Continuity of Care in Family Practice

Part 2: Implications of Continuity

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Continuity of care in family practice cannot be adequately described merely in terms of duration. It is not delineated by the nature of a patient's illness, but involves the family physician's ongoing commitment to the patient and his family as persons. An implicit contract exists between the family physician and the patient. This kind of continuity of care provides several important elements related to patient care, such as the feasibility of long-term observations allowing effective diagnosis with less need for extensive one-time workups, the potential for psychotherapy and counseling through a continuing personal relationship, and the opportunity to perceive illness in the context of the whole person and his environment. Continuity of responsibility by the family physician is achievable despite mobility of some patients and is more a matter of the physician's attitude and style of practice than duration of the doctor-patient relationship.

Continuity of care has been correctly identified as a crucial issue for family medicine. What do we mean by continuity? If we think of continuity of care only in terms of its duration, then family medicine cannot claim to have any monopoly on it. A physician in a diabetic clinic may look after one patient continuously for 20 years. This is obviously not the kind of continuity we have in mind.

Continuity of care in family practice is different in two ways:

1. It is not delineated by the nature of the disease. The family physician's commitment is to a person, irrespective of the type of disease he may be suffering from.

2. Responsibility does not terminate with cure, end of consultation, referral, or end of treatment. It is a *continuity of personal responsibility* which is terminated only by death, by mutual agreement, or by decision of one of the parties. This kind of responsibility implies a contract between doctor and patient. The nature of this contract is, therefore, a central issue for family medicine.

The Medical Contract

Magraw[1] has drawn our attention to the importance of this issue. Human relationships are often governed by contracts, both legal and informal. Contracts are taken for granted between business partners, between employers and employees, and between contractors and clients. Informal and implied contracts also exist in other human relationships, of which marriage is perhaps the best example.

A contract between two people spells out the rights and responsibilities of each. It makes clear what each may expect of the other. The doctor-patient relationship comes under the heading of an implied or informal contract. What terms might we expect in the contract between family physician and patient? I would suggest the following:

1. The physician's responsibility is to the patient as a person, whatever his problem may be. Of course, one would expect the problem to be a health problem, but this would be difficult to define precisely. I suspect that, in most cases, the patient is left to define the type of problem. The important point is that in the family physician the patient has a doctor who will not say, "I am sorry, but I don't deal with that type of problem." He will say instead, "Whatever your problem may be, I will help you with it."

2. The physician's responsibility is continuous. This does not mean that he must always be available, seven days a week, 365 days a year. It does mean, however, that he feels a responsibility seven days a week and 365 days a year. The expression of this responsibility is the provision of deputizing arrangements when he is not available, and his ensuring that these arrangements are known to the patient. Exactly what deputizing arrangements are permissible in family practice is a matter of debate which we need not enter into here. Continuity of responsibility also means that the physician feels a responsibility even after referral to another physician for specialized management.

3. The contract may be terminated by mutual agreement. In a recent study of the system of primary health care in London, Ontario, we found that many people did not know how to terminate their relationship with a family physician.[2] The contract should recognize that not all human relationships are workable and should define a procedure for either party to terminate the relationship. Obviously, it will be in the interests of both parties if this is done by mutual consent and if the physician assists the patient in forming a new relationship with another physician.

4. The physician's commitment under this contract is a very demanding one, and the patient also has certain responsibilities. The physician's continuing responsibility requires that he have knowledge of all aspects of a

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patient's health care. His position of responsibility will obviously be undermined if the patient goes directly to a specialist without consulting him. In other words, the type of continuity we are talking about implies a referral system.

The contract which I have just spelled out does no more than describe the kind of relationship which existed in former times between doctor and patient and which was taken so much for granted that it did not need to be stated. It is only the complexity of modern life that makes it necessary to make the terms explicit. I believe it is the failure to understand and live up to the contract that lies at the root of many of our present problems.

