NORTH OF ENGLAND FACULTY LECTURE

The key to personal care*

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I would like to thank the North of England Faculty for inviting me to give this lecture. It is always a privilege to be asked to talk to colleagues and it is a special honour to talk to such a well known faculty.

Introduction

Confucius said: "Shall I teach you the meaning of knowledge? When you know a thing, to recognize that you know it, and when you do not, to know that you do not know—that is knowledge!" I suggest that we should recognize this and try to find out what it is that we do not know about personal care.

The two best known job definitions of the general practitioner are those of the Royal College of General Practitioners (1972) and of the Leeuwenhorst Working Party (1977). These are very similar. Both state that the general practitioner is a doctor or medical graduate who provides *personal,* primary, and continuing care. Thus in both definitions the word *personal* heads the list of features of the doctor's role.

Much work has already been done on other aspects of being a general practitioner. What has not yet been done, and what now needs to be done, is to focus attention on what being a personal doctor means. I therefore wish in this lecture to analyse personal care, to seek ways of promoting it, and to devise some simple means of measuring it.

The Leeuwenhorst job definition states that the doctor should have empathy with the patient and should use the therapeutic relationship which develops over a prolonged period of time for the benefit of the patient. The implication is clear—that the patient will need to see the same doctor on more than one occasion if the doctor is to become his 'personal' doctor.

It is thus no accident that personal and continuing care come so early and so close together in both definitions. Many of the other aims which follow hinge on knowing the patient as a person. Are we or are we not personal doctors? Do we want to be? Can we be? How does the organization of our practices affect personal care?

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The individual and the group

Schumacher (1973) wrote: "All through our lives we are faced with the task of reconciling opposites which in logical thought cannot be reconciled."

Among his examples were the conflicting demands facing parents and teachers trying to find a balance between freedom and discipline for children. He quotes Tyrell, who coined the terms 'divergent' and 'convergent'. Convergent problems are those which exist only in abstract thought and can thus be resolved by intellectual effort, and divergent problems are the 'real' problems of life, relationships, economics, politics, and education, for which there is no absolute solution. "They demand of man not merely the employment of his reasoning powers, but the commitment of his whole personality." ". . . To have to grapple with divergent problems tends to be exhausting, worrying, and wearisome; hence people try to avoid doing it and run away from it."

I suggest that tension between the individual and the group is another divergent problem. This tension runs through our lives and illuminates many of the great conflicts of history and politics.

For example, one of the great ideals of those politically to the left of centre is the concept of equality of man. Socialists seek to promote a better society—an attitude which derives from an orientation to the group. However, those politically to the right of centre pursue the equally important principle of autonomy for the individual. They seek to promote the dignity of man by providing the maximum amount of freedom of choice and by encouraging the individual to take responsibility for himself—an attitude which derives from an orientation to the individual.

Just as the promotion of the group inevitably restricts and diminishes the individual within it, so the development and promotion of the individual restricts and diminishes the power of the group. The conflict between these opposing and contradictory philosophies can

never be wholly resolved without force. All that is possible in a democracy is a different compromise at different times.

General practice

In the early days, general practice stood for individualism—one patient: one doctor; a system which was defined, advertised, and accepted as a personal medical service. However, a change occurred in the 1950s which has continued ever since, as the number of partnerships has increased. Payment by notional lists, like payment by salary, and bigger partnerships all tend to demote the importance of the individual patient and the growing use of the combined list system represents a further move away from care of the individual patient towards care of a group of patients. In 1952, the year our College was founded, as many as 44 per cent of all general practitioners were still in single-handed practice (British Medical Association, 1970). The change from single-handed to partnership practice was one of the first and probably the most important of the many changes in the organizational revolution of general practice in the 1950s and 1960s.

The advantages to the general practitioner were the reduction of his traditional isolation, the acquisition of modern and purpose-planned premises, and the sharing of ancillary staff and equipment. However, once a practice acquires two or more partners a problem arises. Do doctors and patients see their ideal relationship still as it was in single-handed practice—one patient: one doctor—or do they see it as a group of patients being cared for by a team? Does it matter anyway? Both extremes exist in British general practice today with a variety of compromises between them, though single-handed practices are by definition all personal.

Forman in 1971 was the first to face the issue, but Aylett (1976) first examined in a survey in Wiltshire how many practices tried to provide patients with their own doctor on most occasions. He classified as 'combined list' practices those where doctors and patients interchanged although often maintaining the same doctor for the same episode of illness, and as 'separate list' practices those where an attempt was made for the patient usually to see the same doctor. I prefer to call 'separate' lists 'personal' lists since the system is designed to promote personal relationships rather than separateness.

Aylett found that only a third of principals operated separate lists. He concluded: "The majority of general practitioners working in partnership in Wiltshire no longer organize their practices so that they care for a defined list of patients."

The case for combined lists

The combined list system has some important theoretical advantages.

First, it gives patients considerable autonomy, a principle which is increasingly recognized as being desirable in general practice. By giving patients the freedom to choose between partners every time they consult, maximum satisfaction ought to be achieved. Some patients prefer doctors of a particular age group or sex, or ones who are known to have a particular interest, whether in measles or manipulation. Some women like to consult women doctors for gynaecological problems but are happy to see other doctors for other problems.

Secondly, combined lists fit comfortably with special interests. Once a doctor declares a special interest in any aspect of general practice, patients will start to drift towards him both by referral from partners and by their own choice. This has the important advantage that it brings special skill to a wider variety of people.

In addition, if a doctor has a particular blind spot the combined list allows patients a second opinion within the partnership. Two heads may be better than one, and seeing two doctors in succession may bring to light any errors of omission or commission by the first.

