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71 – The Optimal Practice Size Revisited – a Critical Appraisal of a Topical Discussion in the Light of Academic Leadership in Primary Care

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Practice size has been an issue in general practice for as long as most of us can remember. Although the discussion apparently hinges on the provision of quality of care and maintaining clinical experience, more mundane conditions like the number of general doctors (GP) in relation to the population, or the GPs' ability to generate an income are never far away from the argumentation. There remain substantial differences in the numbers of GPs, proportional to the population [1], and this is also true for the performance of GPs in (primary) health care [2]. But there is no correlation between GP density and actual performance and never has been: in no way are the smaller or larger numbers of patients to be cared for a determinant of the care provided [3].

Against this background, a Workshop was run at the Kos WONCA Europe conference in 2005 on Optimal Practice Size. What To Preserve Of Single Handed Care? [4].The workshop reviewed the available literature and then moved to explore the personal experiences of participants in their own practice setting. The discussions amongst the universally proud GPs were animated, and yielded a diversity of views. And needless to say, that the exchanges were highly valued. But with full respect to the workshop instigators and participants, one might question the value of the exercise: posing the same question over and over again seldom leads to a new answer.

The occasion of this World Book of Family Medicine offers an opportunity to revisit this and explore alternatives to approach the core values of primary care. In this, four angles come forward from which to develop these alternatives.

Variation and value

Variation is a powerful input to examine practitioners' performance, trigger discussion on alternatives and effectuate change [5]. Variation appears to install feelings of unease, differing from one's peers is seen as a sign of underperformance. Yet, the very core of primary health care and general practice is in tuning to the needs of the individuals and the community that is served [6]. As communities' and individual needs differ, therefore general practice should differ in approaching these needs. Numbers of (general) practitioners per population is part of the variation in the context in which primary care operates. Not 'practice size' but how apt the practice is tuned to the needs of its patients and population should be the core of the discussion.

The lone ranger versus the leader of the pack

Single handed practice in the community has been the starting point of general practice, but for decades there has been an evolution in primary care from the general practitioners to the general practice, from an individual to an institutional level. This is in line with the motor car replacing the horse and carriage as the practitioner's transportation, or the telephone with the knock on the doctor's door to invoke care in the middle of the night. Rather than redoing discussions of old, it might have been more appropriate to explore the innovation of practice organisation: how GPs can shape and lead the development of their practice to be able to respond to the challenges in nature and volume their practice environment poses.

General practice or primary health care

This orientation is the more important in the current development in which mono-disciplinary general practice is replaced by an integrated multi-disciplinary primary health care structure. Interconnectedness within primary health care, with hospitals, public health and with other sectors in society is required to fulfil the contemporary mission of promoting and securing health of individuals and populations [7]. This is a generic principle that has to be translated to the conditions on the ground in which GP and practice work and the numbers to consider have to be related to the multi-disciplinary team.

Experience and performance

A returning argument in the opinions about practice size has been the building and maintaining of clinical experience. It goes without saying that hands-on exposure to patients and their health problems are important in developing and shaping clinical reasoning. But exposure in itself does little to generate skills. For this, a process of critical reflection is required, and it is in the quality, not the quantity of these reflections that GPs' professionalisation comes about. This is the more decisive, as the most important clinical decisions may concern the most infrequent health problems. For this, no practice size will ever cater, and exposure alone can never secure the adequacy of clinical decisions. This presents in my view the most compelling reason to get away from the 'ideal' practice size, recognise the vast importance of building skills from clinical exposure and turn to more sophisticated methods to do so. Attributing critical decisions to experience or intuition [8] is mystifying, unhelpful and potentially dangerous. It is exactly in this line of thinking that discussions on practice size have focused. The engagement of experienced GPs in the workshop in 2005 might have made better use of their intellectual skills, by getting to the heart of decision-making in uncertain situations and with few available data – better than fixating on a number for the size of their practice.

Conclusions

Looking back objectively, the workshop in 2005 might have been better directed at the leadership role of GPs – in transforming the context of their practice setting from single-handed, mono-disciplinary to integrated multi-disciplinary teams; in exploring the nature of functional differences between practices; and in focusing on the inner-mind processes of how their decisions under real life circumstances come about – rather than fixating on an ideal number criterion. But GPs work with and in time to solve problems, and this makes 2015 the first opportunity to address these issues after all.

Take Home Messages

- Single-handed general practice is a feature of the profession's past, as a consequence of its ever more prominent role in health care.
- Size and disciplinary composition have to be determined by the needs of the practice community.
- It is not possible to build expertise and knowledge simply on experience from exposure to primary care health problems.
- As primary care has to direct and adopt the local needs and conditions, practice variation can be an indicator of quality as much as lack of quality.

Original abstract

http://www.woncaeurope.org/content/777-wo-optimal-practice-size-what-preserve-single-handed-care

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