Life & Times

What is good general practice?

Recollected

INTRODUCTION

'How to move from managing sick individuals to creating healthy communities', the editorial earnestly intoned.[1]

Luke Allen *et al* went on to argue the case for reorienting the NHS towards prevention, upon which less than 5% of the health budget is currently spent. Social determinants, after all, account for up to 90% of health outcomes. They suggested, among other things, that practices should work alongside public health teams proactively to engage with local communities in furtherance of health promotion. So far, so comprehensible. In the opinion of many readers, I suspect, they then departed Planet Earth:

'We need a greater focus on fundamentally changing the physical and socio-political structure of society ... ' Really?

There are several reasons why their call will go unheeded, notwithstanding a long tradition of public health in general practice (or, for that matter, strong arguments for changing the structure of our society). Few have ever embraced the role of Tudor Hart's community physician.[2] In part, this is because Allen *et al*'s vision is essentially ideological. Public health inclines to centralisation and is largely 'left wing'. GPs, on the other hand, are politically heterogeneous. Closet 'Corbynistas', they are often working in inner cities, rubbing shoulders with more reactionary colleagues from the shires. Vulgar caricatures, of course, but GPs are understandably suspicious of grand plans. The utilitarian values underpinning population-oriented care and budget-holding are sometimes at odds with the individualistic nature of the doctor–patient relationship.

Then there is the ever-present problem of time. Allen *et al* suggest that GPs engage with Health and Wellbeing Boards, Joint Strategic Needs Assessments, and Better Care Fund activity. Even without spare hours in the average working day, how much effort can you expend in such areas and retain the will to live? Are we trained to act as effective advocates for the population's health? The authors make a plea for better undergraduate education. While no one doubts the scope for improving how public health is taught in medical schools, suffice to say that it will always be a minority interest.[3] Finally, while the justification for such role diversification may seem compelling, the evidence to justify it is often rather less so. Do we really know how much impact such activities will have? The vogue for social prescribing is instructive here. Few of the activities we are currently being encouraged to promote are grounded in decent evidence.[4]

Allen *et al* ask: *'Is this the role of general practice?'* What indeed is general practice for and, by extension, what is good general practice? Many luminaries of our discipline have addressed the same questions.

PETER TOON

In a seminal monograph published a quarter of a century ago, Peter Toon elegantly delineated three principal models of general practice: a preventive, public health approach with Hippocratic roots; a biomedical model with its basis in scientific medicine and the Enlightenment; and a humanist model (of which the Balint movement is an example) that is expressive of an older philosophical tradition.[5] All three models have distinctive strengths, weaknesses, and sometimes conflicting ethical foundations. The models are not, of course, mutually exclusive in practice.

THE POLITICS OF PRACTICE

From the early 1800s, GPs served as local medical officers superintending sanitary projects and vaccination programmes at a time when they had but a few symptomatic remedies in their armamentarium. Latterly, despite undoubted benefits, screening and other forms of health promotion have come at a cost: the medicalisation of normal life. The effectiveness of many preventive interventions is contested. Charged with changing behaviours they cannot control, many health workers resent responsibility for essentially political objectives.[6]

From the biomedical perspective, the main focus of general practice today is chronic disease management. Scientific progress has extended impressively the technological range of general practice. Information and communication technologies are continuing to transform medical knowledge and practice. However, most day-to-day practice remains, as it always has been, acute-on-chronic. Evidence-based medicine requires clinical decisions to be rooted in 'health intelligence' rather than in the practitioner's wisdom. The Quality and Outcomes Framework, a large pay-for-performance programme, represented a zenith in this regard. Worthily based on the latest evidence, it successfully reduced variations between practices against a basket of process indicators but, overall, over £1 billion of annual expenditure yielded little evidence of improved outcomes in population health.[7] In the meantime, care has been depersonalised.

COMPUTERISED CARE

The medical gaze is nowadays refracted through computerised protocols and algorithms; first we check the template, then we listen to the patient. The screen has replaced the body as the emblem of contemporary medicine. For all biomedicine's triumphs, central questions concerning the causes of common chronic disease and how best to manage them remain unanswered. The portentous claims made down the decades on behalf of the new genetics ('genohype') have yet to materialise. Comparable disappointment will attend the seductive declarations now being made for 'Big Data'.

Biomedicine is in many respects a confidence trick, prone to 'techno-solutionism' and the neglect of holistic care. Toon's third, humanist, domain sees medicine as quintessentially concerned with human relationships. Rejecting a dualist, more individualistic model of personhood, the role of the doctor is (sometimes) to enhance the patient's coping abilities and promote acceptance of illness as meaningful. For much of what presents in general practice cannot simply

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be suppressed or removed. The goal of care is psychological adjustment and understanding.

Foremost among contemporary commentators, Iona Heath writes eloquently of the need to recalibrate consultations with more emphasis on those aspects for which evidence-based medicine (EBM) has no answers. Scientific reductionism devalues individual experience. While EBM describes people in terms of biomedical data, clinicians must interpret more complex information to help individuals make sense of their illness — and do so under conditions of uncertainty:

'A profound problem is that the map of biomedical science only roughly matches the territory of human suffering.'

She uses literary examples beautifully to bridge the gulf between medical science and human experience.[8]

CONCLUSION

For many practitioners, the language of this teleological domain is arcane and abstruse. The work of Michael Balint on the psychodynamics of the doctor–patient relationship is no longer central to the training of GPs. Too much emphasis on such soft skills can cloak technical failings. Anyway, the argument goes, continuity of care is less important for younger users meeting all their informational needs from their smartphones. Yet, ironically, it is this domain that underpins GPs' ability to deliver both effective prevention and efficient technical care. The hermeneutic approach is facilitated by — and sometimes conflated with — continuity of personal care. There is observational evidence that such continuity may be associated with reduced mortality but policymakers continue to prioritise access.[9] Practitioners recognise this domain as it comprises much of their everyday. Biomedicine is positively unhelpful in promoting the delusion that 'something (technical) can be done' for many conditions. Artificial intelligence is not going to displace the doctor as drug any time soon. Rather, personal contact with a known and trusted source of support will become ever more precious.

Health systems are part of the fabric of social and civic life. They both signal and enforce societal norms through the personal experiences of providers and users.[10] These norms may indirectly be as salutogenic as the technologies provided. However, workforce trajectories suggest that 'relationship-based care' may soon be nurse-led or the preserve of the affluent. Toon's typology (here simplified) helped to map our professional territory. Having analysed the philosophical concepts underlying his paper's title, his conclusions were deceptively simple. He noted two fundamentally different aims of general practice: hedonic (helping patients avoid suffering) and hermeneutic (concerned with patients' search for meaning). He regretted the absence of a theory of justice properly able to reconcile these different aims.

With various views of what general practice is, quality must necessarily be a multidimensional concept. Written at a time when general practice was also *'seriously afflicted by anxiety and uncertainty'*, Peter Toon's magisterial monograph repays re-reading today. We are little further forward.

Allen *et al*'s concerns are commendable. Some doctors will share their crusading zeal and join forces to change society. Others will want to dedicate themselves to a challenge more imminent — preserving a future for the humdrum routines and rituals of day-to-day general practice.

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