# Continuity of care as a core value in general practice;
## Rock solid or on the edge of the cliff?

22nd NCGP in Stavanger June 2022
Associate Professor & GP Bente Prytz Mjølstad

The NTNU General Practice Research Unit located near by St Olavs hospital


Regular GP at Saksvik GP office since 2014

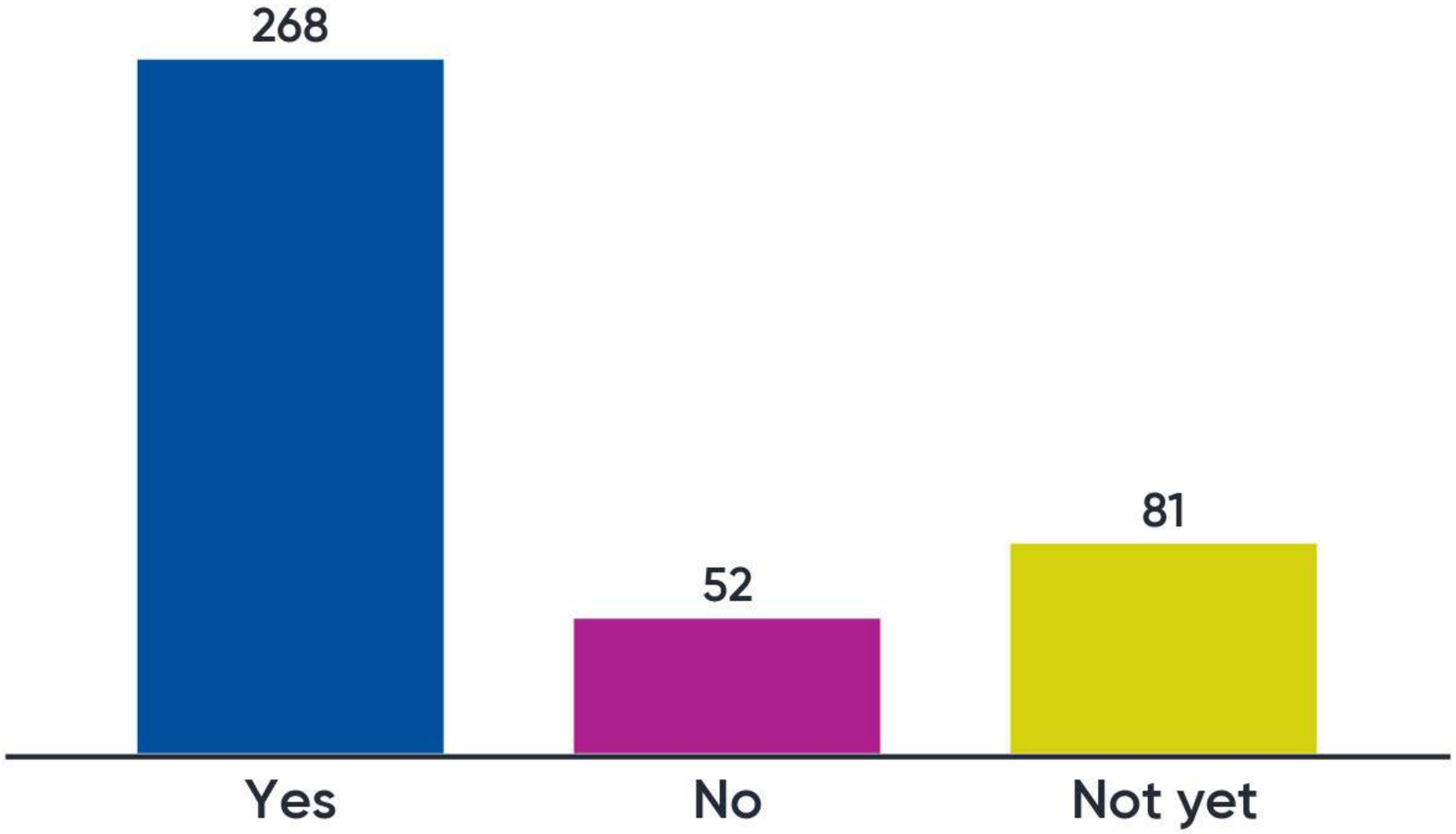
The Norwegian Regular GP service established in 2001

COI declaration, according to the EACCME accreditation rules;
I have no actual or potential conflict of interest in relation to this presentation