Patients who see medicine in a mechanical model and regard illness rather as they regard mechanical faults in cars, tend particularly to favour combined lists. Indeed, there are many conditions which can be dealt with effectively by any doctor. It is unlikely that most young men with knee injuries from football care very much whether they see their own or a strange doctor.

Some doctors can be too possessive and talk as if they owned their patients! A partnership list is an inbuilt counter to such a tendency. Whitehorn (1979) has reported how the single practitioner system can act as a constraint and possibly a monopoly for patients and suggests that flexible systems should bypass obstructive doctors.

Finally, at least a fifth of general practitioners have commitments outside their practice and work as clinical assistants, course organizers, lecturers, associate or regional advisers, or increasingly need time to fulfil a marital or parental role at home.

The combined list system, by making it easier to share care with colleagues, makes it easier to think in sessional terms. Outside commitments are easier to arrange for doctors working in sessions, where the boundaries of time are sharply defined.

The patient's point of view

Although I believe the change from single-handed to partnership practice was necessary, and will be seen in time as a proper prelude to improved professional performance, nevertheless in the short term it represented doctor-centred activity. It was the doctors who were determining their own destiny: the patients were not consulted. This trend has gone so far that both in Canada and the United States some teaching practices are organized so that most of the day-to-day care is provided by residents (trainees) who change every six months (Hall, 1979). A nurse in a teaching practice of a

world famous Canadian Department of Family Medicine told me how the patients often cried to her when the doctors changed yet again. Despite superb buildings and lavish equipment (on-the-spot x-rays and video cameras in every consulting room) what had actually been delegated, and to that nurse, was personal and continuing care.

With some exceptions (MacDonald *et al.*, 1974; Woods *et al.*, 1974; Bolden and Morgan, 1975; Marsh and Kaim-Caudle, 1976; Simpson, 1979) there have been few patient satisfaction surveys. It is interesting that Bolden and Marsh, who both found high satisfaction scores, both work in group practices which were strongly committed to personal lists before and after their studies. The medical profession and the government have been remarkably slow in analysing the opinions of patients on this, one of the most important of all aspects of practice organization. When patients are asked, their answers are consistent. Hill and colleagues (1968) found that patients gave the highest of eight ratings to the statement "A doctor who knows you and your family fairly intimately." Not a bad definition of a request for personal care!

Medical sociologists have sought patients' views on personal versus partnership lists. Cartwright (1967) found that 44 per cent of patients considered their general practitioner to be "something of a personal friend" and this group were happier with this relationship and more likely to discuss a personal problem with their doctor than other patients who described their relationship with their doctor as "businesslike". The longer patients had had their doctor the more likely they were to describe their relationship with their doctor as "friendly". Continuity of care still counts! Cartwright concluded: "Many patients prefer a closer, warmer relationship with their doctor than one where the doctor remains objective and affectively neutral."

In 1972, Varlaam and colleagues contrasted the opinions of patients who had single-handed doctors with patients whose doctors worked in partnership and concluded that single-handed practitioners as a whole were as able to inspire the confidence of their patients as partnership doctors despite other findings suggesting less satisfactory premises and organization. One of their findings was that patients whose doctors were in partnerships, especially women patients, were statistically more likely to report "*un*willingness to confide in the doctor". Lawson (1979) found that among 1,000 patients, 75 per cent "preferred to see the same general practitioner at every consultation".

Finally, Cartwright and Anderson (1979) in their *Patients and Their Doctors 1977* have produced perhaps the most disturbing evidence of all. They compared the replies of patients in 1964 and 1977 to the key question: "Which do you prefer, a doctor working on his own or one in partnership?" In both studies it was found that patients who had a single-handed doctor preferred this by a clear majority—57 per cent in 1964 rising to 65 per cent in 1977. "Furthermore, whereas 10 per cent of those with a single-handed doctor wanted the relationship changed (almost always to be more friendly), nearly twice as many, 19 per cent, of those with a doctor who worked with others wanted it changed." Among patients whose doctors worked in partnership, only 42 per cent preferred what they had in 1964 and 45 per cent in 1977. As a general practitioner who has worked in partnership all my professional life, I find this both disturbing and challenging. Fewer than half of all the patients in partnership practices in Britain are happy with what they have. This is surely one of the most devastating statistics about modern general practice.

Measuring personal care

I wish to offer for consideration a new approach—from the patient's point of view. I suggest that if the patient does not see his or her own doctor regularly, then the care cannot be personal and continuing. The more personal contact between patient and doctor, the better the chance of a personal relationship developing. Although no amount of contact between a patient and a doctor can guarantee a personal and continuing relationship developing, the converse may be important. Without regular contact such relationships cannot develop.

We therefore seem to need in general practice some simple measures which can summarize the patient's access to his or her own doctor and so open the way to comparisons and standards. It is important to refer to consultations which really happened. It is all too easy to rely on good intentions or obvious optimism of doctors and overlook the cold realities of the consultation count.

1. Proportion of patients' consultations with personal doctor

First, let us simply count the proportion of patient/doctor contacts (consultations in the surgery, home visits, or both) achieved by the patients on a given doctor's list with that doctor personally.

2. Personal contact index

From this we can work out a personal contact index. This is the total number of face-to-face contacts with patients on a given doctor's list divided by the total number of patients on the list. It represents the average number of times the average patient on that list makes personal contact with his or her own doctor in a defined time—preferably a year. It can refer to contacts in the surgery, at home, or combined.

3. Ratio of own patients

Thirdly, we can count the number of the patients seen by a general practitioner with the patients on his/her own list as a ratio of all the patients he or she sees. This can be presented as a percentage of surgery consultations, home visits, or both over a defined period,

preferably a year.

