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Continuity of care: A concept analysis

by

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One good way of assessing the state of a science is to look into the state of its concepts .... In moving from the qualitative to the quantitative science, concepts have been hastily resolved and dissolved into variables .... Concept formation is one thing and the construction of variables is another; and the better the concepts, the better the variables that can be derived from them. Conversely, the more the variable swallows the concept, the poorer our conceiving.

Sartori, 1984, pp. 9-11

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies and Research for acceptance, a thesis entitled CONTINUITY OF CARE: A CONCEPT ANALYSIS, submitted by MARIA-RUBILIE GLENN in partial fulfillment of the requirements of the degree of MASTER OF NURSING.

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Date

DEDICATION

In memory of my mother, MRS. LUTGARDA B. ENRIQUEZ, who inspired me to strive for excellence in everything I do in life --an endeavor that is to be fueled always by love and humility. She died before the completion of my Master of Nursing program.

To my husband, GEORGE GLENN, whose patience though stretched to the limit, somehow managed to stand by me throughout the years I was at university.

To my son, CRAIG GLENN, who was always there to lift up my spirit when I needed encouragement.

Abstract

The goal of continuity of care has been a concern to health care providers for decades, yet, this end remains elusive. There are indications that the fundamental barrier to progress in this area may be the lack of conceptual clarity. To date, the concept *continuity of care* remains vague, confusing and ambiguous. Through concept analysis, an attempt was made to synthesize the various interpretations and applications of continuity of care to clarify the concept. The study focuses on the concept of continuity, specifically as it relates to provision of health/illness care. An inductive, descriptive approach to concept analysis was used where concept development was viewed as influenced by time, context and discipline/group usage. Collection of relevant data on the subject covered a span of 33 years from 1960 to 1993. Analysis of the data consisted of identification of attributes, antecedents, consequences, references, surrogate terms, and related concepts that help define the concept of continuity of care in its current stage of development as well as help distinguish it from other phenomena. Implications for further development are discussed.

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Overview and Questions

It can be argued that continuity of care is "both desirable and necessary if medical and nursing care are to yield maximum benefit to a patient, both in the hospital and home" (American National League for Nursing, 1966, p. 13). Accordingly, the concept of continuity of patient care has been and is espoused as an important component in the delivery of health care. However, the existence of a wide gap between the frequent use of the phrase "continuity of care" and its actual application in health care (Cook, 1979; LaMontagne & McKeehan, 1975; Shine, 1983) has been noted as far back as the 1970s. At that time, authors like Hansen (1975) challenged care providers to "choose either to accept continuity of care as an article of faith, or to develop systematic methods to test and document its importance" (p. 439). Several years later, after conducting a comprehensive literature review, Wall (1981) also declared: "Continuity may well represent a premature leap of faith rather than a proven component of quality care" (p.663).

We are now approaching the 21st century and continuity of care remains a poorly understood and unresolved concern in the clinical area; the concept remains ill-defined and ambiguous. While some view it as resulting from a responsibility taken on by the nurse (Cook, 1979; Pennington, 1969), or by a social worker (Society for Hospital Social Work Directors of the American Hospital Association [SHSWD], 1986; Rehr, 1986; "Discharge planning," 1991), some view it as resulting from the accountability, responsibility and/or attitude of the physician (Becker et al., 1974a; Gordis & Markowitz, 1971; Gonnella & Herman, 1980; Hennen, 1975).

Ongoing attempts by nurses, physicians, social workers and hospital administrators to provide continuity of patient care and perceptions that such a goal remains elusive (Borzo, 1992; Premier's Commission on Future Health Care For Albertans, 1988, 1989; Rosenthal & Miller, 1979), indicate that the fundamental barrier to progress in this area may be a lack of conceptual clarity. According to Rodgers and Knafl (1993), "in many situations, problems confronted in nursing knowledge may be primarily, if not strictly, conceptual in nature. Some of the more obvious conceptual problems include vague terminology, ambiguity regarding the definitions of important concepts in nursing, and inconsistencies among theories" (p.3). In the words of Moore (1993), "if a concept ... is vague and poorly defined, we have not progressed in our systematization or development of knowledge; we simply have another contribution to our supply of jargon" (p. 30).

Another factor which may contribute to the confusion and sometimes opposing conclusions about continuity of care is the existence of numerous and various health care workers who usually care for the same patients. This situation has given birth to competition and turf protection (Borzo, 1992; Crittenden, 1983; Kadushin & Kulys, 1993; Sutherland & Fulton, 1992; Tebbitt, 1981) which in turn has led various care workers to define continuity of care from their own perspectives, interests and orientations (Tebbitt, 1981). However, Rodgers (1993a, 1993b) contends that confusing views or varied applications of a particular concept can be synthesized and a clarification of the concept can emerge through an evolutionary view of concept analysis. Her approach to "theoretical clarification explores how a term is utilized, and emphasizes the

significance of analysing concepts as and when they are used by a particular group" (Attree, 1993, p. 356).

Concept formulation as influenced by time, context, and discipline/group use is illustrated by noting some of the changes in views regarding continuity of care. According to Rogers and Curtis (1980):

> In the eighteenth century ... continuity of care ... was enhanced by the stability of population and doctor .... [By the 1980s] concern over continuity of care seems to have grown in direct proportion to the increasing fragmentation of medical care, industrialization, and the mobility of patients and doctors alike. (p. 122)

With increased specialization and technology, planning and delivery of care became a shared effort by a multitude of agencies and/or care workers. Patient care through multidisciplinary teams emerged and the idea of continuity of care as a client-outcome or client-centred process surfaced (Borzo, 1992; Premier's Commission on Future Health Care For Albertans, 1988, 1989; Tebbitt, 1981).

There are some indications that competition and turf protection among care providers act as barriers to achieving the goal of providing continuity of care in practice. However, there is also a tendency by most of the investigators to leapfrog into measuring the effects or outcomes of continuity of care without an established substantive theoretical foundation. And, although "the evaluation of effects or outcomes is an essential activity in any organization, ... an unequivocal perception of what is to be assessed is vital before valid and reliable measurement can be achieved" (Attree, 1993, p. 355). Continuity of care is a concept that needs clarification whereby meaningful representations can be generated and from which operational definitions or constructs can

be formed and verified.

Therefore, the questions that guided this investigation were, "What does the term continuity of care mean?" and "What are the indicators signifying the occurrence of the phenomenon of continuity of care distinguishing it from other phenomena?" The purposes of this study were to explore the use and interpretation of the concept of continuity, specifically as it relates to health/illness care; to present data that will help clarify some of the ambiguities in the usage of the term; and to discover relationships among attributes of the concept on which hypotheses can be based.

Approaches to concept analysis

Morse (1995) defines concepts as "abstract 'cognitive representations' of perceptible reality formed by direct or indirect experience" (p. 33). In concept analysis, these abstractions are essentially dissected for in-depth examination resulting in the categorization of their defining characteristics. As an investigative approach, concept analysis is regarded as a formal, intellectual, and linguistic exercise that allows one to clarify a concept and communicate to others its precise meaning (Walker & Avant, 1988; Wilson, 1969).

There are several approaches to concept analysis developed for use in the field of nursing. Notable are the methods of Chinn and Jacobs (1983, 1987), Chinn and Kramer, formerly Jacobs (1991, 1995), Walker and Avant (1983, 1988), Schwartz-Barcott and Kim (1986, 1993), Rodgers (1989a, 1993a, 1993b) and Morse (1995). The approaches of the first three teams of scholars are more or less fashioned after the work of John

Wilson (1969), whose technique to concept analysis is derived from linguistic philosophy. Schwartz-Barcott and Kim (1986, 1993) name their method the "hybrid model," which incorporates both theoretical and empirical activities. Rodgers (1993a) calls her approach "an evolutionary view" to concept analysis with a strong philosophical foundation and Morse (1995) relies on qualitative methodology and Bolton's (1977) "rules of relation" for analysing concepts.

Chinn and Kramer (1983, 1987, 1991, 1995)

Aside from being informed by Wilson's (1969) work, Chinn and Kramer (1991, 1995; Chinn & Jacobs, 1983, 1987) credit later refinements in their technique to Walker and Avant (1988) and to their own experiences with concept clarification. Chinn and Kramer (1995) suggest that concept analysis involves the creation of conceptual meaning and propose that creating conceptual meaning is one of a number of processes that can be used as a starting point for theory development. Their special interest, as expressed in their latest text, is in the development of midrange theories.

According to Chinn and Kramer (1995), conceptual meaning "does not exist as an 'out there' reality, but ... is deliberately formed from experience .... Conceptual meaning conveys thoughts, feelings, and ideas that reflect the human experience on the concept" (p. 78). In other words, experience means a world view about something, a perception based on the totality of an individual as a human being.

Three sources of experience that interact to form the meaning of an idea include: "(1) the word or other symbolic label, (2) the thing itself (object, property, or event), and

(3) feelings, values, and attitudes associated with the word and with the perception of the thing" (Chinn & Kramer, 1995, p. 78). The relationships between all three sources of experience and the concept have to be taken into consideration when creating conceptual meaning (Chinn & Kramer, 1995).

The analyst who creates meaning "draws on many information sources, examines many possible dimensions of meaning and presents ideas so that they can be tested and challenged in the light of purposes for which the concept is being clarified" (Chinn & Kramer, 1995, pp. 80-81). Data sources from which conceptual meaning are formulated include: Constructing cases, visual images, popular and classical literature, music, poetry, professional literature and people. Sources of evidence may also include word usages of the concept and existing definitions. Chinn and Kramer (1995) assert that although "existing definitions are often circular and will not give a complete sense of meaning for the concept, ... they do help to clarify common usages and ideas associated with the concept. Existing definitions often help to identify core elements about objects, perceptions, or feelings that can be represented by the word. They are also useful to trace the origin of words that give clues to core meaning" (p. 82).

The latest refinement in Chinn and Kramer's (1995) approach, is the elimination of references to first, second, or third step in concept analysis. They speak, instead, of "issues or alternatives that could be addressed in the context of a process" (p. vii) to veer away from the notion of concept analysis as linear and a step-by-step procedure. Five iterative phases to concept analysis are prescribed: Selecting a concept, clarifying the purpose of the analysis, identifying data sources, exploring contexts and values, and

formulating criteria.

The phases of selecting a concept and clarifying one's purpose for the analysis of the selected concept are accomplished very early in the process. Chinn and Kramer contend that selecting a concept involves "a great deal of ambiguity" (Chinn & Kramer, 1995, p. 81) as one tries several alternative words during the process. Nonetheless, the act of trying alternative words itself to describe ideas, becomes part of the analytical process.

It is warned that when conducting concept analysis, it is easy to go astray during the process, therefore, clarifying the purpose of the analysis at the outset is stressed as a very important step. It is the component that provides direction and enables one to set boundaries. For example, if the purpose is to "differentiate between two closely related concepts such as sympathy and empathy .... [the] concern is to create definitions that do this" (Chinn & Kramer, 1995, p. 81).

As a data source, constructing cases is an activity that involves the construction of a prototype or model case that illustrates the object or instance of the experience "so that 'If ... [the object or instance] is not X, then nothing is'" (Chinn & Kramer, 1995, p. 83). Contrary, related, and borderline cases are also constructed to clearly delineate the parameters of the concept. These cases consist of scenarios that do not represent or contain only some of the characteristics found in the model case.

In formulating the defining criteria that will make up the model case, contexts and values and their association with the concept of interest are also explored since the meaning of a particular concept can vary across contexts. Chinn and Kramer (1995)

explain, "Social contexts within which experience and the values that grow out of experience occur from important cultural meanings that influence mental representations of that experience" (p. 87).

Defining criteria for the concept are expected to surface gradually and continuously as various sources of evidence and contexts and values that are associated with the concept are examined. The defining criteria that eventually emerge are described as always tentative. They are tentative "because both the definition and the criteria can be revised" (Chinn & Kramer, 1995, p. 80) depending on what is further discovered about the concept.

Walker and Avant (1983, 1988)

Along with Chinn and Kramer, Walker and Avant (1983, 1988) are recognized as some of the first to popularized the Wilsonian approach (Avant, 1993) to concept analysis in the field of nursing. While Chinn and Kramer present concept analysis as it relates directly to theory development, Walker and Avant (1983, 1988) present concept analysis at the level and in light of concept development with theory development and evaluation as ultimate outcomes. Even so, Walker and Avant's and Chinn and Kramer's analytical processes, with their underlying rationale and caveats, are very similar.

