Family Practice Vol. 20, No. 6 © Oxford University Press 2003, all rights reserved. Printed in Great Britain
Doi: 10.1093/fampra/cmg601, available online at www.fampra.oupjournals.org

Continuity of care: an essential element of modern general practice?

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Freeman GK, Olesen F and Hjortdahl P. Continuity of care: an essential element of modern general practice? *Family Practice* 2003; **20:** 623–627.

For a variety of reasons, GPs are working more and more with unfamiliar patients. The proposed new British GP contract stipulates that in future patients will register with a practice, rather than with a named GP and a recent new definition of general practice did not mention continuing care. There has been persistent confusion about the definition of continuity of care. Evidence for the benefit of patients usually seeing the same doctor is still limited. In this paper we describe some discrete elements of continuity, emphasize the importance of interpersonal continuity and suggest how this may work. The contributions of informational continuity (especially good records) and of excellent consulting skills are put in context. We conclude that further evidence is needed to demonstrate the added value of interpersonal continuity in general practice and that this needs a clear theoretical basis. We propose that such a theory will define the concept of multi-dimensional diagnosis as the key strength of our discipline and that continuity, especially interpersonal continuity, is an important factor in achieving this economically and in a way which satisfies both patients and professionals.

Keywords. Continuity of care, general practice.

Introduction

GPs are often working with patients who they do not know well, particularly in larger practices.[1] Society is more fragmented and specialized. This includes health care services. Stable communities are less common; both patients and professionals move homes and jobs more frequently. The public has also come to expect a faster more accessible service.

While some people change to a new GP more often, increasing numbers of patients are not registered with any GP. Others choose to seek care near their work, for example in a city centre, where their regular GP is inaccessible, creating demand for informal direct access primary care such as is given in 'walk-in' centres.

These societal changes have now been reflected in a proposed new contract for British GPs,[2] a draft of which received majority support in a nationwide ballot.

Received 7 May 2003; Accepted 14 July 2003.
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A significant feature of the proposed contract is that in future patients will be registered with practices rather than with a particular doctor. This change institutionalizes a longstanding trend in the development of group practices with shared lists, where the patients are free to choose to consult with any doctor. However, by removing the idea of a named doctor from the system, this development may further accelerate a trend to devalue the importance of a therapeutic doctor–patient relationship.

It may be no accident, then, that a recent 'new' definition of general practice[3] omitted any mention of 'continuing care'. The authors were keen to offer a central rather than an all inclusive definition of the specialty.

The nature of continuity in general practice

It is sometimes assumed that lost continuity of a personal relationship can be regained by improved continuity of information—particularly through better clinical records, normally now electronic. But this is to confuse separate aspects of care which are neither the same nor mutually exclusive. If we are to recommend continuity in general practice care we must be clear what we mean by it.

Freeman and Hjortdahl addressed the future of continuity of care for general practice in 1997[4] and concluded that there was no evidence that patients should be encouraged to see the same doctor each time against their inclination. But they also suggested that, too often, patients found it difficult to see a doctor they already knew. They suggested ways in which practices could improve this aspect of organization. One US study has shown this is indeed feasible.[5] While the UK government is currently concentrating on offering guaranteed quick access for patients (access to a GP within two working days) it has been silent on the question of helping patients see a doctor they know. Yet this aspect of patient choice is valuable in spite of the fact that it may conflict with quick access.[4]

In 2000, a wide review of continuity of care across all medical disciplines concluded that the concept of continuity of care was so broad as to lead to frequent misunderstanding and imprecision. This review proposed a multi-element definition (Box 1).[6]

GPs have previously recognised most of these elements[7] and participants of recent workshops led by the authors have confirmed this (see Acknowledgements). However, elements 5 and 6 in Box 1 contribute most to the traditional definition of the GP. While it is often assumed that continuity of care in general practice necessarily means usually seeing the same GP (element 5) it is probably more important that a patient has choice and a good interpersonal and therapeutic relationship (element 6) with one or more practitioners.[4,8] The traditional pathways have encouraged a therapeutic relationship across successive episodes of care.[9] Nowadays, it is often only feasible to offer such a relationship within a single care episode.

