

# Continuity of Care: "It Is About Connecting"

Kurt C. Stange, MD, PhD, Editor

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The focus of the third issue of the *Annals of Family Medicine* on continuity of care is generating a vigorous international, multidisciplinary discussion. In addition, dialogue about attention deficit/hyperactivity disorder was lively, and the US Preventive Services Task Force recommendations for promoting breastfeeding generated some controversy. A few themes from this discussion are highlighted below.

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## IS CONCERN ABOUT CONTINUITY RELEVANT ONLY IN SYSTEMS THAT DON'T SUPPORT IT?

"Most of these issues are mainly relevant to systems in which continuity of care is under attack, or in which there is a choice between continuity and non-continuity. ... In countries in which continuity is universal and not a choice, most of these questions are irrelevant," notes Israeli family physician Howard Tandeter.<sup>1</sup>

Like<sup>2</sup> argues that "continuity of care may prove to be an 'acquired taste' for those who have not yet had the opportunity to experience it." Others call for using the research published in the last issue of the *Annals* to make these concerns irrelevant, by using them to inform political processes or systems changes.<sup>1,3-6</sup>

Larry Green finds Saultz's<sup>7</sup> "three component hierarchy ... useful and stimulating."<sup>3</sup> According to Dr. Green, the forthcoming recommendations of the Future of Family Medicine (FFM) project on promoting electronic medical records and a medical home for all represent a potentially powerful combination of personalized care and systems support.

The importance of the medical record is supported by Barbara Starfield, who labels continuity as "a mechanism to assure the flow of information."<sup>8</sup> Contrasting continuity with longitudinality, Starfield notes, "Interpersonal continuity' is not only a matter of information (knowledge) flow. It is, most importantly, a mechanism to increase understanding, ... 'longitudinality' makes possible the attainment of understanding."

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## CONTINUITY IS IMPORTANT TO CLINICIANS

Although the focus of the research on continuity of care in the *Annals* issue was on its effect on patients and the health care system, the most poignant reactions came from family physicians reflecting on their personal experience.

Bruce Bagley<sup>9</sup> "understand(s) continuity in a way that is untouched by the literature. It is about caring for friends, not just patients. ... Continuity is such an inadequate word to describe helping a friend (patient) as he faces death, to deal with pain, loss and unresolved family conflicts. ... It is about trust. It is about connecting. It is about understanding people and providing simple explanations."

Ullven<sup>10</sup> observes that "[t]he sense of responsibility that physicians have for the care of their patients flows in part from the continuous interaction of the physician and his/her patient." He argues that a growing focus on immediate access diminishes continuity to a point that physician investment in the patient relationship suffers, as do the quality of training and patient care. Like<sup>2</sup> questions "[w]hose interests are being served by providing (or not providing) continuity of care?"

What are the unintended consequences of disruption of continuity on clinicians and on the relationships that give meaning to the work of being a healer? Where is the patient voice in this discussion?

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## CONTINUITY AND COSTS: CAUSE OR EFFECT?

The association of continuity of care with lower health care costs<sup>11</sup> generated excitement<sup>5</sup>: "This is what health care managers need to hear!"<sup>4</sup> "Those concerned with health care spending need to have a renewed respect for the value of primary care with continuity."<sup>6</sup>

Several readers, however, questioned whether continuity might be associated with lower costs because of selection factors.<sup>12,13</sup> That is, "it is also possible that cheaper patients are more likely to see the same doctor?"<sup>4</sup>

Regarding the study by Franks and colleagues<sup>14</sup> showing adverse clinical and financial consequences associated with changing insurance, Steven Landers<sup>15</sup> raises the possibility that "the increased utilization may be highlighting the beneficial effects of increased access by previously uninsured and underinsured individuals."

Several readers invite more research, including calls for prospective, even randomized studies,<sup>4</sup> and more qualitative studies.<sup>1,12</sup> After reviewing data from his own qualitative study, Bengt Mattsson notes that "[t]he patients' words and descriptions do not 'prove' in a strict bio-medical scientific way the advantages of continuity, but the reading and interpretation of the interviews has a convincing impact that very well supplements the well-designed study by De Maeseneer."<sup>12</sup>

### HOW DOES ADHD COME TO CLINICAL ATTENTION?

Oren Mason<sup>16</sup> calls for further studies of the process by which attention deficit/hyperactivity disorder (ADHD) comes to clinical attention, and cautions that the study by Sax and Kautz<sup>17</sup> is limited to physician report of who first suggests the diagnosis. Further research is called for by Terry Matlen<sup>18</sup> and MaryLiz Roth<sup>19</sup> as well. Two readers call for more attention to *adult* attention deficit disorder in research and practice.<sup>16,19</sup>

### INTERVENTIONS TO INCREASE BREAST-FEEDING: NOT EVERYONE AGREES

"Breastfeeding is terrific for some women, but not ALL women,"<sup>20</sup> asserts Helena Bradford, chairman of a foundation for postpartum depression awareness. Alan Ryan,<sup>21</sup> a scientist with Abbott Laboratories, manufacturer of an infant-feeding formula, questions the finding in the meta-analysis by Guise et al<sup>22</sup> that hospital discharge packs containing infant formula samples reduce breastfeeding rates. Christine Henrichs<sup>23</sup> calls for further training of family physicians in supporting breastfeeding.

These and other reader insights reveal the potential of diverse viewpoints for putting research into context. For example, the contrast between the health services and policy viewpoint of continuity and the view from the "ground floor" of primary care practice is striking. The former is about dollars and definitions and measurable outcomes in available data. The latter is about personal meaning and understanding. Both are about understanding and improving health care and health. The diversity of experience shared by readers is one key to putting together a more complete and integrated picture.

We encourage readers to examine the full text of these and other thoughtful comments online at <http://www.annfammed.org>. Please contribute your

ideas, understanding, and experiences. Clinicians, please ask your patients to enrich our discussion and understanding by sharing their experiences as well.

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