The Pitfalls and Pleasures of Pick and Mix Careers: Portfolio working and whole-person medicine in General Practice

Pick and mix or ‘portfolio’ careers are increasingly popular in general practice and are a dominant strand of recruitment initiatives in the UK and Canada. Portfolio careers are frequently framed as GPs adopting roles outside of and in addition to general practice, for example working in clinics or other organisations, offering subspecialist care. "Portfolio GPs" are generally employed on a short-term or sessional contract basis, in contrast to ‘partnership’ or salaried employment models. Advertising ‘variety’ for new GPs appears sensible given worldwide workforce shortages and the promise of work-life balance from adaptable work hours. When asked about career intentions, medical students expressing interest in family medicine frequently add the caveat ‘GP *with* a special interest’. Graduates are attracted to developing expertise in sub-specialties and working in different contexts. Yet, in supporting career flexibility, we may in fact diminish the breadth of thinking as the cornerstone of general practice expertise and increase the vulnerability of GP careers. In this article, we reflect on the untoward clinical and educational consequences of ‘pick and mix general practice’ as a potentially counter-productive message capable of eroding the complex nature of general practice work.

Traditionally general practice is whole person medicine.[1] Regardless of the problem, a family doctor works with the patient to consider if and how to attend to any problem presented, its inherent significance, and the potential impact for the patient. In contrast, most other healthcare is organised around disease-based compartments of knowledge, reflected in specialty and hospital infrastructure, referral pathways and medical curricula. However, patients and their concerns do not present in pre-packaged categories (paediatric, obstetric, psychiatric, geriatric, palliative and so on).The first task of a general practitioner is to clarify and make sense of a problem. This requires knowledge of the patient and investment in relationships built over time. It involves adaptable, creative thinking which transcends mind-body dualism.[1] To be effective, GPs need to consider biomedical knowledge, alongside multiple interventions within each patient's social and psychological context. It is this ability to triage and ‘sense make’ that is the hallmark of efficient and effective primary care [2, 3]. When this step of distinguishing distress from disease is omitted, we risk losing an inherent and vital part of generalist practice.

Endorsing a policy of 'pick and mix' primary care working risks new graduates narrowing and 'tailoring' their scope of practice to specific populations and problems – that is specialising. While this reflects the existing organisation of many healthcare systems, it limits the scope of one's commitment to (often) disease-based problems only, rather than to the patient and community more widely. Focused practice is defined by age, organ, gender and pathogenesis, and risks promoting the problem over the whole person.[1, 2] In so doing, it privileges biomedical approaches to problem solving and compartmentalises patient access to care. Increasingly, such focused approaches are characterised by 'managed care' based on proformas, checklists, and Likert questionnaires determined by pathology, leading to (costly) protocolised 'standard' investigations. This diverges from the generalist tradition of 'being there' where curiosity and collaborative problem solving are at the heart of the consultation. By encouraging the fragmentation[4, 5] of general practice we sanction biomedical knowledge as expertise at the expense of continuity and long-term care[6]: the art and intellectual demand is in the integration of the two approaches.

A concerning explanation may be that generalist knowledge is perceived as inferior by undergraduates and postgraduates. To avoid remaining '*just a GP*'[7] graduates seek to bolster their careers and professional self-esteem by adding something "special". Ironically, at a time when there are calls for a zero-tolerance of undermining general practice, the option of pick and mix careers reinforces this hidden curriculum and treatment of general practice as rudimentary knowledge (hence lower status), rather than a field of expert generalism in its own right. For well-boundaried specialist fields it has been relatively easy to establish legitimacy endorsed by the publication of undergraduate curricula. Across the UK, in response to the report *By Choice - Not By Chance*[8], general practitioners in undergraduate education are marshalling efforts to promote generalist practice. Harding et al[9] have proposed a broad, holistic general practice syllabus aimed primarily at improving recruitment, but touch only lightly on the pedagogic demands and opportunities for GPs of preparing all graduates for greater clinical and social complexity. The integration of biomedical knowledge with both patient experience and social context has produced challenges for those attempting to articulate general practice expertise. As a community we need to improve how we articulate the scholarly, intellectually stimulating nature of general practice as a focus of learning, valuable for every future doctor.

Previous authors have raised concerns about portfolio careers as reducing GP-patient continuity attributed in part, to increasing feminization and part-time working.[10] Portfolio GP

roles, we propose, jeopardize a more peripheral position for GPs, minimizing their sense of belonging and integration within practice structures and culture. This may reduce opportunities for supervision, mentoring and organisational learning. Likewise, nurturing GP-patient relationships and continuity become more challenging to maintain, risking isolation from both colleagues and patients, and potentially impacting on job satisfaction and GPs' vulnerability to burnout. GPs keen to complete a 'good job' are likely to stay beyond contractual hours, or adopt short-term efficiencies in working patterns. Longer-term, reduction in opportunities for sharing of experiential knowledge (about patients and organizational working), may challenge sustainability and capacity building for future GPs. This may be particularly true for those undertaking multiple locums or virtual clinics in an attempt to retain control over workload.

Increasingly GPs at all stages find it difficult to provide fulltime patient facing care with the associated electronic bureaucracy. We also recognise that GPs need a sense of progression and new challenges over the course of their careers with options to build on and vary their roles over time. We suggest, however, there is still merit in emphasising the value of general practice as a career in its own right, focusing recruitment efforts on articulation of the complex, varied and satisfying nature of GP work. We make two suggestions to support this: first, we increase structural support for novice generalists to develop expertise through colleague and patient continuity and feedback loops; and second, that we promote portfolio initiatives that explicitly extend and enhance generalism itself as a discipline, through, for example, education, mentoring research and quality improvement rather than encourage fragmented practice in the potentially risky pursuit of "special" interests. As Wass reminds us, 'only general practice itself can raise its status from that of an underling,'[7] and movements are underway.

In summary, we invite readers to re-consider the 'recruitment problem' of GPs and re-engage with how this has been defined and subsequent solutions provided. Through exploration of unintended consequences of previous educational and recruitment initiatives, we can make visible opportunities for students and new ways of showcasing general practice work and careers. Rather than marketing general practice as a dolly-mixture 'portfolio' career - made more attractive with artificial sweeteners that reproduce hierarchies between general practice and hospital specialties – the GP community might review (but not abandon) how careers can be enhanced. We anticipate that re-consideration and re-engagement might both

raise the profile of the discipline, while also providing a more authentic view of general practice work, thereby attracting those to a rewarding, inherently varied, lifelong career.

References

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