Continuity of Care in Family Practice

Part 4: Implementing Continuity in a Family Practice Residency Program

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Although continuity of care is an important goal of family practice residency programs, there are many factors which inevitably prevent its full achievement by individual residents in any program. Each resident is frequently faced with conflicting responsibilities involving the Family Practice Center, inpatient clinical services, and other parts of the residency training program. This paper explores this dilemma and suggests a variety of positive approaches to resolve the issue. All family practice residents must necessarily be intimately involved in providing continuity of patient care and develop the requisite skills and attitudes. However, full continuity of care must ultimately be provided on a program and group level, not exclusively by the individual resident.

Continuity of care is a highly valued component of family practice and represents an essential goal within family practice residency programs. Despite the importance of this concept, however, it is often viewed rather loosely and taken for granted without much analysis. A critical and in-depth appraisal of "continuity of care" is most timely and long overdue.

Two recent papers have advanced our understanding of continuity of care in family practice. Hennen defines this concept in terms of four distinct dimensions — chronological, geographical, interdisciplinary and interpersonal, each comprising specific actions which can be observed, evaluated and learned.[1] McWhinney points out that continuity of care in family practice cannot be adequately described merely by duration, and he acknowledges the dilemma facing those who wish to implement continuity of care by residents in finite residency programs.[2]

Continuity of care is an important issue in the design, operation, and accreditation of all family practice residency programs. This paper will first outline common program goals of family practice residencies, summarize some major issues in the development and operation of family practice residencies, briefly describe some everyday problems in implementing continuity of care within a residency program, and suggest some positive approaches to address these problems.

Common Program Goals

The curriculum of any family practice residency program, in an integrated manner, allows each resident to meet four major goals: (1) required breadth of knowledge, (2) required breadth of skills, (3) appropriate attitudes, and (4) habits of self-evaluation and continuing education.

The overall goal of residency training is to produce well-trained family physicians with several attributes:

1. Excellence as clinicians capable of providing definitive care of over 90 percent of health problems of individuals and their families.
2. Skill in each of the five stages of comprehensive health care:
   a) Prevention
   b) Early diagnosis of asymptomatic disease
   c) Emergency care; management of acute and chronic disease
   d) Rehabilitation
   e) Management of incurable and terminal disease
3. Understanding of own limitations, with ability to relate appropriately to consultants and other community resources.
4. Knowledge and sensitivity to behavioral aspects of health and illness for families, with capacity to recognize, and often manage, common behavioral disorders.
5. Attitudes which facilitate constructive relationships with patients, peers, consultants, and other members of the health care team, and which also allow for sharing of responsibility for patient care in a group setting.

Although individual family practice residency programs may outline somewhat different goals and involve varied areas of emphasis, the above goals probably represent a general concensus.

Some Common Issues in Family Practice Residencies

Designing and operating family practice residency programs to meet these kinds of goals is a large order and challenging to accomplish within a three-year period of graduate training. A number of major issues are immediately raised in the planning, development, and operation of a family practice residency program.[3] Some of the important *educational* issues are as follows: (1) how to provide an adequate depth and breadth of clinical training in three years, (2) how to integrate behavioral science training within the residency program on a longitudinal basis, and (3) how to prepare the resident for varied future practice settings.

Some of the more important *organizational* issues include the following: (1) how can available clinical and educational resources be utilized by the residency program, (2) how can a reality-based program be developed and maintained, (3) how can the resident be prepared for future group practice, and (4) how can physician maldistribution be addressed, which is frequently an expectation by

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state legislatures of our residency programs.

Some of the important *operational* issues include these: (1) how can Family Practice Center commitments be blended with other commitments within the residency program, (2) how can family practice residents relate to other specialty residents, when present, (3) how can hospital expectations for service be met by the residency program, and (4) how can the concept of continuity of care be integrated in a complex program with multiple goals, several loci of activity and varied expectations by others. In my experience, I have found that very different expectations are held by patients, faculty, the medical community, hospitals, and legislatures of what a family practice residency program and family practice residents should do.

