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GENERAL PRACTICE: QUALITY OR RECERTIFICATION?

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Karl Popper, the most important science philosopher of the last century, used to call them “Unintended Consequences” meaning that one of the singular circumstances in social life is that nothing goes exactly the way we planned; everything ends up a bit differently, in fact we face unintended and unforeseeable consequences.

England seems to be following Popper’s theory of unintended effect with the 2012 “Revalidation”, a process every GP has to undergo if he is willing to continue practising.

The most unpleasant of all these consequences is the early retirement of some esteemed, by both colleagues and patients, doctors.

According to Professor Patricia Mary “Trisha” Greenhalgh, General Practitioner and head of “Primary Health Sciences” at Oxford University: Many excellent GPs we know decided to throw in the towel—one, two, and in some cases five or 10 years early—rather than do battle with that system”.(1)

Why battle then? This famous Professor who published more than 220 scientific articles and 8 text books, also considered one of the best world experts in the Evidence Based Medicine field and whose work is appreciated even by Her Majesty Queen Elisabeth II, has no doubts: “The very doctors who have got the most experience of delivering relationship based care, from whom trainees have got much to learn, are the ones who are being driven most rapidly from our ranks by the technocratic logic that has come to characterise the professional standards agenda.”

Worrying exclusively about technical skills instead of giving the right value to the doctor-patient relationship leads to a worse quality healthcare system. On the contrary, the NHS was hoping to make a quantum leap by relying only on up-to-date doctors.

As this is a shortcoming, of course, Professor Greenhalgh worked out a counterproposal: “We need to overturn this trend, even if it means taking aside people like Mike Pringle (president of the Royal College of General Practitioners) and starting a conversation with him about the unintended consequences of this brilliant idea, we need to do this in the spaces where broad based civic engagement happens: blogging sites, social media, debating forums, the Institute of Ideas, and— through gritted teeth I say—the Daily Mail.”(1)

Here we are, again, dealing with the

unintended consequences when it comes to "Revalidation": a strong debate on what being a GP means. It recalls the one held just before the "European Definition of GP" by WONCA, with some pros (it is not confined to the academic world) and some cons (it is not international).

To tell the truth, nobody was expecting such a hard dispute between two of the most important innovators of the British Medicine: The EBM queen (Greenhalgh) VS the man who computerised General Practise (Pringle). These two aspects are indeed two sides of the same coin.

People who are passionate about the epistemology debate have certainly noticed that after 20 years of success, EBM is now going through a critical phase. This is the reason why we need to focus: the "proofs" it relies on are too many and they are not so easy to handle. There are remarkable differences between what is epidemiology and what is clinic and sometimes they go unnoticed. The commitment to mere technical rules may lead us to lose the sight of our target: patients and it is also useless in complex comorbidities as life expectancy is increasing.

Professor Greenhalgh, leading spokesperson of the Anglo-Saxon critical rationalism, doesn't take anything for Gospel, she always seeks for the truth especially when it comes to EBM: "Much progress has been made and lives have been saved through the systematic collation, synthesis, and application of

high quality empirical evidence. However, evidence based medicine has not resolved the problems it set out to address (especially evidence biases and the hidden hand of vested interests), which have become subtler and harder to detect. Furthermore, contemporary healthcare's complex economic, political, technological and commercial context has tended to steer the evidence based agenda towards populations, statistics, risk, and spurious certainty. Despite lip service to shared decision making, patients can be left confused and even tyrannised when their clinical management is inappropriately driven by algorithmic protocols, top-down directives and population targets."(2)

This is why supporters of EBM are working so hard to rebuild it, they want a patient centred EBM and they want it to serve all the citizens with a much more personalised cure and clinical approach.

On the other bank of the river, we can find the the neo-positivist enthusiasm of the "Healthcare Informatics" with a simplifactory and standardised approach. An endless controversy. Some years ago Greengalgh VS Pringle: The zenith and nadir of Medicine. On one hand, a doctor-patient based relationship seen like an alliance (Greenhalgh) on the other hand, a computer junkie GP, focused more on population in general rather than patients themselves, more bookkeeper less doctor (Pringle).

Rivalry between universities: the technological way of Nottingham and

Oxford, humanistic by definition.

What is better? Curing diseases or taking care of people? Clinics or Informatics? A "gatekeeper" doctor or an "advocacy" physician? Trusted by NHS or trusted by patients?(3)

This debate is going to cross national boundaries.

We must keep in mind that the EU favours people who want to work in member countries in exchange of a more standardised education system. What happened with the "Vocational Training for General Practise" born in the UK and become mandatory in Europe is likely to happen again with "Revalidation" which can be linked to CME (Continuing Medical Education).

Furthermore, General Practice is part of the academic world overall in Europe apart from Italy where the process came to a grinding halt.

Professional evaluation of workers was born in the UK; recent experiences teach us a great lesson because they clearly demonstrate how we run into disastrous consequences in the very moment we went from certificating excellence to showing patients that their doctors' skills is "regularly checked by the employer".(4)

Is this kind of Bureaucratisation convenient for patients? What is going to happen when the needs of a single human being are in contrast with the ones of the general population?

The question remains unanswered.

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