

Continuity of care — going out of style?

BRITISH general practice has been the envy of most of the Western world.¹ The Norwegian government, for one, is this year implementing a national patient list system modelled after that in the United Kingdom. A major driving force has been to improve access to, and continuity of, primary health care to all of the country's citizens. But now we sense that something is amiss in UK general practice; the guiding light is dimming. One of the core values of general practice, continuity of care, is under severe attack.² What has gone wrong? Among several plausible factors I see three main reasons.

One major obstacle is that, in spite of having been a fundamental principle of general practice for more than 50 years, we still lack a common and clear understanding of what the term actually implies. It is often lauded but seldom defined.

To me, 'continuity of care' in the strict sense of the phrase implies the patient seeing the same health care worker over time. As such, it is a tool used by the general practitioner (GP). Together with communication skills, continuity of care is probably the most important tool of general practice. For a man building a house a hammer and a saw are important tools, as is the surgeon's knife or the neurologist's reflex hammer. As a tool, continuity is important in itself, but for the concept of general practice it is what this tool is being used for, or what it leads to, that is crucial. Or, to extend the metaphor, it is the kind of house we are building with these tools that matters at the end. And in my opinion the final product is establishing and maintaining a curing and caring professional relationship with our patients. In this building process continuity of care may lead to better knowledge and a sense of responsibility and trust, all of which can be summed up in that rather poetic phrase 'personal doctoring'. There is a close relationship between continuity and personal doctoring, but they should be looked upon as separate entities; the first is a tool and the second is a process.

In my opinion we have to date focused too much on the tool and not enough on the process and results. This leads to the next critical factor: does continuity actually lead to the desired process of personal doctoring and improved quality of care?

Regarding the outcome there is, overall, research evidence for a reasonably strong and consistent association between continuity and patient and doctor satisfaction.³ Indications of associations with improved intermediary medical outcomes, such as compliance, uptake of preventive care, and use of resources (time spent in the consultation, discriminatory use of laboratory tests, and admission to hospitals) are also emerging.⁴

Equally important in general practice are the process factors. Continuity in relationships builds trust, creates a context for healing, and increases the practitioner's and the patient's knowledge of each other.⁵

Sick people have a particular need for trusting others, primarily their family and their doctor.⁶ Personal trust grows in ongoing relationships. It evolves between people with

names, identities, feelings, and faces, and it must be actively gained. Recent studies have shown that higher continuity is associated with a higher level of trust between patient and doctor.⁷ A practitioner's sense of responsibility toward his or her patients increases with the duration of the relationship and with the number of contacts.⁸

Two main categories of contextual or personal knowledge are related to an ongoing doctor-patient relationship. One is a mutual understanding of each other. With continuity of care the patient usually knows what to expect of the doctor during an encounter. The doctor has on his or her side a personal knowledge about the patient's previous history of illness. In addition to this formal knowledge the practitioner frequently has an understanding of the social context of the patient, gathered over time⁹ and important in the management of the patient.¹⁰

The other category of knowledge is related to GPs' development of their own clinical knowledge and skills. You need continuity of care to understand illness and disease in a contextual setting.¹¹ This is, in my opinion, the main reason why 'continuity of information and records' is unlikely to replace continuity of care. The record contains mere information, while the doctor possesses integrated knowledge, much of which is tacit and gathered from several sources and over time.

The third major eroding factor is closely linked to the previous. To date, the discussions and research efforts related to continuity have to a large degree been static, doctor-centred, and limited in scope.¹² With the emergence of a global market, increased consumerism, and better informed patients, GPs are facing a new brand of impatient patients. A basic assumption has been that continuity of care is an inevitable good for all patients; 'one size fits all'. This is not necessarily so, as is well documented by Karen Kearley and her co-workers in this month's issue of the *BJGP*.¹³ In their study in the Oxfordshire region, 64% of the responders to a mailed questionnaire rated having a personal GP as very or extremely important. Having a personal doctor-patient relationship was highly valued by the patients, particularly for more serious, psychological or family issues where almost 9 out of 10 patients valued a personal relationship more than a convenient appointment. For minor illness it had much less value. It is equally interesting that one-third of the responders rated the general importance of having a personal practitioner only as moderately, slightly, or not at all important.

From this it is evident that different groups of patients have different views of the importance of continuity. It is furthermore likely that individual patients hold different views on continuity, both over time as they go through different stages of life, or even at the same time for different health care reasons.

It is a paradox that most studies to date have been cross-sectional when evaluating a process that in its very nature is longitudinal. Longitudinal process-oriented research, where patient trajectories are followed over time, are urgently

needed to understand more about barriers to greater personal continuity and what is needed to maintain and improve such continuity.

Is Norway betting on a losing horse by following Britain and introducing the patient list system? No: it is my firm belief that personal doctoring is an essential part of good general practice, and that continuity of care will even gain importance as the population grows older and medicine becomes increasingly complex.

But we have to think 'new'. Continuity of care is costly to deliver in the day-to-day service, it also carries expenses in the way of personal commitments from the GP. We should thus focus our research and continuity of care efforts on those who want, need, or deserve it, striking the right balance between continuity and accessibility.

Personal doctoring, combined with access and quality of medical care, will be the main criteria on which primary health care systems will be evaluated, not only in Britain and Norway, but also in much of the rest of the developed world.

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Between the hammer and the anvil?