Box 1

1. The experience of a co-ordinated and smooth progression of care from the patients' point of view
(experienced continuity)

To achieve this central element a service needs:

2. Excellent information transfer following the patient
(continuity of information; continuity and coherence of medical record)
3. Effective communication between professionals and services and with patients
(cross-boundary and team continuity)
4. To be flexible and adjust to the needs of the individual over time
(flexible continuity)
5. Care from as few professionals as possible, consistent with other needs
(longitudinal continuity)
6. To provide one or more named professionals with whom the patient can develop a therapeutic and interpersonal relationship
(relational or interpersonal continuity)

The place of continuity of care in modern general practice

First, if we can agree that continuity of care without more precise definition is too broad a term to be helpful, we should limit our focus to consideration of personal or, better, interpersonal continuity. This is because general practice is focussed more on the person rather than on the illness.[8,9] In general, continuity of information is desired by all, though patients (and even doctors) sometimes want a fresh start and/or anonymity. So how essential is interpersonal continuity for the modern GP?

Interpersonal continuity built on repeated (but not necessarily exclusive) contacts is important in building trust and respect. We like it when we use craftsmen, go to the hairdresser or send our car to a friendly local garage. Patients also like it when attending the health care system. The opportunity to leave a consultation with unfinished business and perhaps return later if necessary is much valued by patients[10] and means that the often ill-defined problems can be left to evolve and often to resolve. If further review proves necessary, it is most efficiently done by resuming dialogue with the same doctor. In most systems, GPs are the physicians who most often give this type of continuity. We must ask ourselves if this is unique to general practice? Does the GP's kind of continuity differ from that given by an internist taking care of a diabetic over many years. Does the internist give and get the same satisfaction from continuity of care as a GP? Do the GP and the internist hold a new consultation in the same way, with a patient they have never met before, or does the GP add specific skills to the performance of the health care system?

One of us (FO) has challenged colleagues with the statement 'a surgeon without a knife is still a surgeon!' and has suggested the analogy 'a GP without interpersonal continuity is still a GP'. Here colleagues tend to react with anecdotes to show how knowing the patient has helped some of their consultations. But are such stories specific to general practice, or just much more common? How essential is prior personal knowledge of the patient to the best practice of our discipline? In other words, what is the added value of general practice to the understanding of continuity?

We suggest that interpersonal continuity, over time, develops some essential skills in diagnosis for GPs, the generation of empathy and trust. Next, we hypothesize that most of these specific skills and the theory behind them could be made explicit by focussed research and thus made accessible to young doctors through learning and training. The central skill fostered by interpersonal continuity over time is the ability to make and value a multidimensional diagnosis, based on the biopsychosocial model[11] within the patient's context.[3,12,13]

Our challenge is that the necessary theoretical and scientific evidence base for the social, cultural and

psychological aspects of our patients' behaviour and problems remains rudimentary.[11,14,15]

A way forward

Concerning interpersonal continuity in practice, a GP may ask:

Is it good to have it? Yes, usually.[4]
Is it essential? No, but, depending on the context, it may save resources and/or improve satisfaction (for both patient and doctor).[4]
Is it GP specific? No but it's more prevalent in general practice and arguably more central to the notion that the patient is important as an individual rather than for the diagnoses that may be attached to him/her.[9]

It is also part of the general practice organizational structure which is less represented in other specialities. This is a more stable senior-led service where access is on the patient's initiative rather than by routine review and for *ad hoc* junior doctor assessment. The setting is also more familiar and intimate and in the patient's own community. There may also be something about the nature and timing of some of the contacts and forming a better bond at times of crisis, a sense of having come through things together. This bonding also occurs in some groups of hospital outpatients with particularly difficult problems and stormy courses, but less often. Finally, there is the issue of reputation; GPs are better known locally and have 'over the garden wall reputations' unlike most hospital colleagues. This would tend to argue that it might be a matter of context rather than speciality.

