Introduction

Continuity of care traditionally has been associated with care by the one practitioner from the cradle to the grave, a situation unlikely to be experienced either by patients or by doctors in modern society.1

A review of the literature shows a number of different descriptions of continuity of care focusing on various aspects of the care process.

In 1974, Becker et al.2 proclaimed that “the need to provide ‘continuity of care’ is a basic public health and medical care tenet . . . and a sine qua non to what is currently viewed as ‘good’ medical care.” Hjortdahl’s description in 19903 operationalized continuity of care in the context of general practice, stating that “A central element in this new specialty (i.e. general practice) is continuity of care—an orientation away from fragmentation of patient care and toward an integrated medical care model . . .”

Banahan and Benahan (1981)4 view continuity of care as an interpersonal relationship between doctor and patient, stating that “continuity of care (is) a phenomenon that occurs between a patient and physician, which can best be described as a contract. Since it is a contract involving attitudes, it will be referred to as an attitudinal contract. Analysis of existing good physician–patient relationships reveals three essential characteristics of the attitudinal contract; (1) a beginning point, (2) an end point, and (3) quality.” In 1989, McWhinney1 pointed out that “continuity is not only a question of duration. . . . Continuity in family practice is an unbroken responsibility to be available for any health problem through to the end, whatever course it may take.” In Hjortdahl’s view,3 the process of care should co-ordinate and integrate all of the patient’s arising care needs.

Gonella and Herman (1980)5 suggested that continuity of care is a means to an end—continuity of care “is of value only to the extent that it has an impact on outcomes of care, the prevention or reduction of physical, mental, or social disabilities, the satisfaction of patients, and the costs of care.”

In light of these focused descriptions of continuity of care, this study aimed to seek the understanding of ‘continuity of care’ from practising GPs. It was hoped that their experiences would lead to a comprehensive definition of continuity of care.

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Background. The traditional concept of continuity of care, i.e. care from the cradle to the grave, is no longer sustainable in modern society.

Objective. The aim of this study was to propose a definition of ‘continuity of care’ based on the experiences of a group of practising Australian GPs.

Method. Five focus group discussions were conducted to explore the understanding and practice of continuity of care, the individual’s measurement of having achieved continuity of care in his/her practice and the advantages/disadvantages of providing continuity of care.

Results and conclusions. The experiences of this group of GPs points towards three essential aspects to help with a definition of continuity of care. Firstly it requires a stable care environment, secondly good communication to build a responsible doctor–patient relationship and thirdly the goal of achieving an improvement of the patient’s overall health.

Keywords. Comprehensiveness of care, continuity of care, co-ordination of care, general practice, primary care.
Method

We conducted five focus group discussions with six rural and 22 urban GPs in the Central Coast and Hunter Regions of New South Wales, Australia. Rural GPs attending a GP meeting volunteered to take part in this study. Urban GPs were grouped according to their respective practice size: solo GP; group practice with ≤4 GPs; or a bigger group practice. A random number of GPs from each of the three lists were contacted by phone to seek their participation in the study. The characteristics of the final sample are shown in Table 1. We asked the groups to discuss four broad areas: each participant’s understanding of continuity of care; how to practise continuity of care; how to know that one achieves continuity of care; and what are the advantages/disadvantages of providing continuity of care. Interviews were audio-taped, transcribed and analysed for common themes using the NUDIST 3.046 software package for qualitative research.

Results

All GPs agreed that ‘continuity of care’ cannot be achieved without continuing care, and that their continuing care should aim to maintain and/or achieve an improvement of the patient’s health.

“. . . is the patient always going to the one practice, does that mean they’re getting what is called continuity of care, I mean if they are getting episodic treatment, [they] are just coming in and they are getting episodic treatment from that practice, when they hurt themselves or pain here, or cold, or for whatever reason they come in, that’s what you could call, I would think episodic care, . . . continuity of care I would, maybe, think is more sort of managing patients well being or health in the whole, sort of thing, over a period of time.” (Quote 1: RM)

“What I understand from continuity, of course, is looking after someone, not only in sickness but in health as well, and you have a completely co-ordinated approach [towards your patient’s care].” (Quote 2: PSP)

