Continuity of care

Differing conceptions and values

Dianne Delva MD CCFP FCFP **Jonathan Kerr** MD CCFP **Karen Schultz** MD CCFP FCFP

Abstract

Objective To understand how the conception of continuity of care can influence family physician trainees by exploring the perspectives of established family physicians, physicians working in episodic care who had been trained in family medicine, and family medicine trainees.

Design Qualitative analysis of focus group data.

Setting Southeastern Ontario.

Participants Seven focus groups consisting of members from 3 groups: established family physicians, physicians working in episodic care who had been trained in family medicine, or family medicine trainees.

Methods Semistructured focus group interviews were taped and transcribed. Using constant comparison, the transcripts were analyzed for themes related to continuity of care and how these were valued among the 3 groups of physicians.

Main findings The 3 groups differed on how they valued continuity of the relationship, how they valued informational continuity, and how these concepts affected their perceptions of difficult clinician-patient relationships. Experienced family physicians described long-term relationships as a core value in their practices. In contrast, episodic care physicians valued informational continuity. Family medicine trainees learned about continuity of care through role models and theoretical teaching. They valued the efficiency gained by knowing patients and the reward of being recognized by patients. Family medicine trainees expressed greater distress with difficult clinician-patient interactions than experienced family physicians expressed. It was unclear whether the challenges of difficult relationships were offset by the trainees' appreciation of continuity of care.

Conclusion Different perceptions, settings, and skills can influence how continuity of care is valued, which might affect career and practice decisions among trainees.

EDITOR'S KEY POINTS

- Continuity of care is a core value of family medicine that improves physicians' and patients' satisfaction and patient outcomes.
- The goal of this study was to understand how physicians value continuity of care and how this might be articulated to future family physicians.
- Experienced family physicians valued long-term relationships in contrast to the episodic care physicians, who valued informational continuity and the ability to transfer care at the end of their shifts.
- Residents might need support in challenging physician-patient relationships to appreciate the value of continuity of care.

This article has been peer reviewed.
Can Fam Physician 2011;57:915-21

Continuité des soins

Différences dans son interprétation et son importance

Dianne Delva MD CCFP FCFP **Jonathan Kerr** MD CCFP **Karen Schultz** MD CCFP FCFP

Résumé

Objectif Comprendre comment les résidents en médecine familiale peuvent être influencés par leur conception de la continuité des soins en vérifiant ce qu'en pensent des médecins de famille déjà en pratique, des médecins formés en médecine familiale mais dispensant des soins épisodiques et des résidents en médecine familiale.

Type d'étude Analyse qualitative des données de groupes de discussion.

Contexte Le Sud-Ouest de l'Ontario.

Participants Sept groupes de discussion formés de membres des 3 groupes suivants : médecins de famille en pratique, médecins formés en médecine familiale mais dispensant des soins épisodiques ou résidents en médecine familiale.

Méthodes Les entrevues semi-structurées des groupes de discussion ont été enregistrées sur bande magnétique et transcrites. Les transcrits ont été analysés à l'aide de la comparaison constante pour en extraire les thèmes reliés à la continuité des soins et à l'importance que leur attribue chacun des 3 groupes de médecins.

Principales observations Les 3 groupes avaient des opinions différentes sur l'importance de la continuité des soins et sur la façon dont cette opinion affectait leur compréhension des difficultés de la relation médecin-patient. Les médecins de famille déjà en pratique décrivaient la continuité des soins comme une valeur fondamentale de leur pratique. Par contre, les médecins dispensant des soins épisodiques accordaient beaucoup d'importance à une continuité dans l'information. Les résidents en médecine familiale apprenaient à connaître la continuité des soins par l'entremise de modèles de rôle et des cours théoriques. Ils appréciaient le gain d'efficacité résultant de la connaissance des patients et l'intérêt d'être reconnu par les patients. Par rapport aux médecins de famille en pratique, les résidents en médecine familiale se disaient beaucoup plus affectés par des interactions médecin-patient difficiles. On n'a pas établi si le problème des relations difficiles était contre-balancé par l'importance que les résidents accordaient à la continuité des soins.

