Do the British value continuity of care?

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When a patient seeks resolution of a healthcare problem from a practitioner in the private sector, there is an expectation that the whole of the condition will be orchestrated by the patient's chosen medical practitioner. The process may involve assistance from colleagues, but the bringing together of the various threads of this endeavour would be coordinated by the patient's chosen doctor. This is the epitome of continuity of care. Until recent times this untrammelled patient experience was the norm in NHS hospital practice. Today hospital activity has become impersonalized with up to 70% of medical emergency admissions finding themselves on the 'pass the patient' merry-go-round.

In the past it was the doctors' accumulated experience and the availability of suitable patient accommodation which underpinned their ability to deliver a caring and patient-focused service. Experience cannot be learned from a textbook or journal. It relies heavily on astute but careful observation of the evolution and resolution of the disease process, which in itself may change over time. Medicine is not an exact science. If it were, then the whole process of patient management could be reduced to a simple tick-box exercise – a mindless goal which short-sighted managers crave through being out of touch with the process of continued medical education. It is this continuity of learning which enables the experienced doctor to deliver the continuity of care which will ultimately achieve improved standards of clinical outcome. Continuity of learning requires uninterrupted time in which to gather in this valuable harvest. How has this gold standard of medical care become so devalued in the NHS?

Concerns about serious clinical mistakes being made in the management of medical emergencies identified junior doctors as the scapegoats and their seemingly excessively long hours on call.[1] Reducing the hours on call in the UK changed the problem because it overlooked the effects of limited availability of investigational support, the effects of loss of hospital beds in the face of an increasing target population, and a reluctance of senior staff to modify their hereditary hierarchical work ethic. Reducing doctors' hours of work necessitated an increase in the junior workforce. Managers sought to reduce this financial burden by curtailing what was perceived to be slack periods in a doctor's regular schedule and thereby increase the intensity of work when on duty. With a shorter working week a greater proportion of that time would be spent on handover procedures and not delivering healthcare unless that thread of continuity was preserved by active participation at consultant level. Unfortunately consultant staff found themselves being sucked into this shift work paradigm particularly where there was insufficient depth to specialty team structure. Continuity of learning was the immediate casualty and continuity of care began to ebb away.

The impact of these handicaps could have been reduced if admitting teams had had adequate numbers of beds allocated to their use. In that way junior staff would have found the major proportion of patients they had seen as emergencies were subsequently admitted to the wards overseen by their firm. However, managers thought that if specific consultants were responsible for specific wards then there would be more regular consultant participation in the day-to-day management of inpatients and shorter hospital stays. Perversely managers, wishing to maximize bed occupancy, failed to realize that a specialty ward-based system without adequate numbers of beds to support it, would merely result in patients being admitted to wards where they subsequently became the

responsibility of previously uninvolved junior doctors and consultants.

Clearly there are many factors contributing to this debacle but the two main problems today are the European Working Time Directive (EWTD) and a lack of appropriate inpatient beds. Whereas the NHS Employers are expecting Hospital Trusts to be fully compliant with a 48-hour working week by August 2009, the American Institute of Medicine has vigorously promoted their stance that 80 hours and not the 48-hour EWTD should be the maximum weekly work schedule for junior doctors.[2] The Americans argue strongly that 'continuity of learning' becomes the main casualty of shift working, particularly when those working the shift are under sustained pressure. If junior doctors today are denied this learning experience, it will be the patients of tomorrow who will ultimately suffer the consequences. Whereas a weekly average of 80 hours is excessive, 48 hours would almost certainly destroy continuity of care, but 56 hours could be the practical compromise and should be pursued with greater diligence.

Patient satisfaction questionnaires have so far failed to recognize poor continuity of care as a significant health risk. In this context only emergency admissions are relevant. Since patients admitted as emergencies cannot choose the hospital to which they are admitted it is generally assumed that pot luck will also apply to their hospital experience. Following discharge from hospital, most of these patients will be thankful for having recovered, even if that recovery was only partial. The many and varied medical attendants contributing to their hospital journey are more likely to confuse rather than concern them.

It is rare for the problems which we encounter in clinical practice to be attributable to a single cause. Management needs to appreciate that holistic solutions are required and not micromanagement from a distance by battalions of non medical functionaries tinkering with isolated parts of a multifactorial situation. It is a mystery to me why the medical profession, which made the decisions about patient care before the NHS, now appears to be content to be frogmarched by the Department of Health and its sycophants down the road to perdition. Medical staff should be empowered to provide their best shot when caring for emergencies and not be restrained by blind adherence to arbitrary directives from third parties. There is a pressing need for strong leadership from the medical profession before continuity of care becomes a distant memory to those old enough to remember what it was all about.

References

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