The Goldilocks Principle: getting care ‘just right’ for our patients

Joanne Reeve FRCGP PhD

Academy of Primary Care, Hull York Med School

www.hyms.ac.uk/primarycare

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Solutions from practice

- Problems of too much medicine
- Solutions from generalist skills
- How can we translate skills into the practice-based evidence that can drive change?

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

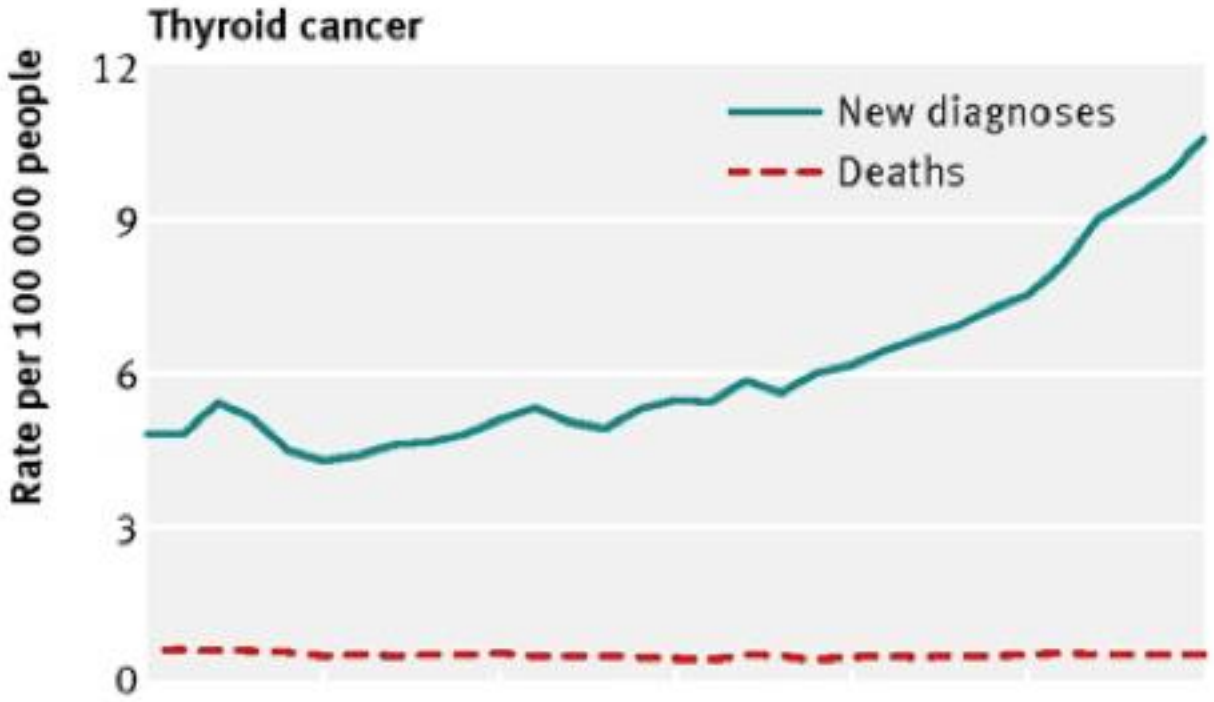
Too much healthcare or…

- "Overdiagnosis means making people patients unnecessarily:
  by identifying problems that were never going to harm or by medicalising ordinary life experiences through expanded definition of disease"

- Characterised by overdetection, overdefinition, overselling
- Broderson et al 2018; BMJ EBM 10.1136

