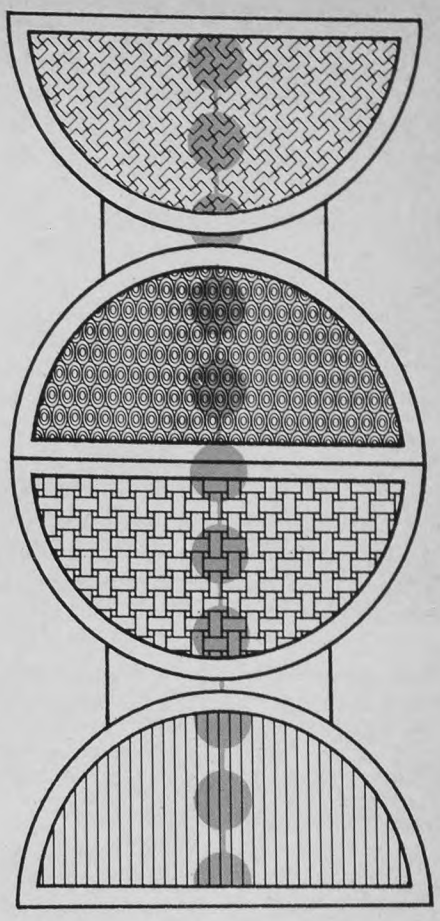
Continuity of Care in Family Practice



Part 1: Dimensions of Continuity

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This is the first in a series of four articles exploring the issue of continuity of care in family practice. There are four dimensions of continuity of care in family practice: chronological, geographical, interdisciplinary, and interpersonal. Each of these dimensions can be measured by specific actions and can, therefore, be evaluated and learned. Subsequent articles will deal with implications of continuity of care in family practice, its measurement and evaluation, and problems with its integration into family practice residency training.

If there is one aspect of the family physician's role that differentiates him clearly from other physicians, it is the degree of continuity of care he provides. Of all the elements of family medicine, only continuity encompasses the others. Alpert and Charney, in their excellent monograph "The Education of Physicians for Primary Care,"[1] reduce primary medicine to three elements: first contact care, longitudinal responsibility, and integration. Family medicine adds a fourth: the family as the unit of care. All of these, not only longitudinal responsibility, are part of continuity.

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First Contact

There must be a starting point. Some call this the point of first contact, the entry into the formal health care system. They refer to the family physician's role in this regard as that of a "gatekeeper." We must make some clear distinctions here, because if we do not, we might let our jargon lead us astray.

First, we should differentiate between the point of first contact and first contact care. The chronological interpretation of first contact care as the initial contact is very limiting and should, in an ideal world, be nonexistent. The term "ideal" is employed merely to suggest what one of our goals should be – that once people are in the formal health care system, they should find it difficult to fall out. When someone changes residence he should merely be transferring his place of care within the system. But our world is far from ideal: we do have people looking for health help for the first time in their lives, and we do have people looking for help de novo in new places of living. We should consider first contact more in the *geographical* sense of closest to the patient than in the *chronological* sense of initial contact with him.

We should also distinguish between the health care system and the formal health care system. People take a major degree of responsibility for their own health outside of our bureaucratic industry, and yet they should be considered as always within the health care system. We should throw away the gatekeeper philosophy and talk instead about an open-door system. We should emphasize re-entry into the formal health care system and see to it that this may be simply and comfortably accomplished.

We can, therefore, consider first contact care an element of continuity when first contact care is closest to the patient and provides for ease of re-entry into the formal health care system which is, in turn, a part of a larger health care system.

Continuity as Action

Continuity is an attitude. Magraw

has stated "The essential element in ongoing care is the doctor's perspective of his professional task."[2] But I define "attitude" as a propensity to act in a predictable way given a certain situation. Continuity must, therefore, be far more than an attitude; it must be action. Only if we act can our attitudes be assessed. Only if we act can the results of our actions be evaluated. If we can learn to act in new ways, we may express new attitudes. If we can create a learning situation in which our students can do new things, they may express new attitudes. Continuity can be done as well as felt. It can, therefore, be learned. Our task is to explore how we can make it easier for our students to learn it. I therefore define continuity in terms of certain behaviors, the expression of which in practice will confirm that continuity of care is being accomplished.