THE paper in this issue on patients' and doctors' perspectives on prescribing proton pump inhibitors¹ describes a familiar scenario. Individuals with complex needs gain benefit from an expensive treatment but its widespread use is discouraged for financial reasons, or because other problems have greater priority, or because scientific judgement differs from advocates' claims. The patients are aware of the need for financial prudence in the NHS but cannot see why they should pay for it with avoidable symptoms. General practitioners (GPs) are then caught between the conflicting pressures of patient demand and resource limitations or sceptical science (or a mixture of both) and adopt defensive measures, including the false stereotyping of feckless or less deserving patients revealed in this study. In this defensiveness we revert to lay thinking, where moral and individualised explanations of health and illness are more common than social and environmental ones, even when the evidence favours the social explanation.² While the truth of patients' accounts of their symptoms and the sincerity of their desire for treatment are not contested, the normality of their situation is challenged and their claim to treatment becomes invalid.³ The new therapy then becomes 'unnecessary' because a desired objective can be reached by simpler (and cheaper) means and 'unwise' because it can divert resources from the treatment of other deserving patients.⁴ The cognitive dissonance created by this defence then adds

to the other workload, emotional transference, and resource stresses experienced by practitioners.

This brings us face to face with the dark side of evidence-based medicine, as an over-determined utilitarian ideology that can be used to justify resource constraints.⁵ Constructed around the ecological fallacy that group averages tell clinicians what they need to know about causal processes in individuals,⁶ evidence-based medicine in the simplified forms used in resource allocation defines evidence too narrowly⁷ and devalues patient judgements about benefits and risk, weighting of severities of outcomes, and different valuations of time.⁸ GPs are in an uncomfortable position between utilitarian and deontological (patient-centred) perspectives and mediate between the reductionism of epidemiology and the subjectivity of the lifeworld.³ And we are likely to become more involved in implementing decisions about resource allocation as general practice moves closer to the centre of an industrialised process of medical care.⁹

A deontological counterbalance to utilitarianism would exist in a world where patients get the treatment they need from clinicians who understand those needs; however, no such world exists, for two reasons. No health care system can escape from resource constraints, unless it provides only for those with unlimited personal wealth and all third-party payer systems are riven with debates about cost con-

tainment. Also, we are embedded in a medical-industrial complex,¹⁰ a web of relationships between medicine and the pharmaceutical industry that gives the industry pre-eminence in postgraduate education and influences so much research. This relationship defines the needs of patients to its own advantage just as much as the administrative processes of the NHS define and re-define eligibility for treatment.

Being caught between the hammer of deontology and the anvil of utilitarianism is painful. Can we endure and survive this experience? What options are open to us in general practice to resolve these conflicting and sometimes contradictory demands? Can we rely on any professional or academic strategy to make patient expectation harmonise with available provision, or are we forced to demonise one or other source of demand?

There are some obvious options. A tiny minority can treat patients who can afford to pay for most treatments that they need. A larger minority could shift, in whole or part of their work, to an alternative funding system based on health insurance where the resource constraints may be less powerful, at least for a while. The majority of us can continue as usual, blaming patients, politicians or primary care trusts on a pragmatic basis for the enduring conflicts that we experience in daily practice, and manipulating the system as best we can. There are also less obvious options, at the micro-level of the consultation, the meso-level of the practice, and the macro-level of professional culture.

At the micro-level of the consultation, some convergence of perspectives may be possible, up to a point. Age, socioeconomic status, and ethnicity all conspire with different understandings of science to establish distinct explanatory models, and different experiences of illness and of medical care produce a variety of responses, with partnership at one end of the spectrum and consumerism at the other. Communication skills, taught for their techniques to make novices competent, will help to repair the doctor-patient divide, but we have no grounds for believing that they will abolish it. Recasting consultations as 'meetings between experts' did not shift the professional concern with diagnoses and staying in control in 1985,¹¹ and it seems unlikely that developments over the past 15 years have made much difference to this aspect of everyday communication. Reflective practice may do so, if its practitioners can focus in a self-critical way on the barriers that impair professional understanding and incorporation of lay perspectives,¹² but postmodern critics will tell us that illness is defined for patients by professionals, so that enhanced communication and deeper reflection are no more than reinforcements of professional power.¹³ So, in the consultation we may have to think about the conflicting nature of our interactions rather than the comforting notion of partnership, and make explicit different views on truth, sincerity, and normality, if we are to avoid systematically distorted communication and achieve instead a rational consensus.³ In the case of proton pump inhibitors, this would mean *me* talking about *my* problems, prescribing an expensive treatment, and the reasons why it has become categorised as *too* expensive, in ways that would allow the patient to act, whether by reconsidering the severity of their symptoms or by writing an indignant letter to their MP. Not only do we have to try to understand our

patients but also the policy context in which they seek help; neither task is easy, and we are trained only for one.

At meso-level, practices may find that discussing and debating the reasons behind current policies may enliven the often jaded and disappointing experience of 'patient participation', even if this approach is in conflict with the corporate governance desired by primary care trusts. Freed from the bureaucratic burden of a Byzantine financial system, practice managers in PMS practices may find that one route to quality lies through continuous dialogue with patients, assuming that they can manage the conflicts that will arise. At macro-level professional bodies and academic departments can do two useful things. First, strengthen the foundations of medicine-based evidence, the kind of research that is driven more by patient and clinical experience than service needs. Secondly, acknowledge that clinicians want guides to action more than they want theoretical understanding, and encourage medical sociology to go beyond interpreting the world and start changing it.¹⁴

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