Conclusion Des perceptions, contextes et habiletés différentes peuvent avoir une influence sur l'importance accordée à la continuité des soins et cela pourrait affecter les choix de carrière et les modes de pratique des résidents.

POINTS DE REPÈRE DU RÉDACTEUR

- La continuité des soins est une valeur fondamentale de la médecine familiale, qui améliore la satisfaction des médecins et des patients ainsi que les issues des patients.
- Cette étude voulait déterminer l'importance que les médecins attribuent à la continuité des soins et comment cela pourrait s'articuler avec les futurs médecins de famille.
- Les médecins de famille déjà en pratique attribuent beaucoup d'importance à une relation à long terme, contrairement aux médecins de soins épisodiques, qui favorisent plutôt la continuité dans l'information et la capacité de transférer les soins à la fin de leur quart de travail.
- Pour être en mesure d'apprécier l'importance de la continuité des soins, les résidents pourraient avoir besoin de soutien dans leur façon d'aborder la relation médecin-patient.

Cet article a fait l'objet d'une révision par des pairs.
Can Fam Physician 2011;57:915-21

Continuity of care is a core value of family medicine that improves physicians' and patients' satisfaction and patient outcomes.[1-5] The concept of continuity of care in family medicine, first described by Hennen,[6,7] had 4 domains: chronological, geographical, interdisciplinary, and interpersonal. Reid and colleagues[8] later described informational, relational, and management continuity.

Since the introduction of this framework in the 1980s, the practice of family medicine has evolved. Changes in demographics, advances in information technology, the explosion of available treatments, and changes in practice structures are important influences on family medicine as a discipline.[9] Many family physicians still provide comprehensive care, although an increasing number in Canada provide focused care, such as sports medicine, care of the elderly, palliative care, or emergency care.[10]

In addition, the trend toward group practices and working in multidisciplinary collaborative teams can affect the one-on-one relationships between family physicians and patients.[11] Research on continuity of care and its effectiveness has focused on patients' perspectives.[12] In this study we wanted to understand how physicians value continuity of care and how this might be articulated to future family physicians.

As part of a study to explore the aspects of continuity of care most valued among training family physicians, established family physicians, and family medicine–trained emergency physicians, we explored differences in concepts and values between these groups.

METHODS

Using a semistructured interview guide, our research assistant explored residents' and practising physicians' concepts of continuity of care in focus groups. Focus groups provide the opportunity for group interaction, which can lead to a deeper exploration of concepts.[13]

Setting and participants

Three cohorts of physicians with varying exposure to long-term doctor-patient relationships were invited to participate. Residents in the Queen's University Family Medicine Program in Kingston, Ont, had the least experience. Family physicians with long-standing practices working in and around small urban centres and family physicians working primarily in emergency departments (episodic care) were expected to have different perspectives on the value and interpersonal aspects of continuity of care. The study was approved by the Queen's University Research Ethics Board.

Interview guide and data collection

The interview guide was developed by J.K. and K.S. using frameworks on continuity of care described in the literature.[5-8] This guide was modified as the research progressed and fewer questions were required to elicit the views of participants. The research assistant obtained consent for recording and led the semistructured interviews. Participants were provided with dinner and an honorarium.

Data analysis

The recorded focus group discussions were transcribed and verified by the research assistant. Both J.K. and K.S. independently reviewed the transcripts to identify common themes and preliminary codes. The codes were refined and tested iteratively until themes and patterns emerged. Discrepancies were discussed and consensus was reached. The author D.D. independently reviewed the transcripts and analysis and confirmed the final results. NVivo 2.0 was used for systematic data analysis and to identify key quotes reflecting themes.

