# Urban continuity of general practice care in the new century

*George K Freeman, Visiting Professor of General Practice, St George's, University of London, and part-time GP*

*Correspondence to: gfreeman@sgul.ac.uk*

***George Freeman** is an academic GP who has always worked in metropolitan general practices characterised by keen colleagues, all with academic commitments and with consequent reduced opportunity for developing relationship continuity. His interest in the topic arose as a result of a failed experiment into specialisation within a group practice that forced additional discontinuity on patients.*

If you want to liven up a group of GPs, criticise the idea of continuity of care! Most will spring to defend it, though some will say it's going out of fashion and one or two may comment that this either matters little or is a small price to pay for progress. Meanwhile, in England, where I work, our political and managerial masters, sometimes unwittingly aided by our own negotiators, continue to dismantle a personal system and substitute so-called 'choice', relying on computerisation and record linkage to bridge the gaps.[1,2] But our biggest challenge lies in the cities where it is hard for us to argue that traditional general practice is currently 'delivering the goods'. Access times are bad – this week my practice was telling patients they must wait two weeks for a 'routine' appointment – and care is increasingly delivered by part-time, short-term doctors. Too often these keen young colleagues will not be around long enough to reap the benefits of time invested getting to know and then help patients with multiple complex problems.

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## Definition – relationship continuity for general practice

After years of confusion,[3] we now have more consensus on what we mean by continuity of care. In this issue, Kljakovic[4] presents the three-part definition of continuity described by Saultz.[5] Haggerty et al. described a very similar typology, but giving more emphasis to issues of coordination of care.[6] Here the three main types of continuity are: *informational* (timely availability of relevant clinical information), *managerial* (good oral and written communication between care systems, institutions, teams and team members, and *interpersonal* or *relationship*. The relative importance of each type varies according to whether you work in surgery, intensive care, maternity, psychiatry or general practice. Relationship continuity – where a patient has a therapeutic relationship with one or more health professional(s) – is particularly valued in general practice. We absolutely agree with Saultz that relationship continuity presupposes sufficient ongoing contact (longitudinal continuity) for relationships to flourish. This is specified in successive definitions of our discipline as Kljakovic says, and lauded by our philosophers.[7,8] Recently Saultz has contributed expert advice to a review project presenting an updated refinement of Haggerty et al.'s classification.[9]

Too often relationship continuity is over-romanticised. Our archetype is the rural practitioner working for many years in a stable community. There is a substantial literature from Pickles onwards.[10,11] In this issue, Kljakovic suggests how this rural idyll may not have reflected the true urban situation for a long time past.[4] Central and inner-city areas are characterised by rapid development and redevelopment. Neither their residents nor their GPs plan to spend their lives here. Moving out is a measure of success for both groups. However, Kljakovic does not present data on contacts between patients and GPs. My experience in two English cities has been that patients often stick with their doctors when they move, so long as they are in the same town (and, in the past, were willing to do house calls).

So perhaps relationship continuity has always been weaker in cities

and yet it is here that our patients might stand to benefit most from personal knowledge and understanding. Providing a good service to urban patients is perhaps the greatest challenge we face as GPs. Can we achieve this with our traditional practice model of small, professionally-led and owned groups with a system of registered lists? Will this cope adequately with deprivation, transient and homeless persons and refugees? With people needing special help from mental health social and legal services?

In the UK, inner-city GPs have been handicapped by the high price of property (premises), the scarcity of suitable sites, and the difficulty of recruiting and retaining staff in areas of high cost housing and poor amenities such as schools. At the same time patients tend to be of lower social class and education with correspondingly greater care needs. In England this disparity between needs and resources was partially addressed by the so-called deprivation allowance in the last decade. But city GPs have been weak politically and their colleagues in more affluent areas have been reluctant to see them apparently getting bonus payments. The result has been that, with honourable exceptions, our best recruits have seen a stable practice in a small country town as the ideal professional aspiration. This is in contrast to the situation for specialist colleagues. While the teaching hospital is again likely to be in a city centre, the increased living costs are mitigated at least by professional merit awards and often by lucrative private practice in addition.

