



Time to rethink continuity

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Continuity of care is a value that lies at the very heart of family medicine. It is one of those powerful, traditional values of general practice that we have accepted as being at the centre of our discipline. It refers to a continuous relationship between one physician and one patient over an extended period. It sometimes involves contact through many illnesses and life challenges.

Research has reported on the greater satisfactions that come from a longitudinal relationship for both patient and physician; on the education and illness prevention that can occur with such long relationships; and on lower numbers of diagnostic tests and hospital admissions, and shorter hospital stays. All these are benefits of a long-term relationship between patient and physician. Such benefits also include a better capacity for advocacy on behalf of patients and, in the long run, better care.

The downside of longitudinal relationships can be complacency on the part of physicians and sometimes patients' perceptions that physicians care little about the relationship.

Today we live in a somewhat fragmented world (some would say greatly fragmented). Relationships generally are short-term and less continuous than they were a few years ago. Young people move away from families to find work. Ideas regarding the community are changing, with less emphasis on long-standing relationships and more emphasis on economic and job opportunities. It is possible to be on the move and remain in a continuous relationship by means of television, with Ally McBeal or favourite hockey team, but not with a physician.

Young physicians seem to want part-time work, to move frequently, and to be less likely to make long-term commitments to a particular practice. (The College of Family Physicians of Canada has been criticized for not training young physicians to take on long-term relationships, but this is an international phenomenon and not simply confined to Canadian medicine.)

At the same time, the physician-patient relationship remains at the centre of our discipline, and patients are clear that they want doctors who listen

and who are able to solve problems. They want this capability more than longitudinal continuity.¹

Continuity through groups

To meet the needs of our patients and to provide effective medical care, we have proposed a primary care system in which groups of physicians (practising in the same location or linked by telecommunications) look after patients by using commonly accessible medical records, thereby providing a form of continuity. With this approach, I hope group practices will overcome the fractures of continuity that occur when patients use walk-in clinics and emergency rooms.

The idea of teams of physicians and nurses caring for groups of patients is commendable and perhaps the only way we can effectively address some of the issues of care for a mobile population. We have some serious issues to consider if we supplant the rich and therapeutic long-term physician-patient relationship with the team concept.

If a team or group of physicians is to provide continuity of care effectively, several elements in the new system must be tackled. It has been proposed, for example, that team members access common patient medical records via computer. Although this idea has been discussed theoretically, electronic systems, software, and technology to support such an approach are not quite up to the job. Programs are cumbersome and complicated, can be difficult to learn, and are full of potential glitches. At some point physicians might be fully proficient with computers, and certainly the idea is worth pursuing. But we are not there yet and will not be for some time, even with application of greater resources.

Another essential for providing a new form of continuity of care is that physicians share and value common approaches to treatment and common abilities to form relationships. I recently received a letter from a woman in our practice saying that, although she had been seeing different physicians in our group over the past 10 years, she was confident that she was being well cared for because the members of the group shared and expressed a common set of values and concern for her.

In the new form of continuity of care there will be little room for the destructive competition we sometimes see among physicians. If we are to care for patients in common we must approach them with shared values and in a spirit of mutual support, collegiality, and teamwork.

Covenant versus contracts

Today, great emphasis is placed on contracts. The new world of continuity of care might need to return to a concept introduced in Scripture and emphasized by recent writers on primary care: the concept of the covenant. In a covenant, physicians agree to go beyond usual contracted obligations and enter into relationships with patients that imply they will do whatever is needed to see problems through. It implies staying with the relationship until either physician or patient decides it should end.²

Team and responsibility

If the new form of continuity of care by teams or groups is to work, we must be clearer about the meaning of shared responsibility and how it functions. The value of the single doctor, single patient relationship was that the lines of responsibility were clear. Lines of responsibility in team relationships can be blurred, and we must become better at developing our team skills and more explicit about who will take responsibility for patients in the final analysis.

New models of care can work, but to preserve the benefits of our primary care system and the healing capabilities of long-term therapeutic relationships, we must address the serious problems of maintaining continuity of care. These are problems created by a new society and the expectations of a new physician workforce. They must be addressed before we get into new models of care, lest we be unpleasantly surprised by failing to care for our patients effectively in a new model that seemed to hold so much promise. ♦

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