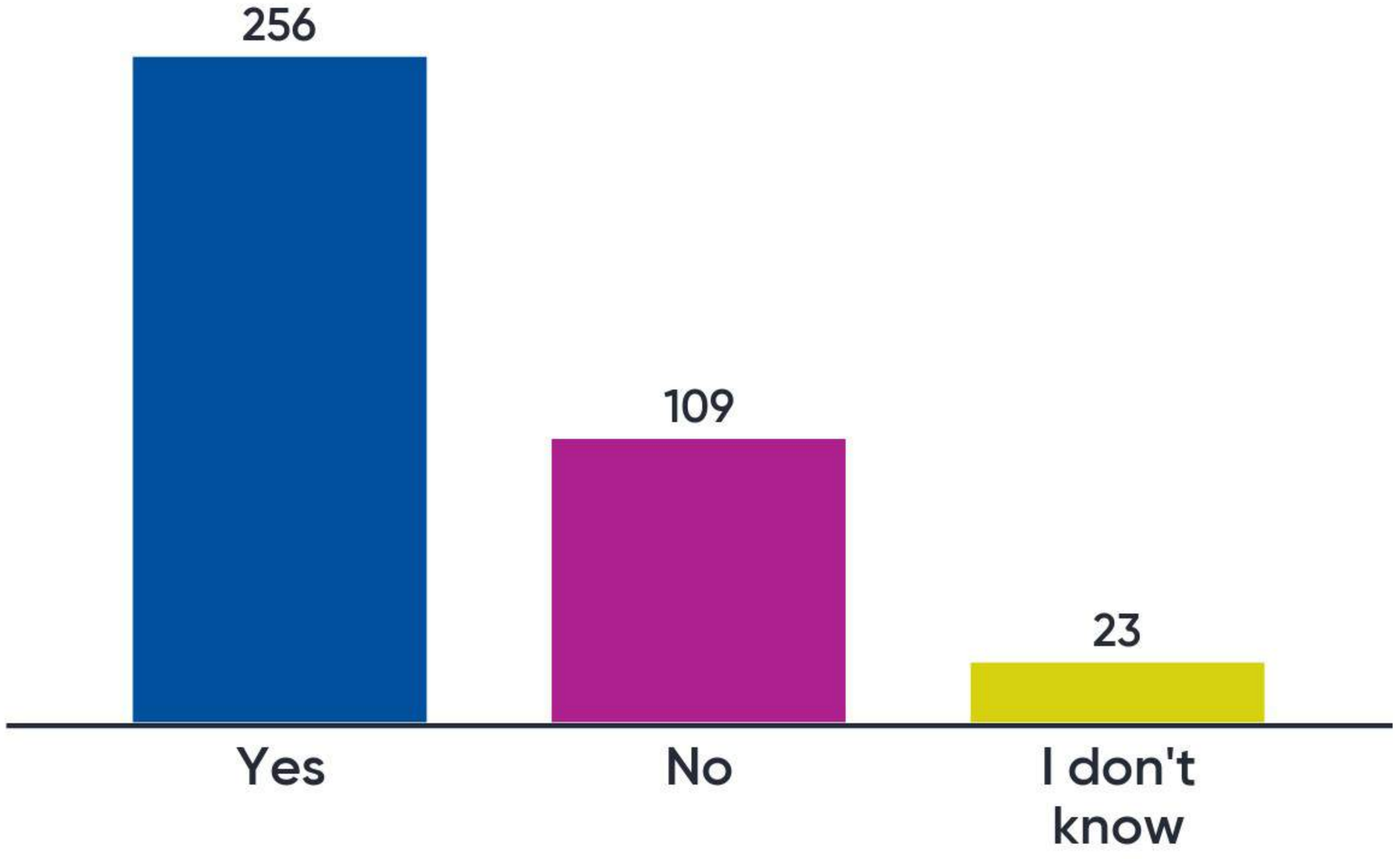
# How are you feeling to day

# What country are you from

# Are you a specialist in general practice



# Do you work in a patient list system

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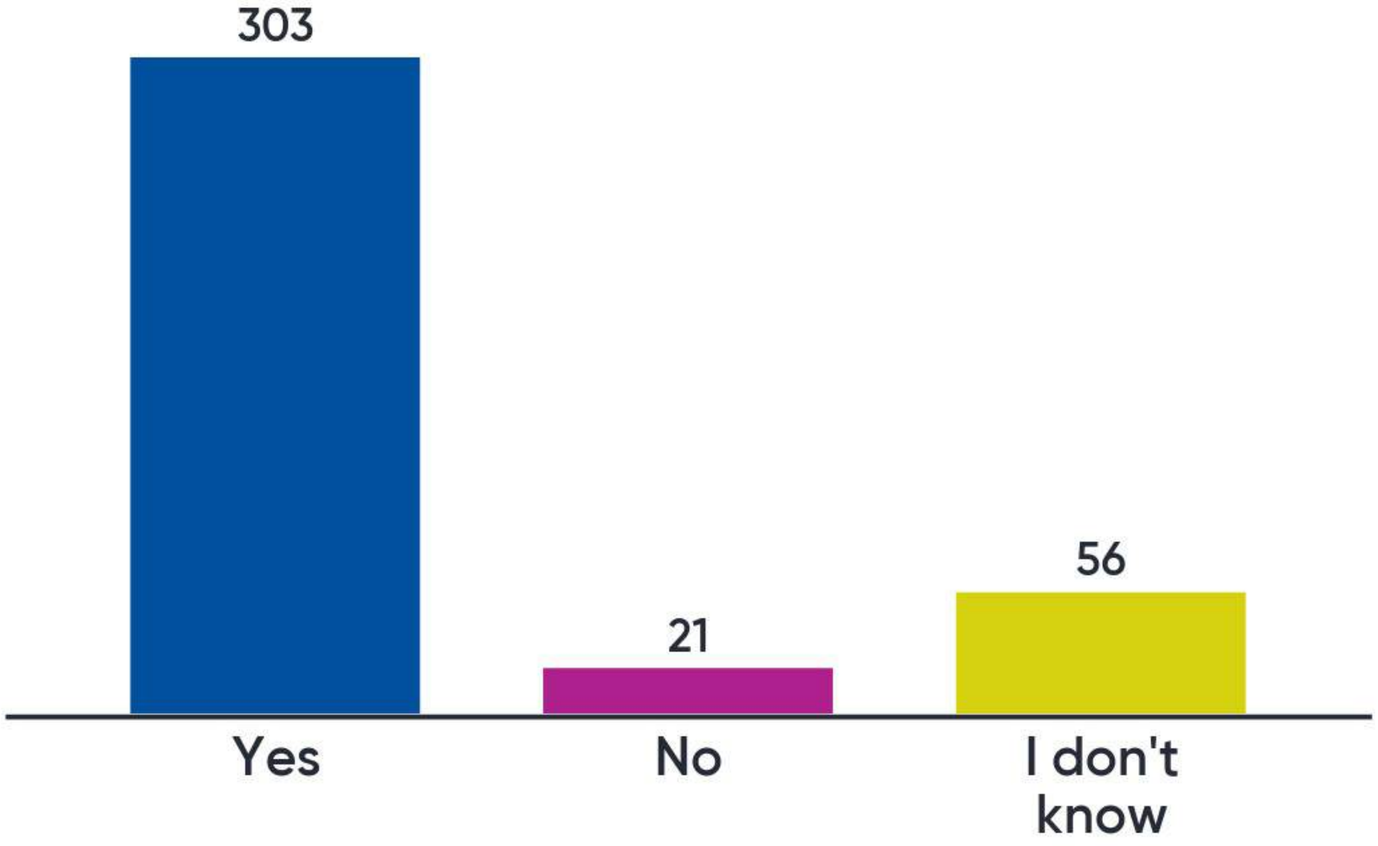
# Would you prefer to work with a personal list of patients



