



Segmentation of family medicine

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The world as we have created it is a process of our thinking. It cannot be changed without changing our thinking.

Albert Einstein

Earlier this year the UK Nuffield Trust published a thought-provoking report entitled *Divided We Fall. Getting the Best Out of General Practice*.¹ In the introduction the author, Dr Rebecca Rosen, states:

The prevailing narrative about general practice is of a broken, out-of-date, cottage industry that needs to be pulled into the 21st century. Repeated face-to-face consultation with a doctor is increasingly seen as the wrong approach to clinical need, with technology-enabled consultations with a variety of health professionals offering new options for assessment, review and treatment.¹

At the heart of the report are the following questions: Is there a role for medical generalism in a highly functional health care system? Can the practice of medical generalism be embodied in the traditional GP? Should the work of the GP be “deconstructed” or “segmented” and shared among other providers (teams) to improve care? Or does segmentation reduce the value of traditional general practice? Finally, what needs to be done to secure medical generalism in the future?

In the past, the principles and practice of generalism were embodied in a single provider—the old-fashioned GP or FP who provided comprehensive care to patients, families, and communities from birth to death. In the past 3 generations, this “ideal” has been found both wanting and hard to sustain. Powerful social forces including urbanization, aging populations, medical advances, consumerism, changing patient expectations, and the rise of information technology have put tremendous pressure on the model of the old-fashioned FP.

In this issue we present a research study by Freeman et al that attests to a generational change in the comprehensiveness of care provided by FPs, with a decline over 3 generations of graduates of one residency program (page 750).² This decline is almost certainly a reflection of these societal pressures, although their current study does not explore this.

One approach to addressing these pressures is to think of the work of the generalist in its parts and divide it accordingly among different members of a “generalist health team.” In the adult populations of high-income countries, for example, about half of all people are relatively healthy and might only

require episodic, acute care for relatively simple concerns.¹ For these patients, access is more important than continuity and they might benefit from seeing a nonphysician provider or from consultation mediated by technology. Deep knowledge of the person over time might not be important. At the other end of the spectrum are the roughly 1% to 2% of patients with complex medical needs for whom continuity and comprehensiveness are crucial.¹ For these patients, face-to-face encounters with an FP, supported by other team members, are necessary and valuable. Among those in between are the roughly 25% of patients with medically unexplained symptoms¹ who likely benefit most from what the old-fashioned FP has to offer—deep knowledge of the person developed over time—which would reduce the risk of overinvestigation and overtreatment, sparing patients potential harm.

A key distinction drawn in the Nuffield Trust report is between the task-based, transactional nature of rapid access primary care and the layered, context-specific nature of medical generalism. An integrated model of segmentation is presented in which rapid access services are combined with medical generalist care into a single organization or team in the hope of getting the best of both worlds.¹ In many places in Canada, teams that look roughly like this exist, but not all are functioning optimally. Implementing effective team-based care is difficult, requiring time and resources to develop a clear vision and integrate processes across many different providers.³ When family health teams were created in Ontario a decade ago, the emphasis was on access to an FP; while teams were created with valuable nonphysician members including nurse practitioners, social workers, dietitians, and pharmacists, no “play book” was provided on how to make them function optimally. One positive finding in the study by Freeman et al was that FPs working in team settings reported that they were able to provide more comprehensive care.²

Whatever the future of generalist medical practice looks like, much will be lost if the personal physician⁴ is not at its core, and Green’s dystopian vision of family medicine and health care in the future will surely come to pass.⁵

References

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