Continuity as prior knowledge can mean both information, for example an available medical record, and a therapeutic relationship where the patient knows the doctor well.[6]

Information is important in most medical settings. All over the world there are moves to improve the sharing and availability of patient specific medical data through the use of electronic and/or patient held records. Problems may arise if patients wish to suppress some details of their medical history but generally more accessible records will enable quicker and cheaper recognition and resolution of problems. However, good systems of recording psychological and social aspects of consultations are lacking and often time is too short for accurate descriptive text to be either recorded or read. This may partly be due to the nature of the information, but it may also be due to the lack of rigour in understanding the underlying concepts and in sharing these across consultations and between professionals. Contextual and cultural knowledge is often too detailed to be summarized succinctly and adequately; also it may be confidential within a specific patient–doctor relationship.[16]

Prior knowledge of a patient is not just about information, even psychological and sociological material. It is also about interaction and relationships, about feelings, trust[17] and empathy.[18] These aspects of care are more difficult and even inappropriate to transmit by any form of medical record. They exist in the perceptions of patient and doctor and in the degree to which these are shared and recognized. The deliberate non-recording of information may even be important as the GP then becomes the keeper of the defining secret through which the patient wishes to be understood, but not challenged.

Thus good availability of relevant medical information, while important, will not substitute for the benefits of more personal knowledge and a therapeutic relationship.

Role of consulting skills

Much can be achieved by good interpersonal skills combined with training, experience and technical expertise. It is probable that GPs working in settings where virtually all their consultations are with new patients can do a very good job and, even as Olesen *et al*. argue,[3] do a better job in the circumstances than non GPs.

Here, though, we can return to the analogy of the surgeon without the knife. Some may say a surgeon without a knife is still a surgeon. But surgery without knives is surely not surgery!

GPs working in accident and emergency (A&E) have been found to incur less costs than specialist trained A&E doctors.[19] They recall patients less, write fewer prescriptions and do fewer tests. They are more willing to refer the patient back to their 'own' GP. To behave like this though they will have to have worked in a setting where they were able to know patients as people and follow up their lives and experiences over time. It is possible that some of this experience can then be translated and utilised in the A&E setting where every patient is a new patient.

So we can argue that knowledge and skills gained through interpersonal continuity of care are key elements in the philosophy of general practice even though, increasingly, many GPs are having to work in settings where this has to depend entirely on new relationships.

An updated and detailed international definition of the GP was launched at the recent European WONCA meeting in London. The working group have specified one of 11 characteristics of the discipline of general practice is that it "(e) is responsible for the provision of longitudinal continuity of care as determined by the needs of the patient". An explanatory note adds: "The approach . . . must be constant from birth . . . until death . . . It ensures the continuity of care by following patients through the whole of their life. The medical file is the explicit proof of this constancy . . . ".[20] This is

the responsibility of the discipline rather than of any individual GP. Thus, for WONCA, continuity has retained its place, albeit more carefully qualified than previously.

More evidence needed

Discussion of the proposed new British GP contract covers divergent views[21,22] with those more hostile emphasizing the potential downside of forecast lost continuity of care, presumably the interpersonal kind.[23] As Roger Jones says, quality of care is notoriously difficult to measure and he could have added that a comprehensive evidence base for interpersonal continuity of care is still lacking.[24]

We need further research to demonstrate the added value of continuity in general practice and, in spite of a recent *Lancet* editorial,[25] we must describe the theory behind the elements we may see. We must show whether interpersonal continuity makes a difference. Here we must turn to the sciences of human behaviour that underpin much of consulting behaviour in general practice and which will enable us to devise theories and hypotheses about behaviours we can test. In relation to interpersonal continuity, sceptics may point to the dangers of dependence while supporters may prefer to talk about attachment. The example of the insidious onset of classical hypothyroidism is often quoted as a picture missed by the familiar doctor and picked up by the locum. However, the most recent patient one of us (GKF) saw with hypothyroidism had had the diagnosis missed for two years through seeing a series of different doctors, each of which ignored work already done by colleagues. Evidence is needed to find out whether important diagnoses are made more quickly or more slowly in the presence of good interpersonal continuity.

Each of the elements illustrated in Figure 1 underpins the concept of a multidimensional diagnosis which may be the real core of the added value given by a GP in a health care system. We can find theory behind each element in the biopsychosocial triple diagnosis to which we would add a fourth element, cultural context. Each part of the model can be made a focus for research across many disciplines, leading to evidence based education. Interpersonal continuity depends most on psychology, while cross boundary continuity draws more on sociology and anthropology. Informational continuity relates more directly to biomedicine but also draws on physics, complexity and systems theory.

