The NHS revolution: health care in the market place

Medical generalists: connecting the map and the territory

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The debate on market reforms must not overlook general practitioners' over-riding responsibility—to recognise and relieve patients' suffering

This article is part of a series examining the government's planned market reforms to healthcare provision

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Despite enormous advances within medical science over the past 100 years, an under-recognised but inevitable gap remains between the map of medical science and the territory of individual human suffering.[1] The task of the medical generalist is to make useful connections across this constantly recurring gap. All doctors carry the medical map, albeit with patchy and varying levels of detail, but only the medical generalist uses it to try and make sense of the whole human person, transcending all the arbitrary divisions of specialist practice. Here we explore the role of the medical generalist and consider how this might be affected by current NHS reforms.

Generalist's role

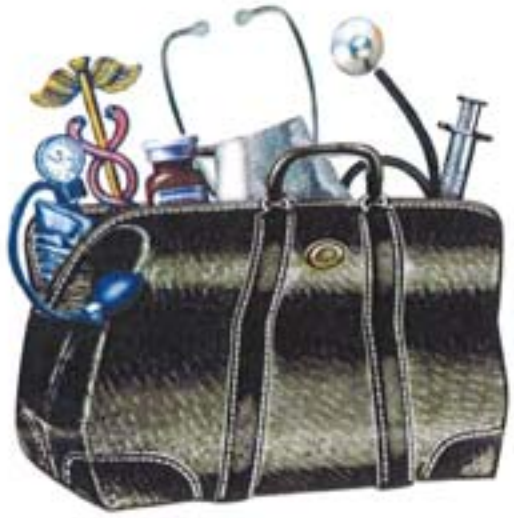
In the initial consultation with a general practitioner, doctor and patient work together to explore the usefulness and the limitations of the medical map in relation to the territory (or subjective experience) of the patient's particular illness. When the patient has an acute and remediable illness or accident, attention will be mostly on the map, but when the patient is dying the attention will revert almost entirely on to the territory.[2] In chronic illness, a careful balance must be achieved and maintained so that neither aspect is neglected.

To work effectively in this context, the medical generalist must maintain a clear understanding of both borders of the gap. This requires a thorough, robust, and continuously updated knowledge of medical science; an empathic willingness to recognise, acknowledge, and witness the true extent of suffering; and an appreciation of the details of individual lives, combined with a respect for the history, aspirations, and values which have made those lives what they have become.

Centrality of medical diagnosis

General practitioners operate in a low tech environment, where, until recently, the most sophisticated instruments available were the stethoscope and sphygmomanometer. Yet they are responsible for making the initial medical diagnosis on which almost all subsequent care is based. The accuracy of that initial diagnosis is crucial and necessitates a high degree of technical and experiential competence, combining a robust appreciation of the range of the normal with a high index of suspicion for the dangerous. Diverse diagnostic challenges such as reviewing the diabetic retina, inspecting the cervix, making sense of multiple non-specific symptoms, assessing the suicide risk in a depressed young man, and carrying out a developmental check on a newborn baby are just part of the normal working day for the medical generalist.

General practitioners encounter diseases at the earliest stages of their development, long before a clear and coherent clinical picture forms. Much illness resolves without reaching the threshold of disease definition, and fully developed disease is much rarer in primary care than in secondary care. The general practitioner must develop the skill of using time to reveal the natural course of a presenting condition.



General practitioners operate in a low tech environment

The inevitable uncertainty of front-line primary care medicine is confirmed by the fact that the predictive tests of medical science do not work nearly as robustly in the low prevalence setting of general practice.[3] One of the contributions of generalist practice to improving health outcomes for populations is mediated by broadly based diagnostic skills that can select, through the referral process, high prevalence populations for specialist practice and thereby ensure the effectiveness of specialists. This skill constitutes a uniquely valuable healthcare commodity.[4] Illness is much more extensive than disease—and the disease which is referred on to specialist colleagues is only just over a tenth of that seen and treated in general practice. At each stage, the prevalence of biomedical abnormality increases and diagnostic tests work more robustly.

Thus general practitioners must use technical and experiential evidence from a multiplicity of sources to formulate both a diagnosis and a response.[5] This process always involves judgment and is always risky. Both too little and too much caution can be dangerous. It is surely right that society should place the responsibility for these risks on those who are most highly trained. The current proposals to replace doctors with nurses, pharmacists, and computers can do nothing to reduce the risks and, in the face of less medical knowledge,

may well increase them. To offer this substitution is to misunderstand the complexity of the generalist's task.[6]

Coordination of care

The role of the general practitioner in coordinating health care across a range of professionals, within and beyond primary care, is often assumed but has been subject to little analysis. The role falls to the general practitioners because of their continuing commitment to the care of a registered list of patients, and because, alone across the whole range of health professionals, the general practitioner is not expected to discharge the patient from his or her care. Patients and general practitioners therefore have a tacit understanding that, if the healthcare system is not working, the general practitioner is in a position to sort things out and has a responsibility to do so. Practising within a defined local area, general practitioners rapidly develop knowledge and understanding of how the local healthcare system works and an awareness of which parts of the service are performing well and which are struggling with, for example, an excessive workload or a staff shortage. This knowledge is continually updated by patients, who return from hospital or from other parts of the service to give an account of their experience.