# Continuity of care
# at the heart of general practice

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# What is the first word that comes to mind when you think of continuity of care

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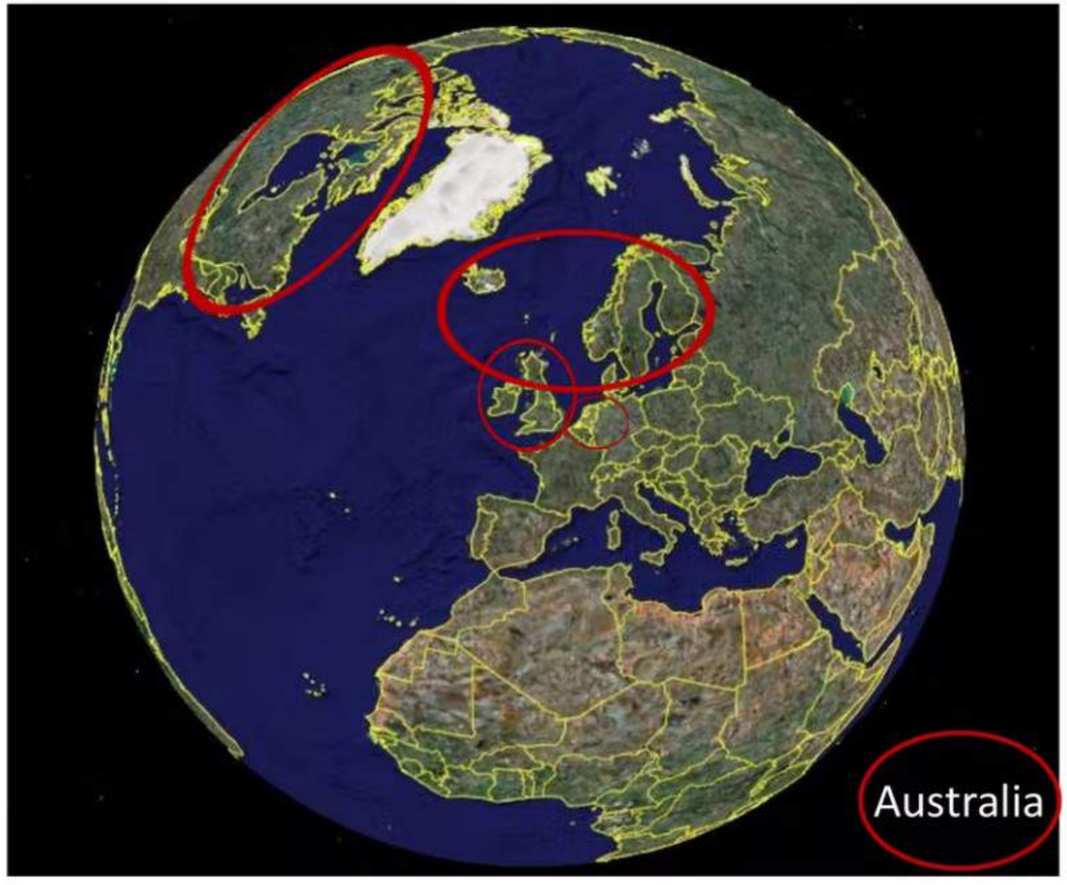
# General practice in a strong position



# Continuity of care – The nr. 1 Core value

**CORE VALUES AND PRINCIPLES OF NORDIC GENERAL PRACTICE/FAMILY MEDICINE**

| | | |
|---|---|---|
| 1. | We promote continuity of doctor-patient relationships as a central organising principle. | The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality person-centred care. |
| 2. | We provide timely diagnosis and avoid unnecessary tests and overtreatment. Disease prevention and health promotion are integrated into our daily activities. | We care for our patients throughout their lives, tending to them through disease and suffering while encouraging progress toward health. We help patients understand their own health – to confront and manage their limitations, improve and maintain their well-being.<br>Overexamination, overdiagnosis, and overtreatment can harm patients, consume resources and indirectly lead to harmful underdiagnosis and undertreatment elsewhere. When equally effective interventions are available, we choose those that cost less. |
| 3. | We prioritise those whose needs for healthcare are greatest. | We aim to minimise inequalities in how health services are provided. We organise our practices to devote the most time and effort to those whose needs for treatment and support are greatest. |
| 4. | We practice person-centred medicine, emphasising dialogue, context, and the best evidence available. | We engage professionally with our patients' current life situations, biographical stories, beliefs, worries, and hopes. This helps us to recognise the links between social factors and sickness, and to deepen our understanding of how life and life events leave their imprint on the human body. We promote patients' capacity to make use of their individual and communal resources.<br>To safeguard our long-term resilience as caregivers, we attend to our own well-being. |
| 5. | We remain committed to education, research, and quality development. | We engage actively in the training of our future colleagues. We implement and promote research that is suited to the knowledge needs of General Practice/ Family Medicine. We take a constructively critical view of new knowledge and approaches within our areas of specialisation. |
| 6. | We recognise that social strain, deprivation, and traumatic experiences increase people's susceptibility to disease, and we speak out on relevant issues. | Respect for human dignity is a prerequisite for healing and recovery.<br>We acknowledge that many circumstances contribute to health inequalities: childhood experiences, housing, education, social support, family income/ unemployment, community structures, access to health services, etc.<br>We recognise our duty to speak out publicly on specific factors that cause or worsen disease, increase inequality in health outcomes, or make resources less accessible to certain people. |
| 7. | We collaborate across professions and disciplines while also taking care not to blur the lines of responsibility. | We engage actively in developing and adapting effective ways to cooperate. |