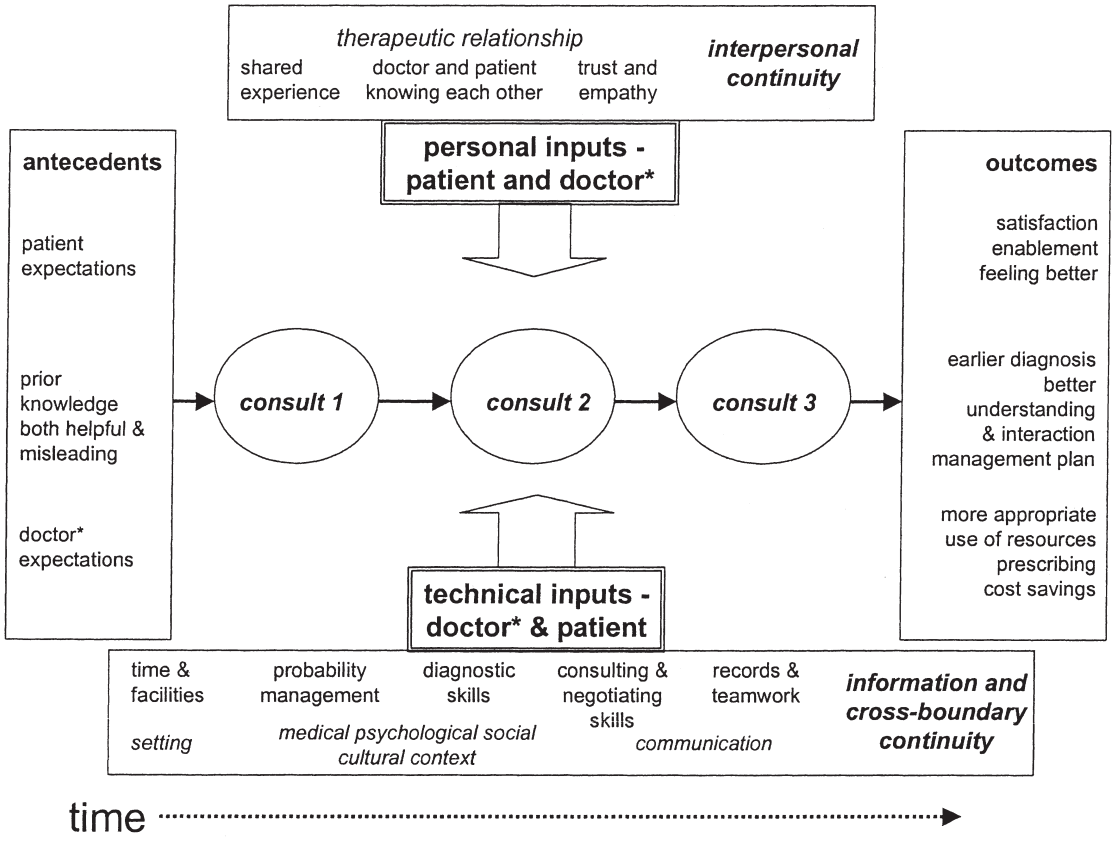

FIGURE 1 *Personal and technical inputs to consultations and their links with continuity elements over time. *Note that, while we have specified* doctor, *these concepts apply equally to nurse practitioners and other primary care professionals*

The challenge for general practice now is to bring forward a balanced agenda for research and education to build awareness of its mastery in making and negotiating multidimensional diagnoses with our patients. Understanding the meaning, strengths and limitations of continuity of care, particularly the interpersonal element, will remain crucial in delivering the best quality of primary care for this new millennium.

Acknowledgements

We are indebted to the enthusiastic participation of and constructive criticism from the participants of a workshop held at the WONCA Europe 2001 meeting in Tampere, Finland: Vas Bilkhu, Nottingham, UK; Derek Browne, Sway, Hants, UK; Steve Cottam, Preston, UK; Reinhard Dörflinger, Wien, Austria; Dolores Fores, Barcelona, Spain; Erik Hagman, Helsinki, Finland; Tom Heyes, Barnsley, UK; Ruedi Isler, Basel, Switzerland; Helena Kemppinen, Varkaus, Finland; Marja Lampio, Taisio, Finland; Jesper Lundh, Nivaa, Denmark; Tony Mathie, Liverpool, UK; Matgorata Palka, Krakow, Poland; Udo Schirmer, Hannover, Germany; Mark Shapley, Newcastle under Lyme, UK; Klaus Witt, København, Denmark. We are also grateful for constructive criticism from Drs Alison Hill, Marilyn Plant, Josip Car and Professor Chris del Mar.

