

Why are diseases treated differently in primary care?

In hospitals the diseases stay the same and the patients change but, in general practice the people stay the same and it's their diseases that change

GP 'has a specific decision making process determined by the prevalence and incidence of illness in the community'.

Problems are presented to family doctors in the community in a very different way from the presentations in secondary care. The prevalence and incidence of illnesses is different from that which appears in a hospital setting and serious disease presents less frequently in general practice than in hospital because there is no prior selection. This requires a specific probability based decision-making process which is informed by a knowledge of patients and the community. The predictive value, positive or negative of a clinical sign or of a diagnostic test has a different weight in family medicine compared to the hospital setting. Frequently family doctors have to reassure those with anxieties about illness having first determined that such illness is not present.

*From the European Definition of General Practice/Family Medicine*

The populations served are very different in general practice and hospital medicine. This is an obvious but forgotten difference that can cause inappropriate management of patients and the muddled teaching of students. Primary care sees a more general mix of patients who present early in their symptomatology. Hospital specialists should only see the patients who have already been selected for referral by their GPs. For instance if a patient presents to a GP with a headache, the GP knows that most patients with a headache have self limiting illness and do not need to be investigated. Only a very few patients will have serious pathology. In general the GP can assume that most patients are normal, be able to reassure and treat most patients, but be vigilant to identify the 1% of patients who have unusual headache that might need referral for further investigation. By contrast a neurologist's clinic is full of the 1% with unusual headaches that have been referred, and the neurologist knows that a high proportion of patients will have an important abnormality so each patient must be assumed to have a serious pathology and investigated. Primary and secondary care work well together when each understands the prevalence of illness in its patient population, its role in the management of illness, and only the appropriate patients are referred to hospital care. The worst scenarios are when this becomes muddled and primary care assumes everyone with a headache needs investigation or referral, or when secondary care assumes that everyone with a headache is normal and doesn't need investigation. This muddle is continued if secondary care specialists don't acknowledge the differences in the patient population in primary care, teach primary care subjects and mistakenly advocate secondary care management for these primary care populations. This may cause GPs to refer more patients to hospitals. The balance between primary care and secondary care is traditionally preserved by the GP gatekeeper role. GPs control who is referred to secondary care. The balance is easily upset if GPs are advised to refer patients more often to hospitals or if hospital specialists (or GPs with a special interest) work in a primary care setting. If the average GP usually refers 4 out of every 100 patients to secondary care, but increases referrals to 5 out of every 100 patients, whilst it has very little impact on the daily work of the GP, hospitals have to cope with a 25% increase in their referrals. and a vicious circle develops where the distinctive differences between primary care and

secondary care are eroded. Patients suffer with unnecessary investigations and referrals, and the NHS struggles to cope with the workload.

Never assume that there is someone else in charge who knows what they are doing, always know what you are doing, and that it's likely to benefit not harm the patient.