

Continuity of care: a changing value as time goes by

John Yaphe*



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 proto-

cols 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

*Associate Professor, Community Health, University of Minho



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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ENDEREÇO PARA CORRESPONDÊNCIA

yonahyaphe@hotmail.com



Electronic counselling: Taking e-mail communication with patients one step further

John Yaphe*

Electronic communication with patients is a developing phenomenon in general practice in Portugal. In this journal, we have published three original studies^{1,2,3} an editorial⁴ and a case report⁵ on the use of e-mail in practice. International experience with e-counselling is also growing. It is time to take a closer look at this to assess what needs to change to promote it.

Since arriving in Portugal, my clinical practice has been entirely on-line, counselling patients in Canada. My experience treating over one thousand patients during the past eight years has been favourable. There is a growing body of literature on the safety and effectiveness of e-counselling to support this. Textbook articles describe the technique in both patient care⁶ and clinical supervision.⁷

Many social factors have promoted the growth of e-counselling. Widespread use of the internet for social communication has created the necessary infrastructure. In Portugal there was internet access in half the homes in the country by 2010.⁸ Pressures on the health care system have made access to care difficult in some places. Both rural isolation and urban crowding with increased demand for services are at work here. Family doctors are becoming increasingly sophisticated in their use of electronic media for patient records, information retrieval, professional communication with peers and communication with patients. Smart phones are in the pockets and purses of many doctors and patients and they are filling up with useful medical applications. Finally, developments in communication and therapeutic skills in general practice are being translated to the electronic forum and doctors have discovered their power in caring for their patients.

The recent Portuguese publications quoted show how doctors help patients with appointment times, test results and practical advice on-line. Evidence from other settings has shown how this can be extended to the assessment and resolution of medical issues on-line. While this will never completely replace the face to face medical encounter, it can be a useful adjunct to traditional services.

My practice is part of an employee assistance program. Workers in many companies have free access to on-line counselling services in addition to face-to-face and telephone counselling. Their counsellor is as close as their computer. They enjoy access at any time of day or night, with a reply in a day or two. Writing down issues is therapeutic in itself. Patients enjoy privacy and anonymity especially for topics they consider to be embarrassing. E-counselling provides words to hang on to. Exchanges may be printed for reading at a later time. Patients with agoraphobia or speech fluency disorders may especially enjoy e-counselling. I have reported on the use of family oriented e-counselling for a child with chronic abdominal pain related to unresolved grief of the child's mother. This resolved after a number of on-line exchanges.⁹

Other advantages of e-counselling are related to the techniques used rather than the medium. A model called the CARE model draws on the spirit of humanistic psychology and the methods of cognitive behavioural therapy. The letters stand for connect and contain, assess and affirm, reorient and reaffirm, and encourage and empower. In three or four e-mail exchanges these four steps can be covered.

Many issues have been successfully managed by e-counselling. I have treated hundreds of patients with anxiety, depression, marital conflicts and parenting problems. A significant number have work-related issues, as expected in an employee assistance program.

*MD Associate Professor, Community Health, School of Health Sciences, University of Minho



Some patients deal with grief and mourning in the on-line forum as we have demonstrated in another case report.¹⁰ As the only medical doctor in the current team of 50 counsellors (others have graduate degrees in social work and psychology), I tend to be assigned clients facing issues with a medical flavour. Many patients in recent years have discussed coping with cancer or the effects of cancer on their families. Other clients have focussed on heart disease, diabetes, chronic neurological disorders and dementia in loved ones. Each story is unique but the principles of patient-centered care with a family orientation can be applied as they are in the office visit for similar issues.

Some problems are less appropriate for e-counselling. There are concerns about missing non-verbal cues, or failing to identify the patient in danger. There are safeguards in place on-line although these don't always work in the in-person encounter either. Patients requesting e-counselling are screened for suicidal risk, risk of harm from others, addictions or formal thought disorders. There is a low threshold for referral to traditional services although the numbers of patients denied access to e-counselling for these reasons is small. Some patients facing toxic issues arising during e-counselling have been helped successfully to overcome them with a transition to traditional helping services.

A pilot e-counselling project has started in Portugal in the health care region of West Porto. Pioneering clinical psychologists have started to provide on-line written counselling services to employees in this region. Initial evaluation of the service has been positive. This will remain a tool in the range of services available for employee assistance here.

For this technique to develop further, family doctors need additional training in counselling skills in the office setting. Specific writing and on-line skills need to be developed to translate counselling skills to the electronic medium. Legal, insurance and data security issues need to be addressed so that doctors and patients can enter into a therapeutic on-line relationship with confidence.

Electronic counselling has shown itself to be a viable therapeutic option in many settings around the world. Portugal possesses the human resources and technical infrastructure to make this happen too. This journal would be pleased to promote this development by publishing the results of case studies, educational programs and research trials of this exciting new treatment method.

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I have been an e-counsellor with Shepell fgi since 2004 but I have no financial interest in the publication of this editorial.

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ENDEREÇO PARA CORRESPONDÊNCIA

yonahyaphe@hotmail.com