General practice:

changing problems, enduring values

In recent months, much has been written about the challenges facing contemporary general practice: some worrying, some reassuring. But, pegs to hang some coats on. Two texts to start with: *'Times change, and we change with them.'*[1] *'The more things change, the more they are the same.'*[2]

These days, new initiatives to improve the clinical process are rarely underpinned by theory. They tend to over-claim potential benefits, and to underestimate dis-benefits. Twenty years ago it was the internal market and fund-holding. Then evidence-based medicine was hijacked by devotees of the randomised clinical trial (RCT). It became inevitable that the evolution of guidelines, targets, and incentives would be inappropriately directive, lacking as they did sufficient acknowledgement of the importance of patient variables and of the context in which consultations take place. The Quality and Outcomes Framework (QOF) followed. And the next phase may be a world dominated by IT in one form or another.[3,4]

One important role of academic medicine is to try to establish the best available theoretical basis for clinical practice. This reflection centres on the consultation, still widely seen as the core activity of general practice (reassuringly, McKinstry's team's recent contribution has shown not only the potential of novel approaches to delivering care, but also that face-to-face consultations are still richer in content than the alternatives under test).[5]

A THEORY OF THE CONSULTATION PROCESS

My model of what happens during general practice consultations is reprinted here in slightly modified form from that published previously (Figure 1).[6]

From the left, the adapted Stott and Davis[7] square shows the potential range of problems patients consult with. Moving right, these are prioritised under the influence of differing doctor and patient factors (such as culture, beliefs and values, and the level of continuity of care) reflecting the classic Balint doctor/patient/illness triangle. This prioritisation is often constrained by a myriad of contextual issues, which I have represented by an enveloping circle. These issues include, again for example, stress on doctors, which we highlighted 30 years ago as bad for both patients and doctors;[8] and incentives, which we demonstrated nearly 20 years ago were associated with negative as well as positive consequences.[8]

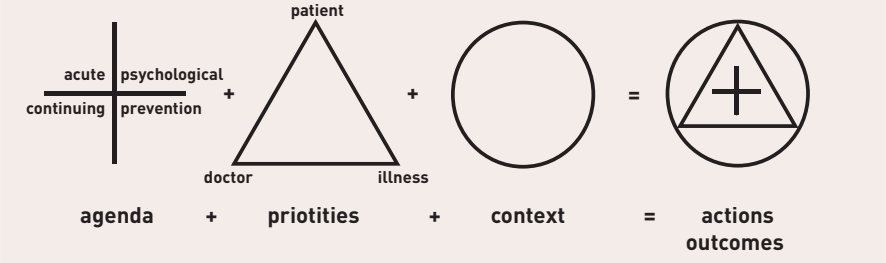

Figure 1. Diagrammatic representation of the clinical consultation.

Actions taken or arranged at the end of the consultation are easy to list. So too are the various outcomes that will follow either in the short-term or the long-term.

GENERAL PRACTICE OR PRIMARY CARE?

While on the theme of contemporary general practice, why do we keep calling general practice 'primary care'? Whatever 'general practice' is, it is certainly much more than 'primary care', which seems to me to trivialise its richness. In turn, I feel this apparent crisis of our disciplinary identity must account to some degree for the problems of recruitment to and retention in the workforce. General practice may be hard to define, but it was once aptly described as 'what GPs do'. Now it would be more correctly described as 'what general practices do', reflecting the many other team roles that contribute to the workings of good modern practices. Taking pride in the services we provide seems a logical and necessary way of confirming who we are and what we do.

There is a corollary to this. Richard Hobbs admirably tracks the contribution over time from *'primary care academics to clinical science'*.[9] In recent years, they have increasingly focused on disease-centred researches, reflecting the realities of the Research Excellence Framework-driven priorities of medical schools, and the integration of 'primary care academics' into specialty-centred research teams. At the same time, much of the teaching undertaken by general practices and general practice academics has been badged within education units in medical schools. The virtual disappearance of free-standing departments of general practice and of professors of general practice must again work against the establishment of the discipline as a positive career choice for graduating students.

Work on the theoretical basis of general practice — always both difficult to do, and difficult to fund — regrettably seems to belong to the past rather than to the future.

CONCLUSIONS

The power of modern medicine to improve the lives of people with illness — particularly serious illness — has improved in ways inconceivable even two decades ago. But, for most of the time, most patients consulting doctors in general practice have problems able to be managed without recourse to complex technology or algorithms. A quarter of them have psychological or social problems interweaved with their reasons for consulting. The model I have offered (Figure 1) provides a way to understand the complexity of the challenges involved in prioritising needs, and choosing which management strategy best fits each occasion. The model applies equally well to hospital medicine, albeit with different

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weightings in its different components,

I became a full-time GP on the first day of the 1966 Charter. My first research publication reported the results of a large, well-designed RCT of antibiotics against placebo for minor respiratory illnesses in normally healthy working-age males.[10] There was no benefit from antibiotics; smokers fared noticeably worse than non-smokers. I soon realised that this work was making little impact on the way doctors prescribed. My model has allowed me to understand why this was the case.

Alvin Feinstein wrote perceptively in the *Lancet* in 1972:

'Until the methods of science are made satisfactory for all the important distinctions of human phenomena, our best approach to many problems in therapy will be to rely on the judgement of thoughtful people who are familiar with the total realities of human ailments.'[11]

Well said, and just as true today as yesterday.

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