The resolution of these issues tends to be incomplete and involves compromise and improvisation as each residency program develops in its own setting. Although there is considerable variation among family practice residencies in the United States, most involve an increase of time and responsibility in the Family Practice Center as the resident progresses within the program. First-year training often consists largely of hospital-based clinical rotations. Behavioral science training is usually integrated as a longitudinal thread during the program. A call system is provided for the Family Practice Center and family practice inpatients. The third year of residency training is most often used for selectives and electives.

Common Problems Concerning Continuity of Care

A number of pressing and real conflicts arise in any family practice residency program, primarily due to numerous commitments of the resident and differing expectations of the the resident by various other faculty members and services. These conflicts are well known to faculty and residents involved in any family practice residency program. The classic conflict is that imposed by concurrent resident responsibilities in the Family Practice Center and on inpatient clinical rotations. This frequently puts the resident in a double bind, torn between Family Practice Center responsibilities and inpatient responsibilities on a clinical service involving rounds, ward duties, and night call. There are other potential conflicts related to rotations in the Emergency Room, care of obstetric deliveries and other urgent problems of hospitalized family practice patients, and electives or preceptorship-locum tenens experiences away from the residency program itself. Additional problems relating to provision of continuity of care in family practice residency programs are incurred by the program relating to multiple hospitals, the requirements of night and weekend coverage of the Family Practice Center and hospital services, vacation times for residents, and the issue of patient compliance, which can itself be a barrier to the maintenance of continuity of care. As a result of these kinds of conflicts, the individual resident is frequently not available when his patients require care for acute problems in the Family Practice Center.

Many of the above conflicts are inevitable if the residency program is to provide adequate breadth and depth of clinical training (ie, if adequate inpatient clinical rotations and other ongoing parts of the residency program are to be maintained.) Clinical experience in the Family Practice Center, while vitally important, represents only a fraction of the total clinical experience required during a three-year residency.

Some Positive Approaches Concerning Continuity of Care

Given the dilemma regarding continuity of care by the individual resident during family practice residency training, I would like to propose nine major ways in which we can approach this dilemma:

1. The modular organization of the residency program into resident teams can go a long way toward facilitating continuity of patient care.[4] There are many ways in which such resident teams can be organized within a program, which are dependent in large part on the size of the residency program, the kinds of hospital commitments involved, the size and staffing of the Family Practice Center, and other factors. Within a resident team, however, it is quite possible for one resident to cover for another when the patient's own resident is otherwise committed.
2. It is important to recognize that much of the present and past medical education process has directly or indirectly encouraged the solo approach to practice. There are few planned experiences in medical education designed to develop skills among students and residents in relating to one another as a group in the care of patients. The family practice residency program must assume a special responsibility in this area and should maintain an environment which promotes a group versus solo ethos of care, supporting residents as they learn the various skills required to function well within a group. The ability to function well in a group setting cannot be assumed, and it involves a set of skills, attitudes, and behaviors which can be learned during residency training.
3. The use of the problem-oriented medical record provides an excellent mechansim for continuity of communication and information, and particularly facilitates the capability of residents and other members of the team to care for patients when their own family practice resident is not available. The use of the problem-oriented record should understandably be a required part of family practice resident training.
4. The pairing of residents on certain hospital inpatient services has proven quite useful in increasing the continuity of resident coverage of specific inpatient services without compromising residents' coverage of the Family Practice Center. The experience of others at the University of Rochester and the University of Washington is useful in this regard.[5,6] Although resident pairing is of potential value on some of the services, such as internal medicine, it is not easily applied to other services in the average residency program due to lack of resident manpower on the smaller services.
5. The development of a family practice rotation in the third year can be extremely valuable in tying together a number of loose areas within any residency program. Such a rotation provides backup and supervisory coverage of inpatient care for hospitalized family practice patients. The resident on a third-year family practice rotation may act in the role of a chief resident, with considerable teaching responsibilities, increased responsibility in the Family Practice Center, and a coordinating role in regular teaching conferences.

