Why care about continuity of care?

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Health and ill health is a continuous state, but health care is necessarily episodic and discontinuous. All health services therefore have to bridge the gaps between episodes or consultations, and it is difficult to disagree with the idea of continuity of patient care being important and worth improving. Unfortunately, there is much less agreement about which aspects of continuity are most important.

General and family practitioners claim continuity as a core value, by which they generally mean that patients have one doctor (or a few doctors) with whom they have a personal relationship, who is/are responsible for all or most of their primary medical care and for co-ordinating other health care. Hospital professionals often focus on continuity in the sense of ensuring appropriate handovers of care, during admissions and across the primary–secondary care divide. Policy usually emphasises good communication across the health care system and consistent management of particular problems through application of national guidelines. So what is continuity, and does it matter?

Haggerty et al. define continuity of care as the *'extent to which a series of healthcare services is perceived or experienced as connected and coherent and consistent with the health needs and personal circumstances of a patient.'*[1] There are many different kinds of continuity identified in the literature, but most can be reduced to three core elements. *Informational* continuity refers to how information is transmitted across time, across place of care, and across professional boundaries. *Management* continuity is how the care of individuals and particular problems is made consistent irrespective of where and when they consult. *Relationship* continuity refers to personal relationships between individual patients and professionals, built on shared experience and interpersonal trust.[1]

In the past, the solo general practitioner commonly embodied all three elements, with relationship continuity underlying informational and management continuity for most patients, supported by the general practice record, being the most complete of the fragmentary paper records of a patient's health care. However society, professionals, patients and the nature of ill health have all changed. Increased mobility of both patients and professionals militates against 'cradle-to-grave' relationships and GPs increasingly only work part-time in practices due to other professional or family commitments (my own academic life being an excellent example). Patient journeys for chronic disease routinely traverse many organisations and involve many different professionals. Primary care practices have generally got larger and the primary health care team has expanded with nurses, particularly, extending their roles. In some countries, policy emphasis on rapid access to primary care has led to organisational changes that prioritise when to be seen over who does the seeing.[2,3]

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The changing nature of health care means that the three elements of continuity have become increasingly distinct. Informational continuity is now largely perceived as what can be written or recorded in paper and electronic medical records, with memory and personal knowledge perceived as fallible and unreliable. Ideas of management continuity emphasise what can be formalised in guidelines and protocols, which are overwhelmingly dominated by the delivery of particular tasks for particular diseases. In the face of these apparently clear elements of continuity, relationship continuity looks ill-defined and less clearly important. However, general practitioners continue to make the case for it being important. There is good evidence that patients who see a doctor they know and who knows them are more likely to be satisfied with the care they receive.[1,4–6] For

many (but not all) patients, care within relationships is perceived to be more tailored to them as an individual, to facilitate involvement in decision-making and to be more efficient because they do not need to repeat their story.[2,7] Relationship continuity is therefore a key component of current policy priorities to deliver patient-centred care.

The evidence that relationship continuity improves medical outcomes is weaker, partly because it is hard to randomise people to 'close' or 'distant' relationships. Instead, trials usually design their intervention around whether or not patients see the same doctor or nurse, and assume that relationships emerge, or that seeing the same person delivers better information and management continuity. What data there is shows broadly positive effects on a range of medical outcomes.[4,6]

Additionally, relationship continuity improves informational and management continuity in patients who are complex. Clearly, communication between clinicians is crucial, but written and electronic communication is largely restricted to the 'facts' of the case. Understanding an individual's preferences and their personal and social context is largely unwritten, not least because neither is static, as individuals rewrite the narrative of their lives in the face of changes in their health. Equally, management continuity, in the sense of guidelines, works best for care of major, acute illness, and in individuals without multi-morbidity or complex interactions of illness[8] and psychosocial circumstance.[9] Much harder is care where all options are uncertain or problematic, and where evidence and patient preference and circumstance conflict. Ensuring information and management continuity for those who need it most is therefore difficult to reduce to simple protocols that can be mechanically followed. So where now for relationship continuity?

First, it is clear that most (but not all) people with chronic disease prefer to be cared for by professionals they know (but not always by a GP), whereas the younger and the healthier are more likely to prioritise rapid and convenient access. However, some patients don't care who they see, most commonly those for whom ideas of 'continuity' do not (yet) apply.[2,7] We all have a past and a future, and for almost all of us, our future will involve chronic ill health. However, for the young and the currently healthy, health care is often a series of largely unrelated episodes, and speed of access and being treated with basic dignity and respect in occasional consultations are what matters most to many. One reason that policy often only pays lip-service to relationship continuity is probably that most policymakers belong to this group, effectively prioritising the wants and needs of the healthy over those of the sick.

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For solo practitioners, the appointment embodies both access and continuity, and there is a natural space within which relationships can develop to suit the patient (although there may be fewer exit options for patients when such relationships are problematic). This breaks down in larger practices, where GPs need to be sure that systems of access allow patients to trade-off who to see and when and where to be seen to suit their preferences and needs. The focus should be on creating opportunities for longer-term patient–doctor relationships. However, since doctors and patients do not always agree when 'continuity' really matters,[10] GPs need to have an explicit discussion about what the doctor and patient values in the relationship, and when and how relationships matter.[2]

Second, relationship continuity with the patient can facilitate informational and management continuity, but none of us is a truly autonomous practitioner in the traditional sense because we all increasingly rely on other medical and non-medical clinicians to jointly care for our more complex patients. The relationship prioritised by GPs is that with the patient, but relationships with other professionals are central to effective informational and management continuity when it really matters. Routine recording and communication of 'facts', and working within evidence-based guidelines when appropriate are a core requirement of a health care system, but are often inadequate by themselves. Bridging the gaps when protocols don't work, or when individual circumstances and preference threaten standard systems, often requires someone to take responsibility for co-ordination, and to manage relationships between many professionals and organisations. This doesn't have to be a GP, but often there are no other volunteers. Fragmentation increases rather than reduces the salience of Balint's observations on the 'collusion of anonymity', where no professional takes responsibility for difficult and complex patients.[9] However, the Balint approach to this problem emphasises the doctor–patient relationship, whereas we must now acknowledge that our relationships

with our colleagues rival the relationship with the patient in importance.

Relationship continuity therefore still matters, but perhaps develops less naturally than in the past (although we should be careful not to be overly nostalgic – the 1840s saw the first recorded lament by a UK GP for the lost golden age of close personal doctor–patient relationships[11]). Training largely teaches the 'consultation' rather than the 'relationship', emphasising a (very important) set of one-off skills over what we claim as our core values.[12] Notably, video assessment of consultation skills is more easily achieved for 'new consultations with patients with a fairly clear clinical problem', rather than consultations where doctors and patients have a relationship.[13] Consultations skills are central to effective practice but, if we are serious about relationships with patients and professionals being important, then we need to put research into this and incorporate the teaching and practice of relationships back into the core of our practice.

Competing interests

None declared.

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