The expert medical generalist

The proposed new Scottish GP contract[1] has suggested that GPs be considered 'expert medical generalists' (EMGs). Helen Stokes-Lampard, Chair of the Royal College of General Practitioners (RCGP), has named GPs 'consultants in general practice'.[2] These new titles beg the question of whether they are granted simply for the completion of vocational training involving 18 months in the field in which we are experts, after a total of 3 years' training post-foundation, or whether there is more involved in developing this expertise.

Much importance has been placed on the regard with which general practice is held within universities and hospitals, and its effect on GP recruitment, and so it is likely that unfavourable comparisons will be drawn between the experience and training required to become a consultant in general practice and a consultant in anything else. Although not based on any evidence, Malcolm Gladwell's 10 000-hour expert theory,[3] representing as it does about 5 years of full-time general practice, would, nonetheless, accord with the time at which many of us begin to feel that we have obtained some mastery of our subject. Gladwell's theory, however, does not simply mean working at the job for 10 000 hours but practising, that is, actively pursuing improvement in order to become expert. This aspect bears some closer consideration.

Reeve *et al*[4] describe three different views of the GP role and suggest that there are at least three different ways of working in general practice. First, there is the 'all-rounder' GP who, expert in consultation skills, delivers specialist defined care in a wide range of areas. Second, there is the GP with a special interest (GPwSI) who combines expert consultation skills with 'some' specialist knowledge. Third, there is the expert generalist who uses interpretive skills to define and address individual patients' problems. I would prefer to think that the EMG would combine all three of these ways of working using the appropriate approach in the given circumstance, rather as Neighbour describes the generalist working sometimes as a specialist and the specialist sometimes as a generalist.[5]

The Scottish contract sees the role of the GP as focusing on undifferentiated presentations, complex care, and quality and leadership. This can be further divided into clinical care, teaching, leadership, quality improvement, and research.

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CLINICAL CARE

The EMG will need to actively seek ways of increasing the expertise of their patient management. This will include consideration of where patients are currently referred for secondary in- or outpatient care, and whether they could be managed within primary care instead. The EMG will analyse their management of complex conditions to find what underlying principles underpin the decisions and recommendations they make so that they become reproducible and their validity can be verified. They can then become the basis of protocols for use by other clinicians within the primary care team.

TEACHING

Most consultants are involved in teaching,[6] whereas most GPs are not (https://www.gmc-uk.org). The EMG must seek out not only the opportunity but also the necessary skills to train medical students, foundation doctors, GP trainees, nurses, and other professions allied to medicine. It is important that any push to involve primary care more in the training of future doctors, nurses, and other staff is not hampered by the lack of willing and able teachers.

LEADERSHIP

In Scotland, at least, the introduction of Health Board-employed members of the primary care team in Phase 1 of the proposed new contract and the removal of the GP's role as employer in Phase 2, the GP's 'right' to lead the team, has also been diluted. Despite the role described in the contract documents including leadership, the EMG will have to rely upon a combination of charisma and training in the skills of leadership, mentoring, and change management should they not wish to see this role taken by others. The EMG will have to offer individual clinical leadership to the other members of the team, as well as collective leadership of the team as a whole. It is important that more guidance is given from national bodies and that training is included not only in the ST curriculum but also for more established GPs.

QUALITY IMPROVEMENT

The Scottish contract places much importance on the quality cluster as the mainstay of quality improvement in general practice. Once again, the ability to contribute knowledgeably and effectively to the work of the clusters and to implement the quality improvement changes in their own practice will require a sustained effort of consideration of guidelines and recent development in the literature, as well as the critical judgement skills to assess how to proceed to achieve the best outcomes in a field of almost infinite possibilities.

RESEARCH

Very few consultants other than in general

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practice reach that position without some published research. The EMG should have a commitment, and again the skills, to further the research not just themselves but by other members of the team, and within and between clusters. There is also a need for EMGs in the UK to develop and maintain guidelines for good practice in primary care, and to remove this function from secondary care and the pharmaceutical industry.

CONCLUSION

Thus there is a considerable amount to be done both by doctors at the beginning of their careers and by more established GPs if the hubris of awarding ourselves the title of expert medical generalists or consultants in primary care is going to achieve anything other than heighten the tittering in the coffee rooms of secondary care. It is also important whether the role of EMG is one that all GPs should aspire to or whether there will be different grades within the ranks of GPs in the future. An important final question is whether embracing this redefining of the traditional view of general practice should purely be left to the individual professionalism of the doctor, perhaps with the assistance of the appraisal system, or whether there is a need for leadership in this area from the RCGP.

'The fault, dear Brutus, is not in our stars, but in ourselves, that we are underlings.'[7]

Much has been written and spoken about how much happier Dutch GPs are than British ones.[8] Although there are likely to be several reasons for this, the degree of control that GPs collectively have and exercise over their own destiny is an inescapable difference. The fact that Dutch GPs have their own union that negotiates their terms and conditions, and the fact that the Dutch College of GPs produces primary care-based guidelines, must play a vital part in the self-esteem of GPs and the respect with which they are regarded by their hospital-based colleagues, the public, and the press. The UK's RCGP needs to consider its support of established GPs in their becoming recognised as EMGs. This should include the possibility of a higher qualification, with perhaps a refocusing on the promotion of excellence in the more experienced GP rather than concentrating so much effort on an entry-level qualification.

Tommy Hunter,
GP Principal, Barns Medical Practice, Ayr.

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ADDRESS FOR CORRESPONDENCE

Tommy Hunter
Barns Medical Practice, 40 Dalblair Rd, Ayr, KA7 1UL, UK.

Email: tommy.hunter@aapct.scot.nhs.uk

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