Continuing care in general practice

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IT has been claimed frequently that the general practitioner undertakes the continuing care of his patients, while specialist care is episodic. The claim may be relatively just but it merits examination in some detail, against the background of the National Health Service in the United Kingdom.

For completeness a study should include consideration of the number and status of doctors who see patients at hospitals. In general a consultant or registrar sees a patient on first reference and on subsequent outpatient attendances he will be seen by a junior hospital medical officer whose period of duty in the department is limited and who may have been replaced by a successor on the patient's next attendance. On admission the patient is 'worked up' by junior staff prior to the making of decisions by the consultant who may carry out major procedures himself or delegate them to his juniors in training.

A fuller examination of the degree of continuity of care that is necessary and practicable inside hospitals should be undertaken. It is the present purpose to consider the extent to which the relationship between the patient and his general practitioner is a continuing one. The popular image is based on the traditions of small stable communities where a practitioner met the needs of his patients over an active period of 30–35 years, handing over to a younger man as his sixties advanced. Thus three family doctors could cover the lifetime of a patient who did not leave the locality in which he was born.

These traditional circumstances apply less frequently now, for a number of reasons. Population mobility is now greater, family ties binding kinship groups to a locality are weaker as dependence on the welfare state has replaced dependence on the mother as adviser and counsellor to the members of a dispersed family. Patients now expect to travel longer distances to seek medical advice, and easier transport helps them, but having moved they will not necessarily return to the 'doctor on the corner' nor will the doctor necessarily be prepared to follow patients who move a distance beyond the area in which he normally works.

Changes in the pattern of practice have also taken place. While the National Health Service made it difficult for many years for doctors to change the locality of their practices, the grouping of practitioners, with change of location of their consulting premises, has taken place all over the country. Rather than follow a doctor, patients may change to another whose group centre is more convenient. There are fewer doctors; those remaining in practice are harder pressed and less able to devote time to visiting distant patients. Time spent in traffic jams profits no one and the doctor himself may suggest a change to those who have moved away from the area in which he works.

An attempt has been made in an urban N.H.S. practice, composed for the most part of patients in social classes IV and V, to examine the duration of the relationship between patient and doctor. An approach was made through the National Health Service Medical Record Envelope which carries on its front cover the names of doctors who have had charge of the patient since his entry to the service.

Two samples, each of 50 medical record envelopes were drawn at random from the

stock of 7,200 medical record envelopes held by the practice. A criterion for selection of the first sample was that the patients were alive at the inception of the National Health Service in 1948 (Group A). This sample was divided equally by sex, as was a second sample consisting of notes on persons entering the list, by birth or immigration, during the last 20 years (Group B). The twentieth anniversary of the National Health Service, 5th July 1968, was considered to be a suitable occasion to examine these two suites of records to see whether different patterns of doctor–patient relationship emerged.

The information on the front of the medical record envelope was abstracted on to *pro formas* and used as a basis for simple calculations. This material is not without disadvantage for, as with many records made for one purpose and used for another, errors may arise from unexpected causes. Among the older patients where the 'boxes' for recording doctors' names had been filled, an adhesive paper slip was customarily stuck on the envelope. In some instances these had to be lifted with the aid of steam to identify the practitioners of the past.

It was found possible to estimate the periods for which a patient was in a relationship to a doctor by noting the date of change. Not every patient who changes his address changes his doctor at once and there is a potential inaccuracy here. The extent to which a patient remained in a continuing relationship with one member of a partnership could not always be defined. Executive council records place a person on the list of one partner and changes in the composition of the partnership—such as occurred in the practice examined—could lead to 'inflation' of the number of doctors. Note was also made whether the person had changed address to another locality prior to establishing a new doctor-patient relationship.

Measurement of the periods in which patients had been in relationship with their doctors was made in months. From the information recorded on the medical records examined it was found that the 100 cards covered 18,446 months of recorded exposure prior to admission to the list of the present practice. The duration of registration in the writer's practice was calculated separately.

TABLE I

TOTAL PATIENT MONTHS OF RECORDED EXPOSURE, BY GROUP, IN MONTHS

Group A (50 pts)		*Group B (50 pts)*	
Male	*Female*	*Male*	*Female*
8693	6388	1913	1552

TABLE II

AVERAGE NUMBER OF MONTHS DURING WHICH PATIENTS WERE IN RELATIONSHIP TO AN INDIVIDUAL DOCTOR, BY GROUPS

Group A		*Group B*	
Male	*Female*	*Male*	*Female*
137	149	36	30

TABLE III

DOCTOR—EXPOSURE OF INDIVIDUALS, BY GROUP

Number of doctors to which exposed	*Group A*		*Group B*	
	Male	*Female*	*Male*	*Female*
1	0	0	0	1
2	4	9	7	10
3	5	7	8	7
4	8	5	6	6
5	5	3	3	1
6	0	1	1	0
7	3	0	0	0

A difference between Groups A and B is at once apparent. A number of those in the second group were born during the last 20 years and a further number entered the medical list as immigrants to the country. Six male and five female patients entered the lists from the West Indies.

