INTRODUCTION

Continuity, a cornerstone of general practice, is not only inherently therapeutic but also a valuable contributor to positive health and well-being outcomes. Consistent associations are seen between continuity and higher patient and clinician satisfaction, better measures of health status, and lower mortality.

The long-term, one-to-one relationship between a GP and patient has been in decline for decades, to the regret of many GPs. Multiple system-level pressures – including rising workload, under-resourcing and staffing, increased policy emphasis on rapid access and plurality of provision, and societal fragmentation resulting in high turnover of patients and staff (especially in deprived localities) – have contributed to a de-prioritisation of continuity within UK general practice. The emergence of multidisciplinary teams covering a wide range of roles and the introduction and expansion of digital and remote modalities have created both challenges and opportunities for the delivery of continuity.

A NEW FRAMEWORK

Academic studies of continuity in primary care have tended to follow a conceptual framework introduced in 2003 by Haggerty et al, which distinguished between relational continuity (an ongoing interpersonal relationship between a patient and one or more practitioners), informational continuity (the use of past, recorded information to make current care appropriate for each individual), and managerial continuity (a consistent and coherent approach to the management of health or illness, often disseminated between practitioners and providers).

While Haggerty et al’s taxonomy has served us well for 20 years, and several definitions and quantitative metrics are derived from it, it was not designed for a general practice delivered increasingly through disseminated, remote approaches and modalities. In particular, ‘informational’ and ‘managerial’ continuity, while conceptually distinct, blur into one another in practice, since we use information to manage, document, and transfer care.

We propose a new framework with four elements based on the essence of what is being ‘continued’: the therapeutic relationship; the disease episode; distributed work; and commitment to the practice community. These are summarised in Table 1.

CONTINUITY IS KEY

Our ongoing ethnographic research in 11 general practices across the UK suggests that achieving continuity, especially for the most disadvantaged and vulnerable, takes additional resource and creative action from both clinicians and support staff (Ladds E, Greenhalgh T, unpublished data, 2023). It may be tempting to conclude that general practice has become so complex and is under so much pressure that continuity has simply become too difficult to achieve. But these very complexities and pressures mean that it is more important than ever to put effort and resource into delivering continuity in the four key areas of relationships, disease episodes, distributed work, and the communities we serve.

Continuity of relationships is more important than ever, not just because, as the example of medically unexplained symptoms in Table 1 shows, costs and harm can be reduced, but also because, in these stressful times, continuity helps both parties achieve narrative coherence – defined by Merriam-Webster as ‘a systematic logical connection or consistency’ in how experiences are interpreted and ascribed meaning. Therefore, higher continuity makes it easier for both patient and practitioner to maintain a coherent sense of self and has been associated with greater psychological wellbeing; conversely, lower continuity is associated with incoherence, which, in a health system context, may contribute to patient harm or dissatisfaction, low morale or moral injury, poor retention of staff, and erosion of resilience at health system level.

Continuity of disease episodes is more important than ever because research and analyses of recent significant events have attributed avoidable events (such as death from sepsis, delayed cancer diagnoses, poor palliative care experiences, and safeguarding errors) partly or wholly to breaches in such continuity, with remote and digital modalities portrayed as contributing to these failures. Moreover, with increasing individuals/services necessarily involved in different disease episodes, potentially each with parallel, internal continuities, the role of an ‘integrator’, for example, the GP or care coordinator, becomes increasingly important. Absent this continuity, the example in Table 1 – an unremarkable patient with altered bowel habit whose stage 1 colon cancer will be promptly diagnosed and easily removed – could ‘slip through the cracks’ and not return until the cancer has metastasised.

“Rather than gaze wistfully back at an assumed golden age where continuity was defined purely in terms of the one-to-one clinical relationship ... we need to embrace an extended, multidimensional definition of the term.”
Continuity of disease episodes is more important than ever because research and analyses of recent significant events have attributed avoidable events ... partly or wholly to breaches in such continuity...
that still has walk-up appointments, solutions may appear paradoxical and take the form of a values-driven push-back against a remote-by-default policy that is judged harmful to the community served.

CONCLUSION
Rather than gaze wistfully back at an assumed golden age where continuity was defined purely in terms of the one-to-one clinical relationship and was mostly achieved without much difficulty, we need to embrace an extended, multidimensional definition of the term. Understanding the different kinds of continuity shown in Table 1 and exploring the interactions between them, for example, whether their attainment should be viewed independently or as a complementary package, and how their success can be evaluated (both quantitatively and qualitatively) may be a pragmatic and positive move towards regaining some of the meaningful value of continuity.

Emma Ladds,
(ORCID: 0000-0001-9864-7408), Primary Care DPhil Student and Clinical GP, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

Trish Greenhalgh,
(ORCID: 0000-0003-2369-8088), Professor of Primary Care Health Sciences, Nuffield Department of Primary Care Health Sciences, University of Oxford, Oxford.

Funding
Emma Ladds is a Wellcome Trust-funded DPhil student (grant number: 223501/Z/21/2).

Provenance
Freely submitted; externally peer reviewed.

Competing interests
The authors have declared no competing interests.

Open access
This article is Open Access: CC BY 4.0 licence (http://creativecommons.org/licenses/by/4.0/).

DOI: https://doi.org/10.3399/bjgp23X732897

REFERENCES