4. Application to broad groups of diseases, problems or activities

The technique of analysing the proportion of contacts by a list of patients with their personal doctor can now be extended to a variety of groups of diseases, problems or activities in general practice.

There is growing evidence that patients with chronic illnesses are likely to benefit from systematic long-term surveillance. As these diseases particularly affect people's way of life, it is likely that a personal doctor will become more aware of the impact and inconvenience caused by chronic handicaps and may be more effective in helping a patient with those handicaps. (Robinson *et al.*, 1977).

It is possible to count the number of consultations from patients with defined chronic conditions such as asthma, diabetes, epilepsy, or hypertension with their own doctor as a proportion of all the consultations by these patients with any doctor in the practice.

Cartwright's research suggests that good personal relationships between patients and doctors make patients more ready to confide about personal medical problems. Hence we can count the number of personal medical problems recorded in writing by a given doctor and by the group of doctors during a year, including all relationship problems, especially marital and sexual, and other problems in interpersonal relationships within a family. Similarly, the same exercise can be applied to the broad group of consultations at which an item of preventive medicine was offered to a patient.

5. Loss of continuity

In a partnership like ours, where all three partners take six weeks' holiday and one week's study leave each year, we can expect in those seven weeks each to miss about 13 per cent of patient contacts. Similarly, through working an evening, weekend, and bank holiday rota with colleagues in adjacent practices we miss another group. Add to this a regular half day per partner each week, two Saturday mornings off in three, occasional days off for family, sickness, or lecturing to the North of England Faculty (!)—plus the presence of a trainee who is free to follow up any patient—and it is clear that in practices like ours it is probably not possible to see personally more than about 75 per cent of all consultations with our own patients throughout the year.

Ejlertsson (1978) in Sweden has calculated that in his practice, 64 per cent is a theoretical maximum. However, one of my partners saw 70 to 75 per cent of all the doctor/patient contacts from his own list in 1978 (Steele, 1979; personal communication). Marsh and Kaim-Caudle (1976) reported the highest figure so far recorded of 84 per cent, for a list of over 3,000 patients.

This approach helps us to think of consultations missed with our own patients, rather than periods of time away from the practice—a reorientation towards patients' needs rather than doctors' interests.

Changing from a combined list to a personal list system

I became a principal in April 1962 and worked for 11 years in a combined list system, first with one partner, my father, and later with two. In 1973 we decided to make a fundamental change from the combined list to a personal list system. The main reason for the change was a vague but increasing uneasiness that we just did not seem to know patients as well as we had in previous years and that this was less satisfying professionally.

It was absurd to suggest that each partner should try to do everything for everybody at each consultation. Some patients were clearly orientated to one particular partner, while some saw several partners in turn. Changing a patient's long-term treatment could be confusing for the patient, discourteous to a partner, and was illogical if one was not maintaining follow-up oneself. In any case, who was responsible for following up what and when?

We gently but steadily started to encourage patients to see the doctor with whom they were registered. In particular, major decisions about management were referred to the partner responsible. We accepted that it would take several years to complete the change-over, particularly as it was a time of disturbance in the practice, and so patients were not rushed. However, for the first time they were actively encouraged to see the same doctor whenever possible.

Marsh first emphasized the importance of filing patients' records by partner (Marsh and Kaim-Caudle, 1976) and we started doing this on 1 January 1974. Thus every time patients contacted the surgery they were asked by the staff who their doctor was, and this helped to underline their sense of identity with one particular doctor. Patients can and do change partners within the practice but are then expected to stay with the partner of their choice. They also change their registration with the Devon Family Practitioner Committee and so have their new doctor's name on their medical card.

Baseline year

From January 1974 onwards, workload records of all the doctors in the practice were started and have been maintained ever since. A full RCGP diagnostic register (E book) was started at first for my list and subsequently for each of my two partners.

In January 1974, when we began to record all face-to-face doctor/patient contacts for those patients registered with me, the average consultation rate was then 2·85 surgery consultations per patient per year and the home visiting rate was 0·50 visits per patient per year. My patients saw me on only 42 per cent of all the occasions they saw a doctor in the surgery. Over the year my average personal contact rate with each patient was 1·20 per person per year for surgery consultations. Thirdly, 33 per cent of consultations were with patients registered with one of my two partners and not with me

Table 1. Number of patients registered with author (= list size).

Date	Number	Figure taken for average list size during year (half annual loss)
1 January 1974	3,008	3,000
31 December 1974	2,992	
1 January 1978	2,632	2,586
31 December 1978	2,540	

The age/sex registers and diagnostic registers (E books) were established and have been maintained as advised by the Birmingham Research Unit of the Royal College of General Practitioners (OPCS *et al.*, 1974). The age/sex and diagnostic registers are separate—one set for each partner.

The Second National Morbidity study allowed recorders to record more than one problem or diagnosis. The term 'episode' was used there to include an illness involving more than one consultation and has been avoided here. The terms 'item' and 'problem' are used and one or more could be and were recorded at a single consultation.

(that is, own patient ratio 67 per cent).

Thus the practice was then working fairly closely to a combined list system; so although our policy of encouraging personal lists had just started, that year nevertheless forms a reasonable baseline for comparisons.

Current year

Five years later, on 1 January 1979, my list had fallen from 3,008 to 2,540 by partnership policy (Table 1). During the 12 consecutive months ending 30 June 1979, my list generated 6,729 surgery consultations of which I did 3,780 myself, that is 56 per cent. The remaining 44 per cent were shared between my two partners, our part-time assistant, a trainee, a colleague in the rota, or a locum. The surgery consultation rate had fallen to 2·65 attendances per patient per year, the home visiting rate had fallen to 0·385 visits per patient per year, while the personal contact index had risen to 1·48 personal contacts in the surgery per person per year.