Read more about The Nordic Federation of General Practice on **www.nfgp.org**

**1. We promote continuity of doctor-patient relationships as a central organising principle.**

The doctor-patient relationship is based on personal involvement and confidentiality. Continuity of care helps build mutual trust and enable high-quality person-centred care.

# My colleagues at Saksvik GP office

# Different types of continuity of care

**Interpersonal**

**Geographical**

**Team**

**Informational**

# The interpersonal continuity

*"In hospitals, the diseases stay and the people come and go*

*In general practice, the people stay and the diseases come and go"*

Iona Heath, GP for 35 years and Past President of the UK Royal College of GPs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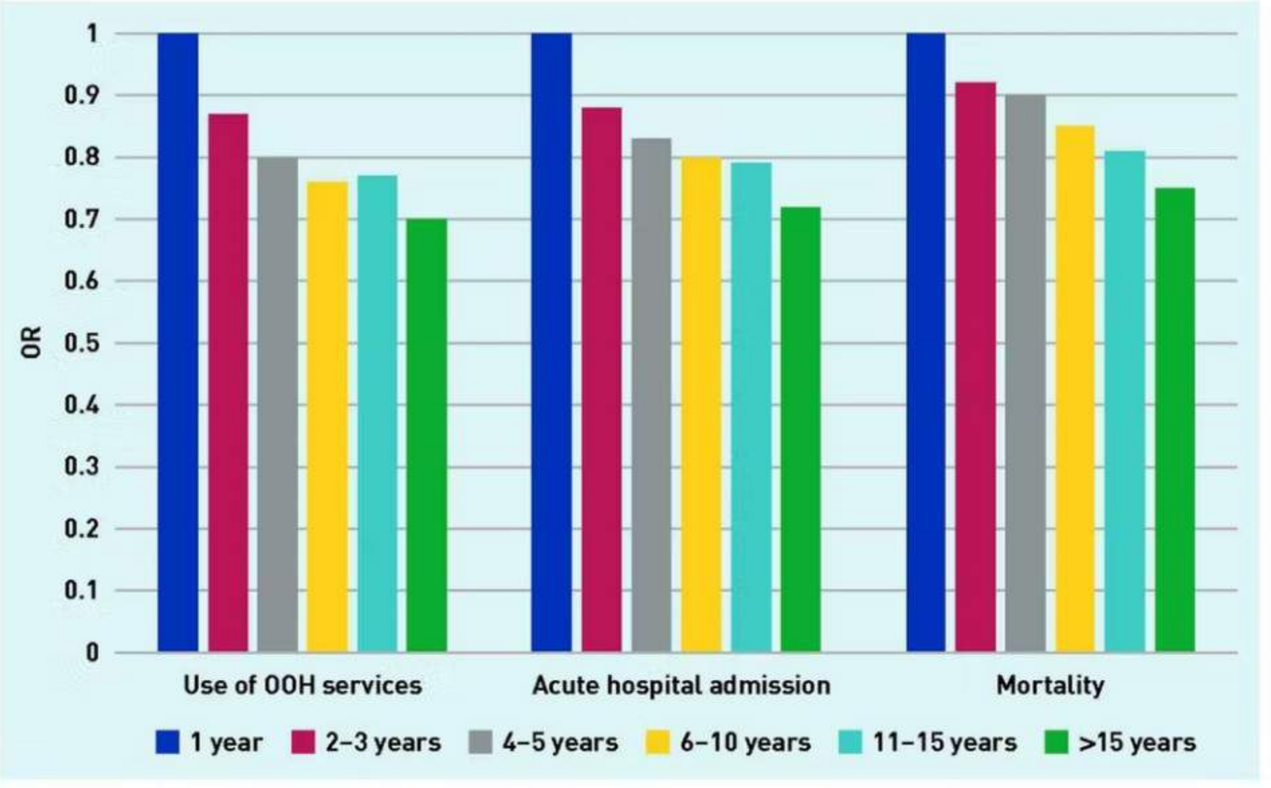
What is rock solid about continuity of care?

