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PRIMARY COLOUR

Helen Salisbury: Experts at the front door

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While doctors in training were on strike last week, consultants and GPs did their best to cover their work and keep patients safe. Some hospitals were quieter, and although this was mostly due to elective activity being scaled back, it was also because senior decision makers were at the front door.

Medical students and junior doctors spend many years learning to do more and more, whereas higher postgraduate training could be described as learning to do less but with confidence. Experience enables doctors to base more of their decisions on symptoms and examination findings: they order fewer tests and can reassure more patients without lengthy investigations or admission to hospital.[1] A major part of medical training is encouraging learners to think critically about their differential diagnoses—what they really suspect might be going on and what unlikely but dangerous possibilities need to be excluded.

Learners are encouraged to whittle down their investigations to ones that will answer clinically relevant questions. Some healthcare systems have financial incentives to over-investigate, or resource constraints leading to under-investigation, but we strive for a "Goldilocks zone" where management is decided purely by clinical reasoning, taking into account the patient's wishes.

If emergency departments were staffed entirely by consultants all the time it would probably improve efficiency—but this is clearly not an option, as there are nowhere near enough of them. Furthermore, if no junior doctors were gaining experience in emergency medicine there would be nobody ready to become consultants when their seniors retired.

In general practice we have a different balance between learners and senior doctors than in hospital medicine, so for most patients the first contact has traditionally been with a fully qualified GP. This contributes to efficiency and is one of the reasons we manage to do so much of the medical work in this country with only 8% of the budget.[2] This model is rapidly changing with the introduction of other healthcare professionals into practices under the 2019 Additional Roles Reimbursement Scheme, which helps to fund physician associates, pharmacists, paramedics, and others. While we welcome their contribution, our efficiency may decrease if non-doctors are the first point of contact dealing with the undifferentiated work of general practice.

Although there is clearly scope for predefined clinical problems to be managed by others—for example, pharmacists adjusting medication for high blood pressure—most of our workload is not related to single clinical problems. In reading my trainees' reflections on their consultations and analysing my own, I'm repeatedly struck by the complexity of our work. We may be adjusting anti-hypertensive medication but doing so alongside a discussion about stress, alcohol excess, and analgesics in the context of a patient presenting with a painful knee. We do all of this in the space of 10 to 15 minutes, and we also examine the knee.

There are now not enough doctors in general practice, and we've come to depend on the contributions of other healthcare professionals. But we should not underestimate the value of our expert generalism. We can, and do, deal quickly and efficiently with almost every problem that's brought to us. Without us, the NHS would grind to a halt.

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1 Li CJ, Syue YJ, Tsai TC, Wu KH, Lee CH, Lin YR. The impact of emergency physician seniority on clinical efficiency, emergency department resource use, patient outcomes, and disposition accuracy. *Medicine (Baltimore)* 2016;95:e2706. doi: 10.1097/MD.0000000000002706. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4753903/. pmid: 26871807

2 BMA. Health funding data analysis. 6 Apr 2023. https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/funding/health-funding-data-analysis