Written evidence submitted by Dr Iona Heath (FGP0381)

Continuity of care

I am Iona Heath. I worked as a primary care physician in a deprived part of north London for almost 35 years and, from 2009 to 2012, I was President of the Royal College of General Practitioners in the UK.

The crucial division between general practitioners and specialists that we see in the UK today, and which has been recreated to a greater or lesser extent around the world, is a gift of history and appeared in Britain during the years between the Apothecaries Act of 1815 and the Medical Act of 1858.

At this point, specialists took control of the newly built modern hospitals. General practitioners were excluded and the principle of referral from general practitioner to hospital specialist was established. As a result:

> The physician and surgeon retained the hospital but the general practitioner retained the patient.

This gradually became translated into the distinction that we teach medical students:

> In hospitals disease stay and people come and go; in general practice people stay and diseases come and go.

Hospital care is necessarily episodic but ongoing relationships have always underpinned the value and effectiveness of UK general practice.

Relationships are fundamental to human existence and human beings seek to create enduring and trusting relationships in all spheres of life. Medicine is no exception. As soon as medicine moves beyond simple technical procedures, the benefits of practising within ongoing trusting relationships are obvious to practitioners and valued by patients.

A system which prioritises access at the expense of continuity is likely to work to the advantage of those who are younger and less ill and at the expense of those who are older and who have a greater burden of chronic illness. Some argue that continuity of information and records will make personal continuity of care unnecessary but the record only contains skeletal information, while, in reality, any doctor providing continuity of care possesses integrated knowledge of the hopes, aspirations, biography and context of each patient, much of which is tacit and gathered from several sources and over time.

Work on 'calling card' presentations demonstrates that some health problems will only be presented to the doctor once a trusting relationship has been established. A system which makes continuity difficult will tend to disadvantage systematically those patients who are more diffident and find it harder to confide or express themselves, and those with more stigmatising, sensitive or intimate health problems.

Discourse analysis and its foundational science of medical semiotics make very clear that the position of an encounter within a series determines its content. The limits and possibilities of the first consultation in a series are very different from those of the tenth. A system which limits the

length of these series will diminish systematically the potential of general practice. Health and illness evolve over time and general practitioners learn to use time as both a diagnostic and a therapeutic tool. The effective use of these tools depends on the ability to offer personal continuity of care.

The benefits of continuity of care are undoubtedly complex but recent painstaking research, most of it from Professor Denis Pereira Gray's team in Exeter, has established that the benefits to patients are multiple and include substantive benefits in terms of both mortality and morbidity.

However effective medical care becomes, everyone eventually will become sick and die. The care of our patients during their final illness brings the arguments about continuity of care into very sharp focus. What kind of care do we want in this situation for ourselves and those we love? All of us will die during the future we are trying to define. It is the care that will be delivered to us that we are discussing. Despite all the arguments about continuity of care, I have never read anyone who fails to value personal continuity in the care of the dying, but if we allow a system which makes personal continuity of care more and more difficult, it will not be possible to pull it out of the hat for the dying.

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