# Rock solid «evidence» for continuity of care

# A dose-response effect of continuity of care




British Journal of General Practice, February 2022

# Personal longitudinal GP- patient relationships
# It's about getting to know patients – as persons

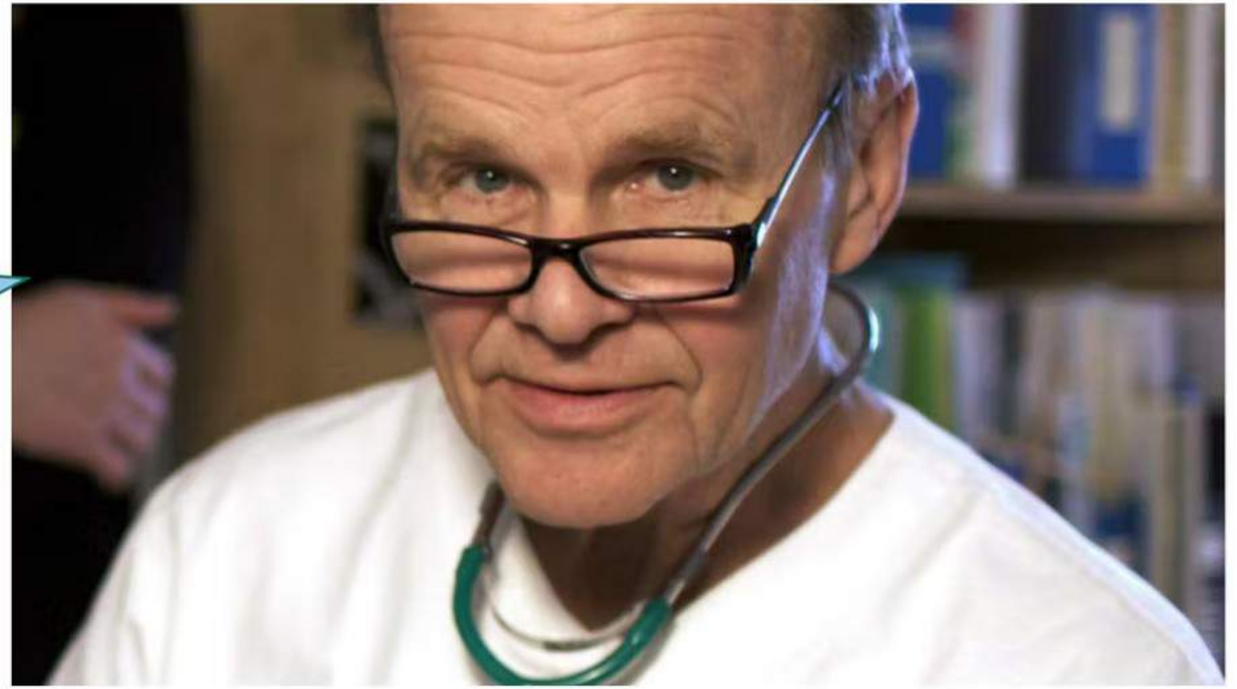
The quality of the relationship is important; it is not merely about seeing the same GP

A matter of trust; it takes time to build trustful relationship

GPs accumulate important and extensive medical, contextual and biographic knowledge about their patients

GPs know their patients' personal characteristics; enables GPs to tailor treatment and follow up

*«Patients sharing their «trifling troubles» teach us to know them, so we're able to recognize, suddenly, when something is seriously wrong!»*



Magnus Eriksson, Swedish GP known from the documentary/TV series "Kvartersdoktor'n"

# The role of GPs' gut feelings in diagnosing cancer

A cancer diagnosis was more likely in patients for whom the GP had a gut feeling

And were reported to be based

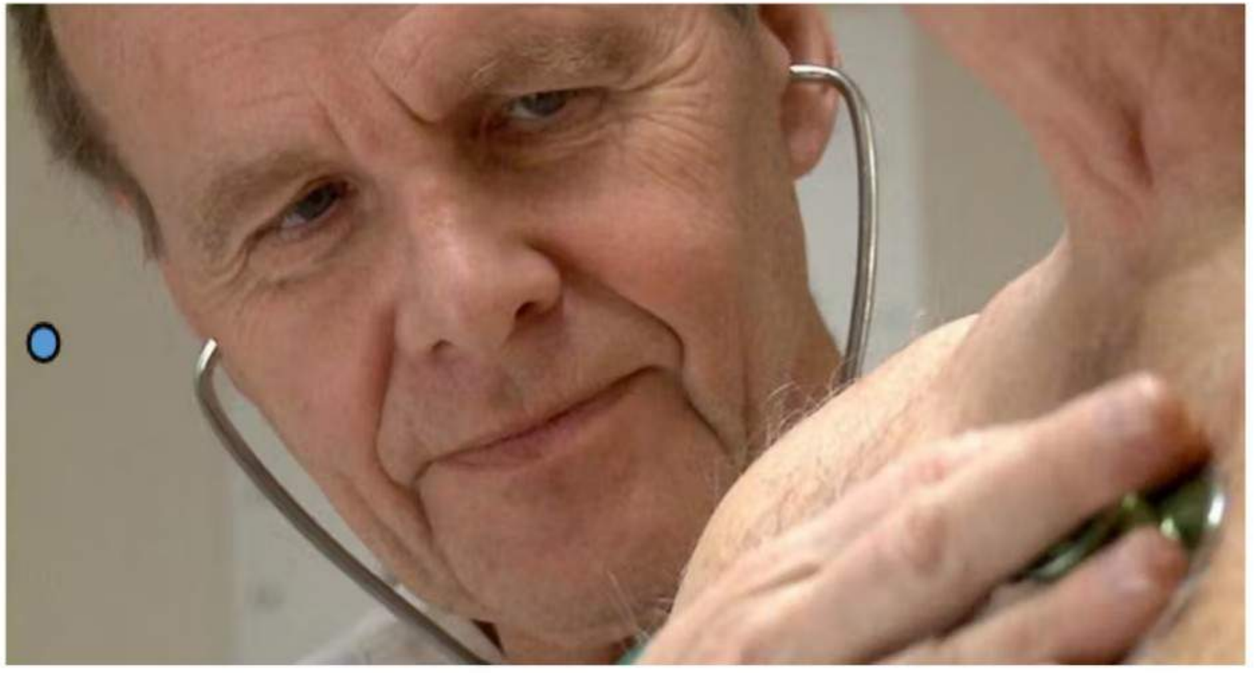
*on deviations from patients' usual*

*presentation or behaviour*


Understanding the role of GPs' gut feelings in diagnosing cancer in primary care: a systematic review and meta-analysis of existing evidence | British Journal of General Practice (bjgp.org)