Walker and Avant (1988) pose concept analysis as one of three strategies for concept development. Other strategies proposed for concept development include *concept synthesis* and *concept derivation*. Concept synthesis is recommended for use if the investigator wishes to develop new ideas, when there is a need for new uses of existing

concepts, or when there is a "need to explain something by classifying it" (Walker & Avant, 1988, p. 58) and concept derivation is used for transporting already defined phenomenon in one field to another, one in which the phenomenon is undefined and unknown, "by relying on an analogous and metaphorical relationship between two phenomena" (Walker & Avant, 1988, p. 65).

Concept analysis using Walker and Avant's (1988) approach involves phases which, like Chinn and Kramer's approach, are performed iteratively. Also like Chinn and Kramer, the process consists of selecting a concept, determining the aims or purposes of the analysis, identifying all uses of the concept, determining the defining attributes, and constructing cases.

Once a concept is selected and the aims clarified, the uses of the chosen concept are identified from a variety of sources such as dictionaries, thesauri, colleagues, and literature. All uses of the term including its implicit and explicit uses are explored. At this stage, a list of provisional criteria can be made and a model or pure case is developed which are both guided by the aims of the analysis. Other cases to be constructed include related, contrary, borderline, and invented or illegitimate. Whereas Chinn and Kramer (1995) include case construction as one of many possible data sources that contribute to the formulation of defining criteria, in Walker and Avant's approach (1988), case construction is the key that serves to distinguish between the defining attributes of the concept and those that are not. The analysis is said to be complete, only when the investigator reaches a stage where no "overlapping attributes and no contradictions between the defining attributes and the model case" (Walker & Avant, 1988, p. 42) are detected.

Walker and Avant's (1988) approach also involves the additional phases of identifying antecedents and consequences and defining empirical referents (pp. 37-40). According to these particular scholars, delineating antecedents and consequences helps in refining the critical attributes of the concept as the procedure establishes a clear differentiation between antecedents and attributes of the concept. The final step in the analytical process is the determination of empirical referents, which are "classes or categories of actual phenomenon that by their existence or presence *demonstrate* the occurrence of the concept itself" (Walker & Avant, 1988, p. 43). In this regard, critical attributes and empirical referents may be identical (Walker & Avant, 1988).

An example of Walker and Avant's approach can be found in Meeberg's (1992) concept analysis of "Quality of life." Meeberg's analysis included a review of selected literature from the field of sociology and health care, dictionary definitions and available tools used to measure quality of life. From this review, defining attributes, antecedents, and consequences were delineated. She constructed a model case and then differentiated the model case from constructed related, contrary, and illegitimate cases. Although she discovered that "there exists no definitive set of empirical referents or instruments for measuring ... quality of life" (p. 37), she convincingly presented the relevance of the concept to nursing, her reported aim for the analysis.

Schwartz-Barcott and Kim (1986, 1993)

Schwartz-Barcott and Kim (1986, 1993) propose a "hybrid model" for concept

development, which builds on and combines the approaches of Wilson's (1969) concept analysis, Reynold's (1971) development of scientific knowledge, and Schatzman and Strauss' (1973) technique in field research. Schwartz-Barcott and Kim's (1993) technique "draws heavily on insights generated in clinical practice" (p. 108).

The hybrid model of approach consists of three sequential phases: Theoretical, fieldwork, and final analytical. Work in the theoretical phase sets a "foundation for the later phases of in-depth analysis and concept refinement" (Schwartz-Barcott & Kim, 1993, p. 110). The theoretical phase consists of selecting a concept, searching the literature, determining meaning and measurement, and selecting a working definition. The focus is "on the essential nature of a concept rather than on the defining attributes, properties, antecedents, or consequences of a concept" (Schwartz-Barcott & Kim, 1993, p. 109).

Schwartz-Barcott and Kim's (1993) approach shows that concept analysis can also begin by selecting a concept from actual encounters with care recipients in clinical practice. One begins by choosing an encounter and describing it in detail, followed by an in-depth examination of the encounter to determine which explanations or concepts fit. From a list of identified concepts, an underdeveloped concept may be singled out and focused upon. Sometimes, as a result of closely examining an encounter, new concepts are created which are later discarded if an appropriate concept emerges as a result of further collection and analysis of data.

The literature search is usually performed across disciplines, to capture the "conceptualization and usage of the selected concept" (Schwartz-Barcott & Kim, 1993, p.112). Focus during the initial literature search is guided by questions that yield a

working definition and measurement of the concept. A working definition is developed by comparing dominant themes and consensus in the various descriptions of the concept. Although a working definition serves as the core of the fieldwork phase, it is suggested that the investigator maintains a tentative stance even when the analysis is deemed complete, since a change in the definition is always possible with further discoveries.

The literature review that began in phase one continues into phase two. In the second phase, Schatzman and Strauss's (1973) field research methods are utilized to collect data for further analysis of the selected concept. The fieldwork phase is "aimed at refining a concept by extending and integrating the analysis begun in phase one with ongoing empirical observations" (p. 113). During the third and final analytical phase, the results from the two previous phases are integrated resulting in a definition of the concept and identification of measurement strategies and problems. At this stage, the investigator "reexamines the findings in light of the initial focus of interest .... If the importance of the initial concept was supported, then the next step is to reconsider the findings in light of the concept's definition and measurability" (p. 123-124).

While Wilson's (1969) analytical approach is used for selecting and presenting case studies that reflect the defining criteria, both Wilson's and Reynold's analytical approaches help in the collection of more data and in strengthening the analysis of data in the second phase. In the third phase, both "Reynolds's and Wilson's analytical approaches help in finalizing the analysis and suggesting possible alterations or refinements of the concept" (p. 110).

An example of the use of the hybrid model is a concept analysis on withdrawal

conducted by Verhulst and Schwartz-Barcott (1993). Based on these investigators' analysis of the concept, the initial working definition that was used for the fieldwork phase was eventually refined and a list of observable indicators was developed for possible measurement of the concept in its redefined form.

Rodgers (1989a, 1993b)

Rodgers's approach is underpinned by the integrated views of philosophers such as Toulmin (1972), Wittgenstein (1968), and Price (1953). However, the actual phases of the analysis in which an investigator goes through, resemble the approaches of Walker and Avant and Chinn and Kramer in a number of ways. Like Walker and Avant's approach, Rodgers's method includes specifications of antecedents, consequences, and referents as components of concept analysis. She also retains the phase of identifying a prototypical or model case with a major difference in approach; the identification of a model case is not performed by constructing a hypothetical case but rather by identifying the prototype case in the literature or in actual situations.

The emphasis of Rodgers's (1993b) technique is on inductive inquiry and on time and context as important elements that can affect a concept's evolvement or devolvement (pp. 77-78). Rodgers (1993a) proposes an approach to concept clarification that advocates external realism, supporting the fuzzy set theory (borrowed from the field of psychology) rather than essentialism (p. 21). In the fuzzy set theory, concepts are held to be "constantly changing, comprised of numerous interrelated and overlapping elements, and interpretable only in regard to a multitude of contextual factors" (Rodgers, 1993b,

p. 73). Rodgers explicates:

> Although concepts are individual and private in nature, the process of abstraction, clustering, and association of the concept with a word (or other means of expression) is influenced heavily by socialization and public interaction. Consequently, the development of a concept for a person takes place with guidance from the social context in which the person interacts and develops concepts. (p. 74)

An uncommon step compared to the approaches discussed previously, is that Rodgers' approach to concept analysis incorporates a quantitative technique in terms of selection of the setting and sample. To Rodgers (1993b), in a "literature-based analysis .... the ultimate goal ... [is to generate] a rigorous design consistent with the purpose of the study" (p. 79). She advocates random sampling of the literature after identifying the population of literature from which to sample. Rodgers (1993b) argues that "while it is not possible to truly identify the entire population of literature ... it is possible to identify the total population of literature indexed" (p. 80). Each domain of interest is to be treated as a separate population and an appropriate random sample is drawn from each discipline.

However, Rodgers (1993b) acknowledges a concern with the type of sampling procedure she advocates in that the volume of identified literature may be quite enormous and difficult to manage. She advises, "The population and subsequent sample can be reduced by delimiting the time frame, choice of disciplines, or choice of literature sources" (p. 82). Rodgers does not address a difficulty one may encounter when one discovers in a sampled publication, that although the concept of interest is mentioned, the meaning of the concept may not be expounded upon by the author. In such a case, the

sampled item becomes useless in the search for conceptual meaning.

In an analysis of the concept of health policy, Rodgers (1989b) demonstrated the use of her approach. The analysis included a detailed account of procedures for sampling the literature. She explored changes that have occurred in the concept over time and areas of agreement and disagreement across the disciplines of nursing, medicine, health care administration, and policy sciences. Examination of the literature from the disciplines included in her analysis enabled her to discover unique aspects of health policy as it was conceptualized within each of the disciplines.

Morse (1995)

Morse (1995) acknowledges Rodgers' evolutionary view as a major advancement in concept analysis but argues that the goal of identifying a model case, derived from Wilson's approach, is restrictive when one attempts to generate a useful theoretical foundation for nursing practice (p. 32). As a result, Morse (1995) favours and proposes a method of concept analysis that uses techniques of qualitative inquiry in combination with Bolton's (1977) "rules of relation" to identify the main characteristics of the concept of interest.

Bolton's rules of relation, as interpreted by Morse (1995), are the "stable patterns of utilization of factors, attributes, properties, or characteristics that form the concept" (p. 35) enabling one to label or name experiences of reality. Morse contends that "while applications of ... [Bolton's] rules of relation identify universal attributes, qualitative methods allow for the extension of the prototype perspective by permitting the

identification of the common attributes of concepts that belong to the same conceptual category but are manifest in different forms" (pp. 35-36). Situations or incidents to be used as exemplars, therefore, must be chosen with care because "while all the attributes may be present in any example, they may be represented in various forms and assume various degrees of importance in different situations .... The better the exemplar, the more obvious the attributes and the easier the task of identifying the conceptual attributes" (Morse, 1995, p. 37).

Morse (1995) proposes six variations of concept analysis that depend on discoveries made during the literature review: Concept development, concept delineation, concept comparison, concept clarification, concept correction and concept identification. Differentiation among the six methods proposed by Morse (1995), lies in the use of the rules of relation. For example, according to Morse, "the difference between concept development and concept delineation is that concept delineation uses the rules of relation to identify attributes developed from data sets, rather than from a single exemplar" (p. 40).

Morse (1995) reports that the technique of concept clarification was used in their analysis of the concept of caring (Morse et al., 1990). In this particular analysis, although the literature for the analysis was immense, questions that guided the delineation of the various perspectives on caring were based on the rules of relation. The use of the rules of relation enabled sorting of data "according to the underlying assumptions ... [revealing] five manifestations of the concept of caring" (Morse, 1995, p. 42).

The methods of concept analysis proposed by Morse builds on the methodologies

of concept analysis put forth by the other experts discussed previously. For example, Morse's exemplars are case studies or real incidents which are also preferred by Rodgers (1993b) and Schwartz-Barcott & Kim (1993) in demonstrating the contextual nature of the concept. The use of exemplars is an extension of Chinn and Kramer's and Walker and Avant's use of prototypical cases to isolate and present the defining attributes of the concept, and like Schwartz and Kim, Morse incorporates a qualitative inquiry approach to concept analysis.

Selection of approach

Selection of an approach to concept analysis depends largely on the researcher's purpose for conducting the analysis. The strategies of Chinn and Kramer and Walker and Avant accommodate a wide range of purposes including developing operational definitions. Chinn and Kramer's approach is useful in determining if the concept of interest exists in a particular situation using a provisional set of criteria geared to developing midrange theories. Walker and Avant's (1988) approach may be used "to distinguish between the defining attributes of a concept and its irrelevant attributes" (p. 35) using constructed hypothetical cases.

Schwartz-Barcott and Kim's (1993) approach to concept analysis can be used as a starting point for further empirical work and elaboration of the concept of interest. Their method can help "identify, analyze, and refine concepts in the initial stage of theory development" (p. 108) by incorporating theoretical and empirical processes. Rodgers (1989a) focuses attention specifically on concept clarification. Her method can be

employed "to identify a current consensus or 'state of the art' regarding the concept, which provides a foundation for further development .... [without imposing] any strict criteria or expectations on the analysis" (p. 77). Lastly, Morse's (1995) approach may be used "to identify the attributes of a concept, to delimit the concept, and to document the various forms that the attributes manifest" (p. 36) using the techniques of qualitative inquiry.

