Editorials

Opportunities and risks within the expanding role of general practice

General practice has been increasingly required to expand its role to take on more complex care — demands enabled by the fluid boundaries of what constitutes 'general practice'. To date, this expansion has largely related to the care of older patients with multiple morbidities; however, medical advances also present increasing opportunities to relocate specific treatments to primary care that have previously been the sole domain of hospital specialists. With the pressures of COVID-19 and yet more proposed NHS reorganisation, is it fair, or even feasible, to expect GPs to take on more responsibility, which may also open them to censure or legal liability?

CHANGING ROLE OF GENERAL PRACTICE

The parameters of 'general practice' shift frequently in response to the exigencies of politics, economics, demographics and changing health needs. Descriptions of the GP role are often imprecise, using language such as 'expert generalist' and referring to abstract values such as 'competency'.[1] The 2018 Scottish General Medical Services Contract is based on the four principles of *'contact, comprehensiveness, continuity and co-ordination'*[2] and the English GP contract requires the provision of 'services' in broad areas such as 'chronic disease',[3] but neither is specific to conditions or treatments. This lack of precision may be inevitable for a profession with the title 'general practitioner', but while it is difficult, and perhaps unwise, to be prescriptive about every aspect of the role, this leaves general practice more vulnerable than most medical specialties to reorganisation. GPs work increasingly with allied health professionals as well as leading teams of support staff whose roles are similarly being expanded. This presents both opportunities and risks in terms of team-working skills and coordination of care, as well as questions over who should bear ultimate decision-making responsibility for complex cases.

Over the years, NHS policy and GP contracts in each of the UK nations have demonstrated continual restructuring and extension of the boundaries of GP care to take on additional services, moving increasingly complex care into the community.[2,4] The means of delivering such care are also shifting, with digital technologies expanding modes of consultation; ongoing technological advances making remote monitoring possible for many chronic conditions; and GPs embedded more pivotally within wider intra- and inter-agency teams. This shifting role is not unique to the UK. Schäfer and colleagues found a significant increase in GPs' involvement in the treatment of disease across 28 European countries between 1993 and 2012, largely driven by health expenditure pressures rather than changing medical needs.[5]

BENEFITS OF AN EXPANDED GP ROLE

There are substantial benefits to an expanded GP role in the UK. The move away from historical 'fix and treat' models of NHS care towards more preventive, integrated, and primary care-focused health and social care strategies brings potential for significant financial savings.[6] A World Health Organization sponsored scoping review on primary health care economics reported GPs used fewer resources and reduced healthcare costs compared to their specialist colleagues, reducing avoidable (re)admissions and costly use of the emergency department.[7] Of note, fiscal restraint in a post-COVID-19 economy will undoubtedly be high priority.

However, monetary considerations alone belie the potential therapeutic benefits of GPs managing increasingly complex care. There is a wealth of evidence demonstrating improved patient satisfaction, better healthcare outcomes, and even longer life expectancies associated with continuity of carer.[7,8] Enhancing the GP role therefore presents an opportunity to combat threats to relational and managerial continuity for people living with multimorbidities. Long-term therapeutic relationships matter. In addition, GPs offering an extended range of services confront ingrained barriers to healthcare for marginalised groups, reducing inequities by offering familiar and local points of access.[7,9] For example, prescribing of hepatitis C virus (HCV) treatment in Australia was expanded to general practice in 2016, contributing to a sharp increase in treatment uptake among people who inject drugs.[10]

Opportunities for professional development are also nurtured by enhanced roles for GPs in complex care. With increasing involvement from diverse health and social care professionals in chronic disease management, GPs may enhance broad transferable skills such as teamworking, leadership, and care coordination. GPs with special interests in particular conditions or groups of patients may also develop knowledge and skills beyond the scope of GP training and the MRCGP exam, becoming GPs with Extended Roles.[11] Such professional development opportunities offer expert medical generalists the options of specialist practice while remaining embedded in primary care.

RISKS OF AN EXPANDED GP ROLE

Demands on general practice continue to rise year on year. In England alone, GP appointments rose from 222 million in 1995 to 308 million in 2018/2019.[12] Cases also continue to increase in complexity with large rises in the number of patients with multiple long-term conditions.[13] This escalating workload is leading to widespread GP burnout and increasing numbers of GPs leaving the profession.[14] Any further expansion in GP role may therefore present risks to individual GPs, patients, and to the profession as a whole if it continues to be pushed beyond capacity.

GPs have argued that they have insufficient time, knowledge, or financial resource to take on more complex care, which may require additional oversight or training.[15] This may lead to practitioner concerns about their ability to provide safe patient care, and the spectre of legal liability if things go wrong. This concern about adequate GP competency may be shared by patients who find they are no longer under the care of a specialist. Complaints to the General Medical Council (GMC) or legal claims for compensation in civil law are brought against an individually named GP or practice, rather than against an NHS Trust as is generally the case in secondary care. Dealing with any litigation can therefore feel more personal and immediate. But while concerns about potential legal liability are understandable, the requirements for a successful claim in clinical negligence are high, with a plaintiff needing to show first a breach of the duty of care (that care fell below what would be considered a 'reasonable' standard according to the standard of a doctor of that level in that specialty[16]) and second, that on a balance of probabilities the negligence caused or appreciably worsened the patient's condition — the so-called 'but for' test. If the patient's injury is due to some other cause or pre-existing illness the claim will fail. Although modified by subsequent case law,[17] the 'Bolam test' remains the basis of clinical negligence law.

BALANCING THE BENEFITS AND RISK OF EXPANDING ROLES IN GENERAL PRACTICE

There are already examples of primary care

taking over a greater share of chronic disease management. It is now standard practice in patients with inflammatory joint disease for a hospital-based specialist to set up a care regimen that is then continued and monitored in primary care.[18] The number of patients with type 2 diabetes is beyond the capacity of secondary care and it is now routinely managed in primary care, including initial diagnosis and prescribing.[19] These are two examples among many, illustrating the expanding primary care role in chronic disease management, minor surgery, women's health, and many other areas.

Despite the increase in workload and complexity as a result of the GP expanding role, the number of complaints to the GMC about GPs has been dropping since 2015, and in 2020 only 6 cases (0.3%) resulted in any sanction.[20] While litigation makes headlines, in practice, adherence to clear and robust protocols, developed in collaboration with subject specialists, should be sufficient to demonstrate a reasonable standard of care.[21] There are many more currently 'specialist' areas of clinical practice with potential for greater primary care involvement. HCV, for example, presents a strong case for early community detection and management, with the arrival of very effective oral treatments transforming a largely incurable condition with complex, toxic treatments into a curable infection.[15] Vaccine and treatment advances for other chronic viral infections may provide further opportunities for an expanding primary care role.

The ability of general practice to adapt and respond to meet changing population and health system demands is a strength that deserves greater recognition and development. Primary care has shown during the COVID-19 pandemic how adaptable it can be to different ways of working as GPs have moved to remote consultations and supported home monitoring of chronic disease, all while helping to coordinate a mass vaccination programme. Primary care is also likely to bear the burden of long COVID.[22] Taking on more will require consideration of both the risks and opportunities that come with this. The continual creep towards increased responsibilities must be accompanied by long-term increased investment as well as clear contractual arrangements and protocols if general practice is to have a sustainable future.

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