Is academic general practice an oxymoron?
Is academic general practice relevant?

Can we exclude exclusions?
PUB QUIZ TONIGHT
PUB QUIZ TONIGHT

no smart arses
THE END OF THE PIER SHOW
The largest ever sighting of Professors of General Practice in Scotland
Luss, 2004
THE CONTRIBUTION OF ACADEMIC GENERAL PRACTICE AND PRIMARY CARE

EXPERIENCE

EVIDENCE
- Epidemiology
- Qualitative
- Clinical
- HSR
- Educational

VALUES
- Habit of truth
- Respect for others
- Caring
- Partnership
- Creativity
- Social justice

EDUCATION
- Undergraduate
- Postgraduate
- CPD
- Health education
- Health promotion
- Information retrieval
- Critical appraisal
- Problem-based learning
- Reflective learning
- Debate

DECISIONS

PATIENT DECISIONS
- To be ill
- Self care
- To consult
- To comply

CLINICAL DECISIONS
- Diagnose
- Do nothing
- Treat
- Refer

STRATEGIC DECISIONS
- Do more
- Do less

ORGANISATIONAL DECISIONS
- Use of resources
  (inputs/outputs/equity)
RANDOMISED CONTROLLED TRIALS

A SYSTEMATIC SOURCE OF BIAS
The epidemiology of multimorbidity in a large cross-sectional dataset: implications for health care, research and medical education

Karen Barnett, Stewart Mercer, Michael Norbury, Graham Watt
Sally Wyke, Bruce Guthrie

LANCET 12th May 2012
SOCIAL PATTERNING OF MULTIMORBIDITY

The graph illustrates the percentage of patients with 2 or more conditions across different age groups and deciles of deprivation. The x-axis represents age groups in years, ranging from 0-95, while the y-axis represents the percentage of patients. The lines indicate the proportion of patients in different deprivation categories, with each line color-coded for easy identification.

- **10 Deprived**: The most deprived group, starting at 0% for 0-4 years and rising rapidly to nearly 100% by 85+ years.
- **9**: Slightly less deprived than the most deprived, with a similar trend but slightly lower percentages.
- **8**: Further down the deprivation scale, showing even lower percentages.
- **7, 6, 5, 4, 3, 2, 1 Affluent**: Progressively less deprived groups, each showing a lower percentage of patients with multimorbidity compared to the most deprived groups.
PATIENTS WITH SINGLE CONDITIONS ARE A MINORITY

<table>
<thead>
<tr>
<th>Condition</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart failure</td>
<td>3% 9% 14% 74%</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>6% 14% 18% 62%</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>7% 13% 16% 65%</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>9% 16% 19% 56%</td>
</tr>
<tr>
<td>Painful condition</td>
<td>13% 21% 21% 46%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14% 20% 19% 47%</td>
</tr>
<tr>
<td>COPD</td>
<td>18% 19% 17% 47%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>22% 24% 19% 35%</td>
</tr>
<tr>
<td>Cancer</td>
<td>23% 21% 17% 39%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>31% 48% 23% 29%</td>
</tr>
<tr>
<td>Asthma</td>
<td>48% 20% 12% 21%</td>
</tr>
<tr>
<td>Dementia</td>
<td>5% 13% 18% 64%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>7% 17% 20% 56%</td>
</tr>
<tr>
<td>Schizophrenia/bipolar</td>
<td>13% 21% 21% 46%</td>
</tr>
<tr>
<td>Depression</td>
<td>23% 22% 18% 36%</td>
</tr>
</tbody>
</table>

Percentage of patients with each condition who have other conditions:
- This condition only
- This condition + 1 other
- + 2 others
- + 3 or more others
MOST PEOPLE WITH ANY LONG TERM CONDITION HAVE MULTIPLE CONDITIONS IN SCOTLAND

% of patients with this condition...% who also have this condition (% = % of all patients with the condition)

- Coronary heart disease
- Hypertension
- Heart failure
- Stroke/TIA
- Diabetes
- COPD
- Cancer
- Painful condition
- Depression
- Schizophrenia or bipolar
- Dementia
- Any other condition

Diagram showing the percentage of patients with each condition and the percentage of patients with that condition who also have other conditions.
DEFINITIONS OF MULTIMORBIDITY

Two or more conditions

The number, severity and complexity of health and social problems within families and households

When sorrows come, they come not single spies but in battalions

HAMLET, William Shakespeare
% DIFFERENCES FROM LEAST DEPRIVED DECILE
FOR MORTALITY, COMORBIDITY, CONSULTATIONS AND GP FUNDING

