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Comment

Benefits of Continuity of Care

To the Editor:

The articles on continuity of care in the January 2009 issue of *Family Medicine* struck a chord with me as a full-time practicing family physician.

The article by Bennett and Baxley looked at the cause of no-show rates.¹ They found that Advanced Access appointment scheduling did not improve a dismal rate of 20.5%; other factors (notably race, insurance status, age, and attendance history) were more predictive.

The article by Phan and Brown found that continuity of care actually decreased under Open Access (ie, same day) scheduling.² Patients saw their usual provider 59% of the time through a traditional scheduling system versus 55% under Open Access. The authors speculate that lack of physician availability, inflexible same-day scheduling, and patients' sense of urgency were key factors.

A commentary by Mainous and Salisbury tried to balance the need for continuity with ready access to care.³ They suggested that both needs could be served by linking patients to a team of providers and allowing them to choose between immediate access or waiting for their usual provider.

All three papers draw necessary attention to the question of continuity of care in primary care. But, to the mind of this practitioner, they miss some obvious points. First, continuity reflects our level of commitment to ambulatory care. It struggles in teaching centers where the inpatient service, obstetrical call, and specialty rotations compete for a resident's time and attention in the family medicine center.

Second, the bridge to continuity is often the receptionist, medical assistant, educator, or mid-level practitioner. Patients know a medical team (a.k.a. a truly patient-centered home) when they experience it.

Third, the value of the doctor-patient relationship lies in its mutuality. Both patient and doctor benefit from the insight, trust, compassion, and loyalty of a good, working relationship. As Mainous and Salisbury point out, continuity of care is not an end but a means to

better relationships that no scheduling formula can guarantee. Such relationships rely upon a commitment to time in the office, self-reflection, and the value of genuine kindness.

Family physicians have always known this to be true. But sadly, in the university setting where educators compete for the respect and favor of students and residents, we have convinced ourselves that skills and procedures, snap judgments, and interventions must be taught and mastered for the survival of the discipline. What do patients need? Rarely these.

Much more often, they need someone to listen, accompany them, and give them hope. And this takes time—time in the office.

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