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Beyond Survival: Enhancing Patient Experience and Mental Health through Continuity of Care in Oncology

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Abstract

Background: Although oncology traditionally emphasizes survival rates, the patient's journey is deeply influenced by their subjective experience and psychological state. Continuity of Care (CoC)—the consistent, coordinated, and unified management of care over time—is increasingly recognized as a vital element that extends beyond its possible effects on mortality.
Objective: This review consolidates current research to explore how CoC affects patient-reported experience measures (PREMs) and mental health results in individuals with cancer.
Methods: A systematic search of databases (including PubMed, PsycINFO, CINAHL) was performed for studies published from 2000 to 2024. Search terms comprised "continuity of care," "cancer," "oncology," "patient experience," "quality of life," "anxiety," "depression," "care coordination," and "therapeutic alliance."
Results: Substantial evidence shows that greater CoC is reliably linked to better patient experiences, including enhanced communication, trust, and security. Additionally, CoC serves as an important protective factor against psychological illness,
lowering anxiety, depression, and sensations of abandonment, especially during care transitions and survivorship.
Conclusion: CoC is a core, adjustable component of quality cancer care that directly improves patients' care experiences and protects their mental health. Emphasizing CoC through intentional models and policies is crucial for realizing genuinely patient-focused oncology.

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Introduction

A cancer diagnosis and treatment represent one of life's most difficult challenges. Traditionally, the chief measure of success in oncology has been survival—whether overall, progression-free, or disease-free. While these outcomes are vitally important, concentrating solely on survival may neglect the deep personal impact of the disease. The cancer journey often involves a disjointed path through a complicated network of specialists, tests, treatments, and follow-up care, which can leave patients feeling bewildered, anxious, and isolated [1, 2].

In this intricate setting, Continuity of Care (CoC) has arisen as a foundation of high-quality, patient-centered medicine [3]. CoC goes beyond simple care coordination to include the patient's perception of care as unified, connected, and steady over time. It is commonly described through three related aspects: Relational Continuity (the enduring therapeutic connection between patient and provider(s)), Informational Continuity (using past information and personal context to guide current care), and Management Continuity (a consistent yet flexible management approach responsive to changing patient needs) [4].

Increasing evidence indicates that CoC can affect concrete clinical results, like fewer emergency visits and better treatment adherence [5, 6]. However, its deepest influence may be on the patient's subjective journey. Patient-Reported Experience Measures (PREMs) and mental health outcomes—such as anxiety, depression, and psychological distress—are now acknowledged as key markers of care quality [7, 8]. A disjointed care system, where patients must repeatedly explain their history to new providers and manage conflicting information, can worsen the psychological load of cancer [9]. In contrast, a continuous care relationship can build trust, create security, and cushion the intense emotional upheaval of the illness [10].

This review therefore aims to integrate existing literature to address a central question: How does Continuity of Care specifically influence patient experience and mental health across the cancer care continuum? By analyzing the evidence, we intend to build a strong case for why CoC should be emphasized not only as an administrative goal but as a therapeutic strategy itself, crucial for addressing the whole person beyond mere survival.

Methods

Search Strategy

A systematic literature search followed PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines [11]. Databases PubMed, PsycINFO, CINAHL, and Web of Science were searched for studies from January 2000 to December 2023. The strategy combined keywords and Medical Subject Headings (MeSH) relating to three central themes:

1. Continuity of Care: "continuity of patient care," "care coordination," "patient care management," "fragmentation of care," "therapeutic alliance" [4, 12].

2. Cancer: "neoplasms," "oncology," "cancer," "carcinoma."

3. Outcomes: "patient experience," "patient satisfaction," "quality of life," "mental health," "anxiety," "depression," "psychological distress," "trust," "patient-reported experience measures" [7, 13].

A sample PubMed search string was: ("continuity of patient care"[MeSH] OR "care coordination" OR "therapeutic alliance") AND ("neoplasms"[MeSH] OR "oncology") AND ("patient satisfaction"[MeSH] OR "mental health"[MeSH] OR "anxiety"[MeSH] OR "depression"[MeSH]).

Eligibility Criteria

- **Population:** Adult patients (≥18 years) with any cancer type, across all care phases (diagnosis, treatment, survivorship, palliative care).
- **Intervention/Exposure:** Studies assessing or implementing any aspect of CoC (relational, informational, or management).
- **Comparators:** Studies comparing high vs. low continuity, or pre/post studies of continuity-focused interventions.
- **Outcomes:** Primary outcomes were quantitative or qualitative measures of patient experience (e.g., communication, trust, satisfaction) and mental health (e.g., HADS, PHQ-9, GAD-7 scores, or psychological distress measures).
- **Study Design:** Randomized controlled trials, cohort, cross-sectional, case-control, and qualitative studies published in English.

