Continuity of care

A challenge during the COVID-19 pandemic

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The COVID-19 pandemic has seen a loss of continuity of care in general practice, with impacts on patient care, including missed preventive health opportunities, delayed diagnosis and over-investigation, as well as GP burnout. As the pandemic continues, GPs need to be supported to maintain continuity of care to achieve the best outcomes for their patients and themselves.

The opportunity to provide continuity of care to patients is part of the appeal and strength of general practice. As the COVID-19 pandemic continues to change the face of healthcare worldwide, loss of continuity of care has been a challenge for both patients and GPs. The ability to provide longitudinal care enables GPs to develop an ongoing therapeutic relationship with patients, which carries multiple benefits including reduced mortality, increased patient adherence to treatment and increased patient satisfaction regarding their care.[1,2] Continuity of care also includes the continuity of medical records and co-ordination of management, which results in decreased hospitalisations and improved patient outcomes.[3] The ability to provide continuity of care also has benefits for doctors, as the doctor-patient relationship is a key reason for GPs choosing to stay in this specialty.[4,5]

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Why has continuity of care been lost during the COVID-19 pandemic?

Throughout the COVID-19 pandemic, GPs have endeavoured to maintain and promote continuity of care. Several factors, however, have made this challenging. First, patients may have been avoiding presenting to a GP clinic because of concerns about COVID-19 exposure. The proportion of people who reported that they delayed or did not see a GP when needed because of COVID-19 was 9.8%.[6] Second, some GPs are providing either solely or primarily telehealth consultations. There are multiple potential reasons for this, including inadequate personal protective equipment and concern over their own health risks, such as significant COVID-19 illness due to increasing age or immunocompromised status. When face-to-face consultations have been necessary, GPs who only provide telehealth have needed to direct their patients to others for part or all of their care, which can impact continuity and strain the therapeutic relationship. Third, the COVID-19 pandemic has exacerbated workforce resource shortages, both of GPs and supporting staff. The increased workload from mental health presentations alone has been a challenge for GPs to navigate, as these are rarely 'short' consultations.[7] In addition, GPs have been key deliverers of vaccines, with over 50% of COVID-19 vaccinations being in primary care settings.[8]

The given increased volume of work for GPs has meant that patients who have struggled to see their usual GPs in a timely manner may instead opt to see 'any GP', which risks fragmentation of their care. It has also contributed to the phenomenon of GPs experiencing burnout: in a survey in May 2021, half of GPs reported at least one negative impact to their wellbeing because of COVID-19.[9]

Why does it matter if there is decreased continuity of care?

Missed preventive health opportunities

GPs aim to identify and manage risk factors before they cause disease. For example, an appointment for 'just a quick script'

1. CASE STUDY: A WOMAN EXPERIENCING NAUSEA

A woman in her 60s has a telephone consultation for nausea and requests a medical certificate for the day off work after 'eating something dodgy yesterday'. The next day she has another telephone consultation as she is not feeling better, and her GP is able to convince her to attend the clinic for a review (she has been hesitant because she does not want to risk exposure to COVID-19). On examination, she is noted to have an irregularly irregular pulse. She has been feeling unwell due to her undiagnosed atrial fibrillation.

could result in a new diagnosis of hypertension, identify a missed cervical screening test or mammogram, or a discussion about a screening bone mineral density test. Identification of risk factors for disease is an important part of preventive care, and the diagnosis of risk factors is rarely the reason a patient books an appointment.

One of the stop-gap measures introduced early in the COVID-19 pandemic to support continuity of care was a Medicare Benefits Scheme rebate for telehealth consultations. This was well received by both patients and GPs. However, it is not without some downsides. It can be difficult to establish doctor-patient rapport outside of a face-to-face setting, which can contribute to patients feeling less secure in disclosing concerns and symptoms. Risk factor identification is also more difficult when exclusively using telehealth consultations. Simple measures such as checking a blood pressure reading or feeling if the pulse rate is regular can identify a risk factor for disease and prompt discussion about risk factor modification. A case study illustrating the importance of physical examination in general practice consultations is provided in Box 1.

Delayed screening is another concern. Available data suggest that patients are presenting less frequently for screening tests – for example, the number of breast cancer screening mammograms performed through BreastScreen Australia fell by over 145,000 during the first six months of 2020 compared with the same six months in 2018.[10] The BreastScreen program was impacted by a suspension of services during the first wave of the COVID-19 pandemic, and the number of screening mammograms increased when services were able to resume.[10] People with cancer who are diagnosed through national cancer screening programs in Australia usually have better survival rates than those who are diagnosed after symptoms develop.[10] By the time a cancer is symptomatic, it may have progressed to a stage that is more difficult to treat. The long-term effect of delayed or missed screening will take years to be quantifiable, although modelling being carried out may help with healthcare planning and resource allocation.[11]

Self-diagnosis and delayed diagnosis

Before the COVID-19 pandemic, it was not uncommon for patients to present to their GP having researched their symptoms online, prepared to discuss their self-diagnosis with their GP. About 80% of internet users reported that they have sought health advice on the internet.[12] 'Symptom checkers' are readily available online, and there are numerous social media pages dedicated to health and wellbeing.

Depending on where a patient lives in Australia, they may have experienced extended lockdowns, increased isolation, loss of employment and GP clinic closures. These factors may have contributed to their seeking medical diagnoses online without the crucial next step of the diagnosis being reviewed by a trained medical professional. The issue with this, of course, is that online 'medical advice' is often inaccurate.[13] When the self-diagnosis is wrong, subsequent actions that patients take, such as delaying correct diagnosis or using inappropriate treatments, could lead to harm, such as delaying correct diagnosis or using inappropriate treatments. A case study illustrating this is provided in Box 2.