During these 12 months I saw 3,932 people in the surgery, of whom only 152 were registered with my partners or who were temporary residents: that is, 96 per cent of all my consultations were now concentrated on patients on my own list (own patient ratio).

Problems of morbidity recording

The diagnostic registers in the practice are kept for each partner and for each partner's patients (OPCS *et al.*, 1974). There are many problems in analysing and interpreting records in diagnostic registers. Problems and diagnoses, for example, do not equate exactly with consultations, as more than one diagnosis or problem may occur in one consultation. Other difficulties include variations in definition and agreement between doctors seeing patients even from one list.

Limitations of these figures

There are also other problems in the interpretation of these figures. First, they come from only one practice with only three partners and 6,837 patients. They cannot and should not be unthinkingly extrapolated to other practices in other places.

Secondly, although the following results fit the "before and after" method of comparison they in no way exclude an important separate variable altering professional practice during the period. Associated changes are never proof of cause and effect. For example, a growing awareness by general practitioners of the needs of patients with chronic physical illness might have led to these changes regardless of the system of personal lists. In the absence of a control group and without a prospective study with some form of random allocation between populations this work cannot be regarded as scientifically valid.

Thirdly, the data are not high quality. We first started recording all consultations and my diagnostic register in 1974. Inevitably when doctors and staff are starting such a new system there must be errors, probably mainly of omission. Under-recording of diagnoses in the first year would have increased falsely the apparent differences from 1978. Furthermore 1974, the year used here as the baseline, was a year of change in the practice in which there was a big change in the premises, and a change in partnership. It was also the year when my part-time appointment at the University of Exeter effectively started.

Fourthly, the planned reduction in my list size between 1974 and 1979 amounted to 468 patients (16 per cent). Such a change must make calculations based on average annual list size less valid.

Even in 1978, when we were accustomed to keeping such records and when all three partners had diagnostic registers established, nevertheless there were 10 different doctors involved with my patients alone, including three trainees and three locums; some inconsistency of classification was inevitable.

Although the work of our practice nurses has been summarized (Jones *et al.*, 1978), it has not been recorded in relation to each partner's list of patients. Nor do we have records of our health visitors' or district nurses' contacts with patients. Thus all the tables refer only to face-to-face consultations with doctors.

Finally, my handwriting is particularly bad. This must have led to errors in transcription and coding. For only a tiny number of specific diseases have we been able to check coding and correct errors.

Reasons for presenting these figures

These figures are therefore offered for consideration with considerable reservation. Nevertheless I hope they may be of interest for the following reasons:

First, at the present stage of development of general practice there is still a need for personal descriptions of

work and organization. Self-audit should be encouraged even if at first the measures are rough and ready. Reports from individuals and small practices can still usefully identify important issues for further research.

Secondly, there seems some danger of personal lists disappearing on present trends (Aylett, 1976). There is a need for the issue to be debated before one of the main options in professional practice is lost.

Thirdly, although Forman (1971) in Devon first powerfully advocated the importance of personal lists and Marsh and Kaim-Caudle (1976) supported the idea and showed high satisfaction reports by patients, there have been no reports by general practitioners comparing combined and personal lists in the same practice.

Fourthly, I suggest that the potential of the RCGP diagnostic index system has not yet been fully exploited. The technique of aggregating groups of problems/diagnoses into a smaller number of broad categories may highlight extremely important trends which are otherwise not easily identified. For example, partners may disagree whether a single consultation should be coded as "oral contraceptive advice", or "other contraceptive advice", or "advice about sterilization", but grouped together all these subcategories of the RCGP index fall in section 18—the trend in the broad category "preventive medicine" becomes clearer.

Analysis of diagnostic registers

1. Chronic illness

The diagnostic registers for patients on my list with the following common chronic conditions of general practice: asthma, diabetes, epilepsy, hypertension, malignant disease, rheumatoid arthritis, thyroid disease (hypo- and hyper-), and schizophrenia have been compared for the two calendar years of 1974 and 1978.

In 1974 my patients had 165 consultations per 1,000 patients per year in which one or other of these chronic conditions was recorded in the diagnostic register. I saw 76 per 1,000 myself, so I did 43 per cent of these consultations personally, that is, the same ratio as for other conditions on my list at that time (Table 2).

In 1978, patients registered with me had 275 consultations per 1,000 patients per year with all doctors in the practice, of which I did 215 per 1,000 patients per year myself. Thus for this group I was now providing in person 78 per cent of all their contacts with doctors.

These figures represent increases of 67 per cent for the total doctor/patient contact rate, and 183 per cent increase for my personal contact rate over the five years for the chronically ill on my list. My patients with chronic conditions saw me more, both in absolute and relative terms, in person in 1978 than they had seen all doctors in the practice in 1974.

Finally, since merely increasing the number of doctor/patient contacts is not in itself any indication of quality of care, the records were examined for objective evidence of assessment of the chronic conditions; for example: blood sugars for diabetes; blood pressure readings for hypertension; anti-convulsant blood levels for epilepsy; serial written records of peak flow rates for asthmatics; and thyroid function tests for both hypothyroidism and hyperthyroidism. There was a 20-fold increase between 1974 and 1978.

2. Personal problems

In addition to the usual categories of the RCGP diagnostic register in our practice, we code some extra sub-groups, such as marital problems, sexual problems,

Table 2. Consultations recorded for chronic illness for all patients registered with author.

