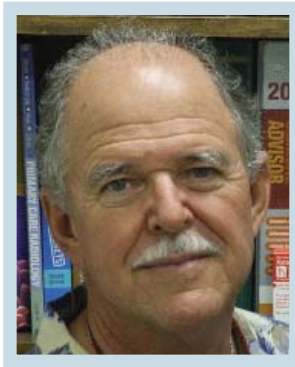


Is continuity of care a victim of progress?

I know in my heart that things change and hopefully for the better. This is especially so in our profession. We are forever striving to improve the outcomes for our patients with new medications, procedures, access to care, and evidence-based medicine. Right?

Yet, we have from time to time had to throw the machinery into reverse. How about all those wonderful medications we used to give to prevent sudden cardiac arrest



secondary to premature ventricular contractions? Anybody remember Rezulin, Seldane, Propulsid, Redux, and last but not least Vioxx for all that ails our patients? Well maybe in the same vein (no pun intended), how about continuity of care?

The first doctor I worked with back in the stone ages (1977) made rounds on his patients twice a day in two hospitals. Once my hospital privi-

leges were established, I was there, too, for 17 years. We made rounds together in the morning, and then I would make preliminary rounds in the afternoon. He would then follow up on those patients who required his attention later that evening. If one of our patients was admitted by another physician after a referral from us, we would make courtesy calls in order to stay abreast of the patient's condition and care. Visits by us to the emergency room, ICUs, radiology departments, and waiting rooms were the order of the day. Why? Because we were masochistic? No! Because the physician and I were taught that the reason we were there was for the patient; the patient was not there for the provider. This required continuity of care. Medicine seems to have gotten so specialized or complicated—possibly both—that we now have separation of state. Is anyone talking to or communicating with anyone else, or otherwise creating a streamlined form of care? We have the primary care physician, aka clinician, doctor, family friend, and the hospitalist, cardiologist, gastroenterologist, oncologist plus -ologists ad infinitum. Lord knows how complicated and magnificently constructed our bodies are and all the pathology that can affect them. Can anyone know it all? If this is improvement, so be it, but I am concerned about continuity of care—not only when the patient heads off to the consultant or the hospital but also when the patient is dismissed back to the clinic.

Case in point: My 88-year-old mother-in-law was admitted to the hospital through the emergency room (sorry—the emergency department [ED]). She was not seen by her primary care provider (PCP), aka doctor, since he no longer

sees patients in the hospital. Instead, the hospitalist group took the baton from the ED. Did the hospitalists know her? Did they have a special relationship with her? When did they see her? How long did her 91-year-old husband have to wait to talk with someone who could tell him what they had found and what the game plan was? When was the specialist called in to perform the procedure needed to relieve her problems? When did the procedure get done? Oh and by the way, did the PCP ever come by as a courtesy call?

The answers are in sequence: no, no, later, a long time, much later, later still, and no. Is there a PA in the house?

And with the transfer to the rehabilitation center, we have yet another provider.

How about medications in the rehabilitation center? They had to be brought from home. The medications initiated in the hospital? The prescriptions had to be written by the doctor who initiated them in the hospital, not by the PCP, which my father-in-law learned from the PCP's nurse after sitting in the waiting room for 45 minutes.

Excuse me! But does anyone reading this article remember the phrase “continuity of care”?

Now that I have gone completely off the deep end, I'm reminded of Gilda Radner's character Emily Litella, who rants and raves about something she has gotten all wrong and has to say, “Never mind!” I have to stop and ask myself: Have

“Lord knows how magnificently constructed our bodies are and all the pathology that can affect them. Can anyone know it all?”

I done everything perfectly over the past 31 years? You all know the answer. So I have to be careful with my comments. With all our advances, though, have we sacrificed something very special, or are we completely disregarding it? Am I the only one concerned about continuity of care? Apparently not, according to Ashley Kent, who in the February 15th issue of *AAPA News* quotes the report *Adolescent Health Services: Missing Opportunities*. This report mentions all the opportunities for continuity of care missed with our adolescents. So you see the lack of continuity does not seem limited to our geriatric patients. Is this the exception, or is it the new rule? You tell me. [JAAPA](#)

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