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Most recently the English Department of Health has tried to improve inner city primary care by bypassing general practice in favour of walk-in centres[12] and is now proposing polyclinics associated more or less closely with hospital accident departments.[13] It seems that we GPs are failing to sell ourselves as capable of offering an appropriate service to inner city patients. Our protests about the importance of a long-term personal system are met with denial ('modern patients think for themselves and don't want this') or by saying we show no signs of delivering this. The fact is that our major job of dealing with the majority of patients that do not need (or would be harmed by) deeper involvement in health care is not appreciated and valued. Instead we are being urged to offer a wider variety of services. In another example this week I met a patient with a four year history of back pain who had been referred by a colleague for physiotherapy. She was back because she had a letter saying she would wait at least eight months. On the face of it this is disgraceful. But on further reflection I have little evidence that physiotherapy by itself will actually solve her problem. I am arranging to reassess her case from the start.

**Patients do like choice – but having found someone they like, they want access to that person**

We certainly have a problem with access now. Several causes are evident. First, we now generate a large ongoing chronic disease management load. In England this has been driven by the Quality and Outcomes Framework (QOF) where GPs are paid to record processes of delivering preventive care. GPs have met QOF targets beyond government expectations, with the result that GPs have too little time for anything else, and the government is running out of money – just as the British economy tips into a downswing. At the same time GPs are involved with service management, with teaching and with research more than ever before. The result is that, individually, they spend less time face-to-face with patients than before. This is compensated by increasing numbers of younger, able, enthusiastic but less experienced doctors who are usually part-time. The result is more medical activity but not necessarily better productivity.

I have never suggested that patients should always see the same doctor.[14] Indeed I think patients have traditionally been far too reluctant to change from seeing a GP with whom they cannot relate or, worse, who has not taken trouble with their care. But the research evidence points the other way – that patients want relationship continuity far more than they are able to get it![15] Patients do like choice – but having found someone they like, they want access to that person.[16] Recent work shows how they have to be very persistent to achieve this,[17] but such tenacity is beyond many patients. Do we really need to set such a high barrier for them?

How can we make it easier for our patients and ourselves? I suggest a three-pronged approach.

First, we need to improve our front of house arrangements, our systems of booking appointments through receptionists. And we need to help patients use our systems, to learn how our systems work and how to get the best out of them. We particularly need to help patients disadvantaged by language, education, or personality from being able to navigate the system to be on more equal terms with their socially more confident, educated and even pushy fellow citizens.

Second, we must revise our own rhetoric and match deeds with words. If we think it would help if a patient consulted with fewer professionals in our group practice, then we should make it easier for them, and if we invite them to return to ourselves personally we should help make this possible.

This approach needs to be tried seriously and our next research aim is to do so, but we need to bear in mind other aspects of the inner-city context. By definition, inner-city populations tend to be less stable and in many ways more energetic and exciting than smaller, more rural communities. This poses special problems for services that are free at the point of access. In general practice we have tended to rely on citizens' sense of fair play not to make excess demands which swamp the service, however intrinsically reasonable and rational they may seem to the individual. But many inner-city patients have such difficult lives that it is very hard for them to hold back in favour of others that they neither know nor identify with. There is not a sufficient sense of community. In fact I believe that well-resourced and well-run personalised general practice is a very good way of helping to develop such community self-confidence and cohesion. This can be done by the way we deal with and value people as individuals, both in the consulting room and across the reception desk or telephone. But we also need to engage with our local communities directly.

So our third method is to relate directly to our local community as a whole, engage with representatives in debate about improving our access processes and service provision, and publicise how our service really works. This must include honest discussion of service resources and the need to allocate (ration?) these fairly. Such an approach may gain support, understanding, and investment from politicians and managers – not the diversion of resources to a rival walk-in centre down the road where the staff are trained to deal with symptoms according to algorithms, resulting in frequent advice for patients to urgently consult a GP!

**Therapeutic relationships don't have to be life-long, but they do require commitment from both professionals and patients over time**

Kljakovic has opened up a new perspective on longitudinal and relationship continuity in urban general practice.[4] His longitudinal approach is especially welcome in a research field characterised by the cross-sectional study of an on-going topic. I hope he is able to pursue this line of enquiry in Wellington and find out how long patients actually remained in touch with their GPs. Kljakovic criticises the longitudinal continuity achieved by the Chianti family because it was not lifelong – but I suggest this misses the point of relationship continuity. Therapeutic relationships don't have to be lifelong, but they do require commitment from both professionals and patients over time. We have clear evidence that urban patients felt significantly better, in the sense of more in control of themselves and their lives, when they consulted with a doctor they knew well.[18] We need to find out how best to make this happen in our towns and cities.

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## Competing interests

None declared.

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