Seeing the same doctor

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SUMMARY. It is not known how many general practices are organised so that patients usually see the same doctor (separate list practice) or how many are arranged so that patients are encouraged to see any partner (combined list practice).

A survey was carried out in Wiltshire which obtained an 85 per cent response to a questionnaire. This showed that a majority of general practitioners working in partnership in Wiltshire no longer organise their practices so that they care for a defined list of patients.

Introduction

ONE fundamental principle of general practice in this country is that the doctor should provide his patients with personal, primary, and continuous care (Royal College of General Practitioners, 1972). In the days when most general practitioners were single handed and, more recently, when partnerships were more a business arrangement than a way of working together, patients almost always saw one doctor and personal, continuous care was not in doubt.

The trend towards more partnerships and more group practices accelerated when financial inducements began in 1966 and increasing numbers of health centres were built with advantage to younger practitioners who often no longer need to find capital to buy their share of practice premises. It is possible that this changing pattern of practice organisation may be leading to a decrease in the degree of personal care given.

The Journal of the Royal College of General Practitioners (1973) in its editorial on *Continuity of Care*, stated that it is commonplace for patients to wait several days to see their own doctor rather than see a partner on the same day and continued, ". . . this aspect of care needs watching, particularly in big group practices."

Many patients prefer always to see the same doctor (Hill, 1968; Miller, 1972; Lloyd, 1974) and the majority of doctors feel that patients should be encouraged to do so (Cartwright, 1967). This is an aspect of primary care which has been little investigated and no previous attempt has been made to quantify this aspect of care.

Objective assessment of the degree of personal care is difficult. One way is to find out how much doctors provide care for the patients actually registered with them. Although free choice within a partnership is quite compatible with a highly personalised system of care, I assume that the more it is the policy of a partnership for each doctor to see only the patients on his own list, the more personal care is likely to be. This investigation examines the degree of personal care measured in this way, given in partnerships in Wiltshire in 1975. Other features of the organisation and the ethos of the practices were not investigated and no attempt is made to define reasons behind the differences which are revealed.

Aims

The aim of the study was to find out whether or not general practices in Wiltshire are organised to encourage patients normally to see their own doctor.

Method

The medical list of the Wiltshire Family Practitioner Committee contains 53 partnerships of two or more principals and questionnaires were sent to the senior partners of these practices in January 1975. The 17 questions asked attempted to find out how much each partner looked after the patients on his list, the first question being, " When a doctor holds a normal surgery, do the patients on his list always see him or her? ". The remaining questions clarified the circumstances in which his patients would see another doctor, including the extent of out-of-hours cover, and whether subsequent care is handed back or not. Though practice organisation varies widely in these respects, most permutations appeared to have been covered and only a few ambiguous or contradictory answers were given.

Although no information was requested that could not have already been known by many patients of the practice, confidentiality was offered with the questionnaire and five accepted the suggestion that the reply need not name the practice.

Results

Forty-five completed questionnaires (85 per cent) were returned and the replies with the number of principals in each practice were analysed using punch cards.

In 12 of the 45 practices, patients always see the doctor on whose list they are, both in the surgery and at home and, if seen out-of-hours by a partner, any follow-up necessary is handed back. This group, which will be referred to as ' separate list ' practices, comprises 27 per cent of the 45 practices and 32 per cent of the 149 principals in these practices.

In the remaining 33 practices, comprising 73 per cent of the groups or 68 per cent of the individual doctors, patients are free to consult any doctor and these are termed ' combined list ' practices. Also in these combined list practices, if a patient is not already under treatment, any doctor may visit them in response to a request made before 10.30 hours.

A discrepancy arises with the combined list practices in that although patients can consult any doctor and any doctor may visit, six answered that any necessary follow-up of out-of-hours treatment would be handed back, " to the patient's doctor ". It may well be that in these six groups, the patients so seldom see another doctor during normal hours that, despite the existence of choice, they operate effectively as separate list practices. If this is so, the proportion of practices giving separate list type of care would be increased to 40 per cent.

Larger groups more often operate a separate list system (figure 1). Of groups of four or more partners, eight out of 17 (47 per cent) are separate list, whereas of the two or three partner groups, only four out of 28 (14 per cent) are separate list practices (table 1).