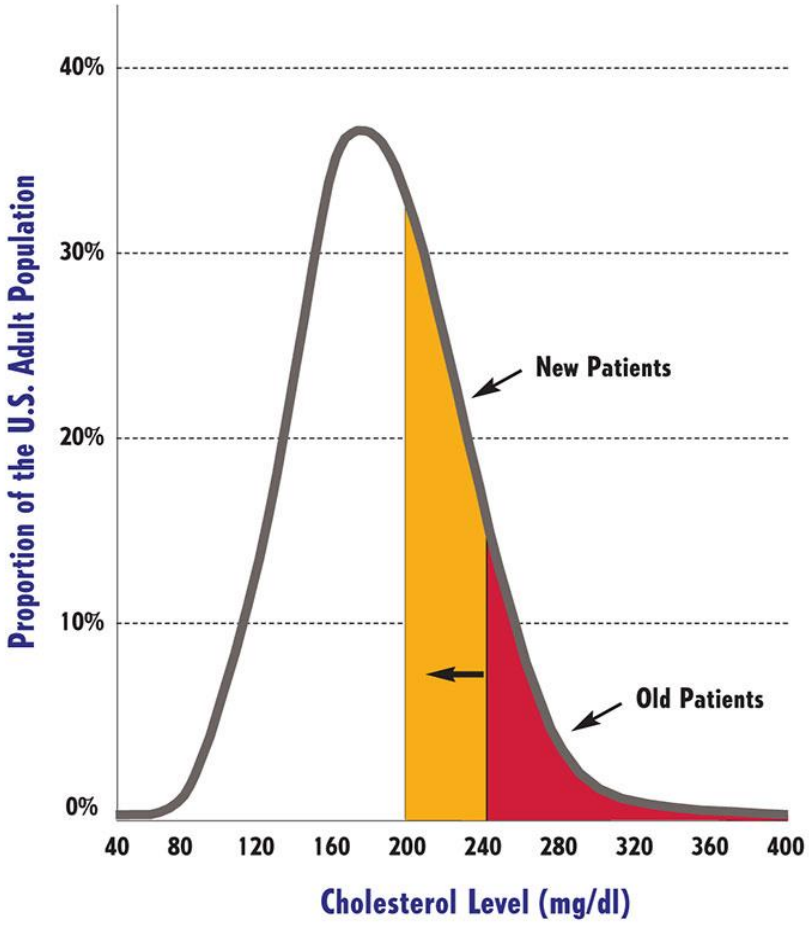
HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Overdetection



HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Overdefinition



HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Overselling

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Too much medicine?

- Is there a problem?
- What are the biggest problems for you in your practice?
- What should we be doing about it, if anything?

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Goldilocks Medicine:
revitalising the practice of medical generalism?

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Defining generalist medicine

Skills to safely **construct** robust, **individually-tailored**, whole-person **explanations** of illness experience; and so **implement person-centred healthcare** designed to enhance health-related **capacity for daily living** [Reeve OPS 2010].

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Generalism and the Bananarama principle

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Clinical scholarship for generalist practice

Life & Times

Revitalising general practice:

unleashing our inner scholar

'I'm exhausted. I can't do any more ...'

These could be the words of very many of us, as our profession deals with some of its most profound challenges to date. But can adversity stimulate creativity?[1] Our profession is at a crossroads — we have reached our very own Reggie Perrin moment?[2] It is time for us to leave behind our Scientific Bureaucratic Medicine[3] chains (policed referral pathways, mandatory measurement ...) on the proverbial beach. And instead to reimagine ourselves, our job, and our role within the context of an intellectual profession leading the highest standards of person-centred health care. It is time to embrace our inner scholar.

'But I'm too busy seeing patients ...'

tasks, and have the flexibility to manage a number of areas of clinical practice. We are technically proficient, and efficient, across a range of tasks, and so can be used to plug many a gap in health service rotas and systems. But our capacity to function in this 'Jack of all trades' role stems from a desired mastery of clinical reasoning and clinical decision making that is medical generalism.[4] This is an expertise built on the academic principle that *it's not what you know, but how you use it* (technically speaking, an expertise built on a different epistemological framework for judging knowledge).[5] People outside of the profession often don't understand what we do when we deliver whole-person medicine, and so instead presume a *'master of none'* approach. This is the justification for quality systems within the [illegible]

with a workshop at last year's conference. This piece launches a new *BJGP* Blog series in which GPs share their experience of everyday scholarship. If you have a story to tell, do get in touch. We are establishing resources to support scholarship across the GP career path: https://sapc.ac.uk/article/gp-scholarship

All so we can move Forward Together[10] to revitalise our profession.

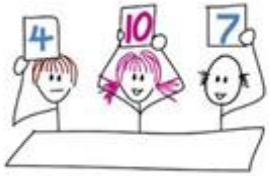
Joanne Reeve,
Clinical Reader, Warwick Primary Care, Warwick Medical School, Coventry.
E-mail: j.reeve.1@warwick.ac.uk

Adam Firth,
GP, Bracondale Medical Centre, Stockport, Cheshire.
E-mail: adfirth@gmail.com

WHAT HAS BEEN YOUR EXPERIENCE OF TRAINING FOR GENERALIST PRACTICE?