“There’s a lot of people who go and see their doctor every couple of weeks and they provide little in the way of care, but it is continuous, so that doesn’t mean anything. There has to be something about what kind of outcomes there are as well, and for me continuity of care has to look at outcomes. It can’t just look at whether I’m still seeing them or not because I can do that, I can get my patients to come back once a month.” (Quote 3: PC)

“In a nutshell continuing care would be the maintenance of a steady environment both from the point of view of the physical and mental well being of the patient and the input needed to maintain that.” (Quote 4: JC)

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Demographic characteristics of the focus group sample</th>
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<tbody>
<tr>
<td>Age (in years)</td>
<td>Solo GP</td>
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<tr>
<td>Country towns— high unemployment rate, many retirees</td>
<td>M</td>
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<tr>
<td>Urban—well off retirees and high-income families</td>
<td>M</td>
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<tr>
<td>Urban—many working poor, commuters and single parents</td>
<td>M</td>
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<tr>
<td>Urban—poor retirees and unemployed</td>
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<tr>
<td>Urban—mixed population</td>
<td>M</td>
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<tr>
<td>Total</td>
<td>6</td>
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<td>Per practice type in age group for practice type</td>
<td>1</td>
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*One doctor works as a locum.
The major challenge to providing continuity of care is time constraint,

“Well, we have problems, as you’re saying, the time constraints, we have too many people we have to service overall, and, I think we perhaps fall short of the, of the desired thing, people may drift off to other practices because they can’t get in to see us, and then the continuity is disrupted, the themes are lost.” (Quote 5: IS)

but a more important challenge is the struggle to satisfy personal as well as patient expectations. In various ways, GPs asked the question of whether it is possible to achieve the high goals that have been proclaimed to be the defining characteristics of general practice?

“. . . you are dealing with a human emotion, it is an art form, not science that we are practicing (mumble), our profession is, and the longer we are in it the more we realise, that it is an art form, but we are expected to behave with a very scientific approach, and that, I find, is the biggest constraint that I have to deal with. The balancing of the two, the two arms as such, of the profession.” (Quote 6: LG)

GPs regard continuing care as an important aspect to patient care, but it may not necessarily be so to patients. There was a strong belief that part of the GP’s role is to encourage a stable but realistic doctor–patient relationship.

“I also feel we have to give patients a bit of education to act responsibly with the continuation of care.” (Quote 7: HY)

Several GPs cited examples showing that indeed not all patient groups seem to feel the need for or appreciate the benefits of continuing care, leaving GPs with a sense of frustration.

“. . . a lot of people you basically still see episodically, the thing is, the young and fit say ‘you don’t really [need to] see me over an extended period’.” (Quote 8: JC1)

“[But] no matter how much we educate them, I think, it depends on the patient too, . . . some of them have asthma, younger kids, they just don’t comply, it’s very very difficult, they feel good, then they stop medications and they don’t see you until they are really really bad . . .” (Quote 9: HY)

In an ideal world, a doctor would see every patient at every consultation, but this is clearly an unrealistic expectation. GPs stressed that it is more important to create a continuity of care environment within a practice, and to communicate this to one’s patients.

“Continuing care doesn’t have to be provided by one person necessarily. It can be provided by different providers, the co-ordination is the important thing. And that requires within the practice a good working relationship with your colleagues, a common approach.” (Quote 10: IS)

“. . . the concept of continuing care not necessarily being seen by one person all the time is a very practical thing that we have to address, and I always say to my patients ‘please get to know one of my partners, because I’m not going to be here all the time.’ [I think] we can provide continuing care, hopefully, from within the practice without it necessarily being the same provider all the time.” (Quote 11: EB1)

A difficulty in such a care environment, however, was seen in the likelihood of different doctors having divergent opinions about a patient’s management. It was seen as important to have opportunities to discuss these differences at a later stage.

“. . . it doesn’t do the practice any good, no matter how right you are, . . . it doesn’t do the practice any good, the patient any good to change somebody’s management midstream.” (Quote 12: IS)

A continuing relationship with the patient gives the GP an extensive knowledge about and understanding of the patient, his/her family and their community. This knowledge and understanding were seen as influencing the approach to a patient and helping with decision-making processes in the consultation.

