Editorials

General practice in crisis:

stop skinning the cat

INTRODUCTION

What a grim time GPs in England are having. I have never seen things so bad. As Medical Director of NHS Practitioner Health (https://www.practitionerhealth.nhs.uk/) I am aware of how my profession is suffering under the strain of their work.[1] But more, rather than being lauded GPs have been reprimanded, unjustly, for not being 'open'. This hurts. General practice is open. Our doors are so widely open that you can drive a coach and horses through them. GPs are delivering 1 million more consultations per week of all kinds (face-to-face, telephone, home visits, video, and electronic triage) than before the pandemic.[2] GPs have moved mountains to help our patients; transferred millions of consultations per day to the virtual space; created hot and cold hubs to make life safer for staff and patients; led the delivery of the highly successful vaccine programme (90% of all 50 million or so doses) to name a few of our achievements over the last 18 months. Done with many of our staff on sick leave or shielding.

I have now passed my 31st year working in general practice and given this longevity am able to look back, not with rose coloured spectacles, which is always a risk, but with a realistic view as to what has worked, what is not working, and most importantly what needs to be done going forward.

Lest we forget, GPs across the NHS do more than our equivalents across the world. We are the front door of the health system, dealing with undifferentiated illness. We keep the NHS safe, accessible, and value for money.[3]

The ideas I bring in this editorial are not new. Every one of them has been a focus of discussions, reports, and recommendations during my professional lifetime. Now is the time to put them into action and to stop skinning the cat.

WE NEED MORE GENERALISTS

Generalism should not just be the domain of GPs, rather an approach taken up also by secondary care colleagues. This was the Royal College of General Practitioners (RCGP) call for action in 2011.[4] Yet true generalists are now hard to find. The general physician has long since gone, replaced instead by a myriad of sub-specialists. Even elderly care consultants, one of the last bastions of generalism have begun the salami slicing of our older-aged patients (falls/elderly, frailty/elderly, and incontinence/elderly). A patient with diabetes, dementia, heart disease, osteoporosis is likely to have multiple hospital teams each providing snippets of fragmented care. Ongoing management has flowed unrelentingly to primary care. This has to stop. Hospital colleagues, in particular those in elderly care, mental health, and clinical medicine must now embrace generalism and care for the totality of their patients, not just parts of them.

> *"Now more than ever the management of complex patients ... must be moved outside the remit of day-to-day care of the GP and instead cared for through intermediate multidisciplinary teams, bridging the gap between hospital, general practice, and home, ... providing enhanced care to patients."*

WE NEED INTERMEDIATE TEAMS

We must accept there are patients GPs don't have the skills to manage (even if we had the time). It takes 3 years for a GP to achieve a certificate of completion of specialty training, far less than other specialties. Yet we are expected to care for some of the most difficult and complicated patients in our communities. GPs bring expertise in managing uncertainty and risk, addressing undifferentiated illness, understanding the patient in the context of their families and community. The NHS needs a new service model, as articulated in 2009 in a joint report by RCGP, Royal College of Physicians, and Royal College of Royal College of Paediatrics and Child Health, recommending partnership working across specialties to manage complex patients or difficult or rare conditions.[5] That need to develop integrated/intermediate services was again articulated in 2013 by RCGP in *The 2022 GP — A Vision for General Practice in the future NHS*.[6] Now more than ever the management of complex patients (including, I would suggest, those in nursing homes, frail elderly, those with complex comorbidities, and those with serious mental illness) must be moved outside the remit of day-to-day care of the GP and instead cared for through intermediate multidisciplinary teams, bridging the gap between hospital, general practice, and home, each adding complementary skills providing enhanced care to patients. This isn't rocket science, but that it is so piecemeal across the NHS suggests structural, training, regulatory, and other barriers, which have to be addressed.[6] Hospital doctors must find a way and come out of their wards and into the GPs' space. They must sit alongside us, caring for patients that should not be GPs' alone.

GPs ARE NOT COMMUNITY HOUSE OFFICERS BUT SKILLED GENERALISTS

We cannot continue to treat primary care as a 'sink hole' absorbing unlimited work. GP trade union leaders have done sterling work in pushing back at the unthinking expectations of 'GP to follow up.' This is a systemic problem extending to the provision of national guidelines which do not adequately consider primary care resource implications. GPs now need to have a hard conversation: what are we not going to do? Without that realisation, without that acceptance, then we are without hope. Hospital doctors must accept their responsibility for their patients, not pass the tasks they can't or won't do to us. If blood tests need chasing or an appointment rearranged or medication amended or an MRI organised or the hundreds of daily tasks hospital doctors ask of us, sort it out yourself. Don't add to our burden by assuming we can do it for you.