	1974		1978	
	Personal consultations with author during year	Total consultations for all author's patients during year	Personal consultations with author during year	Total consultations for all author's patients during year
Asthma	71	124	160	185
Diabetes	43	75	118	157
Epilepsy	15	16	52	68
Hypertension	29	129	79	119
Malignant disease	35	83	44	65
Rheumatoid arthritis	12	17	41	52
Schizophrenia	17	38	22	22
Thyroid disease	7	13	39	44
Total for year	229 (76)	495 (165)	555 (215)	712 (275)

Records from surgery consultations and visits combined for the two calendar years.

Figures in brackets indicate consultations recorded per 1,000 patients registered in that year.

Percentage change in rates per 1,000 patients per year between 1974 and 1978:
(a) consultations by all doctors in practice: 67 per cent rise
(b) consultations by author: 183 per cent rise.

Table 3. Relationship problems recorded for all patients registered with author.

	1974		1978	
	Recorded by author personally	Recorded by all doctors in practice	Recorded by author personally	Recorded by all doctors in practice
Marital problems*	81	96	45	54
Sexual problems*	18	20	34*	35*
Battered women	11	11	4	6
Ill treated children	2	2	5	5
Consultation perceived by doctor as being primarily about a relative/companion	63	74	150	166
Transitory situational disorders, behaviour disorders of children (code 150 of RCGP)	71	95	111	141
Total for year	246 (82)	298 (99)	349 (135)	407 (157)

Records from surgery consultations and visits combined for each calendar year.

Figures in brackets indicate problems recorded expressed as rates per 1,000 patients registered in that year.

*Some deliberate under-recording for confidentiality.

Problem rates listed in this group include multiple problems such as 'marital problem', 'sexual problem' and 'ill treatment' which could be and sometimes were recorded at a single consultation.

Percentage change in rate of problems recorded per 1,000 patients between 1974 and 1978:
(a) problems recorded by all doctors in practice: 59 per cent rise
(b) problems recorded by author: 65 per cent rise.

and child ill-treatment. Adding all these groups together produces a broad group of patients with relationship problems, which is analogous to the broad group of patients with serious chronic diseases.

In 1974, all relationship problems combined were recorded at a rate of 99 per 1,000 patients per year. This had risen in 1978 to a rate of 157 per 1,000 patients per year—an increase of 59 per cent. My own recording for this group of patients rose from a rate of 82 per 1,000 patients per year in 1974, to 135 in 1978, an increase of 65 per cent (Table 3).

Even after allowing for multiple relationship problems being recorded at a single consultation, there is a difference between the proportion of patients who in 1974 consulted with me personally for problems of relationships compared with all problems and problems of chronic illness. Whereas in 1974 I was providing 42 per cent of consultations for all reasons in person, yet for relationship problems it was 83 per cent. Furthermore, this was similar in 1978, when it was 86 per cent. This finding could be explained either by my interest in relationship problems or with the hypothesis that even in combined list systems patients choose significantly with whom they will discuss personal problems (Recordon, 1972).

The total number of my personal consultations for relationship problems in 1978 was still greater than the consultation rate for the same problems four years before with all doctors in the practice combined, despite a fall in the consultation rate per year of about seven per cent. These results are compatible with the hypothesis that a personal list system makes it easier either for patients, for doctors, or both, to discuss personal medical problems.

3. Preventive medicine

A third possible broad grouping of episodes in general practice is preventive medicine (category 18 of RCGP coding). Numbers 500 and over can be aggregated. Our practice has some additional sub-categories such as child care surveillance, coronary candidate, and breast examination taught.

Table 4 shows for this broad category no significant change in the rate of preventive medical activity despite the fall in consultation rate.

The contact rate for items of preventive medicine with all doctors from my list was 331 per 1,000 patients per year in 1974 and 340 per 1,000 patients in 1978 (three per cent increase), and the recorded rate in this category with me personally rose from 216 consultations per 1,000 patients per year to 233—an increase of eight per cent.

Reduction in the number of consultations

Minor self-limiting conditions

In the latest year the patients on my list consulted (all doctors combined) at a rate of 2·65 surgery consultations per patient compared with the rate of 2·85 per patient per year in 1974. This reduction of 7·0 per cent for the 1979 list size is equivalent to 471 surgery consultations in a year—almost the average number of consultations for a month. Yet the analysis of the

Table 4. Items of preventive medicine recorded for all patients registered with author.

	1974		1978	
	Number of items carried out personally	Number of items for author's patients by all doctors	Number of items carried out personally	Number of items for author's patients by all doctors
Cervical smear	63 (21)	122 (41)	81 (31)	116 (45)
Child care surveillance	160 (53)	163 (54)	140 (54)	141 (55)
Contraceptive advice	221 (74)	373 (124)	149 (58)	340 (131)
Sterilization and advice	26	32	31	33
Health education (includes breast examination)	11	11	27	29
Advice about heavy smoking	11	12	58	59
Coronary risk prevention	0	0	28	29
Geriatric surveillance	23	25	10	10
Other items	134	255	79	123
Total for year	649 (216)	993 (331)	603 (233)	880 (340)

Items recorded at surgery consultations and visits combined.

Figures in brackets indicate consultation rate per 1,000 patients registered in that year.

Diagnostic label 'cough' used when no fever or physical signs in chest were found.

For example, if a woman was seen for a second time for a repeat cervical smear this would appear as two items (at two consultations). If a woman had a smear and contraceptive advice this would also be shown as two items (one consultation).

Percentage change in item rate per 1,000 patients per year between 1974 and 1978:
(a) with all doctors in the practice: three per cent rise
(b) with author personally: eight per cent rise.

diagnoses and consultations for the chronically handicapping conditions, relationship problems, and preventive medicine shows that these patients were being seen more frequently in total and significantly more often by me personally.