FINDINGS

Seven 1-hour focus group sessions of 4 to 7 participants were held from May 2007 to February 2009 (**Tables 1** and **2**). Residents were in their first year of training. The practising physicians, including emergency physicians, had completed family medicine residencies.

Themes with differing perspectives among the groups that emerged from the data included how continuity of the relationship was valued (efficient and effective, satisfaction, trust); informational continuity; and 2 issues regarding relationships, boundary issues, and difficult relationships. We identify quotes from the physician group, as individual voices were not discernable on the recordings. Residents believed they would value long-term relationships more than trainees in other

Table 1. Type of physicians assigned to groups

PHYSICIAN TYPE	GROUPS	FEMALE
Residents (n = 18)	3	12
Experienced family physicians (n = 9)	2	6
Emergency physicians (n = 10)	2	6
Total (N = 37)	7	24

Table 2. Age of physicians participating in study

AGE, Y	RESIDENTS (N = 18)	TRADITIONAL FAMILY PRACTICE (N = 9)	EPISODIC CARE (N = 10)
20–29	14	0	0
30–39	4	0	6
40–49	0	4	3
50–59	0	4	1
≥ 60	0	1	0

specialties, as they perceived they self-select for family medicine. Emergency physicians had varied levels of experience in community family practice. Their discussion focused on the links between the emergency department and community care.

Valuing relationship continuity

Residents did not expect to understand the value of relationship continuity until they had practised for some time. Their understanding was theoretical or through role models who described their job satisfaction in knowing patients and families: "[A]t some point in medical school, probably in the context of family medicine, you know, if someone is explaining why they liked their job." (R1)*

They were informed through personal experiences of continuity of care as patients:

> "[A]s a kid being treated as a patient, I really had a good relationship with my family doctor and I liked that I had one family doctor and that they actually knew who I was and what issues were going on." (R1)

Many residents had had meaningful connections with patients through repeat visits and during important life events:

> "That is the one thing, I think, that stands out in family [medicine] and kind of solidified what I thought continuity of care was, being able to see the patient over and over." (R2)

Family physicians emphasized how relationships with patients were valued:

> [It's a] feel-good feeling to have somebody recognize you and show you that they like you and that you have that relationship, so there's a 2-way street in terms of having a relationship. (FP2)

They recognized that relationships took time to develop and were necessary to develop trust:

> There's long-term satisfaction, long latency satisfaction, I think, that comes after you've developed a relationship with a patient and the patient with you (because it's mutual), and as I said before, you've got to trust the patient as well as the patient [must] trust you. (FP1)

The emergency physicians acknowledged that trusting relationships were stronger with family physicians: "[T]hey trust their family doctor more than they trust us because they have a relationship with that person." (EP1)

Emergency phy sicians valued the limits on their responsibilities:

> A lot of people go through to not have continuity of care. There is a great relief in not having responsibility for long-term follow up. My mind is at ease when I go on holidays. (EP1)

> [I]t gives me significant reassurance that a patient will be followed up. It limits the workup you have to do in the emerge department; it can drive away repetition. (EP2)

Effective and efficient

Residents emphasized the efficiency and confidence in providing care if they had encountered the patients previously:

> Myself in clinic here, just seeing a patient a couple of times, I feel more confident in the care that I am giving them. (R2)

> [A] relationship that you have built and being able to tell right away if things are normal or not—that is helpful. (R2)

In spite of their belief that long-standing relationships were needed to understand the value of continuity, residents were able to appreciate how a relationship could build quickly. These encounters provided satisfaction with the work:

> I've had two patients ask if I could be their doctor .... It gives you a little bit of pride that this person thought I was okay and we have a little bit [of] rapport. (R1)

> I saw her two, I think two, appointments before that, and then I followed her to the hospital. I did the rounds after she delivered, and then she came back twice with the baby, and now she is coming back for the postnatal so it's really ... you feel a kind of connection to that patient, and you just want to be there to provide help and support to them. (R3)

Informational continuity

Emergency physicians were somewhat cynical in how well continuity is provided. For them, the availability of information was paramount:

> I think for the patient, continuity of care is important, but the reality of the idea of continuity of care for the vast majority of Canadians is gone; if you

*Interviewee pseudonyms indicate the following: family physician working primarily in an emergency department (episodic care) (EP), family physician (FP), and resident (R), as well as an interview number.

