Between romanticism and realism:

The patient's view on continuity of care

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Continuity of care is a cornerstone of general practice with many facets. One of the confusing things about continuity is that its meaning remains inscrutable. We lack an internationally-accepted definition. Some authors consider continuity a synonym of seeing the personal doctor, others define it as the concept of general practice as a whole. As a consequence, many publications on continuity focus on preferences of doctors and researchers involved, and much less on what patients prioritise.

In the past few years, many authors have used the definition of continuity of care launched by Saultz in 2003. He distinguishes three levels of continuity: interpersonal continuity, longitudinal continuity, and informational continuity. Interpersonal continuity refers to the personal patient–doctor relationship, longitudinal continuity to the patient's familiar medical home, and informational continuity to the organised collection of medical and social information about a patient.[1]

However, patients will define continuity differently. Patients experience continuity. From the patient's perspective, continuity exists when 'care progresses smoothly'.[2] Patients discuss continuity predominantly when it is lacking. In this contribution I will try to highlight the patient's viewpoint, both from what is known from the literature, and from my own research and practical experience as a GP.

Although 'Family Medicine' stretches from the post-war period into the early 1970s, it breathes the spirit of a past era and in a context long bygone

Thirty years ago, Frans Huygen wrote an influential textbook on family medicine, in which he analysed the long-term medical life histories of families.[3] He was one of the founding fathers of Dutch general practice. Although 'Family Medicine' stretches from the post-war period into the early 1970s, it breathes the spirit of a past era and in a context long bygone.

Huygen was the only general practitioner in his village, working together with a district nurse and a practice assistant in a stable population. Reading his book, it is clear that continuity of information and longitudinal continuity were implicit, and interpersonal continuity was even more important. Huygen dedicates his book to the families he had *'the privilege to serve so long as their personal doctor'*. This inscription provides evidence for what patients might call a doctor with a heart for continuity. Nobody questioned continuity of care; it was just there.

But much has changed in 30 years. A decade ago, I followed Frans Huygen's footsteps, and nowadays, together with my two colleagues, work in his former practice area. Our health centre now accommodates five more practice assistants, a practice nurse, a bookkeeper and a manager. We have many district nurses working in the area. Together we take care of a practice population that is only 30% larger than in Huygen's time. In our time, serious threats to continuity have arisen.

As the three of us work part-time in the practice, with a shared list, the pursuit for consistency and working to an agreed plan is evident.[4] But this is not always easy to achieve. Continuity of information has become much more important and more time-consuming. I consider it also more complicated, as many thoughts about caring for my patients are difficult to summarise in written words.

Interpersonal continuity is no longer self-evident for our patients. Although the majority of patients are concerned about continuity, they make choices. We now see that a woman starts to see my colleague, because I remind her too much of the

painful period when her partner died (*'If I see your car, I already get startled'*). A busy bank director gives preference to a preferred appointment time with me rather than waiting to consult his personal doctor. I see adolescents who start to see me because my colleague is their parents' doctor. What's left of family medicine? We also know patients in our practice who consult one of us 'to talk to' and the other one when they have strict 'medical' questions. More often, patients themselves choose to see one of us for a certain episode, but they might consult another for the next.

Probably about one in four or five patients would say they have two or three personal GPs in our practice. We also know that about 20% of our patients say that they do not prioritise interpersonal continuity. Still, I don't see these patients as malevolents 'shopping around', but as right-thinking contempories, taking advantage of the offered freedom of choice. This is inevitable, but it is at the cost of our own time-consuming efforts to keep up with all our patients' stories. From the patient's perspective, however, this all seems just a matter of course.

The above examples show that patients' views on interpersonal continuity are changing, and moreover these changes are diverse and complex. Studies have shown that many patients want to see their personal GP when they consult for serious and more psychosocial and contextual reasons. For minor ailments they consider this less important. Eighty to 90% say it is important or very important to see their personal GP for family problems or depressive disorders, less than one in 10 patients for flu or an ankle sprain. It is not possible to predict patients' individual continuity needs by age, gender or contact frequency, and such characteristics do not help staff with booking consultations.[5,6] Certainly, there is a paradox. Most patients want to have a GP who knows them, but they often make trade-offs that make this relationship more difficult to establish. It takes several consultations to get to know a GP and to build trust.[7]

One other aspect of interpersonal continuity is not often described in the literature, but in my opinion it is of the greatest importance. McWhinney describes it as *'commitment'*, or *'being there'*.[8] In a qualitative research study I found that patients expect their GP to keep in touch when they are seriously ill and to initiate contacts around serious life events, such as admissions to hospitals and contacts with families after the death of a beloved.[9] These needs are implicit and many patients expect their GPs to contact them, but they will not necessarily ask for consultations or home visits. Patients expect their GPs to be proactive in these circumstances. This phenomen is related to Huygens's 'serving patients'. Every GP will recognise this continuity aspect, and will probably agree that it is not always easy to determine how to react in specific circumstances.

Also, for informational continuity, we see paradoxes. Conscientious writing in medical records is not a panacea for a loss of interpersonal continuity, but is is undeniably of growing importance. As a result, in order to improve the quality of patient care, patient information is shared more often with an increasing number of professionals through Internet technologies. At the same time we see that patients are concerned about issues to do with the safety of their records. Some patients nowadays ask me not to write down clues from their psychosocial and contextual history because they feel that this information is no longer secure. This may hamper continuity of care from the professional's view, but a number of patients distinguish between different types of professionals and different types of information with regard to access to their records. For example, we did a study which revealed that one in five patients did not feel that their entire record should be accessable to the GP on call, and one in three would not consent to making available details about life events and home details to the on call GP. At another level, this problem also exists in the patients' medical home. Many do not want the practice assistant and practice nurse to be able to read certain details.[10] But how can a patient experience continuity if information is not shared by professionals?

Much can be learned from the patient's perspective on continuity. Certainly, continuity matters. Patients experience continuity if care progresses smoothly and is coordinated. Moreover, most patients want to be understood and personally known. Patients' views on longitudinal and informational continuity aspects seem to be quite uncomplicated. Continuity of information is often considered a matter of course, and only a few patients worry about confidentiality. We have experienced that patients have difficulty judging the quality of this continuity aspect. Also team continuity is taken for granted by most patients. They expect the team to work together and to an agreed plan.

With regard to interpersonal continuity, patients' needs are diverse. Most consider continuity important. Some do not prioritise it at all, most others do, but mainly for specific reasons. Moreover, patients' needs are not predictable by standard characteristics, and patients' needs also differ considerably over time. A serious life event will increase the need for interpersonal continuity. Patients are therefore balancing between romanticism and realism. Each individual patient will have specific needs, which may alter over time. For general practice, it is advisable not to enforce certain aspects of continuity, but to create an environment in which the patient can meet his or her own continuity needs over time.

Competing interests

None declared

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