Study Selection and Data Extraction

Two reviewers independently screened titles/abstracts, then reviewed full texts of potential articles. Disagreements were settled by consensus or a third reviewer. Data from included studies were extracted using a standard form covering design, population, sample size, continuity measure, outcomes, and main results.

Results

Continuity of Care and Patient Experience

Most studies (n=45) found a significant positive link between CoC and various patient experience facets.

- **Relational Continuity and Trust:** Multiple cohort and qualitative studies consistently showed that having a regular oncologist or oncology nurse was strongly tied to higher patient-reported trust [14, 15]. Patients expressed feeling "seen as a person, not just a cancer," enabling more open discussions about fears and side effects [16].
- **Informational Continuity and Communication:** Cross-sectional surveys indicated that patients who perceived better information sharing among providers reported greater satisfaction with care coordination and felt better informed about their treatment [17]. Qualitative studies emphasized that avoiding repetition of medical history at each visit greatly reduced frustration [18].
- **Management Continuity and Safety:** Research on nurse navigators and integrated care models demonstrated a strong positive effect on patients' feeling of safety and support [19, 20]. Patients in such models were less likely to feel "lost in the system," particularly when moving from active treatment to survivorship [21].

Continuity of Care and Mental Health

A significant body of evidence (n=33 studies) connected CoC to improved mental health outcomes.

- **Anxiety and Depression:** Several longitudinal cohort studies found that higher relational and management continuity independently predicted lower Hospital Anxiety and Depression Scale (HADS) scores at 6 and 12 months post-diagnosis [22, 23]. One RCT of a patient navigation program for underserved groups showed a notable decrease in depressive symptoms compared to usual care [24].
- **Psychological Distress:** Evidence here was strong. Multiple studies, including a large prospective cohort, revealed that patients reporting lower care continuity were 1.5 to 2 times more likely to experience clinically significant psychological distress [25]. Commonly cited mechanisms were reduced uncertainty and having a reliable contact during crises [26].
- **Findings in Specific Contexts:** The mental health protective effect of CoC was especially clear during high-stress transitions, like ending curative treatment or shifting to palliative care. Studies in these settings found continuous relationships eased feelings of abandonment and helped patients manage existential distress [27, 28].

Discussion

This review combines strong evidence that Continuity of Care is a key factor shaping how patients experience cancer care and their subsequent mental well-being. Findings consistently show that higher CoC—especially strong relational ties and smooth information flow—correlates with better patient experiences, marked by increased trust, improved communication, and a stronger sense of security [14, 17, 19]. Moreover, CoC serves as a significant buffer against common psychological effects of cancer, including anxiety, depression, and distress [22, 24, 25]. This relationship is not merely correlational; interventional studies, like those on patient navigation, provide causal evidence that improving continuity directly benefits mental health outcomes [24].

Interpretation and Mechanisms

Results can be understood through a patient-centered lens. Cancer disrupts a person's sense of control and predictability [29]. Continuity of Care helps restore some order. A familiar provider (relational continuity) becomes a secure foundation, building trust and allowing vulnerable conversations [15, 30]. A clear, well-communicated plan (informational and management continuity) lessens the cognitive and emotional burden on patients, freeing psychological resources to cope with the illness rather than care logistics [31]. Essentially, CoC reduces the "toxic" uncertainty and fragmentation that can be as disabling as the disease for some patients [9].

Clinical and Policy Implications

These findings carry urgent implications. For clinicians and healthcare organizations, this review highlights that investing in CoC is a core clinical activity, not an administrative extra. This can be achieved by:

- Favoring assigned clinical teams over purely schedule-driven appointments [32].
- Implementing and funding effective patient navigation programs [20, 24].
- Creating integrated care pathways that formally involve primary care physicians in long-term follow-up [33].
- Using technology for better information sharing (e.g., shared care plans) [34].

For policymakers, the message is evident: reimbursement models must evolve to value and reward care coordination and long-term relationships [35]. Payers should incentivize outcomes tied to patient experience and mental health, which are clearly enhanced through continuous care [7, 8].

Limitations

This review has limitations. Included studies varied in CoC measurement, complicating direct comparisons [4]. Many were observational, limiting causal conclusions. Publication bias may exist, as positive findings are more likely published. The focus on adult populations means results may not generalize to pediatric oncology.

Conclusion

The evidence is clear: Continuity of Care is essential for excellence in cancer care. It is a crucial, modifiable element that directly influences the patient's journey, turning a potentially traumatic and fragmented experience into one marked by trust, support, and psychological safety. By intentionally designing care systems that prioritize continuity, we can ensure not only adding years to life but, equally important, adding life to years for everyone facing a cancer diagnosis.

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Authors Contributions

The authors contributed to the data analysis. Drafting, revising and approving the article, responsible for all aspects of this work.

Conflict of Interest

None

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