2. CASE STUDY: A WOMAN WITH DYSURIA

A woman in her 50s has several days of dysuria, which she self-diagnoses as a bladder infection and treats with cranberry juice. She develops a fever and flank pain but her regular GP is at home awaiting COVID test results, and she does not want to see another GP. She is subsequently taken to the Emergency Department via ambulance with urosepsis, which results in hospital admission for several days. This could have been prevented with early GP review, correct diagnosis and appropriate antibiotics.

Overdoing it

Another issue to consider is overinvestigation and its sequelae. In face-to-face consultations, a patient will often present expecting a prescription, pathology request, imaging request or specialist referral. However, after a targeted history and examination, all that may be required is discussion, reassurance and observation. This becomes a challenge in a telehealth consultation: without being able to perform a physical examination, further investigation can become a default. For example, if you cannot assess clinically for signs of anaemia, you may email the patient a request for a full blood count and iron studies. This risks unnecessary overinvestigation, overdiagnosis and overtreatment, with resulting increased costs to individuals and society.[14] Such a scenario is described in Box 3.

GP burnout

Several factors have been contributing to potential GP burnout since the start of the COVID-19 pandemic. As well as the increased workload, challenges include the constantly changing

3. CASE STUDY: A MAN WITH A COUGH

A man in his 40s with seasonal asthma runs out of his preventer puffer and is unable to see his usual GP for a prescription. He attends a different GP, who does not know him, via telehealth. When the GP hears he has a cough, despite his insistence it is because he has run out of his preventer, she orders a COVID-19 test (which is appropriate given her lack of context and relationship with the patient). When the COVID-19 nasopharyngeal PCR swab is collected, he starts to bleed at the swab site and develops an infection there several days later, which requires several courses of antibiotics. The infection is slow to settle, so an ENT specialist organises a CT scan to rule out a retropharyngeal abscess. The patient has an anaphylactic reaction to the contrast used for the scan and requires admission to the Intensive Care Unit.

guidelines around testing and immunisation. GPs often learn about updates to these guidelines from the media or patients before receiving any official advice, contributing to uncertainty and frustration.

Additionally, GPs have been threatened by patients about provision of COVID-19 immunisations, testing and immunisation exemptions, as widely reported in the media. GPs have also been targeted by antivaccination groups with threatening letters, online vitriol, and verbal abuse and threats in their clinics.

GPs provide more than double the number of episodes of care per year than hospitals for one-sixth of the expenditure, yet they report lack of recognition of their value as a significant concern.[9,15]

Data from the United Kingdom suggest GPs are leaving general practice at a rate of three doctors per day, and additionally indicate a 20% increase in reports of burnout.[16] It will take time for the data to reflect how many GPs have decided on leaving medicine due to burnout in Australia, but it has certainly added, and continues to add, additional stress to the profession.

Continuity of care – where to from here?

Beyond the direct effects of COVID-19, it will take years for the effects of reduced screening, later diagnoses and reduced active management of risk factors and chronic health conditions to be fully appreciated. Additionally, at a time when misinformation is capable of spreading rapidly worldwide, having access to a regular GP to provide reliable information is arguably more important for patients than ever. Continuity of therapeutic patient-GP relationships should therefore be a priority (Box 4).

We need to rethink and re-imagine healthcare delivery in general practice. Even before COVID-19, there was a call to improve the understanding of what patients need from their GP to benefit more from the therapeutic relationship. For example, patients may not necessarily need a single GP; a small practice team (e.g. two or three GPs and nurses) may facilitate continuity while being flexible enough to suit current work practices in primary care.[17] We should also consider how input from a wider healthcare team can be involved with ongoing care relationships. This includes linking secondary and tertiary care sectors with the general practice the patient attends, through shared care planning and community care teams.[18]

Continuity of medical record keeping and co-ordination of complex disease management should also be a focus of improving healthcare delivery. As a nation, we have invested heavily in developing the national 'My Health Record', and although there are legitimate concerns and caveats around its use, we do need to find a role for it to provide optimal benefits to patients. There is potential for it to reduce unnecessary pathology testing and improve sharing of health information between health providers.[18]

4. A PRACTICE POINTS ON CONTINUITY OF CARE DURING COVID-19

- Continuity of care in general practice enhances patient care and improves the therapeutic relationship.
- The COVID-19 pandemic has caused disruptions to continuity of care in general practice.
- Continuity of care is influenced by patient and clinician factors.
- Preventive healthcare should not be forgotten during the COVID-19 pandemic.
- Flexibility in healthcare arrangements and a wider healthcare team are key to enabling continuity of care.
- GPs need support to navigate the increased workload resulting from the pandemic and the loss of continuity of care.

Conclusion

The risk of burnout in the GP workforce is real and of great concern – without a healthy and functioning primary care workforce, continuity of care will be impossible. Almost one in five Australian GPs have indicated their intent to stop working in the next five years, and this loss will not be offset by new GP trainees entering the specialty if current trends continue.[9,19]

COVID-19 will be around for years to come and returning to previous ways of practice may not be sustainable. Innovative and collaborative approaches are needed to help GPs resume their previous workloads (preventative care, chronic disease management, acute care) while also taking on the increased mental health care load, immunisations and 'long COVID' management.

Close monitoring for evidence of effect and broad stakeholder involvement will be pivotal to the success of any new model of care. MT

References

A list of references is included in the online version of this article (www.medicinetoday.com.au).

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