TABLE 1

PRACTICES HAVING SEPARATE AND COMBINED LISTS AND THE EFFECT OF PRACTICE SIZE

	Number of practices		*Practice size*			
			2–3 partners		*4–6 partners*	
	Number	*Per cent*	*Number*	*Per cent*	*Number*	*Per cent*
Separate list	12	*27*	4	*14*	8	*47*
Combined list	33	*73*	24	*86*	9	*53*

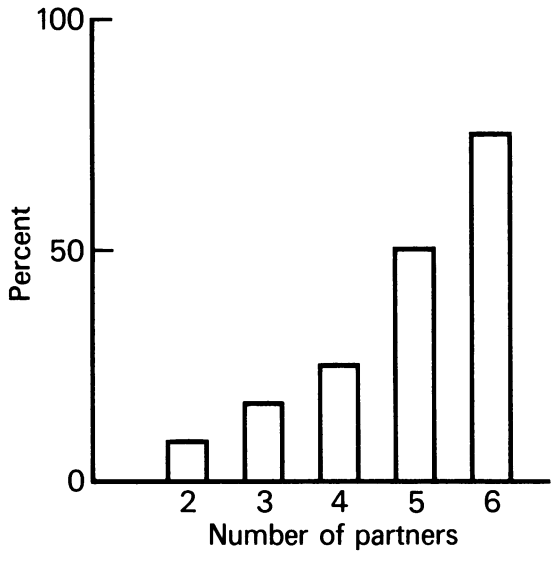

Figure 1
The percentages of practices giving separate list type of care by size of partnership.

TABLE 2
DIFFERENT ASPECTS OF OUT-OF-HOURS COVER AND THEIR OCCURRENCE IN SEPARATE AND COMBINED PRACTICES

	Cover given by duty doctor							
	Weekend		*Evening*		*Night*		*Daytime*	
	Number	%	*Number*	%	*Number*	%	*Number*	%
Separate list	12	*100*	11	*92*	9	*75*	5	*42*
Combined list	32	*97*	31	*94*	30	*91*	20	*61*
	Not covered by duty doctor				*Follow-up handed back*		*Deputy service used*	
	Obstetrics		*Other*					
	Number	%	*Number*	%	*Number*	%	*Number*	%
Separate list	2	*17*	2	*17*	11	*92*	2	*17*
Combined list	7	*21*	9	*27*	6	*18*	2	*6*

Out-of-hours cover

The type of out-of-hours cover given is fairly uniform as is shown in table 2. All practices except one have a duty doctor on call in the evenings and at weekends. In five practices, four of them work separate lists, partners then revert to being on duty for their own patients after 2300 hours. About half the groups have a duty doctor during the day after 1030 hours and this was rather more frequent amongst combined list practices. A day-time duty doctor is also, as would therefore be expected, twice as

common in the smaller groups of two or three partners than in larger ones of four to six. The policy whereby each doctor remains permanently on duty for a particular group of patients, i.e. in 20 per cent of practices for obstetric cases or 24 per cent for other special groups of cases, occurs more often in the combined list practices.

Deputising services exist primarily for the single-handed practitioner, but their frequent use by group practices has been noted (Williams, 1973; White, 1974). In Wiltshire they are available only in Swindon and Salisbury and four practices in this survey, two each in the separate and combined list groups, employed them.

Recent changes

The last part of the questionnaire asked about any alteration within the practice in the past five years which would have affected the degree of personal care. Thirteen practices replied that there had been changes, the commonest, in five, being the introduction of a duty doctor. Four of these had started a formal rota (though in one practice only two of the five partners took part) and the partners in the other practices informally allocated duties at the beginning of each week.

Two practices began using a deputising service, one introduced a partial appointment system, in one the duty doctor took over all obstetrics and one particularly rural practice became more regionalised between partners. Two had taken on an additional partner having previously been one-man and two-man practices and in each case changed from separate list to combined list type of care. Only one practice had changed in the opposite direction, a three-man group had taken steps to encourage patients to see the same doctor.

Discussion

This investigation shows that the majority of general practitioners working in partnerships in Wiltshire no longer organise their practices so that they care for a defined list of patients. Although most patients obtain most of their care from one doctor, they will have a choice as to which doctor they see and may also be visited at home by any doctor. An out-of-hours visit will be made by the duty doctor who takes over in the evenings and at weekends in all practices and also after 1030 in half of them. In four practices the patients will always see their own doctor by calling after 2300 hours.

Assuming that there is a trend towards less personal care in group practice or, alternatively that, many doctors now give less personal care than they did, we should try and discover whether or not this is something our patients prefer, whether or not it suits the doctors themselves and, most important of all, whether it affects the standards of general practice as a whole.