Methods

Rodgers' (1993) approach was used in this investigation. An attempt was made to clarify the current status or state of the art of continuity of care, by identifying agreement and disagreement in the use of the concept among the disciplines of medicine, nursing, social work, health care administration, and patients' perspectives. The historical or evolutionary background of the concept was explored as well.

The following activities for the study were carried out simultaneously throughout the investigation rather than accomplished sequentially. However, for the purpose of this report, each step is discussed in the order presented below (Rodgers, 1993b, p. 78):

1. Identification of the concept of interest and associated expressions.
2. Identification and selection of an appropriate realm (setting and sample) for data collection.
3. Collection of data regarding the attributes of the concept, along with surrogate terms, references, antecedents, and consequences.
4. Identification of concepts related to the concept of interest.

5. Analysis of data regarding the above characteristics of the concept.
6. Performance of interdisciplinary and temporal comparisons.
7. Identification of a model case of the concept.
8. Implications for further development.

Concept of interest

The concept, continuity of care, appears to have varied associations, utility, and importance over time. For example, when one searches for the term continuity of care in the Cumulative Index of Nursing Literature (CINAHL), 1956 - 1960, it can be found in association with progressive patient care and referral systems. By 1971, continuity of care can be found listed under three areas: Admitting and discharge, progressive patient care and referral systems. By 1972, continuity of care started appearing under the listing of comprehensive health care, progressive patient care, and admitting and discharge. In the 1979 CINAHL, articles on continuity of care can be found also under primary nursing. In the International Nursing Index, continuity of care as a separate listing did not appear until 1972.

The historical variation in indexing of continuity of care supports, in part, Rodgers' (1993b) position on conceptual formation. According to her, clusters of attributes of a concept may change over time within a particular context, "by convention or by purposeful redefinition, ... to maintain a useful, applicable, and effective concept" (p. 75). This position has been proven to be true with the concept of continuity of care.

Setting and Sample for Data Collection

This investigation covered a span of 33 years to allow for a discovery of the concept's evolution. Indexed literature (computerized and printed) coupled with cited references from 1960 to 1993 from the fields of medicine (n=70), nursing (n=61), social work (n=16) and hospital administration (n=40) were included since conceptualizations of continuity of care were primarily found in the literature written within these particular disciplines. A few selected articles published beyond 1993 were included and before 1960 to assist in determining the concept's current level of evolvement. To add contextual richness to the results of the analysis, literature that included discussions regarding patients' perspectives on the subject was searched and analyzed as well.

Departing from Rodgers' (1993b) approach, random sampling from a population of indexed literature on the subject of interest (p. 80) was not performed. Instead, the literature included for this investigation was collected through citations and a key-word search, "continuity of care," in the CINAHL and MEDLINE computer data bases as well as in the printed Cumulative Index of Hospital Literature (CIHL). The years included in the CINAHL data base were from 1983 to 1993 since only these years are available in this computerized data base. The years included in the MEDLINE data base were from 1966 to 1993 since these years are available in this particular source.

For obvious reasons, the list of written works in printed indexes outside the years that are computerized were manually searched for titles bearing the words "continuity of care," or similar terms such as "continuous care" and terms that denote transfer of patient among providers, units, or agencies. Literary works (63 out of 250) that contained the

term, continuity of care, but failed to expound on its meaning or add new information for further clarification of the concept were excluded. Each discipline was treated as separate populations "to facilitate more rigorous interdisciplinary comparisons" (Rodgers, 1993b, p. 81). Thus, literature was sorted according to disciplines to facilitate analysis within a discipline and comparison among disciplines.

Collection of Data

An inductive approach was employed during collection of data. Data relevant to the categories of attributes, antecedents, consequences, surrogate terms, and related concepts as well as the references of the concept were collected and analyzed (Chinn & Jacobs, 1983; Rodgers, 1993b; Walker & Avant, 1988). Direct quotes containing both explicit and implicit descriptions of the concept were extracted from the articles and fed directly into the computer. The quotes were kept under coded bibliographic type of headings (each bibliography was separated by page breaks) and grouped under their respective disciplines. These groupings made up computerized document numbers one (medicine), two (administration), three (social work), four (nursing) and five (patient perspectives). The actual article is labeled with the same code making cross checking easier. For example, the code "N84-1" means it is a nursing domain article published in 1984 and the item number is 1. The article and the bibliography (which included the quotes) in the computer were both numbered "N84-1"; the code "M93-1" means it is a medical domain article published in 1993 and the item number is 1; and so on.

A sixth computerized document was created where categories of the concept

(attributes, antecedents, consequences, surrogate terms and related concepts) were grouped accordingly allowing comparison within a discipline. Thematic categorization and sorting (from single words to entire sentences) were performed using Wordperfect's capability such as blocking, search, copy and move. Conceptual categories were separated from each other by page breaks, again, for easy access and cross checks. A seventh document was created where all four disciplines were merged with categories of the concept also grouped accordingly, allowing comparison among the disciplines.

The focus during the collection of data was on the clustering of attributes which were found in discussions or statements that indicate how an author defines the concept of continuity of care. This approach extends beyond titular or dictionary definitions (Rodgers, 1993b). Antecedents, the actual events and/or situations which precede the phenomenon of continuity of care and consequences or the actual events that occur as a result of the phenomenon were identified. Actual situations or references "to which the concept .. [was] applied" (Rodgers, 1993b, p. 83) were also identified and included in the discussions where appropriate.

Those words which represent the concept of continuity of care (surrogate terms) were examined and attempts were made to differentiate them from related concepts. Terms which are associated with the concept of interest (related concepts), based on the premise that every concept exists as part of a network of concepts and which actually enhance the contextual basis of concepts (Rodgers, 1993b), were also noted. However, in this investigation, it was not always possible to separate the surrogate terms from the related concepts, therefore, they are discussed under one heading of "surrogate terms and related concepts."

Analysis of Data

As in the collection of data phase, data analysis was also carried out inductively. A journal was kept where thoughts and insights were jotted and then used as review notes to compare, contrast and develop themes and ideas. Identification of themes regarding the concept of interest is not unlike performing content analysis (Cowles & Rodgers, 1993; Morse, 1995). Analytical induction involves "the careful consideration of all analytical evidence, the intensive analysis of individual cases, and the comparison of cases to one another" (Wilson, 1989, p. 476). To avoid premature conclusions or closure, final formal analysis was performed at the end of the data collection.

As suggested by Rodgers (1993b), each category of data was constantly examined separately to identify major themes "until a cohesive, comprehensive, and relevant system of descriptors ... [was] generated" (p. 87). This phase required an eighth document and together with a ninth document (perspectives on care and caring), data were organized and labelled to describe the major aspects of the concepts. Data were also "examined for areas of agreement and disagreement across disciplines, change over time, or for insight into emerging trends" (Rodgers; 1993b, p. 86). Words, phrases, and/or sentences which contributed to the explication of the identified themes/conceptual categories were sorted, merged and edited by retrieving, switching, entering and exiting from one document to another. The result of this phase is reflected in the discussions under the heading "Discussion and implications" where conceptual categories are presented in a recategorized form.

Identifying a Model Case

In this investigation, as far as the literature included for this study is concerned, no model case can be found for continuity of care. In situations like this, the recommendation is, "it is better not to provide a model case ... than to construct one when it is not warranted" (Rodgers, 1993b, p. 87). The inability to find a model case, according to Rodgers (1993b), usually indicates the developmental level of a concept.

Implications for Further Development

An attempt was made to provide a substantive conceptual foundation from which questions and directions for further research can be identified.

Review of Literature

A review of the literature revealed that although much has been written about continuity of care, there is a paucity of research-based reports. The majority of empirical studies reviewed were conducted in the 1970s and 1980s and mostly in the medical field. The concept of continuity of care, in general, has changed contextually over time supporting Rodgers' (1993b) view that concepts are context dependent and "the relevant context may be disciplinary, social, cultural, or theoretical .... [and] may be conceptualized quite differently relative to the group membership of the person who uses the concept" (p. 77).

Continuity of care has been defined as a series of connected patient care events/activities within and between agencies (Bristow et al., 1976; Hartigan & Brown, 1985); a coordination of services within and between facilities (Alberta Association of

Registered Nurses, 1989; Crittenden, 1983; Gikow et al., 1985; Shulman & Tuzman, 1980) or during the prehospitalization, hospitalization and posthospitalization phases of a patient's illness (Zarle, 1987) and the easing of patients' transfers from the hospital to their homes (Packard-Helie, & Lancaster, 1989). The term continuity of care sometimes is used interchangeably with the term discharge planning (Haddock, 1991; Society for Social Work Administrators in Health Care [SSWAHC], 1993). Still, others view it as seamless services within a hospital (Borzo, 1992; Royal Alexandra Hospital, 1994), or a seamless network of health care agencies in the community (Anderson & Lumsdon, 1992; Lumsdon, 1993).

While there seems to be no disagreement on what is meant by, "continuity," there are a variety of postulations on how "continuity" should be expressed in association with the term "care." The consensus on the word continuity seems to arise from acceptance of its dictionary definition (Webster, 1976) as "an uninterrupted connection or succession; .... a connected or unbroken course or series" (Bass & Windle, 1972; Beatty, 1980a; Bristow et al., 1976; Haddock, 1991; Hartigan & Brown, 1985; Rogers & Curtis, 1980; Shortell, 1976).

Divergence in points of view about continuity in relation to care seem to cluster around three basic overlapping themes: care provider continuity (physician-focused and/or nurse-focused), intra-agency continuity, and inter-agency continuity. The term "care" appears to be the root of ambiguities in the use of the term "continuity of care" as a single concept. Consequently, literature on perspectives on care was inspected to determine how continuity fits within the context of care.

Limitations of the Study

Since there is considerable overlap among the four categories of medicine, nursing, social work, and administration, bias may have been introduced when sorting the literature into these four categories. Core content and/or authors of the material dictated the categorization. In addition, arrangement of data into the various elements of a concept (i.e., antecedents, attributes, consequences, and surrogate/related terms) should not be considered as definitive.

Significance of the Study

If the desire to increase continuity of care or to reduce fragmentation of care, is to be used as a reason for restructuring of hospitals and adopting new care modalities or work designs then further investigation on the subject must be conducted to lend support to the claim that changes are indeed based on adequate data and sound theories. The basic question of what is continuity of care and how it should be evaluated remains problematic. While provider continuity, care modalities, and discharge planning programs have been quantitatively studied to a certain degree, there are doubts whether these factors represent or lead to continuity of care. Although there is an attempt to move towards providing interdisciplinary care, studies of continuity of care focus either on medical care alone or nursing care alone, as if they are mutually exclusive. Since medical, nursing and allied personnel are usually involved in the care of patients, the concept of continuity of care should be studied across disciplines. Also, since care recipients are viewed as the individuals who are supposed to benefit from such

interdisciplinary approach to care, the concept should be studied from the perspective of care recipients as well.

At present, there is insufficient qualitative research to complement quantitative lines of thought regarding continuity of care. According to Norris (1982), "experimental research without concept clarification is meaningless. If a concept is not clear, subsequent research may be based on false assumptions, false premises, and hypotheses that have no relevance to the real world" (p. 11). In addition, "when operational definitions are proposed before a complete conceptual model has been developed, inconsistent conclusions will be reached because of a failure to clearly identify and understand the concept being measured" (Banahan & Banahan, 1981, p. 767).

Perspectives on continuity of care

It is evident that conceptualizations of continuity of care have not progressed much beyond dictionary definitions. The emphasis is usually on "continuity" with the word "care" used to designate discipline-specific activities, i.e., medical care, nursing care, social work or administrative work. Because of the considerable overlapping of activities of disciplines that are distinct, profession-wise, a power struggle amongst the disciplines emerges in the intricate interpretations of continuity of care. As a result, the interpretations themselves paradoxically portray a fragmented view of continuity of care.

Authors, including researchers, characterize continuity of care simply by combining the words continuity and care and applying them to care recipient-care provider interactions specific to their respective disciplines. That is to say, *continuity of*

care is defined as an "uninterrupted succession, unbroken connection, sequence, progression, continuum, chain, or linking" of "medical care," "nursing care," "social work" or "community health services" in general.

