Continuity of care: a changing value as time goes by

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Continuity of care has long been a cornerstone of excellent primary care. The idea of a long-term relationship between doctor and patient appears to be an attractive one, with many benefits and few drawbacks. Healing relationships based on extensive personal knowledge, shared experience, trust and availability are considered to be distinguishing characteristics of general practice. Continuity has also been woven into the package of health care reform in Portugal. As Luís Pisco has stated: «The main objectives for this reform were to improve accessibility, efficiency, quality and continuity of care and increase the satisfaction of professionals and citizens.»[1]

How then can we call this almost sacred tenet into question? It makes more sense in the era of evidence-based medicine to treat this kind of belief statement as a testable hypothesis. Does continuity of care matter? Does it benefit patients? Do patients and doctors like it? Is it cost effective? The published literature is divided in its answers to these questions and perhaps this deserves a closer look.

First, it helps to define the term so that we know what the argument about. One simple definition is that the same patient sees the same doctor over a period of time. This is called provider continuity and may be the simplest to conceptualize and measure. Complications arise when we consider that few family doctors work alone today and very few provide care 24 hours a day, seven days a week, for the 40 years of a medical career. Most of us work in teams and all of us take breaks from our work to preserve our physical and mental health. This makes discontinuity of care desirable and expected by both patients and providers.

When we work in harmonious teams with excellent clinical records that are accessible to our colleagues, we have informational continuity or continuity of records. When we use diagnostic and treatment protocols or clinical guidelines agreed on by all partners then we are said to have organizational continuity. We need to be clear what kind of continuity we are talking about before we praise or criticize it.

Freemen, Olesen and Hjortdahl asked in 2003 if continuity was still an essential element of modern general practice.[2] Changing societies with mobile doctors and patients have contributed to this. They suggest that GPs value interpersonal continuity but that it is not essential to good care and that it is not unique to general practice. They argue that excellent consultation skills can produce good outcomes for patients without continuity.

Patients express mixed feelings about continuity. Their attitudes may depend on the medical situation they face. There are clear differences between a young person with an acute self-limiting illness and an older person with a chronic life-threatening situation. The first patient may be satisfied with episodic care from the first available practitioner. The second would value a long-term caring relationship with a personal doctor. Patients are also clear that they value the quality of the relationship with a single provider. In a paper entitled "It's all about recognition", patients expressed feelings of humiliation when their own doctor could not remember who they were.[3]

Though trainees value the concept, GP trainers have questioned whether or not this is relevant to modern practice asking if we need to bother teaching this idea at all. A study of Dutch general practice found that trainees seem to value the concept of continuity more than their trainers. However both old and young trainees seem to think that interpersonal continuity is important in some cases such as when discussing the future with a patient with a life threatening illness.[4]

It would help if we had solid empiric data showing that continuity of care produces better outcomes for patients. The evidence is divided on this point. One Canadian study of 300 elderly diabetics found that higher

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continuity of care was associated with significantly lower rates of hospital admission and death.[5] However an American study of over 1700 diabetics followed for three years found that continuity of care was not associated with performance of monitoring measures such as testing for glycosylated haemoglobin or serum lipids, or referral for eye examinations.[6] There is evidence that long-term contact with the same provider increases your chances of having cancer screening or vaccination done.[7] In a systematic review of continuity of care and patient outcomes that matter, such as patient satisfaction, hospitalization and receipt of preventive services, Cabana and Jee conclude that continuity of care is a good thing.[8] Saultz's review of 22 studies of the relationship between continuity and patient satisfaction found 19 studies that reported higher patient satisfaction when interpersonal continuity was present.[9] Perhaps these reviews need to be updated with new evidence appearing in the decade since they were published.

Does care given mainly by one doctor mean better care or does it limit access to care? Is it beneficial for patients to see another physician with a fresh outlook occasionally because "a new broom sweeps clean"? Currently in Portugal there are performance indicators that look at the proportion of consultations made by patients in primary with their own doctor. However we have no evidence that this matters to their health. We have powerful tools like SIARS to measure the process of care such as prescriptions and laboratory tests. We have measures of some hard outcomes like death and hospitalization. We have access to measures of intermediate outcomes like control of diabetes and hypertension from the electronic medical record. We have accepted measures of patient satisfaction. Perhaps it is time to put these elements together to determine if continuity of care with the same provider produces good outcomes for patients in Portuguese primary health care. We would be happy to publish the results studies of this nature in the pages of this journal.

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CONFLICT OF INTEREST

The author has no conflict of interest in the publication of this editorial.

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