6. Specific learning objectives should be developed for those competencies required to deliver continuity of care in family practice.These competencies should be identified in the same way as they are for other elements of the residency program, and may focus on such areas as health maintenance, the use of the problem-oriented record, medical audit, communication skills, team relationships, use of drugs on a long-term basis, patient compliance and other areas.

7. Research is needed concerning the impact of continuity of care as we have been discussing it on outcomes of care. The continued development and refinement of family practice residency programs should allow us to pursue such outcome studies. This line of research should be one of high priority, since it is one of our major assumptions concerning the value of the family practice approach.

8. Alternatives should be explored to the present pattern in the United States which usually involves three years of resident exposure in one Family Practice Center. I am not persuaded that this is the only way to meet program objectives, including an adequate spectrum of resident competency objectives. Moreover, in certain settings three years in one Family Practice Center can be a limiting factor to the resident's education if the related hospital and community resources do not fully meet resident needs.

One variant of our present system which I feel has great potential and applicability in many parts of the United States is one involving a first year of resident training in a large teaching hospital, with second and third-year resident training in an outlying community hospital setting. The larger teaching hospitals in metropolitan areas can frequently provide excellent first-graduate-year training but may be less able to provide reality-based training during the second and third years. Conversely, smaller hospitals in outlying communities can often provide excellent second and third-year experiences but may not have sufficient clinical and educational resources to support a first-year program.

9. The development of networks of affiliated residency programs by departments of family practice in medical schools can particularly facilitate and support alternative approaches to residency training.[7] Within the context of a network, for example, it may be possible for first-year rotations to be in the university medical center, with subsequent resident training in outlying affiliated community hospitals with close ties to the university for evaluation, educational support, teacher development, and resident exchange. Such networks can comprise an educational system on a regional basis which, although geared primarily to graduate education, can likewise be involved with undergraduate and postgraduate education. The network approach can better utilize clinical and education resources within a region, strengthen referral and consultation patterns, and impact more effectively on the problem of physician maldistribution through the creation and support of residency programs in outlying areas.

Discussion

The family practice residency is a complex entity, including the Family Practice Center, inpatient rotations, selectives, electives, Emergency Room commitments, night and weekend coverage, behavioral science involvement, and relationships to various hospitals. The family practice residency has numerous educational goals with continuity of care being but one. Overemphasis on the continuity of care issue can detract from meeting other educational goals. Continuity of care is certainly an important goal, but should be met more on a program and group level, and not exclusively or even primarily on the individual resident level. We must prepare residents for group practice, and this involves the learning of specific skills and attitudes. Residents must learn to understand that others can provide good care in their absence, to avoid guilt when they are necessarily not available, and to incorporate their medical lives into the context of their total personal and family lives.

I have several concerns relating to the present status of implementation of continuity of care in family practice residency programs in the United States. In my view, there is a hazard of overemphasis on the Family Practice Center with potential compromise of other aspects of residency training which may frequently lead to incomplete breadth and depth of training. There is likewise a danger of perpetuation of the solo model by excess emphasis on continuity of care by the individual resident (ie, "My patient" versus "Our patient"). There is also a potential hazard of excess rigidity within the accreditation process for family practice residencies in terms of narrow interpretations of the concept of continuity of care in residency programs.

There is not now, nor should there be, one single blueprint for an effective residency program in family practice. Residency programs have varied goals in response to their own community and regional needs. Family Practice is evolving as a discipline and is not static. Individual residents have varied goals. Our evaluation methods are still relatively incomplete, and there is no documented evidence in favor of any single educational methodology at this time.

It is important that we maintain flexibility in terms of development, operation, and accreditation of family practice residency programs.[2,8] The present increase in emphasis on quality control and evaluation of residency programs is welcomed, and should provide us over the next few years with better documentation in favor of specific educational methodologies and patterns of residency program organization. Continuity of care is a vital ingredient of residency program operation and resident training. At the same time, however, duration of such continuity is not the critical feature in terms of each resident learning the necessary skills to provide continuity of care, which in a larger sense must be provided on a program and group level and not exclusively by the individual resident.

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