Etymology and dictionary definitions

According to The Barnhart Dictionary of Etymology (1988) and The Oxford English Dictionary (1989), the word "care" comes from the Old English words *caru* or *cearu* meaning sorrow, anxiety, and grief and from the words *carian* or *cearian* --to be anxious about. In terms of its basic meaning of inward grief, the word is related in origin to Old Saxon *kara* care, Old High German *chara* wail, lamentation; Gothic *kara* sorrow, trouble, care and from Proto-Germanic *karó*. The Old English verb conforms to Old Saxon *karōn* to care, Old High German *karon*, *karēn* to lament, and Gothic *karōn* to care and *ga-karōn* be concerned about

In relation to health/illness care, the application of the word "care" appears to have generated the word "cure" which, as applied to medical care, treatment, healing, and restoration to health, is first recorded in English about 1380 (Barnhart Dictionary of Etymology, 1988). The verb form of cure, *curen*, meaning to "take care of," appeared around 1378. Later it was used to mean "to restore to health, or heal." The expression is reported to be borrowed from Old French *curer* and from Latin *cūrāre* which means "take care, care for, attend, managed," as well as from *cūra* care, concern, attention, management, which in turn came from Old Latin *coirā-*. This Old Latin form is conjectured to be cognate with Gothic *ushaista* meaning needy, which comes from the

expression *kois-* care for, an Indo-European tongue dating back to about 1700 B.C.E. (The Barnhart Dictionary of Etymology, 1988).

The word "*continuity*" (noun) is speculated to exist before 1425, borrowed from Middle French *continuité* and from Latin *continuitātem*, *continuus* --hanging together, uninterrupted (The Barnhart Dictionary of Etymology, 1988); "continuous" comes straight from the Latin *continuus*, "to continue" passes through from Old French-French *continuer* and on its journey from Latin *continuāre* (Partridge, 1966).

The application of the word "care" in association with the word "continuity" is relatively a new occurrence. In this investigation, the term "continuity of care" is first encountered in Carn and Mole's article published in 1949 wherein continuity of care, as a concept, is established to be a nurse-related responsibility. Contemporary definitions of both the words continuity and care include:

The Merriam-Webster Pocket Dictionary of Synonyms (1972):

> **Continuity**. "Continuation, continuance, continuity" shared meaning: a persisting in being or continuing or an instance revealing such persistence. Continuity stresses uninterrupted or unbroken connection, sequence, or extent.
>
> **Care**. "Care, concern, solitude, anxiety, worry" shared meaning: a troubled or engrossed state of mind or the thing that causes this. Care implies possession of a mind weighted down by responsibility or disquieted by apprehension.

Webster's II: New Riverside University Dictionary (1994):

> **Continuity** n. 1. The quality or state of being continuous. 2. An uninterrupted succession or unbroken course.
>
> **Care** n. 1. A troubled, distressed state of mind : WORRY. 2. Mental suffering : GRIEF. 3. A source of worry, attention, or solicitude. 4.

> Caution in avoiding harm or danger. 5. The function of watching, guarding, or overseeing : CHARGE. 6. Attentiveness to detail : painstaking application --v. cared, caring, cares --vi. 1. To be inclined : WISH. 2. To be concerned to the degree of. Syn: Care, charge, custody, guardianship, supervision n. core meaning: the function of watching, guarding, or overseeing.
>
> *Webster's New World Thesaurus* (1985):
>
> **Continuity**, n. 1. [The state of being continuous]-- Syn. continuousness, perpetuity, prolongation, constancy, continuance, flow, succession, uniting, unity, sequence, continuum, chain, linking, train, progression, dovetailing, protraction, extension.
>
> **Care**, n. Syn. heed, concern, caution, consideration, regard, thoughtfulness, forethought, heedfulness, precaution, wariness, vigilance, watchfulness, watching, attending, solicitude, diligence, meticulousness, fastidiousness, nicety, pains, application, conscientiousness, thought, discrimination, carefulness, scrupulousness, exactness, particularity, circumspection, oversight, watch, concentration.
>
> **Care** v. 1. [To be concerned] --Syn. attend, take pains, regard. 2. [To be careful] --Syn. be cautious, look out for, be on guard, watch out, be aware of, heed, take precautions.

It is evident that views espousing the provider or providers to be the element that gives congruency in a continuity of care event are based exclusively on dictionary definitions. Consistent with the provider-focused approach to defining continuity of care, the view that the health care system as a whole is fragmented or consists of gaps and/or discontinuities due to the multiplicity of services and/or providers in contact with a given care recipient is reinforced. This reasoning is used as a foundation for conceptualizing what continuity of care ought to be, oftentimes confusing it with the strategies (e.g., patient-focused model of hospitals, integration of services or discharge planning) that aim to counteract the bureaucratic problems of multiple services and/or providers vying for

a given care recipient.

Conceptual ambiguities become pronounced as each discipline attempts to describe continuity of care according to their own functions and/or tasks and applies the concept to patient care in a general sense. Even so, there is no disagreement among the four disciplines that care is a process. However, the process begins and ends within each discipline's domain.

The medical domain

Historical basis of the concept

The concept of continuity of care in medicine stems from the early years when, according to Gray (1979), "general practice stood for individualism--one patient:one doctor; a system which was defined, advertised, and accepted as a personal medical service" (p. 667). Gray (1979) laments, "A change occurred in the 1950s which has continued ever since, as the number of partnerships has increased" (p. 667). Korsch et al. (1968) further add, "As patterns of medical care have changed, the individual doctor-patient relation is being replaced by short-term encounters with numerous disparate specialists and other health workers" (p.855).

The more specialized and complex medicine has become, Fox (1960) postulates, "the stronger are the reasons why everyone should have a personal doctor who will take continuous responsibility for him [sic]" (p. 752). Eventually, the involvement of several physicians and other health care providers, as opposed to single physician involvement, in the care of a given care recipient came to be identified as fragmented, episodic, and

impersonal care (Alpert et al., 1976; Arber & Sawyer, 1981; Becker et al., 1974a; McWhinney, 1975a; Rogers & Curtis, 1980; Wasson et al., 1984) and widely accepted as the inverse of continuity of care.

In a survey of 297 physicians, Freeman's (1985) respondents defined continuity of care in a variety of ways: Care of one physician, episodes of illness, long-term care by a physician, care by a team, care of the whole patient, communication within practice and with hospitals, consistent care, need for commitment from doctor and patient, some did not specify, and one declared it a jargon. The most common response was care by one doctor. The literature reviewed for this investigation supports Freeman's findings.

Despite the inconclusive as well as conflicting results of studies on usual-physician continuity and its relationship with continuity of care, the practice of employing usual-physician continuity as a surrogate term for the phrase continuity of care in the sixties and earlier lingers in the nineties.

Attributes

Usual-physician continuity. Although there is a hint of an attempt to redefine continuity of care to accommodate a multiprovider health care system, usual-physician continuity remains to be the recurrent theme among the various descriptions and discussions about continuity of care. Usual-physician continuity involves three broad categories of characteristics which are utilized to support the idea of usual-physician continuity as the embodiment of continuity of care: Longitudinal care, responsibility, and knowledge base of the usual-physician.

a. Longitudinal care. Several authors describe continuity of care as longitudinal

care or care over time by a single doctor (Alpert et al., 1976; Banahan & Banahan, 1981; Becker et al., 1974a, 1974b; Dietrich & Marton, 1982; Fletcher et al., 1984; Goldberg & Dietrich, 1985; Hennen, 1975; Hjortdahl & Laerum, 1992; Hansen, 1975; McLeod & Meagher, 1993; McWhinney, 1982; Roddy, 1980; Rogers & Curtis, 1980; Roland et al., 1986; Wall, 1981; Wasson et al., 1984). Longitudinality focuses specifically on the expanse of time in which usual-physician and patient encounters occur.

To determine whether or not continuity of care exists, the model against which comparisons are made is the expectation of an enduring relationship between a patient and usual-physician which is then integrated with the concepts of human life cycle (i.e., birth to death) and wellness-illness continua (Banahan & Banahan, 1981; McWhinney, 1975a). Anything less than an enduring relationship or any interruptions in the relationship between usual-physician and patient in the patient's lifetime is considered a situation that is lacking in continuity of care (Wasson et al., 1984). Although longitudinal care by a usual-physician is believed to span a patient's lifetime, the studies reviewed focus primarily on care provision during a person's illness episodes (Bice & Boxerman, 1977; Breslau & Haug, 1976; Hennelly & Boxerman, 1979; Moorehead & Donaldson, 1974; Murata, 1993; Roos et al., 1980; Shorr & Nutting, 1977; Shortell, 1976).

To integrate usual-physician continuity in a multiprovider health care system, proponents of usual-physician continuity maintain that the usual-physician and patient connection should be left undisturbed and suggest that the usual-physician ought to remain the central control in the health care system from which a patient should be routed. It is believed that the usual-physician serves as a pivotal element in the provision of patient

care in general which should be unrestricted by care setting boundaries. The usual-physician is to maintain contact with the patient by telephone or in person regardless of where the patient is at in the health care system; at the office, in the hospital, or in the patient's home (Sloane , 1979). In other words, the usual-physician is to remain the patient's principal physician (Gonnella & Herman, 1980; Alpert et al., 1976; Steinwachs, 1979) and specialists who become involved are merely consultants. A specialist's involvement is viewed as unavoidable interruptions in a physician-patient ongoing relationship. Once referred specialists conclude their treatment, the patient is expected to return to the usual-physician (Breslau, 1982; Freeman & Richards, 1990; Hjortdahl & Laerum, 1992; Nesker Simmons & Zabrycki, 1993; Short, 1993; Wood, 1993).

Shortell (1976) reasons, "If ... [the patients'] primary source [of referral] is their usual doctor with whom they have had previous contact, problems of interrupted services [or discontinuity of care] ... are likely to be minimized" (p. 390).

b. Responsibility. There is a prevailing assumption that health care, as a whole, is primarily the physician's responsibility (Alpert et al., 1976; Aylett, 1976; Banahan & Banahan, 1981; Becker et al., 1974a; Dietrich & Marton, 1982; Fletcher et al., 1984; Fox, 1960; Geyman, 1975; Gray, 1979; Hennen, 1975; McAuley, 1993; McLeod & Meagher, 1993; McWhinney, 1975a; Roddy, 1980; Rogers & Curtis, 1980; Short, 1993; Wood, 1993). From this premise, continuity of care is viewed as a responsibility that is mandated by an implied contractual agreement between the usual-physician and the patient (Banahan & Banahan, 1981; Dietrich & Marton, 1982; Freeman & Richards, 1990; McWhinney, 1975a; Shear et al., 1983).

Banahan and Banahan (1981) assert that at the beginning point of continuity of care, a "patient perceives a need for medical care and a dependence on the physician to provide this care" (p. 767). In response, "the physician assumes the responsibility for the care of the patient. When both ... accept these complementary attitudes, continuity exists" (Banahan & Banahan, 1981, p. 767). Some authors call this frame of mind "attitudinal contract" (Banahan & Banahan, 1981; Dietrich & Marton, 1982; Shear et al, 1983). The implied contractual relationship between the physician and patient is believed to end "only by death, by mutual agreement, or by decision of one of the parties" (McWhinney, 1975a, p. 373).

c. Knowledge base. It is believed that as a result of the longitudinal care rendered by the usual-physician, knowledge about the patient is accumulated over time. The accumulation of knowledge over time is held to be essential in providing continuity of care (Hansen, 1975; Hjortdahl & Borchgrevink, 1991; McWhinney, 1975a, 1975b; Rogers & Curtis, 1980). The duration of a contact is said to influence or affect the depth of knowledge and the time needed to acquire that knowledge (McWhinney, 1975a, p. 374). A circular reasoning comes to the fore: The knowledge base of the usual-physician is built over time, accumulation of knowledge leads to continuity of care and continuity of care builds a usual-physician's knowledge base.

Antecedents

Two antecedents stand out in the literature: (1) Recognition of a need by a patient for professional medical help followed by actual contact with a physician and (2) Availability and accessibility. Whether or not actual contact will occur is determined by

the physician's availability and accessibility to the patient for care to start and continue from there.

