Reviewer's report

Title: Channelling professionalization processes to better fit medicine to the changing population health needs

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Reviewer: David Gray

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sample article

The title is rather clumsy. I suggest “Channelling professionalization processes to better fit medicine to the changing health needs of the population”.

The authors have produced a compelling argument for changing medical organisation amongst the clinical specialties.

I have the following comments:

The authors make a very valid point in the introduction about over-specialisation in medicine. In the UK, we have stopped training ‘the general physician’, who had a wide variety of ‘general skills and experience’, well-able to look after the needs of patients, referring only to the specialist when a technical procedure was required, such as a cardiac catheter, or when a patient had an admission to hospital indicating a change in severity of disease. A change in training was initiated by the Royal Colleges to meet the demands of the acute services in the NHS, at the expense of those with more chronic disease processes. Hence the introduction of the ‘acute physician’ and the demise of the ‘general physician’. As someone trained and accredited in general internal medicine and cardiovascular medicine, the deficiencies exposed by this strategy were clear. The authors might usefully expand on the impact of this strategy.

I do not believe the specialty of Geriatric medicine is recent- it has been long established specialty in the UK.

The authors make a valid point about ‘power’ but this lies with the specialist bodies and professional organisations, not the individuals. The text should explain this. Professional bodies tend to appoint as 'leader' those who put themselves forward for office- being a leader does not necessarily mean that others follow.

Care models tend to be a ‘one size fits all’ approach that is anathema to the clinician but is liked by administrators and planners, the non-physician managers. The limitations of care models should be expanded.
I have never perceived in the UK a concept of competition between specialties, more a spirit of co-operation to get the best for the patient, especially at local hospital level. Please explain how specialisms compete.

I disagree with “It must be established … at the expense of other vested specialties”. Specialists usually want to incorporate evidence from clinical trials quickly- it is the bureaucrat and cost-cutter that tries to control technology use. Perhaps the authors have different experience they wish to share.

I disagree with “This has far reaching consequences for the staged organization of healthcare systems, in particular the ‘gate’ function of primary care”. In the NHS at least, the gatekeeper and the general physician co-existed happily before the shift towards specialism alone.

“Therefore, professional work that is non-discretionary in nature and which therefore can be standardized or managerially organized will have to be devolved to less educated health personnel.” This could make things worse- in the UK, we have the ‘specialist nurse’ in many areas, working largely to a protocol. This is satisfactory providing a patient has a single disease. I cannot see how less educated health personnel will help in caring for the older patient with multiple co-morbidities. Please explain.

“It will run counter to the existing status quo, as it rearranges specialty domains, resources and incomes”. I see this more as a return to a previous, better, era of the general physician. European directives may prevent the re-introduction of the generalist.

“First and foremost, this asks for medical leadership.” It was the medical leadership in the UK that abandoned the generalist in favour of the specialist.

“the quality of care debate is now moving ahead in evaluating healthcare system performance in relation to population health. For instance, recent research links national mortality rates to healthcare indicators. I would not confuse quality of care with mortality data- the best care may still mean the patient dies.

Which journal?: Appropriate or potentially appropriate for BMC Medicine: an article of importance in its field

What next?: Accept for publication in BMC Medicine after minor essential revisions

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:

No conflicts to declare