The Review

Dismantling Lord Moran's ladder:

the primary care expert generalist

'It's not a choice for me to be a generalist. I would have liked to have done something more.' (Early career doctor)[1]

It is over 50 years since Lord Moran suggested that GPs were doctors who have fallen off the specialist ladder.[2] Then, two-thirds of early career GPs would have preferred to have been specialists.[2] Today Lord Moran's ladder lives on. General practice is still not a first career choice for many graduates, certainly not enough to sustain the workforce we need.[3] Our conversations with early career medics reveal that they value the opportunities for flexible working within general practice. But also that they want 'something more' than the GP role: notably, opportunities to develop 'special interests'. We suggest this represents a failure to recognise, or value, the specific expertise of the GP role itself; and in particular a misunderstanding of the primary care expert generalist approach.

THE PRIMARY CARE EXPERT GENERALIST

We start by considering what we understand by the expert generalist. The role is defined by two elements. First, a principle of personalised decision making which recognises health as a resource for living and not an end in itself.[4] Second, it is the practice of interpretive medicine: the critical use of a range of knowledge in a dynamic exploration and interpretation of individual illness experience.[5] (Knowledge includes the biographical and biotechnical, as well as that derived from professional experience.) Crucially such expertise includes the capacity to judge the trustworthiness of the interpretation.[5] Thus, we can distinguish between the specialist who offers solutions (and may indeed re-frame problems to fit their solution), and the generalist who helps to 'define the problem'.[6]

However the wider literature highlights two differing views of the generalist, as a 'jack of all trades' and as practitioners with an 'acquired expertise'.[6] The former 'all-rounder' view of the generalist GP is widespread both within and outside the profession. In interviews with local GPs, many described generalist practice as 'knowing a little about a lot, rather than a lot about a little'. This is reflected in health service managers' view of generalists as having capacity to take on an ever broader range of care, including the flexibility to plug gaps in the system. Generalists become defined by their range of work, rather than by their expertise.

The failure to recognise, or value, generalist expertise in turn contributes to the creation of technical systems to support 'non-specialists' in delivering 'expert' care. As ever more (specialist) health care is moved into the (non-specialist) community setting, health systems replace the need for 'specialist expertise' with a protocol defining quality of care that can be delivered by a technician.[6] The result is a system of care that overburdens patients and practitioners alike. It arises from a failure to differentiate expertise from specialism: to understand that while a specialist has to 'be able to solve the problem', the expert has to 'know its solution'.[7] However, it also means that generalist practice becomes seen as a technical rather than an expert role, thus maintaining Lord Moran's ladder.

THE GP AND EXPERT GENERALIST PRACTICE

The 'all-rounder' GP is not without expertise. Current GP training develops expertise in consultation skills. This refers to a set of practices describing the way we communicate and relate with patients which helps deal with the diversity and risk faced by the all-rounder, especially when working with undifferentiated problems. The profession, along with a body of evidence, recognises the therapeutic benefit of the consultation and associated doctor–patient relationship. It is also an area of practice that has long appealed to some, albeit perhaps a minority, of early career doctors.[2]

However, general practice is not synonymous with expert generalist practice (EGP). Rather, EGP is an extended role undertaken by many, but not all, GPs. Consultation skills can enable (or constrain) interpretive practice; but do not define the expert generalist. Expertise is developed through formal training as well as experiential learning. Such training needs to address both the values (principles) and skills of interpretive practice. In our experience, EGP is also an approach that excites and interests early career medics considering a career in general practice.

We propose the need to recognise heterogeneity within current GP roles. We suggest that there are (at least) three ways of working in general practice. There is the all-rounder GP with expertise in consultation skills increasingly viewed as a technician delivering specialist-defined care across a broad range of need. Then there is the GP with special interests, combining expert consultation skills with some specialist knowledge. And finally there is the expert generalist using interpretive practice to define and address need specifically for each individual. How would you describe your own practice?