Recognition of a need for professional help. Continuity of care is said to begin when the patient enters the health care system due to a perceived need for professional help (Banahan & Banahan, 1981; Hennen, 1975; Lansky, 1992). Usually, "this results in a person contacting a physician" (Donabedian, 1968, p. 181). From a review of previous studies, Hennelly & Boxerman (1979) found that an individual's health "need is the most powerful determinant of [physician] utilization" (p. 1012). Some authors identify this stage as "first contact" with the health care system (Alpert et al., 1976; Gonnella & Herman, 1980; Hennen, 1975; McWhinney, 1975a). Donabedian (1968) expounds: "Assuming need to exist, a train of events is initiated when the client recognizes need, decides to seek care, and proceeds to do so" (p. 181).

Availability and accessibility. Availability and accessibility, especially accessibility to physicians by the general population, have been used repeatedly by the general practitioners in the defense for their claim of guardianship of continuity of care (Arber and Sawyer, 1981; Banahan & Banahan, 1981; Breslau & Haug, 1976; Breslau & Reeb, 1975; Curtis & Rogers, 1979; Fox, 1960; Freeman & Richards, 1990, 1993; Gonnella & Herman, 1980; Hansen, 1975; Miller, 1973; Roddy, 1980; Rogers & Curtis, 1980; Roos et al., 1980; Shortell, 1976; Starfield et al., 1976; Steinwachs, 1979; Wall, 1981; Ware & Snyder, 1975; Wasson et al., 1984). Arber and Sawyer (1981) contend, "accessibility is particularly important because general practice is the entry point into the rest of the health care system" (p. 1370) so much so that the role of the family physician

has oftentimes been referred to as that of a "gatekeeper" (Hennen, 1975).

The continuity of a usual-physician's service is said to depend on a two-way access mechanism; that is, not only should the physician be available and accessible to the patient but also the patient to the physician (Sloane, 1979; Wall, 1981) if a patient-physician relationship is to endure. Sloane (1979) asserts, "Major efforts must be made to keep physicians and patients together if any degree of continued care is to be provided" (p. 468).

For the first encounter with the physician to be considered a starting point of continuity of care, the first physician-patient encounter must provide "for ease of re-entry into the formal health care system which is, in turn, a part of a larger health care system" (Hennen, 1975, p. 371). The beginning of care and its progression is, therefore, conditional on whether or not subsequent contacts with the "first-contact" physician occur.

Consequences

Although there are numerous claims regarding desirable effects of continuity of care, great difficulty was encountered in isolating any indication as to exactly what can be expected after an instance of continuity of care has occurred. For the most part, the difficulties can be ascribed to the treatment of the terms usual-physician continuity and continuity of care as synonyms.

What is identified as the effects or outcomes of continuity of care tend to be more of mechanisms to effect continuity of care or manifestations of usual-physician continuity rather than consequences of continuity of care per se. It is reported that continuity of

care improves quality of care as measured by patient satisfaction (Becker et al., 1974a; Breslau & Mortimer, 1981; Freeman & Richards, 1993; Hjortdahl & Borchgrevink, 1991; Hjortdahl & Laerum, 1992; Kibbe et al., 1993; Marquis et al., 1983; Shear et al., 1983); facilitates early detection of disease (Kibbe et al., 1993); and increases patient compliance such as in keeping appointments and taking medications (Becker et al., 1974a; Kibbe et al., 1993). However, continuity of care means usual-physician continuity.

Based on the emerging emphasis on measurement of patient outcomes and health status (Kaplan et al., 1989; Tarlov et al., 1989), usual-physician continuity is also purported to improve patient outcomes such as minimizing dysfunctions, encouraging rehabilitation and modifying health beliefs (Fleming et al., 1986; Marquis et al., 1983; Moore & Busing, 1993). Discussions about these outcomes indicate not only do they occur during and not after an instance of continuity of care (usual-physician continuity) but also usual-physician continuity in a causal relationship with patient outcomes are considered debatable (Dietrich & Marton, 1982; Fleming et al., 1986).

Self-care. Self-care appears to be a desired outcome of continuity of care. However, whereas Kaplan et al. (1989) and Becker et al. (1974b) interpret compliance of care recipients with a physician's advice as a representation of self-care or self-reliance, other authors discuss compliance without associating it with self-care. As well, in research, usually the question asked is whether or not usual-physician continuity leads to compliance (Becker et al., 1972; Dietrich and Marton, 1982; Gonnella & Herman, 1980; Gordis & Markowitz, 1971; Kibbe et al.,1993; McWhinney, 1982; Short 1993; Shortell, 1976; Starfield et al., 1977; Wall, 1981; Wasson et al., 1984). Furthermore,

self-care is not viewed as the end of continuity of care. Sloane (1979) submits, as far as physicians are concerned, "in real practice situations ... continuity of care is never complete" (p. 468).

Surrogate terms and Related concepts

Longitudinal care and care over time. Longitudinal care and *care over time* are the most common terms used to express the concept of continuity of care. Other terms are also used as surrogate terms with minor variations in the combination of the words. They range from longitudinal relationship, longitudinal responsibility, longitudinal continuity to long term responsibility. These terms more or less describe certain characteristics of usual-provider continuity and serve only to safeguard the idea that usual-physician continuity is continuity of care.

Summary

Basically, in the medical domain, usual-physician continuity is used interchangeably with continuity of care. The notion of usual-physician continuity presumes that the criteria for continuity of care consists of longitudinal patient care, a mandate to assume responsibility for patient care and an accumulated knowledge about a patient. Usual-physician continuity is held to satisfy these criteria with the assumption that the critical qualitative nature of the care giving-receiving process preexists in the entity of a usual-provider. As a result, the term continuity of care is used simply as a designatory or titular word rather than referring to the care process itself and its dimension of continuity.

Moreover, since continuity of usual-provider is virtually impossible to attain in

a multiple provider environment that characterizes the present health care system and a highly mobile society, usual-provider continuity, rather than continuity of care, is what emerges as an unattainable goal, ideal (Fox, 1960; McWhinney, 1982; Rogers & Curtis, 1980; Sloane & Egelhoff, 1983) or a jargon (Freeman, 1985). Thus, when the phrase *lack of continuity of care* is encountered in the medical literature, it may simply mean the involvement of multiple providers in the care of a given patient and not necessarily a lack of continuity in the care process itself.

The administration domain

In the administration domain, the meaning of continuity of care is assumed to be common knowledge; it is assumed to be the antithesis of "fragmentation" of or "gaps" in care. Within agencies, specifically in hospitals, fragmented care is believed to be represented by the high number of providers and/or centralized departments involved in the care of a given patient (Borzo 1992; CHEF 1991; Lathrop, 1992; Watson et al., 1991). On a wider scale, the health care system as a whole including hospitals along with other health care agencies in the community, is described as fragmented or fraught with gaps in care. This view is derived from observations of duplication of procedures (Ferguson, 1993; Lumsdon, 1993) and the inability or difficulty of care recipients to obtain the necessary services for their health problems, primarily after discharge from a hospital (Anderson, 1993; Charter & Branch, 1964; Christenson, 1970; Ferguson, 1993; Hill & Reynolds, 1991; Lumsdon, 1993; Premier's Commission on Future Health Care For Albertans, 1988, 1989; Worley & Lowery, 1991).

Although the above views of care provision and its state of fragmentation differ from each other and involve different aspects of patient care (intra-agency and inter-agency respectively), the suggested solution for both conditions are relatively similar, that is, what is perceived as fragmentation or gaps in care must be neutralized if continuity of care is to exist.

Attributes

Three attributes of continuity of care can be identified from the literature: Task inclusive, service inclusive and longitudinal contact.

Task Inclusive. It is reported that typically in a large hospital, "patients see a parade of 40 to 50 different employees, including nurses, therapists and technicians--as well as menu passer-outers, light bulb changers and tray picker-uppers--during the course of a three-day stay" (Borzo, 1992, p. 1). In addition, "departments ... number more than 100, each with its own head and turf" (Borzo, 1992, p.17). As a result, "organizationally, ... [hospitals are] a hodgepodge of functional departments .... Although hospitals may offer technological marvels and stunning medical treatments, their primary customers--patients--complain about the fragmented ... care they receive" (Borzo, 1992, p. 1). The solution offered to such fragmentation in care is the patient-focused care model, an operational restructuring approach that has attracted the attention of many hospital administrators in the United States (Weber, 1991; Borzo, 1992; Brider, 1992; Porter O'Grady, 1993) and in Canada (Royal Alexandra Hospital, 1994).

According to Lathrop (1992), a health care delivery systems consultant, the patient-focused care model arose out of queries from senior administrators regarding

"some aspects of task specialization if .. [they] are to create continuity of care for ... patients" (p. 78). The paramount question was: "What if we could re-invent the institution so that for most patients on most shifts, the 'hospital' consists of two or three faces?" (Lathrop, 1992, p.78).

The provision of continuity of care is, therefore, argued to be contingent on the number of providers that come in contact with the care receiver, that is, the fewer the number of care providers involved in the care of the care receiver from hospital admission to discharge, the greater the continuity of care. In a patient-focused care model, this premise is manifested in the form of task inclusiveness, which means doing more tasks for fewer people by the least number of care providers (Blayney et al., 1989; Borzo, 1992; Brider, 1992; CHEF, 1991; Farris, 1993; Moffitt et al., 1993; Townsend, 1993; Watson et al., 1991; Weber, 1991).

According to Lathrop (1991), in a patient-focused care model, "Continuity of care has real meaning--three-day-stay patients no longer interact with 55 employees; they interact with fewer than 15" (p. 20) and Lathrop is convinced that "hospitals across the country are demonstrating, it is possible to redesign the hospital around this continuity imperative" (p. 78) through cross-training and deployment of personnel.

Proponents of the patient-focused care model attest that continuity of care is achieved through the creation of a new breed of nursing personnel, the multiskilled generalists. This new breed of care providers is the product of cross-training coupled with the deployment of personnel from a previously centralized area to the hospital's units along with the services they used to provide such as diagnostic testing and radiography.

The move is also known as decompartmentalization.

In cross-training and decompartmentalization, the care providers' jobs are "redesigned and broadened to include many of the ancillary tasks that were moved to the floor, thereby decreasing the number of people seen by the patient" (Moffitt et al., 1993, p. 512), which in turn is believed to increase direct caregiver-care recipient contact (Borzo, 1992; Farris, 1993; Moffitt et al., 1993; Watson et al., 1991). The result is a multiskilled health practitioner "who is cross-trained to provide more than one function, often in more than one discipline. The combined functions can be found in a broad spectrum of health related jobs ranging in complexity from the nonprofessional to the professional level, including both clinical and management functions. The additional functions added to the original health care worker's job may be of higher, lower, or parallel level" (Blayney et al., 1989, p. 216) depending on the needs of a particular institution (Borzo, 1992; CHEF, 1991; Weber, 1991).

It is claimed that through multiskilling and decompartmentalization, ninety percent or greater of the routine procedures required for a patient are performed without the patient leaving the unit (Borzo, 1992; Brider, 1992; CHEF, 1991; Townsend, 1993). In this regard, cross-training personnel is rooted on the "assumption that patients really do not like seeing a parade of new faces through their rooms nor do they appreciate being taken all over the building, particularly through public corridors, for long waits in deserted spots" (Townsend, 1993, p. 74). This assumption has led supporters of the model to advocate multiskilling and decompartmentalization as a guaranteed approach to continuity of care.

Service Inclusive. Community-wide, the principle of inclusiveness is reflected in the emerging trend of forming a coalition among agencies to form a single or close to a single administrative entity. A network of affiliated agencies provide a wide range of services which may include hospital care, specialty care, nursing home care and home care and operate under one administrative body or a liaison committee consisting of joint membership. The intent is "to overcome the ... barriers to interagency cooperation .... [and] enhance continuity of service delivery across hospital and ... [agency] boundaries" (Dincin et al., 1993, p. 837).

The formation of a network of agencies such as Chicago's Five Hospital Program and Salt Lake City's 24-Intermountain Care System are founded on a need for continuous care (Anderson, 1993; Lumsdon, 1993). The belief is that the coalition of agencies closes "some of the gaps in ... [the health care] delivery system" (Lumsdon, 1993, p. 44) based on the perception that "gaps between services and organizations along the continuum of care .... [is] especially prevalent among unaffiliated providers" (Lumsdon, 1993, p. 44).

Anderson (1993) quotes some of the proponents of integrated systems of agencies: One administrator states they "are moving toward integrated systems of care, so each community will have to look at the services available at hospitals and elsewhere and decide what needs to be added" (p. 31); another administrator indicated they are "determining which components of the continuum of care are lacking .... Locally, ... [they] lack sufficient adult day care and assisted-living programs, so ... [they are] exploring with other organizations their ability to provide these services .... to provide

more options than just home health care or a nursing home'" (p. 31).

