Family Practice Forum

Continuity as an Attitudinal Contract

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Primary care physicians who have practiced for years do not doubt that continuity of care is real and that it adds a special dimension to the practice of medicine. However, when a physician attempts to describe continuity, the concept often seems to elude meaningful words.

Most of the literature on continuity of care has addressed the effect continuity has on the quality of care, utilization of services, and patient and physician satisfaction. Although many studies have indicated that continuity has a beneficial effect on these variables,[1-3] some studies have failed to support such findings[4,5] or have indicated that the relationship may not be straightforward.[6]

Perhaps the most important problem is that in the past most definitions of continuity have been operational in nature. Operational definitions are necessary for the measurement of continuity and are important for evaluating the effect of continuity on the delivery of medical care services. However, when operational definitions are proposed before a complete conceptual model has been developed, inconsistent conclusions will be reached because of a failure to clearly identify and understand the concept being measured.

Continuity of care is a phenomenon that occurs between a patient and physician which can best be described as a contract. Since it is a contract involving attitudes, it will be referred to as an attitudinal contract. Analysis of existing good physician-patient relationships reveals three essential characteristics of the attitudinal contract: (1) a beginning point, (2) an end point, and (3) quality.

The beginning point of continuity is not simply the point at which medical care services are first delivered. Medical care services can be delivered without continuity existing. The beginning point of continuity is the point at which the patient and physician enter into an attitudinal contract.

As with any contract, certain rights and responsibilities are inherent in the attitudinal contract. The patient perceives a need for medical care and a dependence on the physician to provide this care. Ideally the patient will seek comprehensive health services from the physician[7] in such a way that the physician is informed of all the patient's health care needs and that an appropriate referral system is developed.[8] The physician assumes the responsibility for the care of the patient. When both the patient and the physician accept these complimentary attitudes, continuity exists. Continuity of care is a phenomenon that exists when (1) the patient perceives a dependency on the physician for medical care, and (2) the physician perceives a responsibility for the patient's medical care. When either attitude ceases to exist, continuity ends.

The end point of continuity, just as the beginning point, is not related to the actual delivery of medical care services but is determined by the patient and physician's attitudes. Whenever the patient and/or physician cease to have the appropri-

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ate attitudes, continuity ends. The attitudinal contract may be terminated by mutual agreement or by either of the individuals.

Some of the most frequently discussed factors that are related to the quality of continuity are (1) the length of the relationship, (2) the stability of the relationship, (3) the physician's and patient's perceived need for care, (4) the interdisciplinary approach, (5) the accessibility of care, and (6) the amount of information collected. Any of the above factors may enhance the quality of continuity, may be enhanced by the existence of continuity, or may simply be related to the quality of continuity.

Based on the three characteristics of continuity discussed above, three distinct types can be identified. Each type possesses all three of the essential characteristics, but the types differ in other significant aspects.

Type A continuity is the ideal of primary care medicine. It involves a physician-patient relationship that extends not only across periods of illness and periods of well-being but also across significant life cycle changes of the patient.

Type A continuity has the potential for the highest level of quality because of the extended period in which all factors related to quality can develop. Such continuity that spans multiple crises and periods of health, as well as significant portions of the life cycle, give the physician-patient relationship a quality that is well known to seasoned primary care physicians but difficult to describe or accurately quantify.

Type B continuity is perhaps more common today than Type A continuity because of the mobility of society. Type B continuity can be exemplified by the care provided in a residency program in which the physician is present for a limited number of years. This type of continuity extends across periods of illness and periods of well-being but does not span major life cycle changes because of the shorter duration of the relationship. The fact that this type of continuity spans periods of well-being allows the physician to address preventive medicine and health maintenance in a way they cannot be addressed during medical crises.

Type C continuity is the most common form of continuity; however, it is seldom recognized as such because of confusion between longitudinal care and continuity. Type C continuity is the shortest of the three types, extending only across a single illness episode. Although Type C continuity does not include care during periods of well-being, it does encompass all three of the essential characteristics of continuity.

Continuity of care is therefore a phenomenon that occurs when two complimentary attitudes come into existence between the patient and physician. The patient must perceive the physician as being responsible for his or her care, and the physician must perceive and accept responsibility for the care of the patient. This state of continuity of care continues until one or both of these attitudes no longer exists.

Most studies have observed and measured the factors related to the quality of continuity and have not addressed the question of whether an attitudinal contract actually existed. In order for these studies to have measured the quality of continuity, it must be assumed that continuity did exist in the situation and that the attitudinal contract, therefore, was present. Studies have found, however, that some patients do not value the relationship necessary for continuity.[5,6]

This faulty assumption about the basic existence of continuity in every physician-patient contact may explain many of the inconsistencies in previous empirical studies. The conceptual definition proposed here, however, alleviates this problem. This definition of continuity provides a distinct beginning point and end point to continuity of care. Within the framework of the described conceptual model, the factors related to the quality of continuity can be evaluated and their relationships studied. Such further studies will facilitate a deeper understanding of continuity of care.

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