General practice in Sweden

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Hospital orientation

In April 1973 an experimental station in primary care was opened in Göteborg in the suburb of Tynnered. This marks a new era in general practice in this community, but is also significant for the future of medical practice in Sweden.

The erection of several big new modern hospitals has been characteristic of the 1950s and 1960s. At present Sweden has 18 hospital beds per 1,000 inhabitants which is highest in the world. On the other hand consultations by patients with doctors in primary care and as outpatients are correspondingly low. A great enthusiasm for hospital building led to a sharply rising cost of medical care in Sweden, from about three per cent of the gross national product in 1962 to about six per cent in 1972.

Public and professional interest in clinical medicine has resulted in a neglect of primary care, a resulting loss of prestige for the general practitioner, and a tendency for patients to go directly to hospital for medical treatment. A great lack of physicians which has been characteristic of the last two decades has probably also accelerated this process for in many districts there are vacancies for general practitioners with few or no locums.

As a result when a patient has been treated at hospital and is ready to go home the hospital doctor often finds that there is no general practitioner to take over and thus he is obliged to keep the patient attending outpatient departments. In this city one general practitioner can be employed for 20 hours per week for a population of between 15,000 to 25,000 inhabitants, which obviously makes it impossible for him to care for this population satisfactorily.

In 1969 the city of Göteborg, which has 500,000 inhabitants, made a prospective study of doctor-patient contacts at all levels. A medical panel later evaluated the questionnaires and found that only 24 per cent of all consultations were with general practitioners, 40–50 per cent were with specialists outside hospital, and the rest were at specialist outpatient departments at hospital. The panel suggested that perhaps 40–50 per cent of all these consultations/visits could with advantage have been with general practitioners.

An experimental practice

The Tynnered station is an experiment in better primary care. The experience from this station during 1½ years may give an indication of difficulties in primary care in Sweden today. The station is located in one of the suburbs, with a young population, 80 per cent below the age of 40, living in newly-built big apartment houses. Children below the age of 15 form 35 per cent of the population. Single-parent families and multi-problem families are common.

A population of 12,500 inhabitants get their primary care at the centre which has three doctors and one in training. In addition there are nurses giving medical advice, a community nurse, a social worker, and secretaries. The centre is in a big shopping centre close to a big specialist outpatient department.

Of the three doctors working at this centre none is trained as a general practitioner. One has ten years experience in hospital as a pediatrician (KB), another has ten years in general medicine and neurology, but only in hospital. The third post has been vacant with several short-term locums.

During the first 12 months we saw 9,000 patients. The estimated average doctor-patient contact rate is three a year, which means that we probably saw about 25 per cent of all doctor-patient contacts for our population. A planned follow up of this research hopefully will show where the other patients went. However, several specialists take patients without referrals since

freedom of choice of physician is considered of fundamental importance. Many patients prefer to go to the hospital emergency units for immediate treatment. A minority attend private general practitioners.

Attitudes of patients and doctors

Thus, our main problem is to change the attitude of our population towards primary care. It is obvious that several of our patients look on us as second-class doctors, to whom one can go to have new prescriptions of medicine that other doctors have given, or for simple acute infections.

Our policy is to counteract this by a generous acceptance of all patients, taking them in for visits or guiding them to adequate treatment, which may imply advice over telephone. When the patients attend their doctor at the centre we can give them much more time than is usual as we have only 15–20 patients a day. We also make a point of having a complete medical history from the beginning. This is to introduce our specialist-indoctrinated patients to the idea of co-ordinated medical treatment. Each patient keeps the same doctor and we also have all members of one family going to the same physician at the centre. If different doctors at the centre have different medical knowledge this means that the doctors consult each other and perhaps see each other's patients once or twice, but the patients are not switched over.

Social care

One of the particular features of this research project is the integrated social and medical treatment which we can offer the patient. By evaluating social aspects of the patients we hope to identify social problems connected with the acute disease for which the patients come. The social problems can be secondary to disease, cause the disease, or exacerbate the disease.

When we identify such problems the patient is referred to the social worker of our centre. The social worker makes a social evaluation of the patient and suggests action. The doctor, patient and social worker then make an integrated plan for treatment in which medical treatment and social treatment are supposed to support each other and also include the co-operation of the patient.

Patients who already have contact with social workers outside the centre are excluded from this service and in this case the physician co-ordinates his medical treatment with the social plan already made elsewhere. By excluding these patients we can concentrate on early unidentified cases with social problems, for instance families where one parent might be an alcoholic but is not yet so far advanced that the social function of the family has been disturbed, which might lead to early treatment.

The social treatment includes psychotherapy for the patient and his family, economic advice, care for children, and finding a job for unemployed patients. Group therapy for women who are isolated has been one experiment used at the centre so far.

Community nurse

The community nurse is another special feature of this primary care centre. She sees her patients in co-operation with the physicians of the centre, in which case she monitors diabetic patients, hypertensive patients, takes routine controls after tonsillitis, scarlatina, urinary tract infections according to a schedule made out by the physicians of the centre. This means that the doctors are relieved of simple routine medical supervision and that as soon as something wrong is detected at the checks the patient can immediately see his regular doctor, which provides medical security. The community nurse makes home calls. Patients can also see her directly and in particular she takes care of minor problems such as children with rashes for diagnosis, varicose ulcers, and minor burns.

Other arrangements at the centre include co-operation with the local pharmacist who informs us each month of prescriptions which the patients have not collected from the pharmacy. We also have close contact with the sick insurance authorities and unemployment agencies.

Co-ordination with specialist care

One important aspect which is under investigation is optimal ways of co-operation with specialists and the hospitals. This study will have important implications particularly for training future

general practitioners in Sweden and for continuing postgraduate training. With specialists from different fields one agrees on what type of diseases should be treated by general practitioners, what kind of diseases belong to the specialist alone, and what diseases the specialist and general practitioner should treat together. In addition some diseases which require early identification and referral are listed. This means that the different specialists who train general practitioners will have the responsibility of giving the general practitioner adequate training for his job.

Vocational training for general practice

The future training of general practitioners in Sweden will include 18 months of general medicine, six months of psychiatry, three months of pediatrics, six months of primary care, and nine months in a specialty which the doctor himself can choose, in addition to the two years of basic training after qualification examination common to all physicians.

Obstetric and paediatric care

In Sweden we have a well-developed system for health care of pregnant women in close co-operation with the university obstetric clinics which is one important reason why Sweden has the lowest infant mortality in the world. There is no intention of bringing this within primary care.

Similarly it has been considered important that small children are treated and supervised by pediatricians and well-baby clinics do an efficient job, which has resulted in very early diagnosis and treatment of most severe handicaps in children. The official plan for Sweden is to have one pediatrician who is the primary doctor in charge of one district, working with the general practitioners of the district. By having these doctors in the same centre the pediatrician can supervise the treatment of less severely ill children who go to the family doctor of the centre, be in charge of preventive medical care of children, in well-baby clinics, schools, day nurseries and so on, and also give specialist treatment to the more severely sick child who still can be kept at home for treatment.

The Tynnerd project is the first in a big city. Other research projects in primary care have been started earlier in other parts of Sweden, but these are in rural areas. By the special resources for investigations at these centres and co-operation between the different experimental stations, these experiences can be shared for a better future development of primary care in Sweden.