The idea of service inclusiveness stems from an optimistic view that agency and provider boundaries that are thought to be impervious will be easier to traverse or perhaps even eliminated. This is accomplished by expanding services in one form or another resulting in the development of a system where several distinct agencies use "common assessment tools and protocols" (Lumsdon, 1993, p. 44) to control patient transfers to the necessary agencies after discharge from a hospital. Christenson (1970) calls it a "development of a confederation of care" (p. 24), which is considered a contrast to the traditional "episodic, treat-and-cure, acute care model" (Anderson, 1993, p. 32) of health care delivery system.

A slightly different version of an integrated system which also reflects service inclusiveness is the expansion of hospital services into the home setting. In the 1970s in New Brunswick, Canada, the Department of Health committee identified gaps in the health care system and it recommended expanding the range of services provided by the hospitals. It "recommended that a [home-based hospital] service be provided that would eliminate the gap in the continuum between ambulatory (self-care) and institutional care" (Ferguson, 1993, p. 41). Out of this recommendation came the extra-mural hospital.

According to Ferguson (1993), the single system found in New Brunswick, which "serves all of New Brunswick .... was a decision deliberately ... [not only] to reduce costs by having a single administration ... [but also] it was anticipated that this would also obviate turf wars" (p. 48). In addition, there was confidence that "not only would it complete the province's spectrum of care, but it would also serve to provide an

alternative to institutional care for many people either by helping them avoid hospital and nursing home admission or by facilitating early discharge" (Ferguson, 1993, p 42). This perception implies that continuity of care follows certain pathways which can proceed in several directions. Presumably if all possible directions or transition phases are provided for and controlled by one administrative entity, continuity of care will occur.

Longitudinal contact. The identification of this attribute of continuity of care, as the concept is applied within the patient-focused care model, was drawn from the frequent use of the words "direct care." Care, in this regard, is a word loosely used and actually means length of time spent in close proximity by a caregiver familiar to the care recipient. Time spent by personnel in direct contact with the patient is viewed as disturbingly inadequate, impeding the occurrence of continuity of care. The nursing staff in particular is criticized for spending too much time waiting, documenting, coordinating, and scheduling services than in providing direct care for patients (Borzo, 1992; CHEF, 1991; Farris, 1993; Moffitt et al., 1993; Watson et al., 1991; Weber, 1991). According to Farris (1993) in an in-house study at St. Vincent Hospitals in Indianapolis, it was found that "less than 50% of registered nurses' time was spent on direct patient care" (p. 22).

It is reported that in a patient-focused care model, direct contact increases as a result of familiar providers performing almost all the services and procedures their patients require. In addition, providers team up with other providers "across shifts (weekdays and weekends) providing care for the same physician's patients throughout the patient's entire [hospital] stay" (Watson et al., 1991, p. 48). Lathrop (1991) emphasizes:

"Caregivers truly 'own' their patients. Continuity is maintained across shifts and across days of stay. Caregivers admit their own patients and perform medical record coding and abstraction. They perform even mundane tasks of linen changing, tray passing, and phlebotomy" (p. 19).

Superimposing a task-oriented approach to care provision on the length of direct contact between a familiar caregiver and care recipient promotes the idea that any contact between any hospital worker and a care recipient constitutes "care" behavior on the part of the worker as well as the supposition that nursing work and the work of other disciplines, except medicine, are homologous. Furthermore, there seems to be a presumption that for continuity of care to occur, care providers must have a feeling of "ownership" of the individuals under their care, which essentially treats care recipients as objects to be owned.

Antecedents

The general view is that certain restrictions within an organization or among organizations make needed services inconvenient to and/or unobtainable by the care recipients. Availability and accessibility to needed services are considered necessary for care to start then continue. Thus, availability and accessibility may be considered both as antecedents and attributes. It is difficult to ascertain exactly what precedes a care process from an administrative point of view. It can only be assumed that if a particular service in an agency is available and accessible, admission (which perhaps is similar to a first contact episode) into that agency or a group of affiliated agencies begins the process of care continuity. This chain of events does not take into consideration what has

occurred before the agency or agencies became involved in the care process of a care recipient. This approach also follows the medical model of conceptualizing continuity of care.

Availability and accessibility. In a patient-focused care model, clinical, administrative and ancillary services are brought close to care recipients as opposed to the care recipients going to centralized departments in other areas of the hospital. This arrangement allows ready access of care recipients to services and procedures previously performed away from the units. It replaces "over-specialization [which] creates an environment where caregivers have to compete with each other to gain access to patients" (Borzo, 1992. pp. 1, 17).

From a community-wide stand point, the formulation of an integrated network of agencies or the expansion of hospital services into the home allows needed services to become more available and accessible to patients in the community. In areas where there is a wide "dispersion of both the area's population and its health and social service agencies meant limited access ... and all-too-frequent trips outside the area for services that, with some effort and planning, could be made available closer to home" (Anderson & Lumsdon, 1992, pp. 26-27).

It is proposed that an efficient and effective "managing [of] the care of ... patients requires an ability to get patients to the most appropriate level of care .... [There was, therefore, a need] to provide access to wide-ranging services and in wide-ranging locations" (Anderson & Lumsdon, 1992, p. 29). Schumacher (1991) adds, "continuum [of services] extends beyond the hospital, and patients may require care in other settings

to achieve cost-effective and comfortable care sequences" (pp. 56-57). Service inclusiveness permits care recipients to be placed "within rather than having to transfer them outside" (Anderson & Lumsdon, 1992, p. 29) an affiliated group of agencies. Schumacher (1991) asserts that the philosophy underlying the move toward affiliations of agencies is "how the hospital could best serve its patients. It is envisioned that ... patients and families will have access to care within the region in their areas of residences, will have access to information through a well-designed network, and will have access to resources in the event of an acute illness or crisis or need for an unusual intervention" (p. 58).

Two most common terms which attempt to describe continuity of care and are applied both to the intra-agency and inter-agency milieu have surfaced: "Hospital without walls" (Christenson, 1970) and "seamless" care or service (Anderson & Lumsdon, 1992; Borzo, 1992; Brider, 1992; Royal Alexandra Hospital, 1994; Warner-Handelsman, 1991). The use of these terms appear to be based on the premise that physical, disciplinary and/or bureaucratic boundaries of agencies act as walls or seams, preventing care from proceeding after it has began. It appears that the purpose of inclusiveness either by broadening a provider's repertoire of tasks, an agency's range of services or by forming an affiliated group of agencies is to break down boundaries making technical procedures or provision for the next phase of care -- chronic, acute or specialty care, available and accessible to the patient.

Although availability and accessibility of services can be viewed as precursors to continuity of care, these identified antecedents must not only exist so that initial contact

between caregiver-care recipient can happen, they must be present at various transition points as well. They must be present especially during those times when, by virtue of the multiprovider nature of the health care system, a transfer from one provider or agency to another is required to meet the care recipient's next phase of health needs.

Consequences

Quality of care and financial benefits are submitted as major outcomes of continuity of care (Brider, 1992; CHEF, 1991; Farris, 1993; Warner, 1993; Watson et al., 1991). However, not only is quality of care not clearly defined but both quality of care and financial benefits are also difficult to isolate as directly resulting from the approaches of task or service inclusiveness and longitudinal contacts.

Self-care. As an outcome of continuity of care, self-care is not a common topic in the literature examined. In the literature on nursing administration, self-care is briefly mentioned as an outcome to be supported by nurses (Hill & Reynolds, 1991). Self-care as a more specific consequence of continuity of care can be found in Ferguson's (1993) report on a study conducted by the New Brunswick Health Department Committee in 1979. According to Ferguson, the study findings indicated that "the health care system was strong at both ends of its continuum but weak in the middle. The extremities were referred to as self-care and institutional care, and the middle ground embraced home and community care" (p. 41). The term self-care "is used for individuals who are in a position to seek advice at a physician's office or a clinic and can themselves manage the care prescribed without the assistance of health care workers other than the prescribing physician" (Ferguson, 1993, p. 41).

It is further explained that the gap in the continuum of care occurred between self-care and institutional care and that "the goal is discharge [from institutions] to independent living" (Ferguson, 1993, p. 43). Some experts, therefore, view self-care or independence from care-providers as the end result of continuity of care but only as far as providers other than physicians are concerned. This view supports a provider-focused, specifically physician-centric, conceptualization of continuity of care.

Surrogate terms and related concepts

Continuing/continuous care. The terms continuing care, continuous care and continuity of care are often used synonymously especially with regards to inter-agency transition of care recipients. Continuing care can be differentiated from continuity of care in that it signifies a condition wherein care is still ongoing. Continuing and continuous care are sometimes, though more appropriately, known as long-term care (Anderson, 1993; Anderson & Lumsdon, 1992; Ferguson, 1993; Lumsdon, 1993; Rosenthal & Miller, 1979) which indicates a care recipient remains more or less in a provider-dependent relationship. A case in point --what used to be the Long Term Care Institutions Branch of Alberta Health is now called Community/Continuing Care Division based on the assumption that the change in title conforms with the current mission to provide "continuum of care." The change in title is also assumed to be an appropriate response to the proposed initiatives of the federal and provincial governments of Canada, specifically in relation to the formulation of a global budget envelope which is predicted to allow shifting of resources for continuing care (Long Term Care Facilities Sector, 1993; Report of the Federal/Provincial/ Territorial Subcommittee on Continuing Care,

1992). The superficial application of the term, continuity of care or continuum of care and its confusion with continuing care is also exemplified in the purpose for establishing a Regional Continuing Care Services Division under the newly formed Capital Health Authority of Alberta. The services within this branch are meant to address concerns in inter-agency transfer of patients. Services include subacute care programs for care recipients recovering from surgery and medical treatment in a hospital, palliative care, rehabilitation and referral services to home care and continuing care centres (long term care agencies) (Capital Health Authority Continuing Care Division, 1995; Capital Health Authority, 1995).

Bachrach (1981) differentiates continuity of care from continuous and continuing care. She submits that although an individual who has had several separate admissions into different inpatient facilities can be considered as receiving continuous or continuing care, he or she may not be necessarily receiving continuity of care. The implication is that the terms continuing and continuous care can be used to describe the occurrence of several unrelated contacts between caregivers and recipients, whereas continuity of care indicates that several contacts between caregivers and recipients are related in some way.

Summary

In the administrative domain, continuity of care is essentially delineated as a self-functioning phenomenon, activated when conditions that are perceived as exemplars of fragmentation or gaps in care are eliminated or at least subdued. To displace a state of fragmented care, the characteristics of inclusiveness (task and service) and longitudinal direct contact between familiar caregivers and recipient must be instituted. This approach

is manifested in the patient-focused care model and the integrated network of agencies. The underlying assumption in the attributes identified is provider-focused, quantitative in nature and follows the medical model, i.e., the closer the number of providers (individuals or agencies) to "one," the closer one gets to achieving an ideal condition of continuity of care.

The components of availability and accessibility are presented as precursors as well as attributes of a continuity of care event and the consequences of this event are believed to be financial benefits and quality of care, which is not clearly defined. Both outcomes are inseparable from other outcomes such as reduced length of hospital stay and patient/family satisfaction, therefore, difficult to directly associate with continuity of care only.

Although a rare topic in the administrative domain, self-care or independence from care providers, except physicians, is considered a consequence of continuity of care. In this case, what is sanctioned is the idea that physicians are distinct from other care providers and that they are a class of care providers who has special entitlement in the management, which can last indefinitely, of an individual's state of health or illness. It implies that from an administrative point of view, the work of other caregivers is supplementary rather than complementary to the work of the physician in terms of care continuity.

The social work domain

Literature on social work and continuity of care is exceptionally scarce. Only 16

items were included from which conceptualization of continuity of care can be analyzed. In what little literature there is, although the term continuity of care is mentioned, the major focus is typically on social work and discharge planning. Most striking are the attempts at abstracting continuity of care by fusing the ideas of discharge planning and continuity of care and amplifying the qualifications, functions and tasks of social workers. For example, the Society for Social Work Administrators in Health Care (1993) maintains that "the social worker, by virtue of specialized training in leadership, organizational skills, and community systems, is uniquely qualified to carry out functions at the core of any definition of continuity of care" (p. 2). The Society adds:

> Facilitation across the continuum-of-care needs ...[is] within the expertise of the social worker, who is trained to maintain the perspective of the patient and family. The ability to meld the patient's personal culture with emerging medical needs represents the strength social work has to offer in the continuity-of-care model .... The discharge planning function that is part of continuity of care incorporates the knowledge and skill of professional social work practice. (pp. 2-3)

Similarly, Shulman and Tuzman (1980) state: "Discharge planning is a systematic, organized, and centralized approach to providing continuity of care from the time a patient is admitted to a health care facility through return to the community. Social workers, as a result of their education and training, are highly qualified to perform and oversee all aspects of ... [the discharge planning] process" (p. 3). The attributes of continuity of care identified for the social work's domain were drawn from such discussions.