> don't have continuity of care, at least having a common chart is helpful to you. At least you know their history, whether they are able to tell you anything or not. (EP1)

They valued informational continuity in providing efficient and effective care:

> [S]ometimes it is especially helpful: the information that is coming from the family doctor, who knows them, who knows that the dizziness that they get every 6 months means that this is what is going on. It is quite a time saver if we have that information, but it is very rarely that it is accessible to us. (EP1)

Emergency physicians expressed frustration that family physicians were not available to their patients and were not reassured that patients would be followed in a timely manner:

> Nothing makes me more hostile because, as a family physician, my philosophy was, if you are not there for your patients acutely, when are you there for them? If you've got your whole time booked up with blood pressure checkups and you can't double book a couple of times of day to see your sore throats and one UTI, what do you do? (EP2)

> The emerge is not well set up for continuity of care at all, so we struggle with lab reports, cultures that come back positive on a patient who is long gone, x-rays [showing] that some things have been missed .... [Y]ou order a test for like an ultrasound, and then who follows that test up? (EP1)

Residents relied on informational continuity, but found it a challenge both in volume and in the information provided:

> Even though the notes were good, I am not going to read the previous 15. (R3)

> Even if someone has written great notes, you don't have the same, you just don't get the same sort of comprehensiveness if you had been the one to see them at that last visit. (R3)

Family physicians agreed that the information in the electronic medical record (EMR) was distinct from relational continuity and knowing the patients: "EMR information you sort of realize is superficial. [Residents have] access to the EMR, but they don't know the patient." (FP2)

Boundary issues

Family physicians had a deeper understanding of boundary issues that were still prescriptive for residents:

> So, for me it meant really deeply reassessing how I related to patients and in the long run saying, "Well, you know the boundaries that have been dictated to me when I was a student just don't work," and eventually coming around to realizing that I always have boundaries with anyone and natural boundaries come up with anyone. You know, they are different in every individual situation. (FP2)

Residents echoed the straightforward approaches to boundaries taught to students: "[Y]ou kind of want to be her friend, and she wants to be your friend, but you can't really do that, you know." (R2)

They also had some unresolved questions: "How does it affect your objectivity when that relationship gets really, really strong? Do we lose objectivity because of that? Do we give in more because of that relationship?" (R1)

The discussion of boundaries led to concerns about patients' expectations for availability. As noted above, emergency physicians saw their work shifts as providing natural boundaries to availability not extended to family physicians.

Difficult clinician–patient relationships

Residents were frustrated by patients who did not follow their advice.

> [A]nd they're refusing to do it, the things that you are suggesting .... you also experience that [anger] when you kind of run out of batteries and you get frustrated and "I don't know how to help and I don't know how to get through to them" and it is not always a positive, wonderful thing. (R1)

Residents were frustrated when patients did not improve. "[N]o one else has found anything, and now you are the next person who can't help them. You feel incompetent." (R2)

Residents were discouraged by some relationships.