How has an increase in contacts for at least three broad groups risen in association with a fall in the total doctor/patient contact rate?

There may be another important and related trend—a considerable fall in consultations for some minor self-limiting illness. Seeing the same population of patients repeatedly creates opportunities to discuss such conditions (in the well-baby clinic, for example) and to alter future expectations and consultation rates by *not* prescribing and by supporting self-care.

Not only may this factor substantially reduce the number of consultations in a year but it may specially help to improve the doctor's job satisfaction. There is evidence from Cartwright and Anderson (1979) that a low job satisfaction in general practice is associated with the doctor perceiving a relatively high proportion of his patients' problems as "trivial". Taking a record of 'cough' (which I only use in the absence of fever and physical signs) and 'diarrhoea' as examples, there has been a fall of 22 per cent in the rate at which this list of patients consulted any doctor in the practice (Table 5).

Subjective impression

Whatever the value of this evidence, there is no doubt about the profound change in my own personal, but of course entirely subjective, feelings. I have much greater professional satisfaction; I am beginning to know my own list again and could now never go back to a combined list system.

Although I have increased my personal availability only from 42 per cent of my patients' surgery consultations to 56 per cent over five years, nevertheless this represents an increase of a third. Furthermore, this is only an interim report. I am now optimistic that I can achieve in the next few years the theoretical target of conducting in person 70 to 75 per cent of all my patients' consultations throughout a year. It is encouraging that even now in some months such as July 1979, I could see personally 72 per cent of consultations generated by my list.

Furthermore, although there is as yet no proof, Marsh and Kaim-Caudle's very low surgery consultation rate of 2·3 with personal lists when compared with my moderate fall to 2·65 raises the exciting possibility that general practitioners, especially when working closely with nurses and health visitors, may be able to reduce the consultation rate considerably and hence the quantity of consultations, while increasing the time spent on preventive medicine and with the chronically handicapped.

Planning list size

To achieve 75 per cent of my patients' consultations in person, I will, of course, have to reduce my list from its present eight per cent above the national average of 2,351 (DHSS, 1977) to 18 per cent below it, to allow for my part-time university appointment.

Given that the actual number of surgery consultations

conducted personally in the 12 months ending 30 June 1979 was 3,932 it seems reasonable to assume a supply of about 4,000 consultations a year in future. Assuming that the current own-patient ratio of 96 per cent which was achieved in 1978 can be maintained, then the number of consultations with me available per year to my own list of patients is 3,840.

Given that the latest rate at which my patients consult any doctor is 2·65 surgery consultations per patient per year, it can be calculated that my target list size should be 1,932. This is 7·5 per cent below the average list size for unrestricted principals in the County of Devon (House of Commons Official Report, 1977). In October 1976, 22 per cent of unrestricted principals in England had a list size below 1,900 (DHSS, 1977).

An alternative arithmetical approach is to plan on the basis that as I did 82 per cent of the average number of surgery consultations of my two full-time partners in 1977 and 78 per cent in 1978, then it is reasonable to plan for a personal list size of one fifth smaller than theirs. Hence, we are currently planning for each of my two partners to have personal lists of about 2,500 each and about 2,000 for me.

In this way I hope I have shown for the first time a logical basis for planning list sizes—a rational way of deciding the number of patients a partner can personally serve.

The case for personal lists

It has always been traditional both in hospitals and in general practice to have one named clinician in charge. The onus of change must therefore lie with those who want a combined list system, and until they can show why their system is better, I believe personal care should not lightly be discarded.

Doctor/patient relationship

Personal care will tend to be advocated by those who are most conscious of doctor/patient relationships (Balint's (1957) classic work was entitled *The Doctor, His Patient, and the Illness).* Such doctors are most aware of the extent to which people's personal problems, their personalities, their personal relationships (both at home and at work), their homes, and their personal expectations of life and health impinge in the consulting room.

Some patients have difficulty in making satisfying relationships with anyone. A personal list system highlights patients who tend to drift between doctors. In our practice we have identified a "multiple doctor syndrome" and several tutorials with trainees have illustrated this and shown such patients often to have other difficulties in personal relationships. For some of these their relationship with their doctor may be the only lasting and constructive relationship in their whole lives.

Balint's (1957) model of the "mutual investment company" to symbolize the doctor/patient relationship is particularly valuable. If both parties contribute together to form a capital asset then at times one, or even both, sides can draw on this capital at the expense of the relationship; thus for a time either doctor or patient can run in relationship debt.

The patterns of human behaviour which have emerged as being of special importance to health are either personal habits such as smoking, excessive eating, drinking, or personal relationships such as marital sexual, or parent/child.

Importance of personal factors in health

In my James Mackenzie Lecture I summarized the reasons why behavioural medicine had become, for general practitioners, as important as pathology

Table 5. Records of some minor self-limiting conditions in patients registered with author.

	1974		1978	
	Consultations conducted personally	Consultations by author's patients with all doctors in practice	Consultations conducted personally	Consultations by author's patients with all doctors in practice
Consultations recorded for 'cough'	179 (60)	429 (143)	125 (48)	288 (111)
Consultations recorded for 'diarrhoea'	30 (10)	67 (22)	15 (6)	43 (17)
Total for year	209 (70)	496 (165)	140 (54)	331 (128)

Surgery consultations and home visits combined.

Figures in brackets indicate consultation rate per 1,000 patients registered in that year.

Diagnostic label 'cough' used when no fever or physical signs in chest were found.