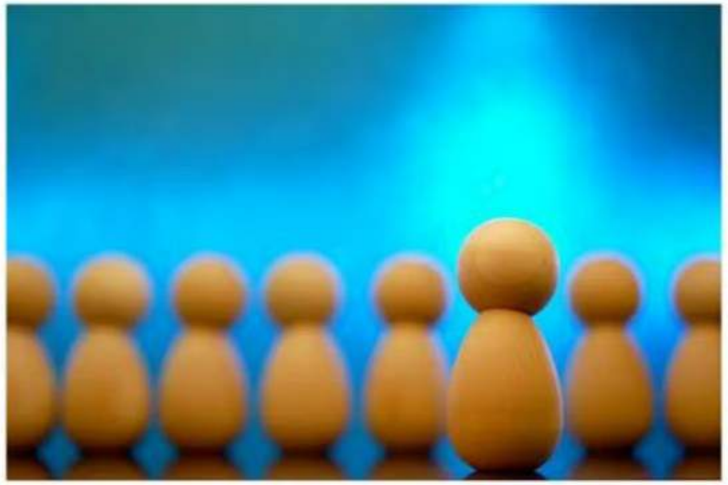
# Referral to the psychiatric ward based on “gut-feeling»…..

“Lars doesn't seem quite in shape today ….”



Dr Eriksson having a gut feeling that «something is wrong»
Often described as a physical sensation;
*“it made the hair stand up on the back of my neck”*

# Does your regular GP know you – as a person? And if so, does it matter?



CauseHealth

November 9, 2017

Health, Illness, Medicine, Whole Person Seminar

biomedical model, patient stories, person centered healthcare

Written by Bente Prytz Mjølstad
(#3 of the Whole Person reflections series)

***Have you ever thought about whether your regular GP knows more about you than your blood pressure or cholesterol levels? If so, might such knowledge be of any medical relevance?***

Most of us visit our regular GP once or twice a year for more or less trivial complaints, and you are probably most interested in the GPs medical skills, and not so concerned about whether the doctor knows you as person or not. However, if you got seriously ill or had a chronic illness, would it still not matter?

# But you'll never get my GP!

"It's only after you have experienced being seriously ill, that you realize how important your GP is…."


Journalist Cato in the local newspaper Adresseavisa

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# Sudden discontinuity of GP care

Open access Original research

BMJ Open

## How does general practitioner discontinuity affect healthcare utilisation? An observational cohort study of 2.4 million Norwegians 2007–2017

Lena Janita Skarshaug ,[1] Silje Lill Kaspersen,[1,2] Johan Håkon Bjørngaard,[1,3] Kristine Pape[1]

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**ABSTRACT**

**Objectives** Patients may benefit from continuity of care by a personal physician general practitioner (GP), but there are few studies on consequences of a break in continuity of GP. Investigate how a sudden discontinuity of GP care affects their list patients' regular GP consultations, out-of-hours consultations and acute hospital admissions, including admissions for ambulatory care sensitive conditions (ACSC).

**Design** Cohort study linking person-level national register data on use of health services and GP affiliation with data on GP activity and GP characteristics.

**Setting** Primary care.

**Participants** 2 409 409 Norwegians assigned to the patient lists of 2580 regular GPs who, after 12 months of stable practice, had a sudden discontinuity of practice lasting two or more months between 2007 and 2017.

**Primary and secondary outcome measures** Monthly GP consultations, out-of-hours consultations, acute hospital admissions and ACSC admissions in periods during and 12 months after the discontinuity, compared with the 12-month period before the discontinuity using logistic regression models.

**Results** All patient age groups had a 3%–5% decreased odds of monthly regular GP consultations during the discontinuity. Odds of monthly out-of-hours consultations increased 2%–6% during the discontinuity for all adult age groups. A 7%–9% increase in odds of ACSC admissions during the period 1–6 months after discontinuity was indicated in patients over the age of 65, but in general little or no change in acute hospital admissions was observed during or after the period of discontinuity.

**Conclusions** Modest changes in health service use were observed during and after a sudden discontinuity in practice among patients with a previously stable regular GP. Older patients seem sensitive to increased acute hospital admissions in the absence of their personal GP.

**Strengths and limitations of this study**

- This study was based on person-level registry data on the entire Norwegian population and their general practitioners (GPs) in the period 2007–2017.
- We had exact dates and objectivity in the ascertainment of outcomes (GP consultations, out-of-hours consultations, acute hospital admissions) and strict criteria for exposure (discontinuity of GP care).
- By following the same patient population over time, we eliminated time-invariant or slow-varying confounding factors related to the composition of patient groups.
- It is possible that the consequences of discontinuity would differ according to the causes of the break, which we were unable to measure due to lack of data.

**BACKGROUND**

Loosing access to your general practitioner (GP) can be emotionally stressful,[1] and patients can be vulnerable during the transition of care from one GP to another.[2] Some discontinuities of GP practice are inevitable, as GPs retire, get sick and take parental leave. A study on American patients forced to change their physician due to healthcare insurance changes, indicated this disruption to be damaging to the patient receipt of quality GP care.[3] Continuity of care is a core value of primary care and general practice, including personal, informational and managerial aspects of continuity.[4] An extensive literature suggest that high continuity of care in general practice reduces hospital admissions,[5–13] readmissions,[10] out-of-hours service visits,[14–16] mortality[17–20] and healthcare costs,[21] but there is little research on how a break in this continuity of care affect patients.

Patients who experience such discontinuity may have reduced access to regular GPs during office hours and shift to out-of-hours services. Also, not being able to see their regular GP could lead to an increase in

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# Video Consultations with the GP

JOURNAL OF MEDICAL INTERNET RESEARCH Johnsen et al

Original Paper

## Suitability of Video Consultations During the COVID-19 Pandemic Lockdown: Cross-sectional Survey Among Norwegian General Practitioners

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### Abstract

**Background:** The COVID-19 pandemic imposed an acute, sharp rise in the use of video consultations (VCs) by general practitioners (GPs) in Norway.