“. . . leaving the door open, [saying] ‘well, these are some problems that I anticipate you might have over the next 6 months, if they occur let me know and we’ll do something about it.’ So they’ll feel you’ve given them a framework, from which they can work, . . . I think being pro-active within the consultation, . . . and then they feel a lot more comfortable bringing it up.” (Quote 13: IS)

“. . . it is much easier when you see a patient that has been coming to you for some time and you know all the problems and probably a lot about the family and all the other outside things that you wouldn’t know with a new patient, for example. It often has a lot of bearing on their illness and their treatment, too.” (Quote 14: DS)

GPs see themselves, and feel that their patients see them, as the stable element in a divergent health care environment. They define their role as the co-ordinator of the patient’s care needs. This may allow them to provide input into a patient’s care provided by other health care providers or occurring in another health care setting.

“. . . from the patient’s point of view the GP is the face to the health system. . . . My feeling is, that because you’ve known the patient for a long time, probably 10 or 15 years, you are in an excellent position to direct them to wherever they need to, and they probably put a lot of emphasis into our
recommendations. . . General practitioners are probably more likely to follow [the other health care providers’ advice] through . . .” (Quote 15: CH)

“. . . the patient goes somewhere and you can either have input into what happens with them or you are at least following what is happening with them . . . you may want to come along and you have the option to input, be it in hospital, be it psychology referral, physiotherapy or whatever . . .” (Quote 16: JB)

As stated earlier, GPs clearly determined that they saw a distinction between continuing (or ongoing) care and continuity of care. The aim of trying to provide continuity of care lies in the achievement of improved health outcomes.

“My feeling is that I achieve continuity of care if I can maintain patients functioning in best capacity like they recover from several illnesses and they are able to live as normally as well mentally, physically and medically.” (Quote 17: HY)

Discussion

These focus group discussions show confusion with the use of the terms ‘continuing’ and ‘continuity’. Strictly speaking, the former refers to an ongoing relationship in terms of place, function and action, the latter in contrast refers to the state or outcome of the above.7 However, viewing the use of the terms in context, these GPs use continuing care and continuity of care interchangeably (Quotes 10 and 11).

The literature review does not provide an accepted definition of what constitutes ‘continuity of care’.8,9 Nevertheless, these focus group discussions support previously published work that has described various elements of the ‘continuity of care’ construct.

In general terms, this group of GPs has a strong sense that the idiom ‘continuity of care’ describes their way of practising medicine and that it is the basis for good clinical practice2 (Quotes 2 and 4).

However, provision of care by one doctor does not necessarily equate to continuity of care (Quotes 1 and 4). GPs distinguish continuing episodic care from continuity of care, continuity of care implying the notion of providing care for all of the other care needs of the patient (Quotes 1, 3, 8 and 9) over and above those specific to the presenting illness.3,4

There is agreement that an ongoing doctor–patient relationship,6,8 is a structural prerequisite to achieve continuity of care (Quotes 3–5 and 7). The continuing relationship between the patient and his/her GP creates the environment in which each can take and share the responsibilities of care.1,4 Such a relationship forms the basis on which the proper co-ordination and integration of a patient’s care needs can occur3 (Quotes 13–16).

Yet the majority of GPs work in group practices. These GPs acknowledge that their practice environment requires the concept of an ongoing relationship to be expanded to actively involve all members of the practice (Quotes 10–12).

These GPs regard the doctor–patient interaction as a key element in the process of providing continuity of care.4 There is some evidence in the literature that a stable doctor–patient relationship has a positive effect on overall patient care.10 The increasing knowledge resulting from a stable doctor–patient relationship has a measurable impact on the doctor’s and the patient’s actions during and following the consultation.11–14 Unfortunately, the direction of these impacts varies for different parameters.

Communication, a vital element of the doctor–patient relationship,1,15 has been identified as an important predictor for ongoing care. A negative experience with the last consultation makes it more likely for a patient to see more than one doctor. In turn, patients who describe good communication as the rationale for their satisfaction with the last consultation are less likely to see more than one GP.16

This group of GPs views continuity of care as providing ‘holistic care’. Accepting this view makes functional health an acceptable proxy outcome measure for continuity of care (Quote 17).

The experiences of this group of GPs points towards three essential aspects to help with a definition of continuity of care. Firstly, it requires a stable care environment, secondly good communication to build a responsible doctor–patient relationship and thirdly the goal of achieving an improvement of the patient’s overall health.

Acknowledgement

I thank all my colleagues who volunteered their time to participate in this study.

References

6 NUDIST 3.04. La Trobe University. Bundoora. Australia.


