THE BIRTH OF ‘GENERAL PRACTICE’

In 1961, a historic decision was made in the National Library of Medicine in Washington, US. It recognised that the Journal of the College of General Practitioners was reporting a new science, within the family of medical sciences, and decided to include it in Index Medicus giving it international scientific recognition. The science of general practice was born. This was the first general practice journal in the world to be recognised. RMS McConaghey, a GP in Dartmouth, Devon, had developed the newsletter of the College of General Practitioners into a new medical journal in 1958. Crucially, he made it a peer-reviewed journal of record rather than a review journal, which most other GP colleges chose, giving the UK a world lead it has retained.1

In 1961, there was no professor of general practice anywhere in the world. Most people had no understanding that general practice could itself become a discipline, and that understanding existed only in the minds of a few GP leaders. General practice lacked respect. Having an internationally recognised journal and a new science started to give general practice respect. Attempts to name this new science included Harris (1970)2 suggesting ‘innominate science’ and me (1978)3 calling general practice a new behavioural science. Neither stuck, so it is time to try again.

‘GENERAL PRACTICE’ AS A DISCIPLINE

Is considering general practice as a discipline or science just an ‘academic’ question? Is it important in the real world? I learned just how much it matters when as President of the Royal College of General Practitioners (RCGP) I was being considered, for the first time for a GP, for the next Chair of the Academy of Medical Royal Colleges. Just before the most important election of my life, the president of a specialist medical royal college said to me: ‘As we get on well, Denis, I owe it to you, to say I can’t vote for you as Chairman’! Thanking him for telling me, I asked why? ‘Nothing personal,’ he said, ‘you have written good papers for the Academy, but I can’t vote for a GP, as general practice is not a discipline.’

He was, of course, wrong, as general practice had then been a discipline for 40 years, but this distinguished professor at a London teaching hospital did not know that or respect general practice. He saw it, as some others still do, as bits of other disciplines practised at a more superficial level.

Mercifully, the other presidents of the specialist medical royal colleges did not share his view and they elected me the first GP Chair of the Academy of the Medical Royal Colleges in 2000. However, the importance of general practice being seen to have a discipline, especially by colleagues outside practice itself, became clear.

Having a new discipline or science, recognised internationally, changed the relationship between generalist doctors and specialist doctors permanently. Before 1961, that relationship was simple: specialists were the teachers and GPs were the pupils. But with its own science, general practice became different, unequal at first, but ever more equal as general practice research evolved within the family of medical sciences. One implication is that we must learn more from other GPs.

BREADTH AND DEPTH

What is the difference between the science of generalist and specialist doctors? Specialists define themselves by developing ever greater knowledge and skills in depth. They are rightly proud of their great successes, which they promulgate well. My family and I are grateful to several specialists for skilled care. But specialist practice depends on drawing a rigid line around a narrow, clinical field, and specialist practice advances by further dividing into ever narrower fields. There are now one-operation surgeons and one-disease doctors—such as diabeticians.

Generalist and specialist doctors are equal and complementary. GPs develop breadth of thought. Alone in the medical profession they accept patients’ problems from top to toe, from migraine to an ingrowing toenail, problems in all parts of the body and mind simultaneously. GPs alone have the privilege of being best placed to see the whole patient, as a person, often in the context of their family and environment, and often over years.

The philosopher Isaiah Berlin wrote a famous essay called The Hedgehog and the Fox.4 He classified people into two groups: hedgehogs who see the world through the lens of one big idea, and foxes who know a lot about many things and cannot be pigeonholed. Many specialists are successful hedgehogs. GPs are foxes and we should rejoice in being foxes! We have breadth, which is different, and just as important as depth, and we can best see multiple problems and competing treatment priorities within a whole-patient perspective. GPs are spared tunnel vision.

OPPORTUNITIES TO INTEGRATE CARE

Of the 20 core principles underpinning the discipline of general practice, two stand out: generalism and continuity of care. Generalism because it is our core identity, strength through breadth, and continuity because as patients return with different problems over time, we get to understand them as people and the context of their lives. GPs have the longest and deepest working relationships with patients of any branch of medical practice. An old saying

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is: in specialist practice the diseases stay the same and the patients keep changing; whereas in general practice the patients stay the same and their diseases keep changing. Specialists promulgate the successes of their specialisms so GPs need to do the same for generalism. Just as specialists take advantage of their fragmentation of the human body into ever narrower specialties, we should value our six special opportunities to integrate care.