Implications for Family Practice

The reason why continuity is so important for family medicine education is that our whole approach to medicine is colored by the nature of our relationships with patients. I will describe three ways in which continuity of care influences our methods of practice:

1. Because of our continuing relationship with patients, observation over time can be used as a very effective tool for the validation of diagnostic hypotheses. Unless there is a need for urgency, the family physician does not have to be in a hurry to solve all problems. This I believe to be the reason for the major differences which we recently found in a study of the diagnostic methods of family physicians and consulting internists.[3]

2. Balint[4] has described the special powers which continuity of care gives to the family physician as a psychotherapist. In the hands of the family physician, psychotherapy is not a finite "course of treatment." Because of the continuing personal relationship, it does not need to have a formal beginning or formal end-point. It can be taken up or discontinued whenever the occasion demands it. The psychotherapeutic relationship arises, in fact, out of the continuing personal relationship.

3. The eventual effect of this personal relationship with patients is that we come to see illness in the context of the whole person and his environment. This can best be expressed by means of an analogy. When doing a jigsaw puzzle, we often find a piece which we can only partly comprehend. Perhaps it has a human face in the center – so far so good – but what are those bits of color around the edge? These will only make sense to us when we have fitted the piece into the context of the whole puzzle.

In family practice, our continuing relationship allows us over the years to build up pictures piece by piece. The pictures we build are never complete. Nevertheless, as they take shape, each episode of illness takes on quite a different significance as a part of the whole, rather than as an entity complete in itself.

The Duration of the Relationship

Continuity cannot be only a matter of duration. How important is duration? It has been suggested that our society is so mobile as to make continuity of care impossible. I believe this to be a fallacy. Our society does contain many very mobile people, and mobility is clearly a feature of certain age, occupation, and social class groups. However, many of the moves which appear in the statistics are moves within the same municipality, which do not necessarily lead to a break in continuity of care. Even a highly mobile practice population is quite consistent with the kind of personal responsibility we have been discussing. A doctor[5] who practices in the central part of London, England, recently told me that his whole practice population turns over in three years. He does not have much time to build up personal knowledge of his patients, so he has designed a highly effective record system, based on Weed's problem-oriented system, which enables him to obtain the maximum information at the patient's entry to the practice and on each subsequent visit. This doctor's feeling of responsibility for his patients is no different from that of a rural practitioner with a very stable practice population. In other words, continuity of responsibility is more a question of attitude than duration of relationship. The effect of duration will be on the depth of knowledge a physician has about his patients and the time he has at his disposal to acquire it.

Implications for Residency Training

In applying the continuity issue to residency training we come face to face with an irresolvable dilemma. The relationship between family physician and patient has no defined end-point. All residency programs are finite. Any arrangement we make, therefore, will contain the elements of compromise. The problem becomes easier once we have accepted that duration of relationship is only one component of continuity and not the most important one. This makes it possible to include under continuity of care experiences which do not necessarily run for the whole duration of a residency program.

What should a resident's experience in the teaching practice do for him? First, it should provide him with an understanding of the contract between family physician and patient. Second, it should enable him to form those relationships with people which are the foundation on which family practice is built.

To meet these objectives, I believe that the experience must provide the right mix of duration and intensity. I doubt whether a "part-time" or sessional experience in family practice – even if of several years' duration – can provide the intensity which is necessary for the development of a full feeling of responsibility.

Our own solution to this dilemma at the University of Western Ontario is for the resident to work one year in the teaching practice. We would like to make this year a continuous experience, but so far have not managed to achieve this. At present it is divided into two blocks, one of nine months and one of three months. During this year, the resident continues to do specialty training on one half day per week, and to attend the Department of Family Medicine's postgraduate seminar program.

Obviously, there is more than one way of approaching this problem. My plea at present is for a flexible, experimental approach. It would be a grave mistake to arrive at a rigid position on residency training at this early stage in our evolution.

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