> [O]ne other downside of continuity of care is when you have a patient you do not like: you know, the one who makes you feel uncomfortable or something every time you are looking after them, and you see them anyway; you just dread them coming in. (R3)

Experienced family physicians described fewer difficult patients, suggesting these relationships helped them grow as physicians:

> I can't really have any heartsink patients because you've kind of figured them out. (FP1)

> I realize the benefit of seeing someone for a long time. And trust: just working with somebody who struggles to trust and realizing that they can trust me now, as much as they are going to trust anyone. (FP1)

DISCUSSION

McWhinney describes the core values of primary care as based on relationships and suggests that continuity alone is insufficient to meet the moral obligation to relieve suffering. It requires continuity of responsibility that "builds trust, creates a context for healing, and increases the practitioner's knowledge of the patient, much of it at the tacit level."[14]

In this study, experienced family physicians expressed a deeper understanding of the benefits and risks of long-term relationships than the other 2 groups of physicians. Long-term relationships were important for developing trust so that patients would share sensitive issues, for establishing appropriate boundaries, and for overcoming difficult relationships. Residents' views of relationship continuity were based on their personal health care and what they were taught. They were less likely to discuss issues of trust and how it might be gained. Their views of continuity focused on improved efficiency and confidence. Relationships were rewarding when patients appreciated their care and were distressing if patients were disliked or did not comply with treatment.

Emergency physicians provided another perspective. They acknowledged the trust patients have in their family physicians but discounted this reward for themselves, preferring to transfer responsibility for patients at the end of their shifts. Many studies have shown that most patients value access over continuity of provider for acute problems but prefer continuity of relationship for chronic, complex, and emotional problems.[2,12] Thus, the fit between the values of continuity and practice could be appropriate for the emergency physicians. We did not explore why they chose to focus on emergency care and can only infer that they preferred acute care to long-term relationships.

The differences in appreciation of informational continuity reflected the importance family physicians place on the personal relationship over informational continuity.[15] Informational continuity can be helpful in transferring patients across the primary and secondary care divide, but typically psychosocial details that are gained from personal contact are missing.[16] The family physicians and residents commented on the limits of the EMR in helping them know the patients and, by inference, limits to the ability to build trusting relationships. The study revealed potential conflict due to emergency physicians' frustrations with access to family physicians for information, urgent appointments, or follow-up.

Discussion of difficult clinician-patient relationships and boundary issues were raised by residents and family physicians. Although dissatisfied patients might leave physicians' practices, biasing their assessment of success, experienced physicians expressed great satisfaction and empathy in developing successful approaches for patients they initially found difficult. Residents focused more on their own feelings of frustration than on the patients they found difficult. As new physicians grapple with their confidence and frustrations, it could be helpful to assist them with developing strategies to acknowledge these feelings and reflect on their effect on patients. Without strategies to connect with "difficult" patients, some trainees could be deterred from committing to practice settings where they must take long-term responsibility for the patients.

Strengths and limitations

Most studies of continuity of care focus on patients' satisfaction and few on physicians' perspectives. We do not know of another study that has addressed the perspectives of family physician groups in various practice settings and experience. The different perspectives can alert family medicine teachers to help trainees develop the strategies to cope with the demands of making a commitment to ongoing relationships.

The study was conducted in one primary care setting with a limited number of participants. The access to care and patterns of practice might not reflect other jurisdictions, although the findings by Stokes et al[15] suggest that the importance of personal continuity is recognized among physicians in Western countries. The focus groups could have inhibited some members from expressing opinions, but this possibility is balanced by the immediate opportunity for confirmation or clarifying other views.

Conclusion

Perceptions of the value of continuity of care vary among physicians and physician trainees. Experienced family physicians value the relationships built with patients over many years, while family medicine physicians in episodic care appreciate the ability to transfer the responsibility for patient care at the end of their shifts. Finding ways to support family physician trainees to develop trusting relationships could ensure that they develop the confidence to maintain the commitment and responsibility of a primary care practice.

Dr Delva is Associate Dean of Undergraduate Medical Education and Professor of Family Medicine at Dalhousie University in Halifax, NS. **Dr Kerr** was a resident in the Department of Family Medicine at Queen's University in Kingston, Ont, at the time of the study and is currently Assistant Professor and Director of Curriculum in the Department of Medicine at Queen's University. **Dr Schultz**

is Associate Professor and Residency Program Director in the Department of Family Medicine at Queen's University.