Percentage change in rate of consultations recorded for the two conditions combined, per 1,000 patients per year, between 1974 and 1978:
(a) consultations recorded with all doctors in the practice: 22 per cent fall
(b) consultations recorded with author: 23 per cent fall.

(Morris, 1967; Lalonde, 1975; Pereira Gray, 1978). Who better than the personal doctor to analyse and understand the patient's personality? It has been well said that for the general practitioner it is as important to know the kind of person who has the disease as the kind of disease the person has.

Brown and Harris (1978) showed that a substantial number of working class women in London are depressed and furthermore that this depression is associated with the pattern of their lives, notably the quality of their marriages, the number and ages of their children, and the degree with which they can confide.

Hence the importance of providing patients with personal and continuing medical care.

Patient power

Just as choice of doctor for each episode of illness is an advantage and a source of power for patients in relationship to doctors in partnership, so there is a corresponding advantage and source of power for patients with just one doctor. A patient can understand and cope with the feelings of one doctor more easily than with a group of them. During a night call which I did with a trainee recently, the patient, who had had more than a little to drink, said of me: "I know him, you see, you can argue with a doctor you know!"

Marsh and Kaim-Caudle asked the interesting question: "Why is it that you prefer your own doctor?" While the commonest reason (72 per cent) was "He knows and understands you," the second commonest answer was "You know and understand him"—given by more than half the patients. Knowing his doctor as a person may give important security to a patient.

Compliance

Heffernan (1978) noted that the more doctors a single patient sees, the greater the number of compounds he will be taking. This suggests that reducing the number of physicians in contact with a single patient will simplify drug treatment. Furthermore, Charney and colleagues (1967) found that penicillin was taken more consistently when it was prescribed by the personal doctor than by a partner. Personal doctoring improves drug compliance.

Boundary of responsibility

Because the role of the medical generalist is wider than that of any other doctor, some boundary has to be drawn if the doctor is to live with himself and his professional conscience. The generalist can do this in one of two ways: either he can limit his interest in the patient by partly specializing himself (or by referring or deferring to a partner with a special interest). Alternatively he can limit the number of patients on his list.

Limiting by the list is the logical boundary for the doctor who wants to be a medical generalist and to look after the whole range of medical problems in people of all ages. The doctor is then freed from the burden of long-term responsibility for his partners' patients. He can deal just with presenting problems in his partners' patients and refer them back to the appropriate partner. He can plan long-term systematic care for his own patients knowing that his partners will respect his decisions about management.

Case finding, say, for hypertension, or screening for rubella titres suddenly becomes much more interesting once one is personally responsible and, equally important, the number of patients needing long-term surveillance at once become manageable. Twenty diabetics are not too bad! Fifteen epileptics can be easily followed—and if one does not do it oneself, nobody will!

Most general practitioners find the boundary of the *practice* list convenient and simple. Family doctors have always been prepared to see the patients of another practice in an emergency, but neither like nor want to see them usually. The personal list can be seen as an extension within each practice of the British tradition of clearly defined boundaries of responsibility for general practitioners.

Once a personal list system is working well, the boundaries of professional responsibility are made clear within a framework which recognizes and indeed exploits human nature. As Forman (1971) noted, "personal care motivates effort", and it becomes surprisingly easy for a doctor to pull out a little extra for a patient for whom he feels responsible.

Flexibility

An increasingly important bonus for this system is the additional flexibility it offers when a partner is away on holiday, study leave, or lecturing. Apart from sick leave, which can only rarely be foreseen, it is usual for the doctor to know when he or she will be away. Appointments can then be planned before and after this time. As the problems patients bring to us are increasingly about chronic illness, relationships, and preventive medicine, so we find patients both can and will wait to see a doctor who they think knows them as a person.

Holiday periods and days away are thus increasingly flanked by times of additional pressure, but this falls appropriately on the partner who is going away and causing the problem and spares proportionally the other partners.

Collusion and conflict

Balint (1957) also introduced the concept of the collusion of anonymity. By this he meant that when more than one professional is looking after a patient the boundaries of responsibility can become blurred and a gap in care emerges. When responsibility between the general practitioner and the specialist is not fully agreed, the patient can slip through the net.

I believe a collusion of anonymity also occurs when two or more general practitioners look after the same patient. Short-term problems are dealt with adequately,

but no one partner gets to grips with deeper problems, particularly when these are emotional, when they involve family relationships, and most of all when they concern the personality of the patient. This evasion is partly inevitable in combined lists because of the proper desire of partners not to oppose each other in the care of a patient. It is particularly likely to occur among patients who themselves have difficulties in making relationships.

Sometimes covert competition between partners occurs. Occasionally a partner consciously or subconsciously takes a dislike to a patient and arranges his consultations so that the patient will come back to one of his partners next time! Such patients can drift around a practice for years without ever having their problems confronted.

Making one doctor responsible for a patient forces that doctor to face his or her responsibilities: if he has a series of unproductive consultations with a patient, he must sooner or later face the fact and come to grips with the underlying problems. Responsibility for repeat prescriptions reveals each partner's prescribing policies. This in itself rapidly leads to reforms!

Personal lists are thus an antidote to the collusion of anonymity: they clarify responsibility.

Comparisons between partners

A personal list system reflects reality. Different doctors do have different personalities, different sexes, ages, and interests, and are therefore bound to manage patients in different ways. The personal list system reflects this. Unless the system of practice organization follows personal lists comparison between partners becomes much more difficult. However, once consultations, visits, diagnoses, management, and outcomes are filed and coded by each doctor's list of patients, then a vast new range of interpartner comparisons becomes possible.