**Objective:** This study aims to document GPs' experiences with the large-scale uptake of VCs in the natural experiment context of the pandemic.

**Methods:** A nationwide, cross-sectional online survey was conducted among Norwegian GPs during the pandemic lockdown (April 14-May 3, 2020). Each respondent was asked to evaluate up to 10 VCs. Basic demographic characteristics of the GPs and their practices were collected. The associations between GPs' perceived suitability of the VCs, the nature of the patients' main problems, prior knowledge of the patients (relational continuity), and follow-up of previously presented problems (episodic continuity) were explored using descriptive statistics, diagrams, and chi-square tests.

**Results:** In total, 1237 GPs (26% of the target group) responded to the survey. Among these, 1000 GPs offered VCs, and 855 GPs evaluated a total of 3484 VCs. Most GPs who offered VCs (1000/1237; 81%) had no experience with VCs before the pandemic. Overall, 51% (1766/3476) of the evaluated VCs were considered to have similar or even better suitability to assess the main reason for contact, compared to face-to-face consultations. In the presence of relational continuity, VCs were considered equal to or better than face-to-face consultations in 57% (1011/1785) of cases, as opposed to 32% (87/274) when the patient was unknown. The suitability rate for follow-up consultations (episodic continuity) was 61% (1165/1919), compared to 35% (544/1556) for new patient problems. Suitability varied considerably across clinical contact reasons. VCs were found most suitable for anxiety and life stress, depression, and administrative purposes, as well as for longstanding or complex problems that normally require multiple follow-up consultations. The GPs estimate that they will conduct about 20% of their consultations by video in a future, nonpandemic setting.

**Conclusions:** Our study of VCs performed in general practice during the pandemic lockdown indicates a clear future role for VCs in nonpandemic settings. The strong and consistent association between continuity of care and GPs' perceptions of the suitability of VCs is a new and important finding with considerable relevance for future primary health care planning.

*(J Med Internet Res 2021;23(2):e26433)* doi: 10.2196/26433

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# GP strategies to avoid imaging overuse

SCANDINAVIAN JOURNAL OF PRIMARY HEALTH CARE
2022, VOL. 40, NO. 1, 48–56
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Taylor & Francis

ORIGINAL ARTICLE

OPEN ACCESS

## GP strategies to avoid imaging overuse. A qualitative study in Norwegian general practice

Karina Ellingsen Walderhaug[a*], Marie Kaltenborn Nyquist[a*] and Bente Prytz Mjølstad[b]

[a]NTNU, Norwegian University of Science and Technology, Trondheim, Norway;[b]General Practice Research Unit, Department of Public Health and Nursing, NTNU, Norwegian University of Science and Technology, Trondheim, Norway

**ABSTRACT**

**Objectives:** The aim of the study was to identify general practitioners' (GPs) strategies to avoid unnecessary diagnostic imaging when encountering patients with such expectations and to explore how patients experience these strategies.

**Design, setting and subjects:** We conducted a qualitative study that combined observations of consultations and interviews with GPs and patients. A total of 24 patients visiting nine different GPs in two Norwegian urban areas were included in the study. Of these, 12 consultations were considered suitable for studying GP strategies and were therefore selected for a more thorough analysis.

**Main outcome measures:** GPs' communication strategies to avoid unnecessary medical imaging and patients' experiences with such strategies.

**Results:** Five categories of strategies were identified: (1) wait and see – or suggest an alternative; (2) the art of rejection; (3) seek support from a professional authority; (4) partnership and shared decision-making and (5) reassurance, normalisation and recognition. The GPs often used multiple strategies. Factors related to a long-term doctor–patient relationship seemed to influence both communication and how both parties experienced the decision. Three important factors were evident: the patient trusted the doctor, the doctor knew the patient's medical history and the doctor knew the patient as a person. The patients seemed to be generally satisfied with the outcomes of the consultations.

**Conclusion:** GPs largely combine different strategies when meeting patients' expectations of diagnostic imaging that are not strictly medically indicated. Continuity of the doctor–patient relationship with good personal knowledge and trust between doctor and patient appeared crucial for patients to accept the doctors' decisions.

**KEY POINTS**

- GPs usually combine a broad range of strategies to avoid unnecessary medical imaging
- The patients appeared generally satisfied regardless of the strategy the strategy used by the GPs and even where their referral request were rejected
- Factors related to a long-term doctor–patient relationship appeared decisive

**ARTICLE HISTORY**
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**KEYWORDS**
Primary Health Care, General Practice, Physician-Patient Relations, Diagnostic Imaging, Communication, Medical Overuse

### Introduction

*Primum non nocere* – first, do no harm – derives from Hippocrates and represents a fundamental ethical principle in medicine. It has gained momentum in recent decades in line with the growing awareness of medical overactivity. This issue has been highlighted internationally through a series of articles such as 'Too Much Medicine' in *BMJ* [1] and 'Less is More' in *JAMA* [2], as well as in several campaigns. Best known is the widespread 'Choosing Wisely' campaign, which originated in the United States, and the Norwegian Medical Association's equivalent 'Gjør kloke valg' [Make wise choices], was launched in 2018 [3].

