Transient Discontinuity of Care

Others Seeing What We Have Missed

Howard B. Tandeter, MD, and Daniel C. Vinson, MD, MSPH
Beer-Sheva, Israel, and Columbia, Missouri

Continuity of care is central to the philosophy and teaching of family medicine.[1,2] It makes possible long-term observation, less extensive workups for arrival at a diagnosis, and decreased use of laboratory and referral resources.[3] Continuity of care also possesses the potential for psychotherapy and counseling;[4] may increase patient satisfaction with physician performance;[5-8] may be helpful in reducing the number of hospitalizations;[9] and may help increase cancer screening rates.[10] A lack of continuity may be associated with additional morbidity.[11]

Some authors, however, have hypothesized potential disadvantages of continuity. McWhinney[1] and Freeman[12] pointed out that a family physician who has seen a patient frequently may miss a slowly developing but obvious disease, something that a physician who has not seen the patient before might immediately recognize.

Although it is common to accept that longer illnesses are treated more effectively if there is a consistent knowledge base about a patient and his or her illness,[13] the following cases from our clinical experience show that these illnesses may sometimes be better treated by a fresh view of the patient. This "discontinuity approach" may benefit the patient, a possibility that has not been explored in the medical literature.

CASE REPORTS

Case 1. A 48-year-old man with Parkinson's disease was followed by his family physician for 4 years.[14] The patient's clinical picture included muscle stiffness, bradykinesia, and tremor of the right hand. He was treated with amantadine hydrochloride and a combination of levodopa and carbidopa. The man's regular physician temporarily left the practice for a fellowship and, during that absence, a substitute physician saw the patient. At that visit, the patient reported that his lethargy, stiffness, myalgia, deep and monotonous voice, and lack of facial expression—all symptoms that were ascribed by the primary physician to the Parkinson's disease—were unchanged. The substitute physician interpreted these signs and symptoms as indicative of hypothyroidism, which was confirmed by laboratory tests. Shortly after starting levothyroxine, the patient's longstanding lethargy ameliorated, his dullness of expression lessened, and his bradykinesia almost disappeared. Some rigidity and tremor persist, and he continues follow-up for his Parkinson's disease.

Case 2. A 35-year-old woman with headaches was followed by her family physician for 1 year. She was given a diagnosis of migraine and was treated with a variety of medications. During the time that the regular physician was away for a fellowship, he was replaced by a 35-year-old female physician. On her first encounter with the patient, the physician asked the patient's age. Learning that she and the patient were the same age, the physician was amazed by the difference in the size of the patient's mandible, face, and hands compared with her own. This observation led to a workup and diagnosis of acromegaly. Her previous doctor, who was accustomed to the patient's features, never interpreted them as abnormal.

DISCUSSION

Roger von Oech wrote "Life is ambiguous; there are many right answers—all depending on what you are looking for. But if you think there is only one right answer, then you'll stop looking as soon as you find one."[15] Physicians often do this during continued patient care; they stop looking for other possible answers to a problem as soon as they find one that seems to be the right one.

A slowly changing object that moves across a static background may be perceived by a continuous observer as if it has not moved or changed at all. Continuity of care, with its long-term relationships and close follow-up, together with the slowly developing signs and symptoms of a new disease, may keep us from seeing gradual changes in our patients and may leave us with the illusion of a lack of change. When the overlooked changes are those of an insidious new disease developing on top of previous pathologies, the failure to diagnose a significant problem can result.

Similarity (2 different diseases appearing with similar signs and symptoms), synchronism (more than one pathology developing at the same time), and the slow development of a disease (as in the cases we reported) produce major diagnostic challenges.[14] Of these 3, the last is potentially the most problematic for a physician with a continuity relationship with the patient. In both of the cases presented, a substitute physician was quickly able to see what the treating physician was missing. The obviousness of the diagnoses is a feature that makes these anecdotes particularly memorable.

Occasional input by a physician who does not know the patient may have great value in the recognition of insidious, serious, and easily missed diagnoses. Such input can be sought when the physician senses a diagnostic uncertainty or lack of progress and asks a colleague for a consultation, or when the primary physician does not see the problem and does not sense anything wrong. At such times, a lack of continuity can benefit the patient by providing a fresh perspective, even when the

Submitted, revised, September 29, 1998.
All correspondence should be addressed to Howard Tandeter, MD, Department of Family Medicine, Ben-Gurion University of the Negev, PO Box 653, Beer-Sheva (84105), Israel.

need for one was not perceived.

How can we artificially create a discontinuity effect? One possibility may be to consult peers,[16] who can look at the patient from a different perspective. This type of consultation should be done periodically, and not only after a problem with the diagnosis has been recognized. Once you recognize that you may be missing a diagnosis, the problem almost solves itself.

How can this be done systematically? In group practices, one approach would be to schedule annual general assessments of your chronic patients with other doctors in the practice, especially the chronically ill, difficult, or "stuck" patients who may benefit greatly from in-practice second opinions. For solo practitioners, the same type of consultation may be arranged with a nearby peer. For a pilot experience in Israel, a family doctor opened a consultation center for the referral of patients being treated by other family physicians. This idea of having family physicians as consultants for other family physicians is an interesting model of consultation. Since solo practitioners might fear losing patients to peers during consultation, a model like the one in Israel could prevent this.

We do not intend to question one of the cardinal values of family medicine, nor should our examples be used to defend health care systems that do not foster continuity. However, in the debates regarding the value of continuity and in research into its effects, we should keep in mind that, sometimes, its suspension could be beneficial.

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