THE INVERSE CARE LAW IN SCOTLAND
IʼVE JUST INVENTED A MACHINE
THAT DOES THE WORK OF TWO MEN.
UNFORTUNATELY,
IT TAKES THREE MEN TO WORK IT

SPIKE MILLIGAN
Patients and caregivers are often put under enormous demands by health care systems

Frances Mair, Carl May
Thinking about the burden of treatment
BMJ 2014;349:g6680 doi: 10.1136/bmj.g6680 (10th November 2014)
HEALTH CARE AS A PINBALL MACHINE
### EXHIBIT ES-1. OVERALL RANKING

<table>
<thead>
<tr>
<th>Country</th>
<th>AUS</th>
<th>CAN</th>
<th>FRA</th>
<th>GER</th>
<th>NETH</th>
<th>NZ</th>
<th>NOR</th>
<th>SWE</th>
<th>SWIZ</th>
<th>UK</th>
<th>US</th>
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<tr>
<td><strong>Overall Ranking (2013)</strong></td>
<td></td>
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<td>Quality Care</td>
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<td>Effective Care</td>
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<td>Patient-Centered Care</td>
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<td>7</td>
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<td>6</td>
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<td>4</td>
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<td>6</td>
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<td>2</td>
<td>1</td>
<td>9</td>
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<td>Cost-Related Problem</td>
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<td>10</td>
<td>4</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>1</td>
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<td>1</td>
<td>11</td>
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<tr>
<td>Timeliness of Care</td>
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<td>10</td>
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<td>7</td>
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<td>7</td>
<td>4</td>
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<td>6</td>
<td>1</td>
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<tr>
<td>Healthy Lives</td>
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<td>1</td>
<td>7</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>10</td>
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<td>Health Expenditures/Capita, 2011**</td>
<td>$3,800</td>
<td>$4,522</td>
<td>$4,118</td>
<td>$4,495</td>
<td>$5,099</td>
<td>$3,182</td>
<td>$5,669</td>
<td>$3,925</td>
<td>$5,643</td>
<td>$3,405</td>
<td>$8,508</td>
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</table>

*Notes: * Includes ties. ** Expenditures shown in $US PPP (purchasing power parity); Australian $ data are from 2010.

*Source: Calculated by The Commonwealth Fund based on 2011 International Health Policy Survey of Sicker Adults; 2012 International Health Policy Survey of Primary Care Physicians; 2013 International Health Policy Survey; Commonwealth Fund National Scorecard 2011; World Health Organization; and Organization for Economic Cooperation and Development, OECD Health Data, 2013 (Paris: OECD, Nov. 2013).*
<table>
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<td>85</td>
<td>15</td>
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<tr>
<td>84</td>
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</tbody>
</table>
Applying the CARE measure and Patient Enablement Instrument (PEI) after general practice consultations

YOU CAN GET EMPATHY WITHOUT ENABLEMENT

BUT YOU NEVER GET ENABLEMENT WITHOUT EMPATHY

Mercer SW Jani BD Maxwell M Wong SYS Watt GCM
Patient enablement requires physician empathy: a cross-sectional study of general practice consultations in areas of high and low socio-economic deprivation in Scotland
BMC Family Practice 2012, 13:6
BRIEF ENCOUNTERS

SERIAL ENCOUNTERS

To Be Continued...
1930's & 1940's SERIAL MOVIE POSTERS
WHO NEEDS INTEGRATED CARE?

POTENTIALLY ANYONE BUT MOSTLY

THE 15% OF PATIENTS

WHO ACCOUNT FOR 50% OF NHS WORKLOAD
A MINORITY OF PATIENTS GENERATE LOTS OF ACTIVITY

10% of patients with 4 or more conditions accounted for

34% of patients with unplanned admissions to hospital and

47% of patients with potentially preventable unplanned admissions.

Payne R, Abel G, Guthrie B, Mercer SW.

The impact of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study.

SCHEHEREZADE

TELLING 1001 TALES
HOW COULD THEY TELL?

Dorothy Parker
BRINGING IT ALL TOGETHER- ARLENE

- 68 yr old wife, mother, grandmother X3
- About 5 yrs ago, started feeling unwell
- Saw several docs, “borderline diabetes”, BP “a little high”; prescribed meds, told to “exercise & lose weight”
- Couldn’t make follow up appts, fill rx’s
- Continued poor control over 5 yrs
- Admitted to ED with acute MI...