The next calculation showed the average period in months during which patients in

the defined groups were in relationship with one doctor.

The number of doctors among whom the care of the patients was shared was expressed in the same terms.

There is some consistency of pattern here, though the number of doctors sharing the care of persons in Group B differed little from those who cared for the more senior patients in Group A. This agrees with the shorter individual doctor-exposure figures in table II.

Patients and doctors change their relationships with one another for reasons which may be ascribed to both. Doctors come and go, patients move from one place to another or from the care of one doctor to that of another (table IV).

TABLE IV

CHANGE OF ADDRESS IN RELATION TO CHANGE OF DOCTOR, BY GROUPS. ACTUAL FIGURES

Group A				*Group B*			
Male		*Female*		*Male*		*Female*	
With change	*Without*	*With change*	*Without*	*With change*	*Without*	*With change*	*Without*
42	39	27	27	33	24	33	13

Two or three patients in the senior group maintained a continuing relationship with one doctor, one female patient achieving 468 months and one male 400.

The tables above related to the association between patients and the doctors whose names were recorded on their medical record envelopes, and took no account of the date of registration on to the list of the author's partnership practice. This practice was established before the National Health Service. A separate analysis was made of the records of those patients who were alive in July 1948 (Group A).

In this count the 50 patients achieved a total of 6,606 patient-months in the practice. They were distributed as follows:

Evidently half the senior members of the practice became acquainted with their doctors comparatively recently, and with only a quarter could the doctor claim acquaintance over 20 years. Further confirmation of this is shown by the experience of 18 patients born between 1948–1958, only two (11 per cent) had been registered with the practice for ten years or more and 16 (89 per cent) had been so registered for less. Of 12 children born since 1959 only one had been registered with the practice since birth.

TABLE V

DURATION OF ASSOCIATION OF PATIENTS IN GROUP A WITH THEIR PRESENT PRACTICE

	More than 20 years	*Between 10–20 years*	*Less than 10 years*
Male ..	6	5	14
Female	6	9	10
Total ..	12 (*24*)	14 (*28*)	24 (*48*)

Discussion

No two practices, even in the same neighbourhood, are alike. They are influenced by the characteristics of the population from which the patients come, and by the characteristics of the doctor or doctors who provide the service. The social class and the mobility of the population influence the pattern of the practice to a critical extent.

In the practice described a stable relationship between patient and doctors is unusual. The propensity of the patients to change their medical adviser is shown by the

earlier tables and this may well be a pattern met with elsewhere in the seedier neighbourhoods of large cities. In such a practice context a pattern of medical care based on long-established personal relationships is hard to achieve.

There is no doubt that under other circumstances practice stability can be achieved, and not only in isolated and rural areas. Practitioners in better-class areas of cities and in towns will find longer personal relationships to be the rule, and this fact influences the way in which they set about their work.

A pattern of practice appropriate and optimal for a fluctuating population may be quite wrong when applied in a practice with the characteristic of stability and the extent to which the population receives the kind of practice most suitable to its special needs has not been sufficiently studied. Neither kind of practice is wrong in its proper context. To create stability from shifting sands is impossible and it is impracticable to base practice methods on something which does not necessarily exist.

It may well be that practices form a spectrum from the most stable to the most fluctuant and that each occupies some point along the scale. The practice described comes midway, being in transition towards increasing instability and the doctors who work in it have to adapt to this change, as indeed do many others in similar practice environments.

A possible outcome may be the recognition of population stability and fluidity as characteristics of a practice and the evolution of different patterns to meet each need. A common denominator must be an effective records system though the manner and nature of entries may be vastly different. In a fluctuating practice the element of personal acquaintance may be less but that of personal involvement with the problems presented need not be so. One function of efficient records is to enable all practice staff to bear their full share of personal involvement.

So it is that the concept of the general practitioner as the provider of continuing care is now less clear. For many people the practitioner is 'their doctor' for less than a decade after which the patient may move, or his doctor may be replaced. The implications of this are important and insufficiently appreciated, for differing patterns of provision of medical care are necessary to meet differing circumstances. The social scientist and the general practitioner could well combine their skills in future studies in this area. Only systematic records can replace the series of memories in which a patient's medical history may at present reside, in greater or lesser detail.

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