Rethinking generalist health care:

opportunities from challenges

Health Education England describes a vision of future health care built on whole-person, generalist care.[1] But, if this is to succeed, we must first address some misconceptions about medical generalism. My team have been working on three.

NOT 'SOFT SKILLS' BUT 'TAILORED CARE'

Ask someone, 'What is person-centred care?' and they commonly describe the importance of the so-called 'soft skills' — communication, empathy, relationship-based care. These certainly matter — research and clinical experience confirm the therapeutic value of relationships. But it was a patient who made me think again. Let's call her Helen.[2] Helen was dying from breast cancer. She was a busy wife, mother, employee. Terminal cancer had turned her daily life upside down. Helen spoke movingly about how much she valued her relationships with her clinical team. Their empathy, care, and understanding of her illness as being 'more than about cancer' created invaluable personal care. But she criticised the same professionals for their failure to translate personal care into personalised health care: '... *they do listen, but they don't think they need to take notice*'. She talked of professionals repeatedly offering 'evidence-based' justifications for clinical decisions, but being apparently unable (or unwilling) to create tailored approaches. This left Helen feeling '... *stuck on a conveyor belt*'.

Helen's story highlights that personal care — soft skills — are important, but insufficient. Person-centred care also needs personalised, beyond disease-guideline, care: a model of practice that is anything but 'soft'.

NO JACK OF ALL TRADES BUT AN EXPERT KNOWLEDGE WORKER

People have long described the person-centred, generalist role as a 'jack of all trades' (omitting the implied 'master of none') — someone who 'knows a little about a lot'. Helen's story supports professional voices who argue that modern professional practice is defined not by what you know, but how you *use* what you know.[3]

Every time we work with a patient, we explore their illness using information from patients, evidence, and professional experience; to construct a tailored (whole-person-centred) explanation. We use this to create and implement a management plan, which we follow up and evaluate (review and revise). This whole-person-centred care[4] relies on the daily task of collecting, creating, and critiquing knowledge-in-practice-in-context.[5] This is the knowledge work of everyday clinical practice.[6]

The distinct knowledge work needed for tailored, expert generalist care is grounded in scientific practice, but it is a different understanding of scientific practice than used by disease-focused Evidence-Based-Medicine (EBM).[7] EBM is important for person-centred care, but insufficient. A short YouTube animation explains why.[8] Expert generalist care requires us to create, use, and evaluate tailored[7] knowledge-in-practice-in-context.[5] Clinicians have told us they don't feel confident doing this complex knowledge work — so we created the WiseGP[9] and CATALYST[10] programmes to help. Both aim to support the distinct knowledge work of expert generalist practice, and in so doing champion a new vision of professional practice.

But the same clinicians also tell us that their workplace prevents them from working in this way. So we need also to think about context.

NOT JUST BETTER INTEGRATION BUT NEW DESIGN

Research consistently highlights a number of contextual barriers to person-centred, generalist care including the failure to value, prioritise, recognise, and support this complex work.

Health service leaders have described that we must change the culture and systems in which we work.[11] Currently, change is focused on improving integration — the coordinated, efficient delivery of care. However Lewis recognised that integration is important, but insufficient, if it just delivers more of the same.[12]

To improve care, we need to design person-centred knowledge work into the way we run healthcare systems. But how? Some of the answers lie in current health services research. Gabbay and le May's account of primary care knowledge work

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(the generation of mindlines) has sparked a rich stream of research for us to draw on.[5] My team's recent synthesis of the evidence on deprescribing[13] revealed a number of key components to design into new systems including prioritisation of the knowledge work, digital data integration, and re-negotiation of teams.

But we should also look outside of healthcare systems for inspiration — to the wealth of thinking and research on supporting knowledge work to be found within other sectors and studied within business schools.[14] Health care is not alone in grappling with these challenges.

OPPORTUNITIES ARISING

Rebuilding health care around whole-person-centred practice offers crucial opportunities to re-imagine GP careers; remodel daily practice; and redesign health systems. We're already seeing benefits through our work at the Academy of Primary Care and WiseGP, and are using those messages to challenge whole-system thinking.[15] If you're doing this too, we'd love to hear from you.[16]

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