Continuity of care matters

The current focus on increasing access makes it more difficult for patients to see the same doctor. But **Bruce Guthrie and colleagues** argue that relationships between doctors and patients are central to good care

Continuity of care refers to how an individual's health care is connected over time.[1] Whether continuity matters therefore depends on how important such connections are. Continuity is often of little immediate concern to young healthy people consulting with minor, acute problems. However, current care cannot be isolated from past and future care for people with more serious or chronic problems, who are the heaviest users of the service. For these patients, there is general agreement that continuity matters across all three of its core dimensions—informational, management, and relationship continuity (box 1).[1 2] But there is less agreement about which dimensions matter most, or the right relation between continuity and access. We argue that an effective healthcare organisation has to embody all dimensions of continuity, alongside good access and systematic care.

Continuity in a changing world

All three types of continuity used to be embodied by a patient's personal doctor: relationship continuity was assumed, informational continuity resided in this doctor's memory and paper records, and management continuity flowed from the doctor working alone and only occasionally referring to specialists. Although continuity was high, the quality and style of care varied depending on the doctor's knowledge, skills, and attitudes.

But society and health care have changed. Patients and doctors are increasingly mobile and solo practice is becoming rare. The rise in chronic diseases means patients now routinely receive care from different organisations and different disciplines. Such changes potentially fragment care and reduce all types of continuity.

Box 1 | Three types of continuity of care

Informational continuity—Formally recorded information is complemented by tacit knowledge of patient preferences, values, and context that is usually held in the memory of clinicians with whom the patient has an established relationship

Management continuity—Shared management plans or care protocols, and explicit responsibility for follow-up and coordination, provide a sense of predictability and security in future care for both patients and providers

Relationship continuity—Built on accumulated knowledge of patient preferences and circumstances that is rarely recorded in formal records and interpersonal trust based on experience of past care and positive expectations of future competence and care

CHRISTOPHER DODGE/FOTOLIA

How can patients be helped through the care maze?

The policy response to potential fragmentation has been to emphasise management and informational continuity through guidelines, care pathways, and electronic health records. Lip service is paid to relationship continuity, but little is done to promote it. The underlying assumption is that relationship continuity is increasingly irrelevant to most patients and increasingly difficult to achieve in team based care. However, although informational continuity is necessary to link care, and underpins management continuity, by itself it does not guarantee that management is consistent or coherent. Guidelines and care pathways are useful in ensuring that routine care is standardised but often break down when patients have multiple problems[3] and are problematic if care fails to take account of patient preference, particularly when the risks and benefits are finely balanced. In the face of such complexity, a clear role remains for individual clinical judgment applied within an ongoing relationship. Neither informational nor management continuity therefore directly substitutes for relationship continuity.

"Relationship continuity facilitates informational and management continuity when they matter most"

Does relationship continuity matter?

There is good evidence that patients are more satisfied when they see the same doctor.[4] Evidence of its effect on other aspects of quality of care, such as disease control and hospital admission, is also broadly positive, although less consistent.[1 2 5 6] Patients who have chronic or serious disease particularly value relationship continuity,[7-9] for the practical reasons of efficiency (not having to repeat complex histories), effectiveness (the relationship creates greater space for involvement in decision making), and trust that their doctor will take responsibility for their current and future care.[10]

Physician responsibility is a key concept, as identified by Michael Balint in the 1950s. He described the "collusion of anonymity," where general practitioners and specialists avoid taking responsibility for complex patients who attend both, each assuming that the patient is the other's problem.[11] Fifty years later, in the face of increasing fragmentation of care, Balint's conclusion remains true: generalists are best placed to take responsibility for holistic care, coordination, and advocacy for the most complex patients. That generalist is currently almost always a doctor, but nurses and case managers may increasingly take on this role. Despite its neglect in policy, relationship continuity remains vitally important, both because it matters to patients and because it facilitates informational and management continuity when they matter most.

Improving continuity

Continuity matters, but it is not enough by itself. Mirroring recent UK suggestions for the future of general practice,[12] the American College of Physicians has proposed the advanced medical home model, in which patients get traditional, personal care from a known physician who has responsibility for coordinating all of their care to ensure that it is coherent, integrated, and effective. Central to the model are systems of access to promote the relationship between patients and their physician.[13] However, the medical home concept equally emphasises informational and management continuity, access, quality, and safety. The college envisages that medical homes would routinely use information technology to share information, implement guidelines to improve consistency of evidence based management, and design their systems around the Chronic Care Model to ensure that they are effective, efficient, and safe. Equally, the medical

home would enhance access through flexible appointment systems and greater use of telephone follow-up and secure electronic communication, although not at the expense of relationship continuity for patients who want or need it. For most patients, the medical home would be a primary care generalist practice, although it may be a specialist setting for some patients with one problem that dominates their health care.

