only become family physicians but also write a PhD thesis on a research topic in family medicine.

At the moment, there are approximately 35 family medicine residents in The Netherlands following this program. We think these residents will generate a lot of new and relevant research in the future because of their experience in both family medicine and research. In this way, family medicine in The Netherlands prepares clinical scientists for a practice-oriented research career. We notice the advantages of this combined training program every day in daily practice. Moreover, it is a challenging way of becoming a research-oriented family physician. Maybe this could be part of the missing link in creating “research-savvy” graduates who practice evidence-based medicine and participate in research.

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References

Author’s Reply:
In reply to the letter by olde Hartman and colleagues, I applaud the efforts in The Netherlands to train residents who are interested in research by creating a special training program that includes a research project in primary care. I would be interested in following the paths of these 35 residents following graduation to see whether this training has the desired effects of increasing research capacity. We have similar training at the postgraduate level through fellowship programs, but I am afraid that these types of programs reach only a small minority of our residents—those who have a passion for research.

I would like to see us reach all of our residents with an enhanced curriculum that guides them toward evidence-based practice through using evidence at the point of care and gives them the skill and interest to pursue their clinical questions. Perhaps through residency program participation in systematic data gathering through practice audits, local quality improvement projects, or even state and national research networks, residents might broaden their ideas about research to include everyday practice. Then we might truly see a large cadre of graduates who practice evidence-based medicine and participate in research.

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Continuity of Care

To the Editor:
“When I use a word,” Humpty Dumpty said in rather a scornful tone, “it means just what I choose it to mean—neither more nor less.”

“The question is,” said Alice, “whether you CAN make words mean so many different things!”

The concept of continuity of care is elusive, and investigation has been hampered by the difficulty of establishing a clear, agreed-on definition. Some models of continuity of care are rather broad, as exemplified by the American Academy of Family Physicians definition, while other authors have proposed simple numerical indices measuring the proportion of consultations with a named physician. Multidimensional models of continuity of care2,3 recognize two core concepts: continuity as a “continuous caring relationship” (relational or interpersonal continuity) and continuity as a “seamless service” (management continuity or team and cross-boundary continuity). These may be supported by continuity of information.

In their recent empirical study, Nair and colleagues held focus groups with diabetic patients to explore their experiences of continuity of care. They argued that a researcher-focused definition of continuity of care may miss aspects of continuity that are important to patients. They therefore asked patients to discuss concepts of continuity of care but “few parameters were placed on participants’ discussion” (page 119). The resulting data were used to develop a classification of five factors that enhance or detract from continuity of care, including access to services, interactions with physician, interactions with other health care providers, personal self-responsibility, and communication. These were used to inform the development of a questionnaire measure. However, we question whether the concept of continuity of care can be used to mean so many different things. In particular, we question how self-care or personal self-responsibility can be justified as representing an aspect of continuity of care according to existing models.

Like Nair et al, we have recently been investigating the values and experiences of diabetic patients with respect to continuity of care, but we used a different approach. Unlike Nair et al, we did not ask patients to discuss “continuity of care” because we believed that patients would not be familiar with the meaning of the concept in the context of health care. Instead we referred to a conceptual model of continuity of care that encompassed the six elements of continuity described by Freeman et al.2 For example, without mention of continuity, we discussed patients’ views concerning the value of seeing a regular professional, factors that
facilitated follow-up over time, and experiences of coordination of care between different members of staff and between care settings. In this way, we were able to test whether our initial conceptual model was consistent with patients’ values and experiences. The empirical data were used to adapt and refine the model of experienced continuity of care. Our findings will be reported in detail elsewhere.

The patient perceptions reported by Nair et al encompass many aspects of quality of care in diabetes. While some may be related to aspects of continuity of care, others such as self-care or personal self-responsibility have not been justified as elements of continuity of care. Continuity of care should have quite a specific meaning, and this is not just what patients or providers choose it to mean.

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REFERENCES


Authors’ Reply:

Gulliford and colleagues have adequately described some of the difficulties of conducting research related to continuity of care such as lack of agreed-on definitions and varied methods of assessing continuity of care. We too recognized that these issues are problematic and thus accordingly sought to better understand the concept of continuity of care. As clearly indicated in our paper, we specifically sought to examine the patient perspective and chose to use qualitative research methods to do so.

The crux of Gulliford et al’s argument seems to rest on a concern that meaning is problematical and subjective and that there is a danger with allowing continuity of care to be “just what patients and providers choose it to mean.” However, what they fail to grasp is that the use of a phenomenological approach is precisely for this purpose, for understanding how people experience or understand a particular phenomenon. We would suggest that the meaning of continuity of care proposed by our research is based on the subjective experiences of patients with diabetes, and this is absolutely appropriate for this qualitative methodology.

The finding of a factor related to personal self-responsibility was novel and suggested a different way of looking at continuity of care that was not meant to be based on “existing models.” Simply because continuity of care had not been conceptualized in this manner before does not mean that it is incorrect. It should also be noted that, unlike Gulliford et al, we were not interested in validating someone else’s conceptualization of continuity of care—this would be an entirely different research question and accordingly would utilize a different research approach.

Finally, it is concerning that Gulliford et al have suggested an almost paternalistic approach to research and are not open to considering a different view simply because it has not “been justified as elements of continuity of care.” Gulliford et al state that continuity of care “should have quite a specific meaning,” but it is their meaning that they believe should be adopted. Our work demonstrates that patients’ reflection on their experience with the health care system may not be fully aligned with the conventional concepts and definitions used by evaluators and policy makers. This research is a starting place, and we would encourage others to further develop and explore the findings of our study.

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Comment

Do Resident Work-hour Regulations Really Increase Patient Safety? A Resident’s Perspective

To the Editor:

On July 1, 2003, the Accreditation Council for Graduate Medical Education (ACGME) instituted residency work-hour regulations, limiting resident work hours to 80 hours in a week and no more than 30 hours in a single shift. This was done after studies showing that sleep deprivation contributes to an increase in medical errors, presuming that limiting resident work hours would in turn enhance patient safety.

However, as a third-year resident who has worked both before and after the work-hour restrictions, I believe that these regulations, although well-intended, actually increase the potential for medical errors in some situations. Before the ACGME regulations, it was considered almost cruel to have a fatigued, post-call resident see his/her continuity clinic patients. Instead, residents were usually assigned to their respective inpatient or outpatient rotations, during which almost every step of our medical decision making was supervised by an attending physician. However, the work-hour regulations have led to post-call continuity clinic being the norm. This enables the hospital to maximize our time at work, since the rules state that after 24 hours on call, residents “may spend up to 6 additional hours” in outpatient clinic. As with any regular continu-