References

[1] Guthrie B. Continuity in UK general practice: a multilevel model of patient, doctor and practice factors associated with patients seeing their usual doctor. *Fam Pract* 2002; **19:** 496–499.

[2] General Practitioners Committee and The NHS Confederation. *Investing in General Practice: the New General Medical Services Contract*. London: British Medical Association, 2003.

[3] Olesen F, Dickinson J, Hjortdahl P. General practice—time for a new definition. *Br Med J* 2000; **320:** 354–357.

[4] Freeman GK, Hjortdahl P. What future of continuity of care in general practice? *Br Med J* 1997; **314:** 1870–1873.

[5] Kibbe DC, Bentz E, McLaughlin CP. Continuous quality improvement for continuity of care. *J Fam Pract* 1993; **36:** 304–308.

[6] Freeman G, Shepperd S, Robinson I, Ehrich K, Richards S. *Continuity of Care: Report of a Scoping Exercise Summer 2000 for the SDO Programme of NHS R&D*. London: NCCSDO, 2001. www.sdo.lshtm.ac.uk

[7] Freeman GK. What priority for continuity of care: a survey of 280 Wessex general practitioners. *J R Coll Gen Pract* 1985; **35:** 423–426.

[8] Kearley KE, Freeman GK, Heath A. An exploration of the value of the personal doctor–patient relationship in general practice. *Br J Gen Pract* 2001; **51:** 712–718.

[9] Mcwhinney IR. *A Textbook of Family Medicine*, 2nd Edn. New York: Oxford University Press, 1997.

[10] Hill AP. *Of Healing Bondage: the context and content of unsatisfactory consultations in general practice*. MSc thesis. Department of Human Sciences Brunel University, Uxbridge, Middlesex, 1998.

[11] Horder J, Byrne P, Freeling P, Harris C, Irvine D, Marinker M. *The Future General Practitioner: learning and teaching*. RCGP working party. London: BMJ publications, 1972: 16–18.

[12] Williams GC, Frankel RM, Campbell TL, Deci EL. Research on relationship-centered care and healthcare outcomes from the Rochester Biopsychosocial Program: a self-determination theory integration. *Fam, Syst Health* 2000; **18:** 79–90.

[13] Engel GL. The need for a new medical model: a challenge for biomedicine. *Science* 1977; **196:** 129–136.

[14] Hjortdahl P, Laerum E. Continuity of care in general practice: effect on patient satisfaction. *Br Med J* 1992; **304:** 1287–1290.

[15] Hjortdahl P, Borchgrevink CF. Continuity of care: influence of general practitioners' knowledge about their patients on use of resources in consultations. *Br Med J* 1991; **303:** 1181–1184.

[16] Helman C. The culture of general practice. *Br J Gen Prac* 2002; **52:** 619–620.

[17] Hall MA, Dugan E, Zheng B, Mishra AK. Trust in physicians and medical institutions: what is it, can it be measured, and does it matter? *Millbank Quarterly* 2001; **79:** 613–639.

[18] Rudebeck CE. Imagination and empathy in the consultation. *Br J Gen Pract* 2002; **52:** 450–453.

[19] Murphy AW, Bury G, Plunkett PK, Gibney D, Smith M, Mullan E, Johnson Z. Randomised controlled trial of general practitioner versus usual medical care in an urban accident and emergency department: process, outcome and comparative cost. *Br Med J* 1996; **312:** 1135–1142.

[20] Wonca Europe. The European definition of general practice/family medicine. Barcelona: WHO Europe Office, 2002.

[21] Keighley B. The new contract—worth voting for? Viewpoint 1. *Br J Gen Pract* 2002; **52:** 601.

[22] Marshall M, Roland M. The new contract: renaissance or requiem for general practice? *Br J Gen Pract.* 2002; **52:** 531–532.

[23] Heath I. The new contract—worth voting for? Viewpoint 2a. *Br J Gen Pract* 2002; **52:** 602.

[24] Jones R. The new contract—worth voting for? Viewpoint 2b. *Br J Gen Pract* 2002; **52:** 602–603.

[25] Anomymous editorial. Is primary-care research a lost cause? *Lancet* 2003; **361:** 977.