WHY DOES IT MATTER?

As health systems struggle to balance resources with ever increasing demands, there is a growing need to take a critical look at how we deliver primary care. Other health professionals are now delivering technical care supported by excellent consultation skills. By recognising different patterns of working, we open practice up to a critical consideration of impact, but also questions of who can and should deliver care. Perhaps we need to evolve the all-rounder GP role into a primary care expert generalist practitioner role? Maybe in this way we can finally dismantle Lord Moran's ladder.

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In the spirit of the recent SAPC conference, we offer this as a Dangerous Idea (http://www.sapc.ac.uk/index.php/conference2012/dangerous-ideas) intended to spark discussion and debate. The thoughts are our own and do not necessarily represent the views of the organisations we work for.

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Where have we gone wrong?

The November *BJGP* Viewpoint article by Morrison and Gillies about the tragic death of Dr Pat Manson serves as a timely reminder of the pressures that UK general practice is under.[1] I was sad when I heard of Pat's death and 2 weeks later I became even more distressed when another GP working in rural Scotland took their own life.

These tragedies mark the tip of an iceberg. The litany of burnout, depression, alcoholism, drug misuse, and relationship breakdown among GPs goes largely unseen and unrecognised. At the same time we have a culture where GPs who are struggling are reluctant to take time out as they know that the burden of their workload will fall on their colleagues (or, in the case of single-handed GPs, there may be no-one to take up the burden) at a time when many GPs feel they have nothing more to give. Many GPs now feel that 'traditional' general practice is being sacrificed on the altar of box-ticking bureaucracy.

Primary care has become dramatically more complex and demanding in under a decade. There has been a deliberate, cynical shifting of workload from secondary to primary care without an accompanying shift of resources and without relevant professional support, training, and development: we are just expected to 'get on with it'. It feels like there has been a concerted attempt by politicians, with the help of the press, to smear and diminish the medical profession in the eyes of the public, which I think has worked to some extent. We now have a more consumerist, demand-driven society that talks about rights but says little about responsibility and, in many areas, treats the NHS as though it were a 24-hour supermarket or take-away outlet. This is coupled with the explicit encouragement (often by health managers no less) for the public to complain about services and an increasingly irresponsible legal profession which has fuelled a culture of litigation against doctors on a 'no win, no fee' basis.

Many of our politicians remain ignorant. One Member of the Scottish Parliament effectively told me at a meeting earlier this year that all the problems of rural general practice could be solved by rural GPs taking back responsibility for out-of-hours care!

It's all very well for our attention to be focused on pensions. But the current pension dispute is not simply about the significant devaluation of our pensions. It's about much more: longer working lives; the one-sided abandonment (without negotiation) of a mutually agreed arrangement made in 2008 which we were promised at the time would not be touched for at least half a generation; the fact that income for GPs has fallen by over 20% in the last 5 years while their personal costs for providing top-notch primary care continue to rise; 5 years and more of anti-doctor bias among politicians and in the media; the imposition of a non-evidence-based system of revalidation which has at its heart (in the form of multisource feedback) an ambiguous system of evaluation that has been shown to be a potentially destructive process; and an NHS bill in England and Wales which, at its heart, seeks to shift the blame for the deficiencies in funding, capacity, and service provision onto the shoulders of clinicians.

The government is becoming increasingly 'autocratic' about the GMS contract, imposing changes which are not evidence based and which will be, for many GPs, simply unattainable.[2] My practice was recently offered a new service level agreement for an enhanced service for diabetes by NHS Highland which basically came with the choice of 'do more work for 30% less income or do more work for nothing at all'.

Morrison and Gillies' article also mentions my former, superb GP trainer in the Scottish Borders, who was also my role model. He decided to take early retirement and stopped being a doctor altogether to devote his time to other things. He recently told me that he had never been bored in the 6 years since retirement. Perhaps therein lies a lesson for us all.

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