Other surveys

In Canada, in a free medical market without the constraints under the British National Health Service, Hill (1968) found that 83 per cent of patients had not been cared for by another family physician since they began attending their present doctor. These patients placed " A doctor who knows you and your family fairly intimately ", at the top of a list of eight statements, as the most important quality required in a family doctor. Watson (1971) reporting a public attitude survey from Perth, Western Australia, found that 43 per cent would be prepared to see their doctor's partner. Millar (1972) compared patient attitudes in two practices working in one health centre, one a typical separate list and the other a combined list practice, and found that 77 per cent of the patients of the latter asked for an appointment with a particular doctor. He also thought that there was good reason to assume that some patients did not voice their preference in the hope of seeing a doctor sooner.

Lloyd (1974) questioned 1,489 patients attending a university teaching practice and found that seeing a particular doctor was not important for 21 per cent, sometimes important for 35 per cent and usually important for 44 per cent. In this practice, all six principals had teaching commitments and there were two trainees, therefore the expectation of the patients in this respect was likely to be less than in an average practice.

In several reports, patients do not express a strong preference for seeing a particular doctor, but in each case this appears to be in circumstances where it is easy to see the doctor of choice. Stevenson (1967) noted that less than two per cent were prepared to wait for a day, or at the most two, because they were unable to see the doctor they preferred and he argues from this that it is only the doctor who wishes to maintain the one-to-one relationship. But in his practice, only 3·2 per cent of 4,000 appointments were postponed because a session was fully booked. In a report in *Practice Team* (1974), where 84 per cent of 40 patients said they always saw the doctor of their choice, only 16 per cent objected to seeing another practitioner though this is hardly the opposite of expressing a preference. Similarly, MacDonald *et al.* (1974) investigating patients' attitudes found only six people out of 375 expressly saying that they only ever wanted to see their own doctor but again, 89 per cent of these patients had been able to see him at their last attendance.

The attitude of doctors, on the other hand, towards personal rather than group care is less easy to define. The Royal College of General Practitioners (1973) in its Reports from General Practice No. 16, as expressed in *Present state and future needs of general practice*, continues to stress the importance of the practitioner knowing personally his patients and their families. Clyne (1974) has stressed that not only is there no real interpersonal relationship on a medical level without a feeling of compassion or sympathy but, to be therapeutically useful, there must be empathy of which the doctor is aware and which he is able to control.

Personal statements such as that of Sir Theodore Fox (1960) "—the independent practitioner, outside hospital, will survive as a personal doctor—or not at all", or of Marsh (1972) who believes that the family doctor has an absolute responsibility to the individual and whose group practice accepts the concept of one patient one doctor, represent the views only of individuals.

Their critics may claim that they are unrepresentative or may go as far as Stevenson, who thought that doctors are merely perpetuating their egotism and infallibility.

The only investigation into the views of large numbers of doctors is that reported by Cartwright (1967) whose survey included 552 general practitioners who were a nation-wide representative sample. They were asked if they agreed or not with the statement, " If general practitioners working in partnerships are to establish satisfactory personal relationships with their patients, it is important that patients should be encouraged to stick to the same doctor ", 71 per cent of all doctors agreed and 16 per cent disagreed.

There is no evidence of whether the degree of personal care affects the standards of general practice as a whole. Though the increase in group practices and health centres is sometimes accompanied by a less personal approach and atmosphere, this is often associated with an increase in the efficiency and an expansion of the services provided. The patient may therefore, in balance, prefer the new organisation whilst regretting the passing of a more personal doctor. Nevertheless, it is to be hoped that the 44 per cent of patients attending a health centre who said that if they moved to another part of the country, they would prefer to attend a traditional surgery rather than another health centre, are not typical (Dixon, 1971).

Hopkins (1974) thought the essence of medical practice is the continuity of care for the patient and that the doctor's job satisfaction is reduced by the dilution of

responsibility for his patients. From the point of view of optimal personal care, it may be that the best compromise is that of Gambrill (1974) who suggested that, in the future, more single-handed practitioners should work together as such within health centres.

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PRACTICE NURSES

Doctors are strongly advised to employ only registered or enrolled nurses in general practice and to check their qualifications with The General Nursing Council in England or appropriate registration authorities in Scotland and Northern Ireland. Practitioners should appreciate that it is an offence under The Nurses' Act 1957 for any person, knowing that some other person is not registered or enrolled according to the act, to make any statement or to do any act calculated to suggest that that other person is registered or enrolled.

Many qualified nurses may not have received formal instruction during their training on certain procedures delegated to them in general medical practice. Practitioners, therefore *must* ensure that any necessary instructions are given and must be satisfied as to the nurse's competence to perform any particular procedure before delegating it.

Practitioners are advised to ensure that nurses they employ are members of the Royal College of Nursing (see benefits of membership (5c), page 76).

REFERENCE

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