Acknowledgment

Financial assistance was received from the Physicians' Services Incorporated Foundation through a Resident Research Grant. **Dr Kerr** was a second-year family medicine resident at the time of project development and initial data collection. (Investigators: **Kerr JR, Birtwhistle RV, Delva MD, Schultz KW**, Understanding Interpersonal Continuity of Care from the Physician's Perspective, 2007, $18 000.)

Contributors

Dr Delva was involved in study design, data analysis, and writing the final paper. **Drs Kerr** and **Schultz** were involved in study design and data analysis, as well as editing and reviewing the final paper.

Competing interests

None declared

Correspondence

Dr Dianne Delva, Dalhousie University, Undergraduate Medical Education, Room C-125, 5849 University Ave, Halifax, NS B3H 4H7; telephone 902 494-1890; fax 902 494-8884; e-mail **Dianne.Delva@dal.ca**

References

1. Cabana MD, Jee SH. Does continuity of care improve patient outcomes? *J Fam Pract* 2004;53(12):974-80.
2. Guthrie B, Wyke S. Personal continuity and access in UK general practice: a qualitative study of general practioners' and patients' perceptions of when and how they matter. *BMC Fam Pract* 2006;7:11.
3. Saultz JW, Lochner J. Interpersonal continuity of care and care outcomes: a critical review. *Ann Fam Med* 2005;3(2):159-66.
4. Ridd M, Shaw A, Salisbury C. "Two sides of the coin"—the value of personal continuity to GPs: a qualitative interview study. *Fam Pract* 2006;23(4):461-8. Epub 2006 Apr 4.
5. Gray DP, Evans P, Sweeney K, Lings P, Seamark D, Seamark C, et al. Towards a theory of continuity of care. *J R Soc Med* 2003;96(4):160-6.
6. Hennen BK. Continuity of care in family practice. Part 1: dimensions of continuity. *J Fam Pract* 1975;2(5):371-2.
7. Hennen BK. Continuity of care. In: Shires DB, Hennen BK, Rice DI, editors. *Family medicine: a guidebook for practitioners of the art.* 2nd ed. New York, NY: McGraw-Hill; 1987. p. 3-7.
8. Reid R, Haggerty J, McKendry R. *Defusing the confusion: concepts and measures of continuity of healthcare.* Ottawa, ON: Canadian Health Services Research Foundation; 2002. Available from: **www.chsrf.ca/Migrated/PDF/ResearchReports/CommissionedResearch/cr_contcare_e.pdf**. Accessed 2011 May 11.
9. Beaulieu MD, Rioux M, Rocher G, Samson L, Boucher L. Family practice: professional identity in transition. A case study of family medicine in Canada. *Soc Sci Med* 2008;67(7):1153-63. Epub 2008 Jul 20.
10. Bailey T. The evolution of family medicine. *Can Fam Physician* 2007;53:1113 (Eng), 1114 (Fr).
11. Rodriguez HP, Rogers WH, Marshall RE, Safran DG. Multidisciplinary primary care teams: effects on the quality of clinician-patient interactions and organizational features of care. *Med Care* 2007;45(1):19-27.
12. Saultz JW, Albedaiwi W. Interpersonal continuity of care and patient satisfaction: a critical review. *Ann Fam Med* 2004;2(5):445-51.
13. Kitzinger J. Qualitative research. Introducing focus groups. *BMJ* 1995;311(7000):299-302.
14. McWhinney IR. Primary care: core values. Core values in a changing world. *BMJ* 1998;316(7147):1807-9.
15. Stokes T, Tarrant C, Mainous AG III, Schers H, Freeman G, Baker R. Continuity of care: is the personal doctor still important? A survey of general practitioners and family physicians in England and Wales, the United States, and The Netherlands. *Ann Fam Med* 2005;3(4):353-9.
16. Agarwal G, Crooks VA. The nature of informational continuity of care in general practice. *Br J Gen Pract* 2008;58(556):e17-24.