The definitions of terms related to medical overactivity are often ambiguous. In general, healthcare overuse consists of both unnecessary testing, overdiagnosis and overtreatment. Brodersen et al. described overdiagnosis [4] as 'making people patients unnecessarily, by identifying problems that were never going to cause harm or by medicalising ordinary life experiences through expanded definitions of diseases',

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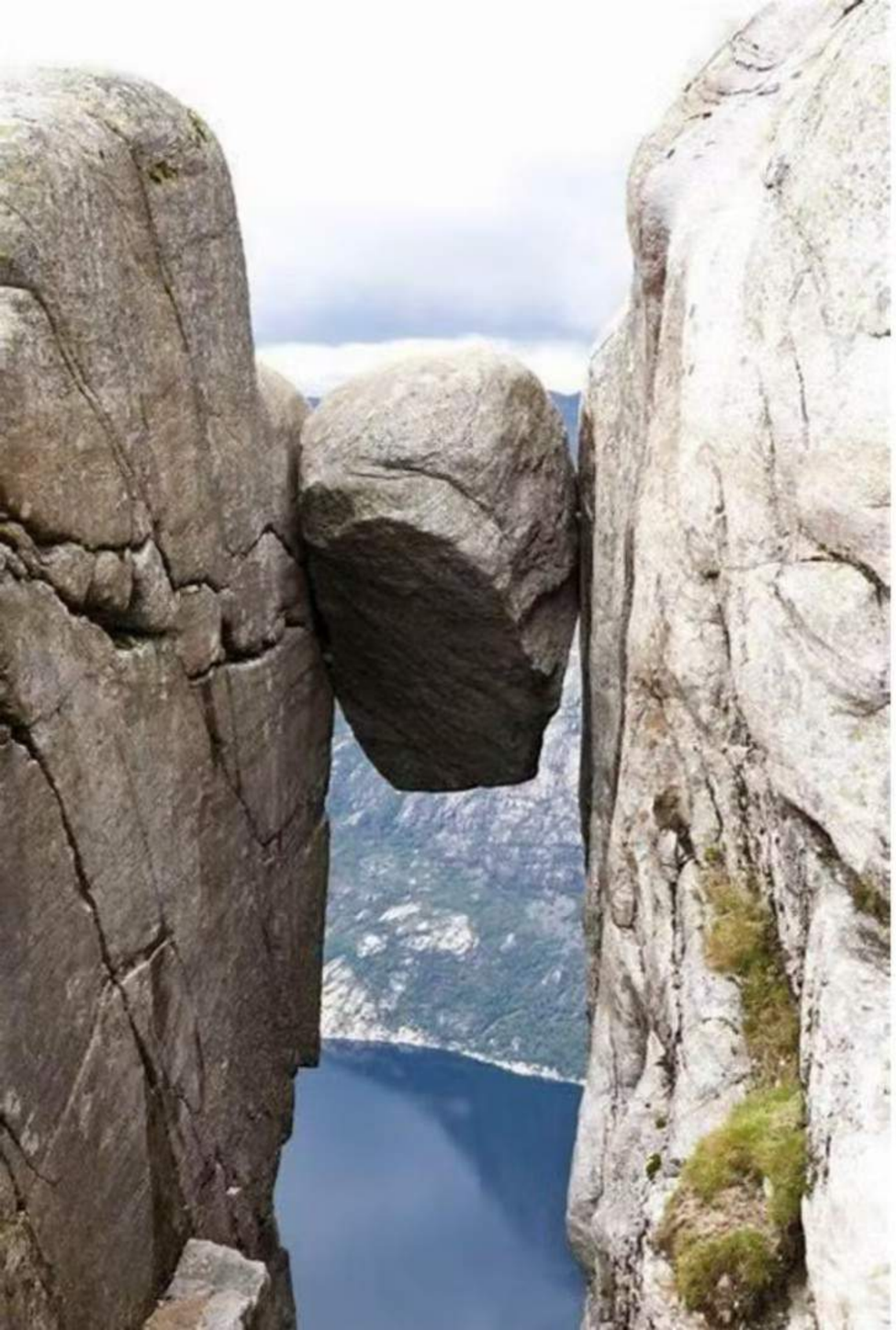
Is continuity of care
- on the edge of the cliff?



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# The GP crisis

The Kjerag bolt

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# The GP crisis

The Hia bolt

# Continuity of care under pressure – will it stand or fall ?


# «It's getting in - that's the problem!»

**No 1 reason for patient dissatisfaction**

Different preferences?

- Younger patients
- Older patients
- Urgent health problems
- Long-term conditions

# Future perspectives..

Norsk medisinstudentforening

Fagforening og interesseorganisasjon for studenter

# Call for Action

## Continuity of Care in General Practice/Family Medicine

The World Health Organization defines primary health care as a cornerstone of cost-effective and sustainable health care systems. General Practitioners/Family Physicians are key medical providers within the primary health care system.

In the context of General Practice/Family Medicine, we define continuity of care as *a longitudinal relationship between a patient/citizen and one doctor of the patient's choice, backed by a team of other healthcare providers.*

Continuity of care is an essential element of high-quality General Practice/Family Medicine. There is good evidence and growing international consensus that continuity of care entails significant health benefits, both for patients and the health care system. It increases patient satisfaction, improves uptake of preventive measures and adherence to treatment recommendations. It decreases the use of out-of-hours care, the need for acute hospitalizations and, ultimately, it is associated with lower premature mortality.

Crucially, continuity within doctor–patient relationships is also good for the wellbeing of doctors.

The above knowledge is embedded in the 2020 statement on *Core Values and Principles of Nordic General Practice/Family Medicine* issued by The Nordic Federation of General Practice.

**The 22nd Nordic Congress of General Practice, held in Stavanger 21st - 23rd of June 2022, encourages politicians and all other stakeholders of the health care service to support and facilitate health systems that promote relational continuity. This implies that all patients should have access to a General Practitioner/Family Physician of their own choice, together with a team of health care providers who know them and their circumstances.**

Stavanger, June 23rd 2022.

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The Shoemaker's Crag - the third big-wall peak in Rogaland