Guest Editorial

Continuity of Care

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Why do family physicians set so much store by continuity of care? One reason is that human relationships are valued for their own sake. Because relationships take time to grow, continuity in the physician-patient relationship is essential for their development. Duration, however, is only one aspect; intensity is another. According to a conversation with L.P. Carmichael, MD (July 1982), experience suggests that the bond is strengthened by the sharing of some of the great experiences of life: pregnancy and childbirth, the raising of children, serious illness and recovery, chronic illness, and terminal illness. The ideal of the personal relationship between physician and patient, as well as between physician and family, can be fulfilled in any of these circumstances. It is, therefore, attainable by any physician who cares for patients. For family physicians, however, the relationship means something more. It means a relationship that transcends individual episodes and crises. It also means the kind of relationship with families that comes from having the family members as patients, not just as patients' relatives. There is reason to believe that for many family physicians, this becomes the chief reward of their life's work.

If challenged to defend this attitude, a family physician might reply: "I don't have to. I value relationships for their own sake, and no amount of data will destroy my faith in their value." But the skeptic might respond: "I can show you that many people don't particularly want continuity of care with a personal physician; and what about the risks of continuing care, like missing insidious diseases which a new physician will spot immediate-

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0094-3509/82/050847-02$00.50

ly? Anyway, our population is so mobile as to make continuity an impossible ideal."

To this, the physician might well respond: "I don't claim to provide this kind of continuity to my whole practice. There are some I hardly ever see, mainly because they are rarely ill. I don't expect these people to value continuity very much, since they have never experienced the need for it. The risks I accept, and I think my patients accept them too. Everything we do has risks, and these are the price we pay for the rewards. As for population mobility, this is overrated. For example, in Canada (a very mobile society), one half the population moves every five years, but one half of these moves are within the same municipality. Moreover, the mobile population is overwhelmingly in the age group of 20 to 35 years. In older patients, movement is much less a problem."

In this scientistic age, a belief in the value of continuity is unlikely to cut much ice. The skeptics demand a demonstration that it is effective. They may have a point, since we as family physicians make claims for the benefits of continuity. A closer study of the issues is therefore to be welcomed. As soon as we begin to examine them, however, we come face to face with their complexity. The term *continuity* itself can be used in a number of different senses. The outcomes that can be influenced by continuity are affected by many confounding variables, and it is difficult to design studies in which all these variables are controlled.

Hennen[1] advanced the thinking on continuity by describing four dimensions of the "continuity environment": chronological, geographic, interdisciplinary, and interpersonal. With these four dimensions, he made us think of continuity as extended not only in time, but in space. The geographic dimension refers to continuity among office, home and hospital; the interdisciplinary refers to continuity across organ system and specialist boundaries.

Rogers and Curtis[2] based their model of continuity of care on Hennen's four dimensions and added three more: the informational, the accessibility, and the stability dimensions. Wall[3] also used Hennen's dimensions in a model that reflects the dynamic relationships among the dimensions. In this issue, Dietrich and Marton[4] provide a rigorous analysis of 16 studies of longitudinal care (a synonym for the chronological dimension). The studies were reviewed for internal validity and general applicability. Only four were considered acceptable enough for definitive conclusions to be drawn. The remainder were used to provide supporting evidence. The inferences from these studies are that longitudinal care is associated with increased patient and staff satisfaction, greater compliance with medication and appointments, and greater readiness to disclose confidential information by mothers of child patients. There is no evidence of adverse effects of longitudinal care, and there is some indication that longitudinal care may lead to reduction of costs.

Dietrich and Marton found no adequate studies of the effect of continuity on morbidity, mortality, preventive services, or speed of referral. Perhaps this is too much to expect. On the other hand, if the physician-patient relationship is as powerful as the placebo effect suggests, should it not be possible to demonstrate more rapid healing in different types of illness? The results of some studies also suggest that, with an appropriately designed study, it could be shown that continuity is related to economy.

The few studies so far available tend to support a belief in the value of continuity. As Dietrich and Marton have shown, however, the studies that stand up to rigorous critical examination are few and far between. Many studies, moreover, come from pediatrics and internal medicine rather than family medicine. Here is a challenge for family medicine research.

References

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