The general practitioner's coordinating role[7] becomes absolutely crucial given the increasing number of patients who have more than one health problem, each of which affects the course and management of the others.[8] Such comorbidity occurs disproportionately within populations that are socioeconomically disadvantaged or elderly, and particularly within populations which are both.[9]

Social solidarity

The NHS is an expression of social solidarity by which citizens, through taxation, provide health care, free at the time of need, to each other.[10] The current emphasis on rights within health care without a balancing emphasis on duties threatens the survival of the underpinning social solidarity. The right to see a general practitioner within 48 hours, and at any time of day or night, with no allowance for the degree of need, minimises the duty of citizens to use the limited provisions of the NHS in a manner that is proportionate to their needs.

General practitioners working within a nationally funded service will always have a role as agents of distributive justice, if only in the way that they choose to allocate their time to different patients competing for this limited resource. This means that general practitioners and other clinicians must retain both the ability to allocate their resources on the basis of perceived need and the responsibility to try to modify health seeking behaviour. The emphasis on rights at the expense of duties also makes it more and more usual for people to demand a level of service for themselves and their families while declining to pay the level of taxes that would be needed to provide that same level of care for everyone.

Suffering

Much contemporary discussion about general practice focuses on the profession's response to the enormous pressure for change within the NHS.[11] How will general practitioners adapt to new relationships with other professionals? How will they deal with the challenges of new technologies and new interventions? At the heart of general practice however rests the central, enduring responsibility of doctors in any society—the recognition and relief of suffering.

Paradoxically, the successes of medicine have enabled an increasing number of people to survive many previously fatal events and diseases including heart attacks, strokes, and cancers. As a result, more people live long enough to experience one, or more likely several, chronic conditions. These common conditions (such as hypertension, diabetes, ischaemic heart disease, chronic obstructive pulmonary disease, and dementia) remain incurable, debilitating, and progressive.

As general practitioners focus increasingly on the management of people with multiple and compounding conditions, the balance of technical with compassionate care must be continuously negotiated so that it makes sense in the context of the patient's life story and acknowledges the full diversity of their health and social problems. In such a situation, the values and priorities of the individual patient must always be allowed to trump the dictates of medical science and evidence based guidelines. The ever present, malevolent potential of illness to destroy an individual's personhood can never be forgotten. Although biomedical interventions may become more sophisticated, and service delivery more slick, the responsibility of the general practitioner to acknowledge and where possible relieve suffering endures and can never be abrogated.

Summary points

General practitioners' skills encompass both the principles of science and the experience of suffering

As more people survive to endure multiple and compounding chronic illnesses, the need for generalist skills to integrate care of the whole person becomes greater

In a system of health care predicated on social solidarity, the rights of the individuals have to be balanced against the duties of citizens

The current emphasis on radical transformation of the NHS demeans the enduring responsibility of doctors in any society: the relief of suffering

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Competing interests: IH and KS are general practitioners and will therefore be directly affected by the government's planned changes to healthcare provision.

1 Korzybski A. *Science and sanity: an introduction to non-Aristotelian systems and general semantics*. Lancaster, PA: International Non-Aristotelian Library Publishing Company, 1933.
2 Heath I. Uncertain clarity: contradiction, meaning, and hope. *Br J Gen Pract* 1999;49:651-7.
3 Ahlbom A, Norell S. *Introduction to modern epidemiology*. Chestnut Hill, MA: Epidemiology Resources, 1984.
4 Forrest CB. Primary care in the United States. Primary care gatekeeping and referrals: effective filter or failed experiment? *BMJ* 2003;326:692-5.
5 Gill CJ, Sabin L, Schmid CH. Why clinicians are natural bayesians. *BMJ* 2005;330:1080-3.
6 Sweeney KG, Griffiths FE, eds. *Complexity and healthcare: an introduction*. Abingdon: Radcliffe Medical Press, 2002.
7 Starfield B, Lemke KW, Bernhardt T, Forrest CB, Weiner JP. Comorbidity: implications for the importance of primary care in 'case' management. *Ann Fam Med* 2003;1:8-14.
8 Royal College of General Practitioners. *Hard lives, improving the health of people with multiple problems*. London: RCGP, 2003.
9 Watt GCM. The inverse care law today. *Lancet* 2002;360:252-4.
10 Towell D. Revaluing the NHS: empowering ourselves to shape a health care system fit for the 21st century. *Policy Politics* 1996;24:287-97.
11 De Maeseneer J, Hjortdahl P, Starfield B. Fix what's wrong, not what's right, with general practice in Britain. *BMJ* 2000;320:1616-7.