Continuity's Four Dimensions

There are four dimensions of the act of providing continuity of care. They are: chronological, geographical, interdisciplinary, and interpersonal.

1. The *chronological* dimension includes those aspects of health applied to changes over time, such as individual human development and family development. This leads to the family physician's offer of care to persons of all ages in the context of their family attachments or their absence. The chronological dimension further applies to the natural history of illness and the manner in which family physicians use repeated observation over time as a diagnostic and management tool. Such long-term observations are also the basis of the scientific study of family medicine that will lead to new knowledge.

2. The *geographical* dimension refers to the provision of primary care regardless of the site. It may be in the home, the physician's office, the acute care hospital, the chronic care hospital, the rehabilitation institution, the nursing home, or the community resource center. The important thing is for the family physician to be the closest physician to the patient throughout his contacts within the health system. Nowhere, even in the tertiary care or highly specialized hospital unit, should the patient be out of contact with his family physician.

3. The *interdisciplinary* dimension includes those aspects of continuity that cross the traditional clinical disciplines. For example, a patient with chronic osteoarthritis develops a recurrent urinary tract infection and becomes depressed. The arthritis remains static, the episodes of urinary infection respond quickly to management, and the depression responds gradually to supportive psychotherapy. His wife has phobic anxiety and migraine. She will require care also.

The family physician, while caring for a patient, may find himself managing diseases of several body systems (each at a different stage in its course), supporting the patient in dealing with problems of living which may or may not be related to his diseases, managing a similar constellation of illness in other family members, and coordinating these managements to the optimal function of the family as a whole.

4. The *interpersonal* dimension of continuity includes doctor-patient relationships, interpersonal family relationships, and interprofessional relationships.

The first involves, for example, the establishment of rapport, mutual trust or, as Carmichael described it, "that tenured relationship" which gets you out of bed at night.[3]

The second involves the understanding of a daughter's fear of liquor because of her dad's drunkeness and the strong possibility of subsequent adolescent drinking by her son in reaction to her prohibitive attitude.

The third involves trust and reliance on specific associates – the surgeon who will come because he knows you do not ask for help without cause – the social worker who returns your call promptly because you do likewise – the admissions clerk who can usually secure you a bed because you stop in personally to explain your patient's needs – the associates, professional and non-professional, who work in your office every day and develop continued understanding and familiarity with each other's styles, strengths, weaknesses, and idiosyncrasies.

Cementing these interprofessional relationships involves the skill of continuity of information, which relies to a great extent on the written record. The proper record system records acute episodes and ensures their follow-up; records the progress of the chronic illness; records the multifaceted problems of physical, social and psychological illness; and draws together information about the various family members.

Each of these dimensions of continuity are capable of demonstration by specific actions, as the following examples demonstrate:

– applying the Denver Developmental Grid to infants,
– anticipating specific stress periods in the life cycle of the family,
– considering the significance of why the patient came with that symptom at that time,
– ensuring appropriate follow-up for the acute illness,
– planning ahead with the patient for his chronic illness,
– guiding the patient's course from the house call, into the hospital, into the nursing home, and back home,
– comfortably handling illness of different body systems coincidentally with the stress of a poor family situation,
– responding to the tug of responsibility when the malingerer's wife calls to say she cannot cope anymore,
– anticipating the new father's reluctance to hold the crying baby and showing him that the baby will not break if he picks it up,
– recording accurately on the patient's record the natural history of his illness,
– making use of the family record to check on junior's hearing while mother is in for her Pap smear.

We very often apply different combinations of these dimensions at the same time. Perhaps the best example is caring for a family in which one member has a fatal illness. We care for the person, specifically treat his (often multisystem) disease, deal with the fact he is dying, and care for his family before and after the event of his death.

These are the dimensions of continuity. They require action. They can be observed. They can be learned. Their learning can be evaluated.

References

1. Alpert JJ, Charney EC: The Education of Physicians for Primary Care. Department of Health, Education, and Welfare, Bureau of Health Services Research. DHEW Publication (HRA) 74-3113, 1973

2. Magraw RM: Ferment in Medicine – A Study of the Essence of Medical Practice and of its New Dilemmas. Philadelphia, WB Saunders, 1966

3. Carmichael LP: Family medicine. Talk presented at a workshop of The Society of Teachers of Family Medicine, Miami, Florida, January, 1969