

# **Continuity of Care: Of course, but whose?**

## **A Sleight of Slogans**

– letter to Family Doctor Association

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Continuity of Care is a phrase increasingly used to indicate a cornerstone of good practice. But the phrase is often used with very different assumptions and intent: personal and institutional continuity are often discordant. Personal care and family-doctoring are both an art and an ethos: we must beware of ultimately expensive and mass-produced imitations.

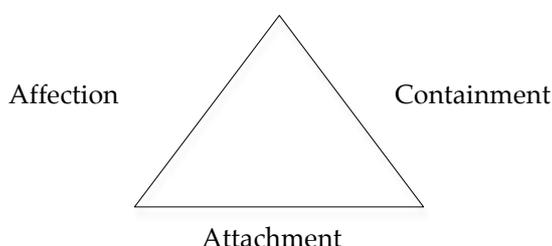
Names and titles quickly convey a designation, sometimes evaluation. Similarly, slogans attempt to transmit a message – often moral or transformative – with sharp economy, sometimes wit. Sloganeers aim to rapidly catch our interest and affiliation.

And so it was. Some years ago I was ‘caught’ by the title of *The Small Practices Association* (SPA): I joined. I was – and resolutely remain – a well-defined, small practice. Single-handed in London’s centre, I sensed the rising cultural tides running against me. I steeled myself: I would have to be articulate and resilient to guard and nourish the kind of personal understandings and relationships that have been at the heart of my working lifetime’s vocation. Long experience has fuelled my conviction that a small practice is best suited to the delivery of person-centred healthcare. The SPA’s title vaunted (and provided) valuable support to stand against the tide.

In more recent years the SPA rebranded itself as the *Family Doctor Association*, the current FDA. I liked this title, too. For my work is much enriched when I can see and understand an individual’s struggles and afflictions within broader frames of life-cycles and relationships: a family-perspective is essential to this. There are here some interesting and daunting parallels. In earlier years I experienced my work as being part of the broader endeavours of a kind of colleagueial healthcare ‘family’ – in this some individuals were close and well-known, others invisible and unknown – an extended ‘family’, nevertheless. Sadly, for expedient organisational then cultural reasons, doctors now usually have much less personal knowledge of patients and families, and are less likely in their work to feel affiliated into a national healthcare ‘family’ Both kinds of family-contact in our work are impoverished.

I mourn the loss of these subtle personal nexae. I see and fear the consequences. But there is restitution – the FDA’s slogan, *Continuity of Care*, enlivens and encourages me: it draws from timeless principles of healing. These principles help us revise and revitalise a healthcare that is increasingly anonymised, alienated, algorithmised – a culture that has steadily lost any individual view of people in its exponential development of the schematic

and managerial. For any real reconciliation here, we need to exert a kind of healing. Central to healing processes are two triads. One develops *within* the individual (the intrapersonal): immunity, growth and repair. This first triad is induced by a second, which develops *between* individuals (the interpersonal): attachment, containment and affection.

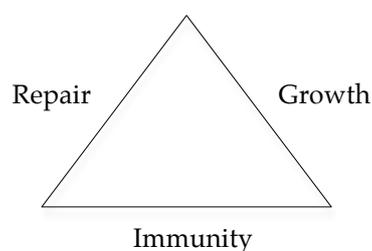


**Figure 1: Interpersonal healing inductions**

*The 'family' ethos of well-fared welfare*

Difficult to measure

Personal



**Figure 2: Intrapersonal healing inductions**

*The 'family' effects of well-fared welfare*

Difficult to measure

Personal

Clearly, for any of these to occur, the presence of good therapeutic rapport is likely to be crucial. How can these things evolve without continuity of care? This seems a rhetorical question.

The professional responses, though, are less straightforward; we need to look carefully.

'Continuity of Care' can be constructed very differently by, say, patients, administrators and different sorts of doctors. *Personal* continuity is the familiar face, voice and ambience: the uniquely evolved complex of contacts, events and personal understandings. This kind of continuity is what we yearn for when a condition renders us vulnerable because of its chronicity and complexity. If we live long enough we all suffer this vulnerability, and will seek succour in personal familiarity and continuity. This succour often has a kind of organic growth, for the nourishing and warming benefits to patients of personal continuity are often equally important to practitioners. For the more humanly interested doctor, it is the *relationships* that keep heart and mind alive, fresh, engaged and integrated. And here is a powerful and

wonderful mystery: caring for those that matter to us adds to our own lives and energies.