You're not alone…Barriers to generalist practice

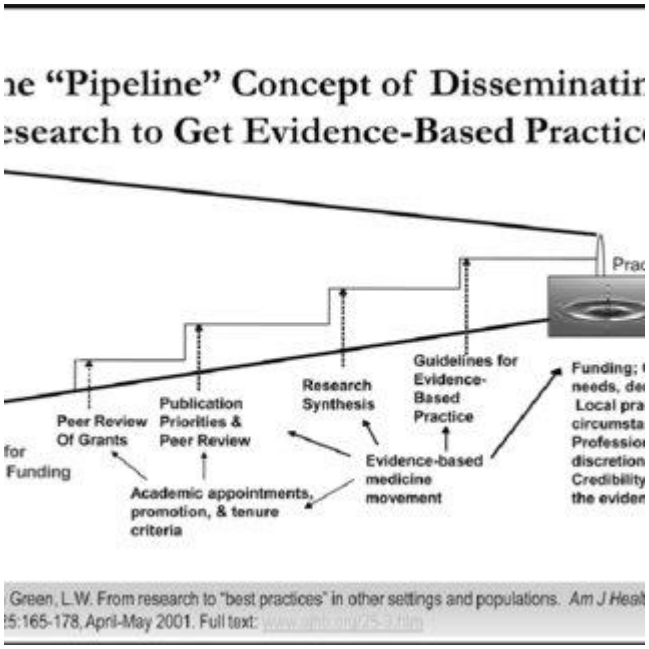
- **P**ermission
- **P**rioritisation
- **P**rofessional training
- **P**erformance management



Reeve et al. J Royal Society of Medicine Short Reports 4, 2013
Reeve et al. BMC Family Practice 2018; 19(1): 17

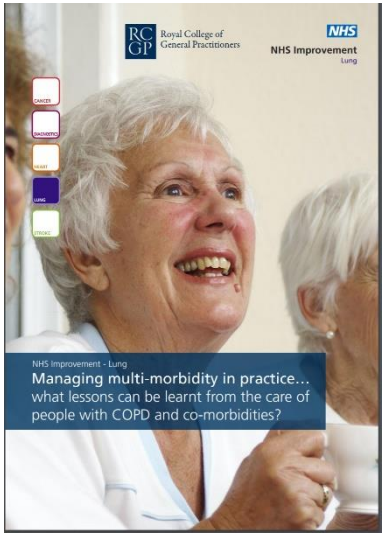
Generating Solutions and Evidence from Practice

- We need Practice Based Evidence
- Living Lab solutions?
- Examples to date…



HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Tackling Problematic Polypharmacy: The Complex Needs project



Supporting Janet

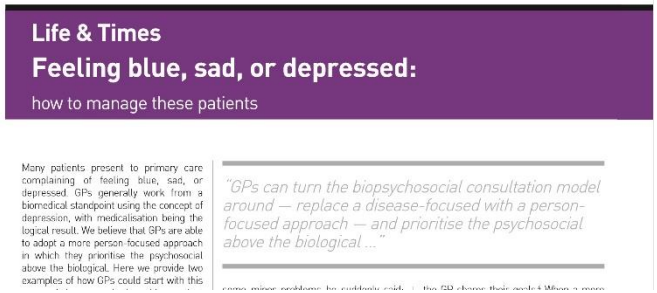
- Benign intracranial hypertension
- Diabetes (type 2) and complications
- Essential hypertension
- Depression
- Mobility issues
- Chronic pain
- Hypothyroid

- Polypharmacy: diabetic meds x3, antihypertensives x3,thyroxine, pain killers inc cocodamol gabapentin, statin…

Generalist approach to problematic polypharmacy: 3 tools from practice based research

- **Principles**: person centred needs assessment flipped consultation model
- **Practice:** individually tailored prescribing Scottish Prescribing Guidelines
- **Professional reflection**: trustworthy interpretation? SAGE consultation model

Assessing need: the flipped consultation model



Life & Times

Feeling blue, sad, or depressed:

how to manage these patients

Many patients present to primary care complaining of feeling blue, sad, or depressed. GPs generally work from a biomedical standpoint using the concept of depression, with medicalisation being the logical result. We believe that GPs are able to adopt a more person-focused approach in which they prioritise the psychosocial above the biological. Here we provide two examples of how GPs could start with this

"GPs can turn the biopsychosocial consultation model around — replace a disease-focused with a person-focused approach — and prioritise the psychosocial above the biological ..."

Reeve *et al. BMC Health Services Research* (2016) 16:470
DOI 10.1186/s12913-016-1726-6

