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Short Communication

Continuity of Care Versus Episodic Care

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Abstract

Continuity of care is a key element in the care of people regardless of the level of care at which they may be treated. However, there is confusion and a lack of data. There are numerous statistics on the length of the patient list seen by the general practitioner (GP), minutes per patient, drug use, pharmaceutical expenditure, referral rates, and expenditure on additional tests, etc., but how much data is there on the average time a GP remains in the same practice within the healthcare system? How does the permanence of the same GP in the same practice affect the care dynamics? What factors explain the higher or lower turnover of GPs in certain practices? What can be done to encourage this permanence (if it is to be encouraged at all)? This remains an "invisible" issue.

Keywords: continuity of patient care; primary health care; physician-patient relations; metaphor; general practitioner

Introduction

Continuity of care, a concept associated with the doctor-patient relationship, is one of the great strengths of general practice. There is overwhelming evidence of its usefulness: it improves clinical outcomes, fewer hospital admissions, a reduced mortality rate, reduced risks of complications, reduces demand and attendance, benefits health, longevity, is cost-effective with more efficient use of healthcare resources, improves prevention and epidemiological intervention, and increases both patient and physician satisfaction [1-8]. Although little or no improvement in other health indicators has also been reported, and poses numerous difficulties, significant methodological heterogeneity in some studies limits the ability to meta-analyze the findings [9, 10]. To understand various healthcare and medical concepts, sports metaphors have frequently been used: tennis, golf, soccer, etc. [11-13]; the same can be applied to continuity of care, as we will see later. General medicine is defined in terms of relationships, rather than in terms of diseases or technology. The continuity of relationships between GPs and patients in their setting, even if tacit, builds trust and creates a therapeutic, curative context [14]. For GPs, continuity implies a longitudinal relationship between patients and their caregivers, which transcends multiple episodes of illness and includes responsibility for preventive care and care coordination. Ideally, this longitudinal relationship evolves into a strong bond between doctor and patient, characterized by trust, loyalty, and a sense of responsibility [15]. When GPs see the same patient's day after day with a variety of problems, they acquire considerable personal understanding of them, which can help manage subsequent problems. At each visit, within the context of the continuum of care, GPs build an effective long-term relationship with each patient as a building block for their work together, and they use this relationship for its healing potential. So, GPs, using personal self-awareness, as well as the basic tools of effective relating: positive acceptance, empathy, being genuine, attend to the whole patient and their needs without always having to interpret or intervene. Doctors recognize that different patients require different approaches and use themselves in different ways to meet and resolve patients' needs. The evolution of the doctor-patient relationship over time allows the doctor to see the same patient with different problems in different settings over years and also to see the patient through the eyes of other family members [16]. It has been suggested that continuity of care is a luxury needed only by a subset of complex patients, while everyone else will be fine seeing any doctor. However, we don't always know from the outset who or what will be complex. We can guess that older patients or those with multiple diagnoses will be in this group, but also patients with mental health conditions or families with safeguarding needs. Even with physical diagnoses, complexity is not always obvious at first glance: the teenager who vomits may have self-limited gastroenteritis, or it may be the first presentation of diabetes or an eating disorder. Night sweats and insomnia may be menopause, but they could be symptoms of lymphoma. If I already know my patients, I am more likely to recognize when they are ill [4, 17]. Therefore, it must be emphasized that continuity of care is one of the main distinguishing features of general medicine. Continuity of care is a situation where the general practitioner and primary care team maintain control over a patient over time, even though the patient may have various diagnoses and be treated by different physicians. It

could be compared to that play in soccer, in which a player and a team maintain control of the ball, passing it in a calculated and planned manner to various players, who return the ball to each other while simultaneously breaking away from their opponents, thus positioning themselves in advantageous positions to score a goal. In contrast, episodic care is one of the main features of secondary medicine or hospital care (including outpatient consultations with hospital specialists: digestive specialist, cardiologist, pulmonologist, urologist, endocrinologist, ENT specialist, ophthalmologist, neurologist, etc.). Episodic care is a situation where a medical specialist or subspecialist treats a specific episode of a patient's illness: acute heart failure, pneumonia, stroke, myocardial infarction, etc. Once the patient's symptoms improve, they are discharged from the hospital or outpatient clinic, so, in principle, the patient is not seen again. Furthermore, 1) during that or those episodic visits, the specialist focused on a health problem that falls within their specialty and failed to consider the patient's other potential problems (so the GP subsequently has to perform integration work to achieve a holistic view); and 2) the hospital specialist failed to take the patient's context into account (so the GP subsequently has to contextualize those recommendations or treatment for the patient upon discharge from the hospital to place them in the patient's real-life context). This episodic care could be compared to a soccer play in which a player kicks the ball hard, without planning its trajectory or calculating which other player the ball is aimed at, sometimes going out of bounds, or landing at the feet of a player from the opposing team, or colliding immediately with the body of a player from the same team. It is a crude or crude play, indicating little planning for the future game, and can only be justified as a last resort in desperate situations. Furthermore, beyond the GP consultation, the boundaries between healthcare levels are artificial. They are due more to the pure organization of work-related services than to the real needs of individuals and families. However, since they exist, it is logical that coordination between healthcare services overcome them to offer care precisely to users [18]. However, in practice, continuity of care remains "invisible"; there is a gap between responding to users' demand for continuity of care and the expectations of professionals to fulfill their professional responsibilities. In order to implement continuity of care strategies, healthcare organizations tend to establish different organizational mechanisms such as professional training, planning and decision-making, medical record information systems, or interdisciplinary work through protocols, which continue to focus on professional satisfaction rather than on the real needs of patients. Ultimately, continuity of care must become a priority objective for any healthcare system, and we must move toward structures that meet the needs and demands of patients if we want to win the match by playing excellently.

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