

Guest editorial

Shifting interventions from specialist to general practitioner is not new. But how realistic is it?

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This editorial has been inspired by the article by van Bodegom-Vos *et al.* 'Are patients' preferences for shifting services from medical specialists to general practitioners related to the type of medical intervention?' published in this issue of the Journal.¹ The authors found that respondents more often preferred treatment or examination by a specialist rather than by a general practitioner (GP) for complex invasive treatments and diagnostic examinations, and preferred GPs for follow-up treatment and non-complex invasive treatments. The reasons for preferring GPs related to access and amenity, and for specialists, better skills, lower perceived risks of treatment and more confidence in the specialist. The authors concluded that policy makers, commissioners and practitioners should take patient preferences into account next to quality, efficiency and technical feasibility as criteria for effectively substituting special services to GPs.

The authors raise some important and topical concerns for patients, doctors and policy makers, including the cost of health services and rationing, patient perceptions of the competence of different practitioners, patient choice and knowledge of services available, shared care and accountability, some of which are not discussed in detail by the authors and which will be referred to here.

Cost-shifting services from specialist to GP is not new. An early example of shifting services from hospital to GP concerned situations in which treatments such as fertility drugs and chemotherapy, initiated in hospital, were transferred from hospital to general practice due to cost-shifting changes in the outpatient dispensing policies of major acute hospitals in England.² Wilkie *et al* raised concerns that, at that time, GPs may have lacked the knowledge, and in some cases the technical resources, needed to monitor the dosage, side effects and response of patients to specialist drug regimens; neither did they necessarily have access to the expertise of a hospital pharmacist. In a second paper from the same study,³ the authors found that

GPs did indeed believe that they lacked the knowledge and in certain instances the technical resources to monitor drug dosage, side effects and responses to certain more complex treatments not normally dealt with by GPs. The authors recommended systems of shared care between hospital and GP combined with better communication between hospital and community professionals to ensure that patients received the appropriate information and support. In neither of these studies were the views of patients ascertained. However, there was at that time considerable anecdotal evidence from both specialists and GPs that patients attending specialist-led renal and haemophilia clinics tended to 'use' these clinics to seek advice for more general problems not necessarily associated with their underlying condition, choosing to bypass their GP. Patients explained that it was easier to seek advice from people whom they knew and who understood their problems.

A major role of GPs is the gatekeeper function of deciding whether to refer patients to a medical specialist, although this may not be appreciated by all patients or by the public in general. In the USA, managed health care has emphasised the role of primary care physicians while also restricting direct patient access to specialists.⁴ Such a system is considered cost-effective compared with health systems in which patients can access specialist services directly. Western health systems no longer have the economic resources to indefinitely meet the rising demands for health care due to, amongst other factors, an ageing population and more people living with long-term conditions and multiple morbidity. Thus different ways of providing more cost-effective services are being examined by policy makers.

In 2002, Wanless⁵ delivered a stark message to the Treasury that there needed to be changes in the current trends in health spending and that any changes for a sustainable NHS would need to have a fully engaged public taking a direct role as co-producers of their own

health. According to Wanless, this required a change in the culture of professionals and policy makers to match the new environment of health and illness and public expectation. Harry Cayton⁶ supported this when he was UK Patient Tsar, arguing that services were still run mostly in the interests of producers because the interests of service users were assumed rather than explored.

It is not only policy makers and professionals who are concerned about NHS finances. It is important for the public that resources are used wisely.⁷ Patients and the public also wish to know about proposed changes, about how they can appeal against a local decision or go elsewhere, and about treatment options.⁸ While patient and public involvement is now more obviously on the agenda of health organisations and the government, Coulter suggests that the UK is falling behind other countries in its attempts to keep pace with the need for engaged care.⁹

The work by Franks and Fiscella in the USA¹⁰ suggests that having a primary care physician responsible for certain procedures is associated with improved outcomes for the patient as well as reduced costs. An advantage for the patient is that there is a guarantee that the doctor who sees the patient will be the doctor who performs the procedure, and that consultations are conducted in a small familiar environment. This is popular with patients and was supported in the work by Brown *et al.*¹¹

Patients must be able to expect that the doctor treating them is safe and can demonstrate up-to-date clinical knowledge. It is interesting to note that Richard Titmuss,¹² in a paper presented to the annual meeting of the BMA in 1968, suggested that patients would increasingly be looking for scientific expertise and continuity of care. Martin Roland¹³ in his 1998 Mackenzie lecture suggested that patients hope to find technical competence and continuity of care in GPs and this is increasingly borne out by patients. GPs on the specialist register have the skills to carry out minor surgery and can provide competent treatment. But is this what patients want? Do they have a choice? And is access to GPs so easy?

In the van Bodegom-Vos study, 52% of respondents preferred GP services because of shorter access times. However, a recent report by Baker and Tarrant¹³ suggests that GP services will be under intense pressure over the next 10 years as they will be expected to relieve hospitals of as much patient care as possible. They conclude that 'policy makers must do their utmost to maintain that capacity of general practice to meet demand, otherwise hospitals will be swamped and the sustainability of the NHS in the present climate of austerity will be brought into question'.

Different polls suggest that GPs are still popular with patients. While many patients may choose to have certain procedures carried out by their GP, they

need to know what the choices are. Can the patient choose to have the procedure carried out in hospital or is there an alternative of the specialist carrying out the procedure at the GP surgery or in the local community hospital? In their paper, the authors raise questions about the importance of assessing the preferences of patients and taking these into account before substituting certain medical interventions from medical specialist to GP. There is real concern from a patient perspective. Can GPs cope with the increased demand? How will GPs deal with extra demands on their time? Patient access to GPs is already under pressure and is likely to continue due to demographic changes, an increase in population and in particular an increase in the number of older people with multiple morbidities.

Full patient-centred practice by definition demands a positive two-way relationship between doctor and patient, and its adoption should recognise the need to tailor practices according to the individual patient, their preferences and their abilities.¹⁵

Shifting care will require a process of shared decision making between patient and GP so that the patient understands the options for the proposed procedures and is able to articulate their preference for whether a specialist or GP carries out the procedure as is suggested by van Bodegom-Vos *et al.* This means assessing the views of the patient, informing them of the choices available, and discussing the skills and experience of those who carry out the procedure. This is not complicated. Sadly, the evidence to date¹⁶ is that efforts to implement shared decision making in practice have had very limited success.

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CONFLICTS OF INTEREST

None.

PEER REVIEW

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