1. Integrating past and present
GPs, more than other clinicians, integrate past and present. GPs are the most aware of the past experiences of their patients, particularly events they have ‘witnessed’. GPs are best at interpreting current problems in the light of the patient’s previous experience and suffering. Much research reveals that patients who experience ‘adverse effects in childhood’ can pay a lifetime price, influencing patients who experience ‘adverse effects in adulthood’.

2. Integrating physical and mental health
As medical generalists, GPs alone have the widest perspective in medicine to do well, since integrating physical, psychological, and social factors, while simultaneously strengthening a good relationship with the patient, is a great skill. Katerna et al measured the complexity of consultations by cardiologists, GPs, and psychiatrists, finding that GP consultations were the most complex.

3. Managing multimorbidity
There are a growing number of patients with several diseases at once, for whom generalist doctors are best at integrating care across multiple diseases and competing treatment priorities. Guideline treatments of different conditions may conflict. What matters most to the patient may take time to find out.

4. Integrating preventive and curative medicine
GPs integrate treatment and preventive care more than doctors in any other branch of medicine, with millions of immunisations, for both young and old, plus cervical smears, checks on blood pressure, glycaemia, and lipid levels. Patients get much preventive care and treatment in the same place and by the same team. Patients accept offers of preventive care significantly more with GP continuity.

5. Integrating social factors into care
GPs integrate social factors into care. Social determinants of health and disease are undervalued. Loneliness can kill and is mostly a GP diagnosis. Human relationships at home and at work influence thousands of GP consultations. GPs’ position as clinical generalists in the community allows them, better than other kinds of doctor, to lead on the human side of medicine by learning about and integrating numerous social determinants into day-to-day care.

6. Integrating present and future
An important GP privilege today is that, with our computerised clinical systems calculating risks, we are now integrating the present with the future in a new form of anticipatory care. Understanding that a patient has a 10%–20% risk of a cardiovascular event in 10 years’ time is a new kind of medicine. This can’t be done as well by specialists, because they do not see the beginning of most illnesses. I estimate general practice already quietly prevents about 15 000 heart attacks and strokes a year by implementing the National Institute for Health and Care Excellence guideline (CG181) as discussed by Duerrden et al, with many more to come. GPs (full-time) save 4.7 lives a year and are increasingly reducing patients’ future risks.

The registered list of patients is an asset allowing GPs to integrate personal and population medicine more easily than hospitals can do. It is easy to identify patients who have missed out important aspects of GP care. Health inequalities are a notable example. The expanding GP team is well placed to close such gaps in care.

These six ways of integrating care occur simultaneously and make general practice the integrating specialty in medicine.

IMPLICATIONS
Several implications follow from having a unique, integrating discipline, one of which is that generalist and specialist medicine are complementary. This complementarity is an advantage for patients.

General practice is the easiest branch of medicine to do superficially as the risk of an immediate bad outcome is low. It is also the hardest of all the branches of medicine to do well, since integrating physical, psychological, and social factors, while simultaneously strengthening a good relationship with the patient, is a great skill. Katerna et al measured the complexity of consultations by cardiologists, GPs, and psychiatrists, finding that GP consultations were the most complex.

While simple problems, such as impetigo, can be resolved in a single GP consultation, it is often not possible to provide optimum care in just one consultation. Once it is clear that patient-centred medicine in general practice means getting to know the patient as a person in their context, especially understanding their individual experiences, hopes, and fears, then time with patients becomes important, and 15-minute consultations and GP continuity become features of high-quality care.

The challenge of finding time has become easier by the discovery that patients are more empowered after seeing their regular GP, compared with those seeing other GPs in the same practice, returning after a significantly longer time. For frequent attenders, as many as 5.2% of GP consultations can be reduced. Continuity counts!

Understanding that integrating a wide breadth of information into care is a core function of general practice illuminates how general practice should be learned and taught. Experiential teaching (‘I have found this useful’) has its place, but the six

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strands of the integrating discipline need to be demonstrated to students and trainees. The role in preventive medicine and anticipatory care and the lives it saves needs careful unpacking as students can leave GP placements without appreciating this.

Another implication is self-image. Some new doctors, after 5 years of medical school training, where over 90% of their teachers are specialists, can think general practice is inferior to specialty practice, since specialists know more than GPs about any given disease.

Learning that general practice is a discipline in its own right, independent of any single disease focus, and one which can integrate care in breadth for individual patients is liberating. Students and GP trainees need to study the opportunities in general practice that specialist medicine cannot match: seeing the earliest presentations of disease, generalism, the registered list, family care, life-saving anticipatory care, the privilege of seeing many patients over years, and the long-term outcomes of diseases and treatments. These features can give newly qualified doctors more self-confidence and encouragement to work in general practice.

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