Similarly the personal list system is particularly valuable in acting as a charter for new partners in partnerships where one or more partners are senior or well established. It prevents a hidden hierarchy and gives them exclusive responsibility for their own patients. It thus ensures that they develop into fully independent clinicians as well as independent contractors in their own right. Parity is reached in more than just financial terms.

Take, for instance, the problem of the 'popular partner' who is always booked up weeks in advance while his colleagues fit in all the extras! Careful recording will reveal that he or she is either indulging a special interest, bringing an excessive number of patients back for follow-up, taking too long over consultations, taking too much time off, or trying to look after too many patients.

The way is cleared for quick and simple clinical audits within a practice as described by Stott and Davis (1975). One of my partners (Buxton, 1979; personal communication) recently analysed the diagnosis, management, and recurrence rates of 187 episodes of vaginal discharge in our practice and showed interesting differences between our three partners. Similarly, one of our trainees (Stead, 1979; personal communication) compared and contrasted the diagnosis rates and follow-up of all the patients in the practice with asthma. He too showed important differences between the partners from which all three partners learnt.

Without lists linked to doctors, inter-doctor comparisons are limited to process. With personal lists it is at last possible to achieve a long-term aim of general practice—examining *outcome* of care in a defined group of patients in relation to the doctor. Such inter-doctor comparisons are not odious—they are essential!

Is this the key we need to open the lock of quality of care?

Conclusion

My defence in offering an anecdotal description of the philosophy of one practice is that until our generation does identify the main issues in general practice today we cannot begin to research them.

These limited figures prove little. Such as they are, however, they may offer pointers towards uncovering some of the reasons for the tremendous subjective increase in job satisfaction and professional interest in the work which has occurred since the change from a combined to a personal list system.

In summary these figures show that between the years 1974 and 1979 there was:

1. An increase of one third (42 per cent to 56 per cent) in the proportion of consultations in which I was available to my own patients in person.

2. An increase of two thirds in the rate at which patients with chronic conditions were seen by a doctor in the practice and an increase of 183 per cent in the rate at which these patients saw me personally.

3. An increase of 59 per cent in the rate at which patients had relationship problems identified and recorded by all doctors and a 65 per cent increase in which I recorded them myself.

4. Although there has been no significant change in the rate at which all items of preventive medicine were recorded for my list (an increase of three per cent), there has been an increase of eight per cent in the rate at which this was carried out by me in person.

5. All these increases have occurred during a period when both the surgery consultation rate fell by 7·0 per cent and the home visiting rate fell by 23 per cent.

6. This list of patients consulted on about a fifth fewer occasions for two of the minor self-limiting conditions.

General practitioners have spent years documenting the details of appointment systems, yet have never stopped to ask what the main aim of the appointment system is. Which doctor does the patient want to see? Which doctor do we want the patient to see, and why?

As a profession we have always valued personal care and put it as the first factor in our own job description, yet so far we have not defined what it means or devised any way of measuring it. In other words, we must now derive written aims and objectives for personal and continuing care (Pereira Gray, 1979). That, I submit must be one of our main challenges for the future.

I am of course aware that this idea will not be popular. It runs counter to the deeply held opinions of many colleagues, especially those who are committed to limiting the generalist's interests rather than his list. It is already a minority system, as Aylett (1976) has shown, but Marsh and Kaim-Caudle (1976) have shown that it is feasible. It certainly means greater responsibility and, I think, harder work. Now further research is required, so that these findings are challenged and tested in other partnerships.

I see personal lists operating within group practices as a great unifying concept. Here, perhaps, is a way of reconciling the patient's need for a personal doctor with the doctor's needs for the advantages of partnership. This system can also reconcile the divergent problem of the doctor's relationship to a whole group of patients with his relationship to the individual patient. An ancient conundrum is to find a way of squaring the circle. Could it be that we can make the four sides of the square of general practice—doctors, staff, premises, and equipment—now fit the never-ending circle of the patient's needs?

Here, I believe, is an all-embracing system applicable in town and country, in the north and in the south, and in groups of all sizes. Here, perhaps, is a way of opening the door to inter-doctor comparisons without the complications of the partnership consensus. Single-handed doctors of the previous generation, like my father, really knew their patients. Single-handed doctors today still do. Here is a way of diminishing the generation gap and reducing the growing gulf between single-handed and partnership practice. Here, in short, is a way of preserving one of the oldest traditions in medicine within a framework of modern group practice.

Sir Theodore Fox stated in 1960 that the independent practitioner outside hospital would survive as a personal doctor or not at all. I support that view. In my personal opinion, personal lists in partnership practice are the key to personal care.

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General Practice in Plymouth

Eighty-four per cent of those questioned replied that they were satisfied with the care given to them and their families by their general practitioners. This is a heartening response and says a great deal for the services provided by the general practitioners in Plymouth to the City. In answer to the question, "Give reasons for your satisfaction or dissatisfaction", the majority of patients commended the fact that nothing was left to chance, and that very good diagnostic attention was provided. Other aspects of health care commented on were that general practitioners had very efficient appointment systems, that they were readily available, and had a pleasant manner.

Surprisingly, in view of the high satisfaction rate shown, there were more comments to the question, "Give reasons for your dissatisfaction". These included: restricted surgery hours and appointment system only; too little time for examining patients; prescriptions rather than cures being given; and the doctor's attitude and response to the patient making the patient feel uncomfortable; the doctors being unhelpful; and receptionists diagnosing and issuing prescriptions.

In answer to the question, "What, if any improvements can you suggest?" comments were made that doctors should visit the housebound elderly regularly; that there should be more general practitioners and better locums; that more time should be given by doctors to individual patients; and that more positive advice should be given.

All these comments should be put into the context of the massive response of patient satisfaction with the general practitioners.

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