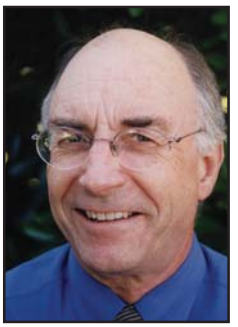
Editorial



Tony Townsend has been a general practitioner for 30 years. Although he has dabbled in medical politics, medical ethics, community-based teaching, university-based teaching, quality improvement and assessment, his passion remains clinical general practice. He is currently a full-time general practitioner in Whangamata.

The theme for this issue expands on Marjan Kljakovic's paper on *Continuity of care provided by general practice in Wellington over 100 years.*[1] I have always considered continuity of care to be one of the principles that define our discipline.

The importance of this concept has been emphasised by Ian McWhinney: *'Continuity of care has been correctly defined as a crucial element in family practice. Continuity is not only a question of duration. A physician in a diabetes clinic may look after a patient continuously for twenty years, but this is not what we have in mind. Continuity in family practice is an unbroken responsibility to be available for any health problems through to the end, whatever course it may take.'*[2]

It is what Ray Greco was referring to when he wrote in his reflection on developing insight into the complexities of the patient–doctor relationship, *'He's my patient, I'm his doctor. There is no beginning. There is no end.'*[3]

Without continuity of care it is impossible to develop the relationship with, and understanding of, a patient that is essential to the practice of our profession. Francis Peabody, when writing about the care of patients 80 years ago, said, *'The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient.'*[4] This cannot be achieved in a single consultation.

Although the concept of continuity of care sounds simple, it is in reality quite complex. It requires attention to access, communication, record keeping, availability and self-care. To elaborate on this principle, we asked three leading general practitioners, all of whom have a special interest in continuity of care, to write a brief paper for this issue. They all agreed and their papers that follow this brief introduction contribute to an understanding of how we can incorporate the principle of continuity of care into modern day general practice, without creating a burden that is too difficult for individual GPs to bear.

This is particularly important as there are now pressures being made on general practice and on general practitioners that directly conflict with this principle. Some of these include fragmentation of care, part-time work, job-sharing, financial incentives for patients to change their primary care provider, an increasing mobility of general practitioners, an increasing prevalence of locum providers, a broader primary care provider team incorporating nurses and nurse practitioners, and the increased ability of patients to access medical information, both good and bad, and to manage their own health problems, appropriately or inappropriately. If the practice of continuity of care disappears (in a similar manner to the loss of general practice obstetrics) or becomes so diluted that it no longer seems to be important, we will have severely damaged our foundations and thereby our status as a profession.

Our theme papers comment on the future of continuity of care and will, I am sure, stimulate readers to reflect on how we can best retain the fundamental principles of general practice medicine in an ever-changing primary health care environment.

We also publish two scientific papers in this issue. The first provides some hard evidence about the considerable cost of falls by older adults in the community. The second continues a trend that we have encouraged, to publish papers relevant to primary care practice nursing. This study makes some comparisons between primary care nursing in New Zealand and the UK. Although there are important differences in health care organisation and delivery in these two countries, there are also many similarities. Incorporating the expanding skills of practice nurses more effectively into general practice teams makes a lot of sense and also has implications for continuity of care.

References

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3. Greco RS. One man's practice. Philadelphia: JB Lippincott Co; 1966.
4. Peabody FW. The care of the patient. JAMA 1927; 88:877–882.