CONTINUITY OF CARE

ALTHOUGH continuity of care is one of the cardinal features of general practice, it is an aspect that is underrated, understressed and undertaught.

Increased mobility in society threatens continuity, especially in cities, and the growing tendency for practitioners to limit their lists to small areas also ruptures some long-standing relationships. Nevertheless, even in Birmingham, the College Research Unit reported that a third of its patients had been in the practice more than seven years, and one in eight for more than 16 years.[1] In one of today's papers Munro and Ratoff show that even in a deteriorating area in Liverpool over a quarter of the patients had had continuity of care for more than 20 years. In country areas and in provincial towns, care for many years is more common.

While patients may see their general practitioner on average five times a year for only six minutes, this is nevertheless half an hour a year and a total of five hours in ten years. In a nuclear family with two children, the family doctor after ten years will have spent on average 20 hours with the family unit. This elementary arithmetic underlines the strength of continuity: many specialists consider that they know their patients well if they have spent two or three consultations of half an hour with them without ever meeting the rest of the family or entering the home.

Importance of continuity

Continuity in general practice is so important and so all-pervading that paradoxically it tends to be overlooked. It is the key to day-to-day care because few doctors, in any branch of medicine, could provide a good medical service based on a five or six minute consultation (the average in general practice) without it. It is this knowledge of the patient's past history, family history and work which, coupled with the general practitioner's knowledge of the probabilities of primary care, make his work possible.

Most specialist medicine is episodic and it is difficult for doctors who have been trained and who have worked throughout their lives in episodic medicine to appreciate the fundamentally different approach of long-term care.

The significance of continuity only became widely appreciated when general practice was first studied as an independent discipline. As Miss Southern notes in her delightful article today Mackenzie always taught the importance of " wait and see ". Balint (1954) emphasised that the doctor-patient relationship could be considered as a mutual investment in which both sides contributed capital. This emphasised the mutual sharing and underlined the loss when the relationship ended.

The explosion of interest in the doctor-patient relationship which has dominated the last 20 years can now be interpreted as a struggle by general practice to analyse and to understand continuity of care. Without continuity there is no relationship.

For general practitioners, time is a dominant dimension. Their skill lies in their sense of timing, their understanding of the natural history of disease, and their judgment of probabilities. Decisions about whether or not to intervene and if so, when; about

whether or not to refer and if so, when, all hinge on timing. The right move at the wrong time may wreck the results.

Two key questions illustrate the dimension of time: " Why has this patient come now? " and " What will this patient do when this happens again? ". These questions are rarely uppermost in the minds of hospital doctors, but are fundamental to management in long-term care.

Advantages to the patient

Continuous care from a known individual is normally an advantage to patients. Most patients and most family doctors get on well together. When offered a choice, patients usually choose to see their ' own ' doctor and it is commonplace in practices all over the country for patients to choose to wait several days to see a particular partner rather than accept an appointment on the same day with another doctor.

A moment's thought explains this. Few people find it easy to talk about important and sometimes intimate subjects to strangers. Furthermore, the difficulties that patients have in communicating their needs are only now coming to be understood. The phenomenon of the real subject of the consultation emerging as the patient leaves the room, with one hand on the door, is but one example of the patient's need to test out the doctor before entrusting him with important knowledge. Patients confronted with a series of medical strangers feel threatened, and this aspect of care now needs watching, especially by big group practices.

Advantages to the doctor

The decisions of a family doctor are based on his assessment of his patient's personality. It is notoriously difficult to evaluate this at a single interview and the precision with which family doctors get to know their patients is largely due to their ability to see them in different places, with different conditions, and at different times. Practitioners can make the patient act as his own control and may learn much when behaviour differs from a previous illness. As much of general practice depends on recognising patterns of disease and patterns of behaviour, time is essential.

Some diagnoses even depend on timing. Anniversary depression can only be diagnosed if the key event to which it relates is known to the family doctor and a whole myriad of psychosomatic diagnoses hinge on linking patients' feelings with time and place.

Teaching

Continuous care is difficult to describe, hard to analyse, and can only be taught in conjunction with experience. Now that vocational trainees are appearing in increasing numbers, there is a chance to show the significance of continuity in the teaching practices.

Evaluation

Hodgkin today cleverly exploits continuity to introduce an evaluation and audit of general-practitioner care. He uses the dimension of time to study diagnostic delays. Long-term care provides a chance of ultimate evaluation and is a unique educational experience. It gives a chance to evaluate a whole host of medical and surgical assessments and treatments.

Whatever the doubts, whatever the diagnosis, whatever the procedure or prognosis, the general practitioner sees what happens in the end.

REFERENCE

Research Unit of the Royal College of General Practitioners (1973). *Journal of the Royal College of General Practitioners*, **23**, 415–16.