along with input from office nurses, physicians, and staff during practice meetings.

Another practice efficiently and effectively managed its internal operations based on a sophisticated practice-generated development plan. The plan integrated patient involvement, clinical practice improvements, team building, education, and practice-based research. This practice also had an extraordinary Patients Association charged with meeting patient needs without putting an extra burden on the practice staff. Patient volunteers provided a wide array of

services, including transportation, shopping, home visiting, parenting groups, and support groups for children with special needs, carers, and bereaved patients.

After one practice visit, I had the opportunity to attend a Primary Care Group meeting, during which performance data for local GPs were examined and their implications debated. Combining population data with local knowledge and responsibility appeared to be a powerful forum for developing locally applicable strategies to improve the quality of care.

These practices, even if not representative, show tremendous progress in British general practice since the Collings report. They show what is possible when GPs work together with patients, staff, and professional colleagues within a larger system that attempts to provide essential medical care for its entire people. My overall sense from observing these practices and from contrasting research in the US[13,15] is that the generalist approach, nested within a health care system that provides access for the entire population, is immensely adaptable to meeting the needs of diverse communities and the different types of individuals who are providing and receiving care. Despite the current sense of crisis, these brief observations give me great hope for the possibilities inherent in general practice as the foundation of a population-focused, community-centred, and publicly funded health care system. Continued progress will require acting on evolving insights.

A vision for the next generation of general practice is emerging. This vision integrates and prioritises comprehensive care within the context of ongoing relationships. It is based on systems that support care of a broad range of specific illnesses,[16] while nourishing the caring relationships that personalise the many commodities of health care.[15,17] The emerging vision of generalist practice emphasises connections — with patients, families, and communities, and with colleagues within the practice and in other disciplines. The emerging vision of generalist practice develops the increasingly important role of patients in managing the health-related behaviours that cause the largest burden of illness in Western societies.[18,19] It provides a better balance between the reactive stance in which most practices find themselves and the proactive mode needed to foster change.

It is difficult to contemplate a new vision when feeling overburdened by administrative hassles, overwork, and limited power. However, the title of this article points to an essential paradox. Often, the worst of times, which are burdened by problems, simultaneously are the best of times for making changes that represent quantum leaps. Complexity scientists tell us that the greatest potential for innovation occurs at the 'edge of chaos' where we are rousted from our usual complacency and are open to change in response to information and new challenges.[20-26]

At such times of chaos, we often find that our weaknesses are our strengths, and vice versa. For example, our relationship-centredness is a major source of our ability to help patients. It is also a limitation when it causes us to become complacent about patients' chronic illness-inducing behaviours or our own inability to foster positive change. The breadth of care provided in general practice may result in our performing more poorly than specialists, according to guidelines for care of specific illnesses.[27] Yet, the competing demands[28] of providing comprehensive care also represent competing opportunities[15] to prioritise and integrate care for the whole person. This integrative, relationship-centred approach explains why generalists use fewer resources than specialists while producing similar health outcomes for patients with chronic disease.[29,30] The added value of this integrative function may also explain why health care systems that emphasise primary care have better health status among their populations than specialist-dominated systems.[31-33]

How are we to reconcile the paradox of the strengths and weaknesses of generalist practice? It is important to avoid getting stuck in 'either/or' thinking.[34,35] We must look for ways to both optimise our care for specific illnesses[16] while simultaneously integrating care of multiple problems. Systems are needed to support the essential primary care functions of prioritising and integrating care of multiple acute and chronic illnesses, prevention, and mental health within the context of family and community.[15,17]

Many current efforts to improve quality of care use an industrial quality improvement model[36] that attempts to reduce variability[37] around the evidence-based care of one disease at a time.[38] However, not all variation is bad.[39-41] Desirable variation comes from personalising care based on the local needs and strengths of patients, families, and communities, and the practitioners who serve them.[17,23] Therefore, it is also important to develop systems that enhance this beneficial variability.[23]

New knowledge is needed to support the next phase of generalist practice because primary care requires the integration of different ways of knowing. The generalist approach incorporates the objective perspectives of biomedical information and systems knowledge and the subjective perspectives of the clinician, the patient, family, and community.[17] Some of this new knowledge will come from practice-based research networks[11,42] that incorporate reflective practice[43] and the active participation of patients and communities[44] to generate the relevant questions and research. Generating this new knowledge will require use of both qualitative and quantitative methods[12,45,46] and the development and evaluation of innovative, locally applicable complex interventions.[47]

Primary Care Trusts have the opportunity to incorporate research into practice through clinical governance, while including the perspective of practice in research through participatory inquiry and quality improvement efforts.[48,49] These efforts will require a better understanding of the function of complex adaptive systems[20-26,41] and varied and creative approaches to managing organisational change.[50] For quality improvement efforts to be successful and sustainable, they will need to incorporate local knowledge and relationships as well as centrally-determined solutions.[43] This is a tall order, but one that British general practice, situated within the National Health Service, is well positioned to pursue.

Compared with the US, the British health care system achieves greater population health for a much lower percentage of the gross domestic product.[31,32] One reason is the central role of general practice in providing a medical

'home' for every person in the UK. Some of the short-term problems with general practice and with the NHS may be solvable by additional resources. In addition, while remaining grounded in communities and clinical care, generalists must periodically step back from the daily satisfactions and hassles of practice to take responsibility for generating creative systems-level solutions. Sustainable health care strategies are likely only if patients, GPs, general practice staff members, and specialty and health systems colleagues work together in ways that focus their complementary perspectives on the common good. The egalitarian ethic that led to the establishment of the NHS, and the general support that still exists for that ethic, is a major strength that could now be built upon in the next phase in the development of primary care.

The problems of general practice and of the NHS reflect the problems of the larger society — poverty, social upheaval, loss of family and community relations, and inadequate resources amid growing need. The fact that you have a system in which general practice and the health care system are not divorced from the problems of the larger society is a major strength. It is an opportunity to work together to solve the problems of the health care system, and the vital role of general practice within that system, in a way that is congruent with the overall needs of society. As an outsider practicing general (family) practice in the much less supportive and less equitable US health care 'system,' I congratulate you on the progress you've made, and the role of the College in your recent successes and future opportunities. I encourage you to continue to build on the many strengths of a system that gives you responsibility for the health care of individuals, families and communities, and keeps you close to their needs and desires. Building on what is fundamentally good about general practice will turn what feels to many like the worst of times, into the best of times for all.

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