There is evidence that organisations embodying key features of the advanced medical home deliver higher quality care,[14] but it currently remains an aspiration rather than a routine reality, particularly in countries such as the United States where primary care is weak. However, even in countries with stronger primary care like the United Kingdom,[12] the model adds value to older definitions of primary medical care. It clearly indicates that although relationship continuity is central, excellent clinical practice requires equal attention to access and the coordinated and systematic delivery of high quality clinical care. Some primary care practices already embody many of the elements of the medical home (box 2),[15] but there has been little attempt to systematically describe or create such organisations.

Box 2 | Example of good continuity of care

The Pacific Family Medical Group is a family practice on three sites, each with 4-6 doctors, and has consistently high performance on clinical quality measures and measures of patient experience and satisfaction.[15] The practice:

- Strongly encourages (but doesn't force) patients to see the same doctor, and increases the consultation time available by shifting routine tasks to medical assistants and administrative staff when possible
- Recognises the value of management continuity, standardising care whenever possible through implementation of guidelines and protocols
- Maintains a highly organised medical record with monthly audit to ensure that information is clearly and consistently recorded and accessible
- Has a highly organised change management process owned by front line staff, focusing on a small number of important problems or conditions over sufficient time to ensure that improvement is implemented and sustained

Turning aspiration into reality

The advanced medical home will not become the norm unless policy-makers, researchers, and clinicians work together to make it so. There are two key ways that policy-makers can help create or strengthen medical homes and relationship continuity. Firstly, they can require that quality improvement and performance management systems routinely measure coordination of care and patients' experience of continuity to ensure that these are clearly identified as desirable objectives of health systems. Development of appropriate measures is in its infancy but without measurement, continuity and coordination will remain aspirational. Secondly, policy-makers can ensure that payment systems adequately reward doctors for time they spend coordinating care for patients rather than incentivising higher volumes of particular tasks or procedures.[16]

Since there are so many opportunities for discontinuity when care crosses disciplinary and organisational boundaries, continuity in its broadest sense will always depend on individual clinicians taking responsibility for the longitudinal care of patients with whom they have ongoing relationships. This requires professional training to inculcate the value of relationships and preserve it as a professional expectation. However, good relationships themselves cannot be mandated. In practice, the clearest way in which clinicians can facilitate relationships is to ensure that their systems for patient access maximise opportunities for relationship continuity. Although speed of access matters, rigid systems of triage or walk-in care that limit choice of clinician discourage long term relationships[17] and ultimately compromise quality of care, particularly for patients less able to negotiate personal care for themselves.[18]

We currently lack measures and standard quality improvement models for truly advanced access that properly accommodate both when and whom to consult.[10 19] Although greater use of telephone follow-up, email, and electronic monitoring of disease promises greater flexibility,[13] there is a clear need for research to design and test better patient centred systems of access.

Conclusion

Relationship continuity has been particularly neglected by recent policy despite the high value placed on it by many patients, especially those with chronic and complex problems. Policy needs to recognise the importance of relationships and coordination of care by requiring the development and use of appropriate measures, and by rewarding them appropriately. Clinicians can facilitate relationship continuity by ensuring that their systems of access are flexible and sensitive to patient circumstances. Although its implementation and elements require evaluation, the medical home provides an attractive framework for primary care organisation that balances all types of continuity with equal attention to access and quality of care.

Contributors and sources: All four authors have researched continuity in primary and secondary care. BG, JWS, and GKF are practising family physicians. The paper draws on their knowledge of the research literature, including systematic and narrative reviews conducted by them (JWS, JLH, GKF), policy and research scoping work (JLH, GKF), and review and summary of multiproject research programmes in the UK and Canada (BG, JLH, GKF). BG wrote the first draft, which was separately revised by JWS, JLH, and GKF, with BG coordinating rewriting and agreement of the final article. BG is the guarantor. During the initial writing, BG was supported by a Harkness fellowship from the Commonwealth Fund. The views presented here are those of the authors.

Bruce Guthrie professor, Primary Care Medicine, University of Dundee, Tayside Centre for General Practice, Dundee DD2 4BF

John W Saultz professor, Department of Family Medicine, Oregon Health and Science University, Oregon, USA

George K Freeman visiting professor of general practice, Community Health Sciences Division, St George's, University of London, London

Jeannie L Haggerty Canada research chair, Départements de Sciences de la Santé Communautaire et Médecine Familiale, Université de Sherbrooke, Québec, Canada

Correspondence to: B Guthrie **b.guthrie@dundee.ac.uk**

Accepted: 15 May 2008

Competing interests: None declared.

Provenance and peer review: Not commissioned; externally peer reviewed.

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Cite this as: *BMJ* 2008;337:a867