BMC Health Services Research

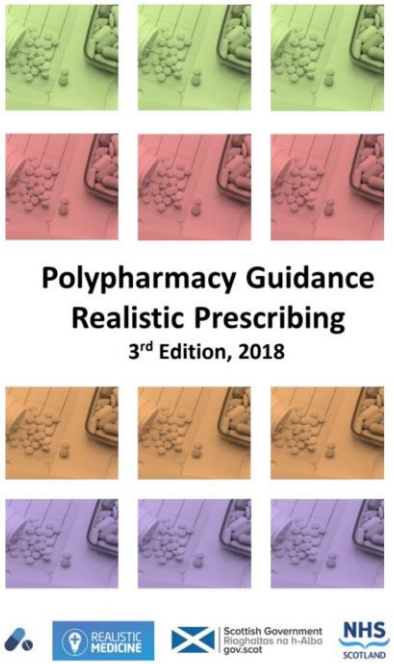
RESEARCH ARTICLE Open Access

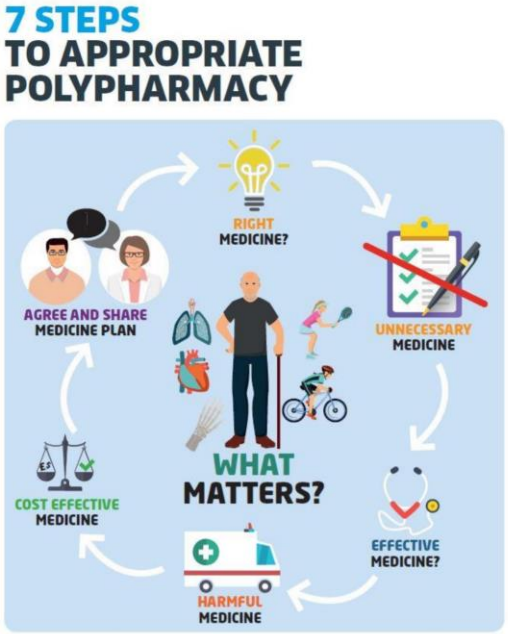
Developing, delivering and evaluating primary mental health care: the co-production of a new complex intervention

Joanne Reeve[1,2,4*], Lucy Cooper[2], Sean Harrington[3], Peter Rosbottom[3] and Jane Watkins[3]

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Tailoring care: the Scottish prescribing guidelines





***Drug Efficacy (NNT)* table**

Medicine / intervention	Comparator	Study population	Outcome	Duration of trial	Number needed to treat (NNT)	Annualised NNT	Comments	Ref
Hypertension								
Blood Pressure control (<140/90mmHg)	No treatment	Patients with hypertension and age > 80 years	Total mortality	2 years	333	666	High risk is defined as patients with a previous history of stroke Cardiovascular mortality and morbidity includes fatal and non-fatal MI, sudden cardiac death, aneurysms, congestive heart failure, fatal and non-fatal stroke and transient ischaemic attacks Total mortality is death from all causes NB the evidence base to support the NNT for impact on mortality in the over 80 years is very limited	34
			Cardiovascular mortality and morbidity	2 years	35	70		
Blood Pressure control (<140/90mmHg)	No treatment	Patients with hypertension and high risk* and age > 80 years	Total mortality	2 years	333	666		
			Cardiovascular mortality and morbidity	2 years	16	32		
Blood Pressure control (<140/90mmHg)	No treatment	Patients with hypertension and age > 60 years	Total mortality	4.5 years	83	374		
			Cardiovascular mortality and morbidity	4.5 years	23	104		
Blood Pressure control (<140/90mmHg)	No treatment	Patients with hypertension and high risk* and age > 60 years	Total mortality	4.5 years	33	149		
			Cardiovascular mortality and morbidity	4.5 years	9	41		

https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2018/04/Polypharmacy-Guidance-2018.pdf

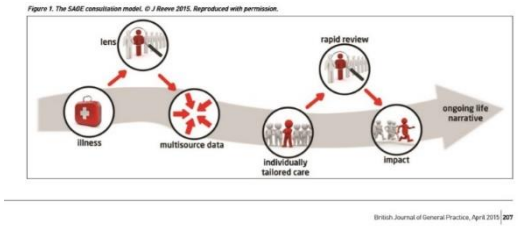
HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Do either of these help you with Janet?

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Reflective Practice: the SAGE framework

DATA	Rpt consultations, using Flipped approach
EXPLORATION	Imbalance of resources and demands, exploring goals
EXPLANATION	Priority mental health and mobility
SAFETY NET	Discuss with Janet and team
IMPACT	Reduced polypharmacy burden, improved mental health though not mobility



Reeve The SAGE Consultation model. BJGP 2016

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Generalist approach to problematic polypharmacy

- Principles: person centred needs assessment (flipped consultation model)
- Practice: Scottish Guidelines for deprescribing
- Reflective practice': SAGE consultation model
- **The rest of the 4Ps…**

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Solutions from practice

- Practice-based research generating tools for action
- Where are the ongoing opportunities, gaps to fill?
- And what would stop us working on this together?

HULL YORK MEDICAL SCHOOL | ACADEMY OF PRIMARY CARE

Joanne.reeve@hyms.ac.uk