Because social workers integrate discharge planning and continuity of care, further search of the literature specific to discharge planning was conducted. However, the

investigation revealed that discharge planning is not always associated with continuity of care.

In the United States, the close relationship between social work and discharge planning, as well as the social workers' claim to responsibility for continuity of care, appears to have been influenced by the 1965 Medicare Bill and its subsequent amendment in 1972, known as Public Law 92-603 (Crittenden, 1983). The law mandated hospitals and other health agencies to formulate discharge planning (Blumenfield, 1986; Crittenden, 1983) and based on this mandate, standards were set by the Joint Commission of Accreditation of Hospitals (JCAH). The JCAH delineated social workers to facilitate continuity of care "whether the service provided is to be *continued* [italics added] in a home care or out of home care setting" (Crittenden, 1983, p. 5). This could be the reason behind the concentrated effort placed by social workers on inter-agency transitions as they relate to continuity of care.

Attributes

The inter-agency transitional period of care recipients is fostered as the critical area in which continuity of care ought to transpire and is believed to be illustrated when two characteristics are present: Linkages and unidirectionality.

Linkages. The Southern California Discharge Planners Association, defines discharge planning as a mechanism which "assures continuity of care between units within a hospital; from hospital to another care facility; or from hospital (or other care facility) to home" (cited in Crittenden, 1983, p.4). In 1986, the Society for Hospital Social Work Directors of the American Hospital Association (SHSWD) corroborated the above

definition. It defined discharge planning as "any activity or set of activities which facilitates the transition of the patient from one environment to another" (p. 76). In 1993, the Society for Social Work Administrators in Health Care essentially used the same definition of discharge planning for continuity of care. They defined continuity of care as a process which "facilitates the patient's or client's transition between settings" (SSWAHC, 1993, p. 1).

The actualization of the preceding definitions is professed to be embodied in the social worker who acts as a link among health care services, especially between hospital and posthospital services (Harrington, 1991; SHSWD, 1986; Shulman & Tuzman, 1980). After all, it is argued, "social workers are very adept at locating, assessing, and utilizing community support systems which meet the posthospitalization needs of patients and families" (SHSWD, 1986, p. 76). Moreover, it is asserted that "social work knowledge of community systems, resources, and financial or payment resources helps establish vital linkages to ... resource networks so that care can indeed 'continue'" (SSWAHC, 1993, p. 2). To this end, there is no distinction between continuity of care and continuing care (Crittenden, 1983; Oktay et al., 1992; Proctor et al., 1993; Rothman, 1991; Shulman & Tuzman. 1980; SHSWD, 1986).

The consensus is, providing continuity of care rests on the social worker functioning as a bridge; working within the hospital and within the community as it relates to hospitalized patients (Crittenden, 1983) with "much of the activity ... [performed] 'behind the scenes,' such as telephoning and arranging for services" (Proctor et al., 1993, p. 274). Thus, the linking or bridging aspect of continuity of care

is mainly in the form of making referrals from the hospital to other community health and/or social agencies (Crittenden, 1983; Lindenberg, 1963; Proctor et al., 1993; Rehr, 1986; Shulman & Tuzman, 1980).

The meaning of continuity of care is also conveyed by portraying care recipients as going through a succession or "continuum" of health services (within and among institutions) involving multiple providers. A social worker enters the succession of services at some point and acts as the care recipient's "traveling companion" (Rothman, 1991, p. 524). He or she then takes on the responsibility of keeping up the momentum of the care recipient's movement through the services. Lindenberg (1963) explicates:

> With an infinite variety of patient needs, no one agency can be all things to all patients. Therefore, we must remember that the patient whom we see at our particular point in the continuum of community service may need other services also, if he is not to be frozen at the point where we meet him. (p. 598)

Therefore, it can be inferred that linking activities, such as referrals, which aim to shift care recipients from one milieu to another, is believed to be that which constitutes continuity of care. However, the coupling of care continuity with discharge planning has limited the concept of continuity of care to transition of care recipients from the hospital and onward, despite the acknowledgement that continuity of care should occur within an institution as well.

The emerging trend is an attempt to stretch the boundaries of discharge planning to accommodate continuity of care within the hospital. The argument is that "in today's health care climate we must broaden our thinking and planning for patient discharges; .... We are talking about continuity of care planning" ("Discharge planning," 1991, p. 1).

To widen the perimeter of discharge planning, it is suggested that "discharge planning should begin on the day of the patients' hospital admission and should be included as part of the patient education programs" (Crittenden, 1983, p. 4). In addition, discharge planning is promoted as a process that is interdisciplinary and hospital-wide (Proctor et al., 1993; SSWAHC, 1993).

In its expanded version, discharge planning is made to conform with the notion of linkages within the hospital. This is evidenced in the assertion that the skills and knowledge or input of other health care professionals during the care recipient's hospitalization are coordinated by social workers (Crittenden, 1983; Shulman & Tuzman, 1980). It is also asserted that it is the social worker "who follows the [care] plan through to completion, including postdischarge follow-up to determine if the plan was put into practice and the assigned roles [of the various care providers involved were] fulfilled" (SSWAHC, 1993, p. 2). Social workers, therefore, view themselves not only as the link that ties together distinct agencies but also health professionals within those agencies. Blumenfield (1986) contends, "Discharge planning must expand to encompass the variety of transitions that people will pass through in the changing health care system .... Wherever those transitions occur,... social work has a role to play" (p. 54). As is often encountered in the literature, these assumptions tend to confuse the idea of coordination (arranging or organizing other care providers' work into a harmonious effort) with the concept of continuity of care.

Unidirectionality. Within the context of discharge planning, continuity of care is also portrayed as a unidirectional experience for care recipients. That is, forward

movement means a successful link has been made and successful linking is measured in terms of whether or not a care recipient is readmitted into the hospital after discharge. If a care recipient is readmitted, he or she is said to be "caught in a revolving door" (Rehr, 1986, p. 49) pattern of care.

The emphasis in the unidirectionality of continuity of care is ensuring "patient needs are met in lower levels of care" (Proctor et al., 1993, p. 263) and patients remain discharged. Exactly what high level of care (hospital care) and low level of care (care outside the hospital) consist of is unclear. Nonetheless, in social work, readmission into the hospital after discharge is considered a determinant, which when present, renders an event short of continuity of care. This postulation is evidenced in the endorsement that hospital readmission is an illustration of gaps in the health care system, fragmentation of care or failure to provide continuity of care (Blumenfield, 1986; Proctor et al., 1993; Rehr, 1986; SHSWD, 1986; Simmons, 1986).

Discussions reflecting the idea of unidirectionality are, by and large, centred around hospital-posthospital transitions. It is, therefore, difficult to ascertain under what conditions the direction of a care recipient's movement is considered a forward motion other than in a hospital-posthospital transition.

Antecedents

From the social worker's perspective, continuity of care is not always needed presumably because "in most instances, the patient and the family are in a position to facilitate the transfer from hospital to home and to assure ongoing resources" (Rehr, 1986, p. 49). This postulation suggests that for social work, actual continuity of care

starts when other community services are accessed upon discharge of a care recipient from the hospital.

Accessibility. Accessibility to what is perceived as traditionally inaccessible health and social services can be considered a forerunner or antecedent to, as well as an attribute of continuity of care. The attribute of accessibility calls for multiple points of access, social work being one of the access points. Multiple points of entry is identified as one of the key components of continuity of care (SSWACH, 1993). Harrington (1991) points out, "the social worker sees that links are made and community services accessed" (p. 8). Reb[illegible]86) adds, "high quality health care services are lodged in a social health care continuum--guaranteeing access to care" (p. 47). This is based on the premise that without accessibility to services, linkages cannot be formed. Especially for the elderly people and in many areas, community services are thought to be "highly fragmented, inadequate, and inaccessible to care recipients after they are discharged from the hospital" (Oktay et al., 1992).

Consequences

There are several proposed outcomes of continuity of care. These include: "Enhancing efficient use of the continuum of care and preventing costly hospital readmission" (Proctor et al., 1993, p. 262); maintaining "at least a minimum level of, prevent[ing] deterioration of, or, ... [enhancing] the patient's social functioning" (Shulman & Tuzman, 1980); and compliance with care plans (Simmons, 1986). However, these so-called results occur while continuity of care is in progress rather than after the occurrence of the event, which is consistent with the idea of continuing or ongoing care.

Self-care. Self-care, which includes family care, can be considered an aspired outcome of continuity of care. Some authors propose that self-care is an objective of care plans which must be discussed with care recipients as part of the discharge planning process (Rehr, 1986; Blumenfield, 1986). The idea of self-care is expressed in the goals of discharge planning which, in turn, is purported to be either a representation of or part of continuity of care. These goals include: A restored healthy and productive life style (Crittenden, 1983), self and family equilibrium (Rehr, 1986); regained determination and a sense of independence (Simmons, 1986); and a restored maximum functioning, with or without disability (Shulman & Tuzman, 1980).

Given that continuity of care and continuing care are used interchangeably, it is difficult to reconcile the perpetuity of continuing care with the consequence of self-care since there seems to be an inconsistency between a "continuing care" or ongoing event and a state of "self-care." Nonetheless, noted is a jump from continuing care to self-care or functioning independence as an outcome of continuity of care through the mechanism of discharge planning.

Care continuity is also depicted as an event that is in a perpetual state of incompleteness. Rothman (1991) states, "In those ... instances when a dependent patient is evaluated as well enough to receive a clinical discharge, the commitment to continuing care does not terminate. New circumstances may require reestablishment of services, with a looping back to the access to agency or intake functions" (p. 526). This outlook is also in keeping with the provider-focused approach to conceptualizing continuity of

care. In other words, when a care recipient moves from a dependent state to independence from professionals for their health needs, social workers view themselves as still committed to that care recipient, to provide for his or her future needs (Rothman, 1991) whether or not those needs are related to the original purpose for seeking professional help or are actually met in the future by the social worker.

Social workers are portrayed as providers who know the patient and family and are always in readiness to offer the needed help (Blumenfield, 1986). The social workers' commitment to the possibility of a future event, rather than the actuality of an event, is what gives continuity of care the property of constancy. It also explains why continuity of care is viewed as an ongoing occurrence. Care in this case becomes a state of mind and remains as such.

As far as the proposed goal of self-care is concerned, it can be surmised that it is based on a number of considerations. For example, it is recognized that for some care recipients "who go through many transition points, continuity of care ... cannot be addressed by discharge planning alone" (Blumenfield, 1986, p. 54). In addition, there is admission that social work dovetails the work of other care providers such as nurses (King & Fasso, 1962) and that continuity of care is an interdisciplinary undertaking (Proctor et al., 1993). Hence, although social work is viewed as the key component within a continuity of care structure, self-care is recognized as an ultimate outcome involving mechanisms other than discharge planning and agents other than social workers.

Surrogate terms and related concepts

Continuing care. The term continuing care can be categorized both as a surrogate

and a related term. As a surrogate term, continuing care is often used interchangeably with continuity of care, a usage that is the same as in the administration domain. As a related concept, continuing care is used to denote an unfinished process in need of completion, which lacks a connection with the idea of self-care as an end point of a completed process.

Discharge planning. While in some cases authors define discharge planning and continuity of care in similar ways making it difficult to distinguish one from the other, in most cases, discharge planning is presented as a mechanism that results in continuity of care.

Summary

What is common in the literature examined on social work and continuity of care, are discussions about continuity of care within the context of discharge planning. Some experts view discharge planning and continuity of care as being the same event and some view continuity of care as a consequence of discharge planning. Although continuity of care is portrayed as an ongoing event or an endless loop of linking and unidirectional events, the ultimate aim or desired consequence is for self-care or functional independence of the care recipients.