... story totally unlikely, or all too familiar?
Listen to the patient
He is telling you the diagnosis

SIR WILIAM OSLER

Listen to the patient
She is telling you her treatment goals

PROFESSOR JAN DE MAESENEER
MEASURING OMISSION

THE RULE OF HALVES

50% were diagnosed
50% were treated
50% were controlled

i.e. 12% get best care

THE IMPORTANCE OF GOOD INFORMATION
INTRINSIC FEATURES OF GENERAL PRACTICE

Contact
Coverage
Continuity
Coordination
Flexibility
Relationships
Trust
INTEGRATED CARE DEPENDS ON MULTIPLE RELATIONSHIPS
Health practitioners need to ask not only “What do I do?” but also “What am I part of?”

Don Berwick
Head of US Medicare and Medicaid
BUILDING SOCIAL CAPITAL

RESOURCE POOR

RESOURCE RICH

PEOPLE RICH

PEOPLE POOR
WHAT MAKES PEOPLE ENJOY THEIR WORK?

AUTONOMY

MASTERY

PURPOSE

but only after basic needs are met
The NHS Act

1. Took money out of the consultation
2. Established GPs as gatekeepers
3. Gave doctors the role of responding proportionately to patients' needs
4. Provided population coverage via the list system

COVERAGE
QOF

50-60 clinical targets
Requiring high population coverage
Doctors warn austerity is damaging patients’ health

GPs in deprived areas see sharp rise in social issues

STEPHEN NAYSMITH
SOCIETY EDITOR

GPs working in the most deprived communities in Scotland have warned of increasing levels of mental and physical health problems among patients affected by austerity.

The Deep End group of GPs, representing 960 doctors in 100 practices, said job losses, welfare reform and cuts to social services were all affecting the health of their patients.

The 100 Deep End group of general practices that serves the most socio-economically deprived areas of the country was set up in 2009. It is backed financially by the Scottish Government.

In a new report, the group says austerity measures are causing increased distress and poverty among their patients, and an increased workload for family doctors.

The GPs add that the growing impact of benefit cuts means much of their time is taken up with social issues rather than patients’ underlying health problems.

In February, the group surveyed members to ask about their experiences of austerity. Doctors responded that patients were suffering deteriorating mental health, and also physical problems.

The report says: “GPs report long times to deal with physical problems, as these are now no longer a priority for the patient.”

Benefits changes were also a concern for many GPs, because they felt patients were wrongly being declared fit to work in medical tests on behalf of the

So many people who are clearly unfit for work are being assessed as capable of work after a cursory assessment

The report draws attention to the impact of cuts in other public services, such as education, social work and addiction support. Dr Craig added: “The minimum pricing of alcohol is a great thing, but addiction services are falling by the wayside. Austerity measures also affect children, but social work only have the resources to get involved in the most disturbed and difficult situations.”

Dr Graham Watt, professor of General Practice at Glasgow

ON THE FRONTLINE: GPs Margaret Craig, left, and Petra Sambale are part of the Deep End group of GP practices. Picture: Colin Mearns

Cases of concern

Patients and doctors in the report are anonymous to protect confidentiality.

- Another doctor saw a young woman who had been sexually abused as a child and had struggled with alcoholism. She was found to be capable of work but worried that her mental health will deteriorate. Her benefits were stopped. She was diagnosed with type 2 diabetes… instead of working with her setting goals for her diabetes I wrote a letter for an appeal and referred her to the benefit.

- A third case is a former labourer in his early fifties who was out of work due to osteoarthritis. His disability allowance had been cut and he was unable to afford his mortgage. “This patient’s mental health problems have escalated and he is being seen psychologically cope with maintaining.

E.ON_to_freeze_its_prices

ENERGY giant E.ON reassured its five million customers after it pledged to keep residential energy prices

HOSPITALS in large cities act as “breeding grounds” for the superbug MRSA, which then spreads to smaller regional hospitals and health centres, according to a new study.

Researchers from Edinburgh University found evidence that shows for the first time how the superbug spreads between different hospitals throughout the country.

The study involved looking at the genetic make-up of more than 80 variants of a major clone of MRSA found in hospitals.

Scientists were able to determine the entire genetic code of MRSA bacteria taken from infected patients.

They then identified mutations in the bugs that led to the emergence of new variants and tracked their spread around the country.

Dr Ross Fitzgerald, of the Roslin Institute at Edinburgh University, who led the study, said: “We found that variants of MRSA circulating in regional hospitals probably originated in large city hospitals.”

