

Discourse

Reflections on Continuity in Contemporary Canadian Primary Care

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Though subject to various conceptualizations, continuity may be said to capture several key components: an awareness on the provider's part of basic health and related information about the patient; a relationship with the patient that extends over time; a patient-provider relationship that incorporates mutual trust and personal regard; and, finally, a commitment on the part of the provider to collaborate with the patient in the management and coordination of diverse care services (Reid, Haggerty, & McKendry, 2002; Saultz, 2003). Continuity, so defined, is more central, in Canada, to primary care (McWhinney, 1998), home care, and long-term care than it is to the more episodic character of specialty or hospital care.

The literature indicates that continuity is strongly linked to increased quality of care and enhanced outcomes. Continuity has been shown to be associated with improved management of specific clinical conditions such as diabetes (Parchman, Pugh, Noel, & Larme, 2002), with enhanced preventive care (Kasper, 1987) including childhood immunization (Christakis, Mell, Wright, Davis, & Connell, 2000), and with an increased likelihood of patients complying with prescribed treatments (Hjortdahl & Laerum, 1992). Continuity is also associated with higher patient satisfaction with care (Nutting, Goodwin, Flocke, Zyzanski, & Stange, 2003), which is an important component of quality. Finally, patients whose primary care incorporates continuity have lower rates of hospitalization (Gill & Mainous, 1988; Mainous & Gill, 1998) and make less frequent use of emergency departments (Christakis, Mell, Koepsell, Zummerman, & Connell, 2001).

If the issue is as clear-cut as these findings suggest, there is a powerful incentive for policy-makers to create models of primary care delivery that ensure continuity. But is the evidence as compelling as it appears, or does the notion of continuity demand more nuanced scrutiny?

Mobile and busy patients may prefer rapidity of access to the comfort of continuity. In an Alberta study, for example, 43% of walk-in clinic patients sought services during hours when the offices of their regular

family physicians were open (Szafran & Bell, 2000), which suggests that rapid access trumps continuity for patients with acute illnesses. Moreover, the apparently positive impact of continuity on quality of care may apply selectively to the treatment of chronic conditions and prevention but not to much of the acute care provided by family physicians. In a sample of Ontario walk-in clinics, family practices, and emergency departments assessed for eight sentinel conditions, the walk-in clinics and emergency departments (venues that are not associated with continuity) scored significantly higher for quality than the family practices (Hutchison et al., 2003). Finally, in a survey of physicians in walk-in clinics and office-based family physicians, those in walk-in clinics were less satisfied with their relationships with patients but more satisfied with availability of consultations, support staff, income, and vacation coverage (Williams et al., 2002). Importantly, physician and nurse employment satisfaction have been shown to be associated with the quality of care provided (Grindel, Peterson, Kinneman, & Turner, 1996; Weisman & Nathanson, 1985; Williams & Skinner, 2003). These disparate findings suggest that continuity may not be essential for quality care and indeed for the type of care that is preferred by some patients.

Continuity in primary care is traditionally conceived of as applying to the relationship between the patient and the family physician. This iatrogenic model requires re-evaluation. Compelling clinical evidence that nurse practitioners can deliver quality primary care dates from a landmark 1974 Canadian study (Spitzer et al., 1974). Twenty-five years of further research, summarized in a systematic review (Horrocks, Anderson, & Salisbury, 2002), has not altered this essential conclusion. The review's authors conclude that the literature indicates patients are more satisfied with nurse practitioner care than physician care and that there are no differences, in terms of patient health status, in the two types of care; though nurse practitioners tended to spend more time with patients and to order more tests, no differences were noted in the number of prescriptions, return visits, or referrals to specialists. Despite such clear evidence, the integration of nurse practitioners into the delivery of primary care has been slow to occur in Canada. This reticence is related to issues of funding and definition of practice boundaries and to practitioner concerns about liability. However, if continuity is deemed a desirable characteristic and if, as many predict, the current shortage of family physicians becomes more acute, a window of opportunity may exist for expanding current concepts of continuity to include team care.

A neglected component of most discussions of continuity is a recognition that the concept refers not simply to human relationships but also to the flow of information supporting such relationships — that is, instead of relying solely on contact with a single practitioner or team of

providers, we should build an element of continuity into disparate sources of care through the electronic patient record. At present the availability of patient data is not conducive to continuity. For example, when patients are discharged from hospital a summary of their admission is sent to the family physician and to the home-care provider, if this service has been ordered. Unfortunately, these discharge summaries are rarely received in a timely manner and often are uninformative on key points. A study of summaries concerning internal medicine patients discharged from two Ottawa teaching hospitals found that 34% lacked an admission diagnosis, 25% lacked a discharge diagnosis, 23% did not include discharge medications, and 40% were never received by the family physician (van Walraven & Weinberg, 1995). A subsequent randomized trial comparing the traditional dictated report with a report generated from a database found that family physicians considered the latter to be just as complete and informative as the traditional report (van Walraven, Laupacis, Seth, & Wells, 1999). The ability to ensure that information follows the patient across disparate sectors of the health-care system would represent a significant contribution to continuity of care.

Clearly, continuity is a goal to be pursued in primary care. However, policy-makers must appreciate the fact that continuity of care means considerably more than simply ensuring that each person is able to register with a family physician. Flexibility of care venue, team continuity, and the use of integrating information technology are all areas of innovation in primary care that offer an opportunity to place current concepts of continuity into a broader policy context.

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