But there is a very different ethos of continuity of care that is increasingly vaunted by planners, managers and, now, a new generation of practitioners. This emphasises institutional and administrative *impersonal* continuity: here it is the designated 'Team' that delivers; any desire for *personal* attachment is discouraged. Personal understanding becomes an obsolescent and irrelevant impediment: data is the official currency. The intention is that anonymised healthcare professionals and patients can all be speedily referred to managed Services Care Pathways and Team Protocols. These administrative devices attempt to template a kind of *in loco parentis* for personally responsible and responsive care. This will, of course, take us far away from care anchored in the personally familiar. Where, then, does all this lead? Here are two examples:

- Suki has deep-rooted dysthymic mental health problems that cannot be simply 'treated', even less 'cured'. Her early childhood was rent and wounded by unstable, inconsistent and incompetent parenting. What seems to work for her – very slowly – is the reverse of all these in her healthcare: kindness, consistency, patience, imaginative and respectful interest. As her GP I try to provide this by offering my personal continuity of care: her appreciation of this is subtly evident and demurely expressed.

Nevertheless, she gets mentally ill, and this is when attachments fragment and unravel. In one turbulent year she encountered the following psychiatric teams: Hospital Liaison Psychiatry, Community Mental Health, Assertive Outreach, Emergency Psychiatry, Crisis Resolution, Home Treatment, In-Patient Psychiatry, Early Discharge and Recovery. Each of these bounded teams transferred electronic abstracted 'data' to the next team, to prime their very long and formulaic assessment. The *electronic* continuity might seem seamless and neatly well-functioning to a manager or detached clinician. Suki's experience is shockingly and instructively different. At the times when she most needs familiar and trusted faces, and attachments rooted in *personal* knowledge, she instead

encounters a procession of strangers who interrogate her, often never to be seen again. She describes these often stilted disquisitions as if they are conducted for an unseen third person, but not really for her. She rarely remembers their names or designations.

I tell some senior managers and clinicians what I have heard and seen. They diplomatically imply that my view is lacking in clarity and sophistication. They tell me that Suki is the recipient of a well-honed system of 'Integrated Care': she is being managed through her 'Patient Journey'; the procession of strangers are, in fact, choreographed specialists, each tending a complex niche in this engineered journey. I think: whose language and needs are being heeded? And who decides?

- I have had a part-time hospital post for many years. Much of my work has been to help patients with complex interweavings of substantial physical disease and emotional distress. I have heard patients' accounts of their medical encounters for decades. Until recent times, patients would almost always know who their GP was: often the rapport was deep, trusted and clearly valued. This is now very rare: most frequently patients know the names of their health centre, but not any particular doctor. 'I used to see Dr J, but now when I go it always seems to be someone different ... the last time it was a young woman: she seemed nice enough but spent most of the time looking on the screen. No, I don't know her name ...' This is typical of our increasing healthcare data-centred anonymity.

This serious loss of personal attachment has been accelerated by the abolition of Personal Patient Lists. This administrative fiat discouraged the development of particular personal bonds and replaces them with Systemic Management; when I now go to my GP I am not to think of myself as cared for by my doctor, Dr X: my care is now managed by the Hillside Primary Care Medical Centre.

There are essential differences between these contrapuntal kinds of continuity of care: the personal and the administrative. Generally planners and managers will favour and better understand administrative and systemic

continuity as this can be (theoretically) delivered with detachment and objectivity. Clearly, these kinds of continuity must always be available – for no individual practitioner can provide invariable, eternal, perfect and instant personal care, or not for long! We must all be allowed absences, holidays, and the errors and vicissitudes of life. Yes, personal continuity can rarely be complete and there must always be institutional back-up plans and resources.

So, we must have both kinds of continuity of care: personal and impersonal. The problem then is how do we define, find and assure the best mix or compromise in each situation? Certain principles can guide us. Where a patient and practitioner wish for personal continuity of care for a non-acute condition – and this possibility is feasible and competent – then this should take precedence. Yet this personal continuity should be contained within, and in some ways accountable to, a systemic continuity: this is the safety-net, lest the personal continuity breaks or fails.

None of this is easy. In our risk-averse times we have become haunted by spectres of breakage and failure. And personal continuity of care – like love – is vulnerable to loss and damage. Yet to attempt to avoid these risks – by driving out personal attachments and replacing them with ‘safer’ generic management – may lead to different, but greater, breakages and failures. Broken spirits and hearts are common and often ineluctably important in our health and welfare. Such complex humanity eludes management and measurement: at these times we need a harbour of experienced compassion and imagination. Skilled and personal continuity of care may be the best kind of harbour we can offer.

It is better to have loved and lost, than never to have loved at all.

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