“The high levels of patient traffic in large hospitals means they act as a hub for transmission between patients, who may then be transferred or treated in regional hospitals.”
% DIFFERENCES FROM LEAST DEPRIVED DECILE FOR MORTALITY, COMORBIDITY, CONSULTATIONS AND FUNDING

THE INVERSE CARE LAW IN SCOTLAND
CONSULTATIONS IN DEPRIVED AREAS

Multiple morbidity and social complexity
Shortage of time
Reduced expectations
Lower enablement (especially for mental health problems)
Health literacy
Practitioner stress

Mercer SM, Watt GCM
The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland
GENERAL PRACTITIONERS AT THE DEEP END
DEEP END REPORTS

1. First meeting at Erskine
2. Needs, demands and resources
3. Vulnerable families
4. Keep Well and ASSIGN
5. Single-handed practice
6. Patient encounters
7. GP training
8. Social prescribing
9. Learning Journey
10. Care of the elderly
11. Alcohol problems in young adults
12. Caring for vulnerable children and families
14. Reviewing progress in 2010 and plans for 2011
15. Palliative care in the Deep End
16. Austerity Report
17. Detecting cancer early
18. Integrated care
19. Access to specialists
20. What can NHS Scotland do to prevent and reduce heath inequalities
21. GP experience of welfare reform in very deprived areas
22. Mental health issues in the Deep End
23. The contribution of general practice to improving the health of vulnerable children and families
24. What are the CPD needs of GPs working in Deep End practices?
25. Strengthening primary care partnership responses to the welfare reforms
26. Generalist and specialist views of mental health issues in very deprived areas

www.gla.ac.uk/deepend
ISSUES ESPECIALLY PREVALENT IN THE DEEP END

Mental health problems
Drugs and alcohol
Material poverty
Vulnerable children and adults
Migrants, refugees and asylum seekers
Fitness to work
Sexual abuse history
Homelessness

GENERIC ISSUES

How to engage, with patients who are difficult to engage
How to deal with complexity in high volume
How to apply evidence
SIX ESSENTIAL COMPONENTS

1. Extra TIME for consultations (INVERSE CARE LAW)

2. Best use of serial ENCOUNTERS (PATIENT STORIES)

3. General practices as the NATURAL HUBS of local health systems (LINKING WITH OTHERS)

4. Better CONNECTIONS across the front line (SHARED LEARNING)

5. Better SUPPORT for the front line (INFRASTRUCTURE)

6. LEADERSHIP at different levels (AT EVERY LEVEL)
THE CARE PLUS STUDY

An exploratory cluster RCT of a primary care-based complex intervention for multimorbid patients living in deprived areas of Scotland.
CARE Plus prevents decline in QOL (EQ5-DL)

Effect size = 0.35
Cost < £13,000 per QALY
NICE currently supports a cost of £20,000 per QALY
THE IMPORTANCE OF CO-DESIGN
Finding 1: High levels of recruitment and retention attained to date

Practice recruitment
Invite: 95; Reply: 26 (27%); Agree: 12 (46%)

Patient recruitment and baseline
Invite: 225; Agree and baseline data: 152 (68%)

Randomisation 4 + 4
CARE Plus = 76
Usual Care = 76

Follow-up
No contact: 6; left practice 3
6 month = 91%
12 month = 88%

No contact: 4; left practice 3
6 month = 89%
12 month = 88%
BY POWERFUL PEOPLE ?
BY CLEVER PEOPLE ?

LEADERSHIP
FOR INTEGRATED CARE

BY STEETWISE PEOPLE ?
BY THE PEOPLE ?
LEARNING BY TRIAL AND ERROR

SPOCK to KIRK: “It’s not logical, captain”
FIXING IT FOR PATIENTS
WHO ARE FLOUNDERING
BETWEEN DYSFUNCTIONAL,
FRAGMENTED, SERVICES
BUILDING PRODUCTIVE LOCAL SYSTEMS

CREATING A SOCIAL REVOLUTION IN HEALTH CARE
Robson J Hull S Mathur R Boomla K
Improving cardiovascular disease using managed networks in general practice: An observational study in inner London
BJGP 2014:64;e268-e274

Watt G (editorial)
A landmark study of collective action by general practices
BJGP 2014:64:218-219
A NEW BUILDING PROGRAMME FOR INTEGRATED CARE

PATIENT STORIES

LOCAL HEALTH SYSTEMS

MACHINES THAT DO THE WORK OF TWO MEN
Is academic general practice an oxymoron?