WE NEED TO STOP THE INORDINATE EXPANSION OF GPs' ROLES

The mantra 'GPs are best placed' must stop (something I was guilty of years ago before life as a GP became intolerable). Unless of course, that 'best placed' is where we bring our generalist skills and add value (the basis of GPs' with special clinical interest).[7]

It must not, as now, be merely to do the work hospital colleagues either no longer

want or, more often, are pressurised to push out to primary care in the quest for efficiency and cost containment. Aligned to this is the desire to pull GPs into the hospital space (to do the work specialists deem not their role anymore). Removing our precious workforce just to meet demands in another is robbing Peter to pay Paul and bleeds our doctors away from their core primary care work. GP are the most versatile doctors in the workforce, and rightly have developed their special interests. But this has been abused. GPs must get parity of esteem and pay, we are not a cheaper alternative to consultant care or fodder to fill service gaps.

GP TRAINING IS NOT LONG ENOUGH

The role of the generalist has been squeezed by pressure, on one side, from taking on additional tasks and responsibilities, and, on the other, from an increasing dependence on protocols in order to deliver care in a systematic way.[8] We now need to ensure GPs are equipped to cope with these new demands. The frequent, unimaginative calls for 'more education' from single issue campaigns are well meaning, if often self-serving (examples range from management of neurodevelopment disorders, diabetes, or dementia). GPs bristle at the narrow field of vision of highly specialised colleagues who have little appreciation for the expert generalist's role. Yet within lies an uncomfortable kernel of truth and it is one that has been long recognised among GPs. Training is too short, and it is imperative that extended training, from 3 to 4 years agreed in 2012 is implemented.[9] The starting date is already 6 years behind schedule.

Furthermore, exposure of hospital doctors to general practice is long overdue. All hospital doctors, irrespective of their specialty, must do a core part of their training in general practice — I suggest a minimum of 6 months, not in their foundation years, but when they can best gain from training in this difficult area, so at least ST4 level.

ORGANISING PRIMARY CARE

I have been making the argument for nearly 20 years that the partnership model is outdated and holds us back. I accept that many of my colleagues disagree with me. I would like to suggest a variation on a theme. The pandemic has shown the value of GPs working together — within primary care networks (PCNs). Patients and staff have benefited from the greater flexibility size gives. We should build on this and pool patient lists across PCNs; allowing for continuity provided through personal lists (adjusted in size to address numbers of clinical sessions GPs undertake). Digital triage will facilitate better access, helping direct the patient to the right clinician, with the right degree of urgency and at the right place, capitalising on the transformation that we have seen during the pandemic.

PROPER JOB PLANS

We must cap the number of patients GPs routinely see per day and per week. The current situation is intolerable, unsustainable, unsafe, and leads to burn out, depression, and poorer quality care. We must look to split the GP's working week into digital, face-to-face, continuity, and multidisciplinary contacts — each given the necessary time with appropriate limits. GPs must have built in time for reflective practice where all mandatory training takes place, not alone in the sterile online spaces. We must drop the term 'portfolio' careers. It is confusing and denigrating. GPs are doctors working across different domains of our specialty. That some of this is clinical, some managerial, academic, educational, and so on, does not make us less of a GP.

PULL YOUR OWN OXYGEN MASK DOWN FIRST

GPs need to recognise their role in this current crisis. As doctors we are trained to make the patient our first concern. This is hard wired into us and part of our identity as a doctor. The triad of guilt, shame, and an overvalued sense of responsibility means that doctors, especially GPs, will deny their own needs for those of their patients. This must stop.

CONCLUSION

We have been here before. Each crisis leads to a resolution which gives us, in part, a better work–life balance.[10] My solution will mean GPs working differently and acknowledging that they have to give things up. What I describe in this article is no doubt being delivered somewhere, by someone or some team. Now we need whole scale change if we are to restore the jewel to its crown.

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Competing interests
Clare Gerada is past Chair RCGP Council 2010–2013; RCGP Council Member continuously since 1998; current member BMA council; past member GPC: co-Chair NHS Assembly; senior partner Hurley Group; medical director Practitioner Health Programme; board member and founder of eConsult; and independent advisor to Cygnet Health Care Advisory Board.

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