Generally, it is believed there are natural gaps to be bridged among health care services and/or professionals that provide the services, especially from the hospital to community care. The social worker's bridging function is proposed to be that which is continuity of care. Continuity of care is also viewed as a one-way directional movement of care recipients from a hospital to posthospital state with readmission as a reflection of

unfilled gaps, fragmentation or discontinuity in care provision. As a result, central to a continuity of care event are the social workers who are viewed as the structural link and the work they perform as the process that builds bridges among providers and/or agencies.

The nursing domain

In agreement with medicine, administration and social work, in the nursing domain, continuity of care is customarily referred to not by evidence of its occurrence but rather by the perception that it is absent in the clinical area. For example, Cabela (1980) comments, "Fragmented care rather than continued care is the rule rather than the exception. As a result, families are often left with large gaps in their care or are faced with the difficult task of coordinating their own care" (p. 13) implying that coordination in association with continuity of care is a difficult endeavour with which care recipients should not be burdened. Peters (1989) further explains, "Continuity of care is suffering because the patient receives highly skilled care from many different providers, including both hospitals and community agencies, with minimal coordination. This leads to fragmentation and gaps in care" (p. 18).

By and large, the concept of continuity of care can be extrapolated from some of the descriptions and prescriptions, which are found in anecdotal and evaluative material and textbooks, on how to bridge or close the perceived gaps in care. Although Goggans (1964) argues that "continuity of nursing care is an idea--a concept--not a bridge between two or more places" (p. 83), the application of the concept of continuity of care seems

to be based on the idea of "bridging gaps" or traversing juncture points as care recipients shift among providers, disciplines, and agencies. Within the hospital, juncture points consist specifically of transitions of care recipients from shift to shift, day to day, ward to ward, and outpatient department to home (Eriksen, 1988; Gillon, 1969; Parsons, 1980).

Attributes

There are two major areas in the health care system in which the negotiating of junctures are seen to be problematic and are viewed as the location or causes of gaps in care continuity. These involve traversing work schedule and multiple provider boundaries in intra-agency transitions and traversing agencies and disciplinary boundaries in inter-agency transitions. The belief is that continuity of care allows care recipients to negotiate these junctures with ease. Three main characteristics, which are held to reflect continuity of care, can be identified from the literature examined: singularity, planned event, and intermediation.

Singularity. The idea of singularity is based on the premise that for continuity of care to occur, consistency in care must be maintained when provided over a period of time. Both in medicine and in nursing, usual-provider continuity is thought to be the ideal embodiment of this premise. In a classic study on nursing care in Toronto in the late 1950s, Allemang (1959, 1960) observed that the minimum number of caregivers participating at the bedside within a 24 hour period was nine and the maximum was 28. This finding coupled with the finding that the average amount of time staff nurses spent at the bedside was 23 minutes a day, led the author to conclude that the situation

precludes continuity of care.

Over the years, various organizational nursing care modes have been introduced into the work place and with the implementation of one care modality after another, the provision of continuity of care remained one of the major concerns. For example, according to MacPhail (1991a), fragmentation of care was one of the predominant undesirable outcomes of both functional nursing (introduced in the 1920s) and team nursing (introduced during World War II). As a result, primary nursing, which is based on the principle of usual-physician continuity, was introduced in the late 1960s to address the disadvantages of team nursing.

In agreement with Allemang's observation and conclusion, the assumption that continuity of care is high when the number of nurses involved in the care of the care recipient approaches one (Munson et al., 1980; Piltz-Kirby, 1991) became widely accepted. This criterion is believed to be fulfilled through primary nursing wherein a nurse is assigned to a group of care recipients on a 24-hour basis and throughout the care recipient's entire hospital stay (Closs & Tierney, 1993; MacPhail, 1991a; Smith et al., 1985; Young et al., 1980). Thus, a primary nurse's ability to traverse work schedule boundaries (e.g., shift-to-shift or day-to-day) within an agency and his or her bearing of responsibility for nursing interventions became accepted as an illustration of continuity of care.

To understand the association of primary nursing with continuity of care, it is important that *primary nursing care* should not be confused with *primary care*. Smith et al. (1985) amply differentiate these two terms:

> Primary care originated in, but is not limited to, medicine .... Primary care is one part of a health model which divides health care [services] into primary, secondary and tertiary levels of care .... [and the word] *primary* in primary care refers to the *first* contact the individual has with the health care system ....[Delivery of] care ... can include medicine, nursing and other specialized health care providers .... Thus, the primary care worker provides direct patient care and follow-up which includes diagnosis, education and consultation .... [Whereas,] primary nursing is a nursing concept which refers to a specific method of delivering nursing services .... In primary nursing there is one nurse who is *primarily* responsible for planning, coordinating and evaluating the nursing care of a patient. (pp. 174-175)

In essence, continuity of care is directly related to the primary nurse's core activity of planning, coordinating and evaluating care throughout the care recipient's hospitalization (Fairbanks, 1980; McPhail et al., 1990; Pennington, 1969; Zarle, 1987) and, "rather than completing a list of tasks, [primary nurses] help their patients meet certain goals" (Fairbanks, 1980, p. 91). However, the primary nurse is also expected to provide direct services to the care recipient when he or she is on duty (McPhail et al., 1990). It is this expectation to provide direct services that is usually a focus in some studies on primary nursing (Chavigny & Lewis, 1984; Hamera & O'Connell, 1982; Shukla & Turner, 1984) and perceived as a reflection of care. Care continuity is then determined in terms of whether or not there is a high degree of contact between a primary nurse and a care recipient (Allemang, 1959, 1960; Stillwaggon, 1989; Vogelsang, 1990) compared to other care modalities.

Before or at about the time of the introduction of primary nursing, Goggans (1964) attempts to expand the idea of usual-nurse continuity. She steers away from a definition of continuity of care based on usual-nurse contact or task allocation which some

experts believe leads to a decomposition or depersonalization of both nurse and care recipient (McCormack, 1992). Goggans (1964) postulates that continuity is "care that is so well coordinated ... among the nurses and between the nursing staff and all other staff involved that the patient feels as though [he or] she is being cared for by a single nurse who understands [his or] her needs .... although many different nurses on different work schedules, and also in different settings, may provide services" (pp. 83-84). Buckwalter (1985) also submits, "The core of continuity of care is the premise that help continues when the helper changes" (p. 9).

Since the ideal of usual-provider continuity is an impossibility in a multiprovider system, the idea of coordination is often used to help explain continuity of care in a multiple provider/agency involvement (Beatty, 1980b; Cabela, 1980; Chezem, 1980; Deakers, 1972; Kotthoff, 1980; Marquez, 1980; McKeehan & Coulton, 1985; Peters, 1989; Rusch, 1986; Skidmore and Mitchell, 1980; Zarle, 1987). This approach has added difficulty in isolating continuity of care because this structural element is sometimes used to define continuity of care. For example, Zarle (1987) defines "Continuing care ... as the coordination of services rendered to patients throughout ... [the] phases of their illness" (p.2). Other authors like Skidmore and Mitchell (1980) clearly differentiate coordination from continuity of care; they assert that continuity of care is an outcome of coordination. Marquez (1980) further explains that coordination is a facilitator of continuity of care and mentions discharge planning as one of the strategies of coordination.

It is well known that although a primary nurse is responsible for a given care

recipient, several nurses and non-nurses are usually involved in the care of that patient over the course of a 24-hour day or a seven-day period. Through the idea of singularity, the focus is on the thinking processes that guide the actions of several providers, rather than on the actions themselves (Buckwalter, 1985; Fairbanks, 1980; Goggans, 1964). The idea of singularity suggests that although care may begin in one setting or with one provider, it may or may not advance nor culminate in the same setting or with the same provider but a common endpoint is what keeps the actions of several providers coherent. The principle of singularity in a multiprovider environment calls for all providers involved in the care of an individual to be in a "oneness of mind" mode or at least be in agreement regarding the care needed by a given recipient so that coherency in action is found from one care provider-care recipient encounter to the next.

Planned event. Planning is strongly emphasized as an activity integral to nursing for continuity of care (Alberta Association of Registered Nurses, 1989; Buckwalter, 1985; Ciambelli & Sauve, 1980; Elliot & Winschel, 1991; Gillon, 1969; McKeehan & Coulton, 1985; Neidlinger et al., 1987; Peabody, 1969; Pennington, 1969; Stillar, 1962; Urbanic & McKeehan, 1985; Zarle, 1987) and care plans are espoused to be the main tools for monitoring standards of care as well as continuity of care (Dake, 1984; Rusch, 1986). Demi (1980) asserts "Continuity of care does not occur spontaneously but rather is the result of deliberate planning" (p. 136). A lack of planning is considered the cause for a lack of continuity of care (Buckwalter, 1985; Ciambelli & Sauve, 1980; Guthridge, 1973; McKeehan & Coulton, 1985; Parsons, 1980; Urbanic & McKeehan, 1985; Zarle, 1987) both in intra-agency and inter-agency care recipient transitions.

Assertions about planning contain two basic ideas: Planning of care along with continuity of the action of planning and continuity of the care behaviours themselves. *Planning of care* is manifested in the development of care plans and such planning continues as circumstances change. To effect continuity of care when planning for care, hospital nurses are advised to take "into account the patients' personal milieu -- the one which does not begin and end with the length of hospital stay" (Rusch, 1986, p. 29). The person admitted to a hospital is seen as someone who has come from somewhere and will be returning to that somewhere (Rusch, 1986; Zarle, 1987). In this regard, Beatty (1980a) and Grier (1991) contend there have to be complementary prehospital, hospital and posthospital services if continuity of care is to transpire. *Continuity of care* itself, therefore, involves the behavior of the participants during the implementation of the care plans.

There is no clear distinction between the two ideas above and essentially they give rise to two ways of viewing continuity of care; either from the point of view that continuity of care is a component of a care process (McKeehan & Coulton, 1985; Parsons, 1980; Zarle, 1987) and which is intermixed with but distinct from planning of care or that continuity of care is a direct result of care planning (Guthridge, 1973; Parsons, 1980; Urbanic & McKeehan, 1985). From the latter perspective, analysis of the concept of planning for care as a phenomenon in which continuity of care may be a direct consequence, deserves a separate investigation. Otherwise, the components of *planning of care* and *continuity of care* of a care process become too entangled to appreciate fully the specific part each may play in care or caring encounters.

Discharge planning, which is considered an essential part of a care plan, is specifically linked with continuity of care so much so that the term, discharge planning, is sometimes used interchangeably with the term continuity of care (Haddock, 1991; Urbanic & McKeehan, 1985), an application that resembles the social worker's view of continuity of care. As in social work, discharge from the hospital means a care recipient is faced with crossing a major juncture as care progresses, that is, care recipients experience a shift from acute care to non-acute care and physical movement from one care setting to another. Discharge planning is declared to ease the traversing of this major juncture (Bristow et al., 1976). Nursing, however, includes a focus on shifting of the care recipients' interactive experience, i.e., from interaction with hospital-focused providers to community-focused providers.

From a much broader perspective, Kotthoff (1980) argues that hospital care may not be necessarily experienced by all care recipients. Following this line of thought, some authors use the home as a reference point when attempting to articulate the meaning of continuity of care. Pennington (1969) asserts that care at home may precede, follow, or be interspersed with care in the hospital and Peters (1989) describes care as a continuum with extremes of the continuum being received at home. The question of where discharge planning fits in relation to continuity of care if a care recipient does not experience hospitalization becomes obvious.

Discharge planning reflects linkage only as care recipients move from an institution to the community. Jowett and Armitage (1988) note this weakness and submit that planning for hospital admission is also a contributor to continuity of care. The

authors draw attention to a subject matter that is rarely discussed in the literature, i.e., transition of care recipients from prehospitalization to hospitalization as part of a care continuity event where hospitalization, as a part of a care recipient's therapy, does occur. The nurse-physician council at the Marian Health Center in Iowa took this phase of care continuity into consideration when, as part of its demonstration project in 1991, it initiated a prehospital assessment to help "better continuity of care between the physician's office and the hospital" (Welte, 1991, p. 54). Structurally, continuity of care is represented as a care process that may, but not always, consist of a "home-physician's office-hospital-home" transition pattern.

Intermediation. While primary nursing and care plans are viewed as linking elements within an agency and discharge planning is established to be an inter-agency connecting component, these elements remain "tangibly" confined within the limits of the hospital boundaries. Once the care recipients are physically out of the hospital, some experts believe that professional providers are needed to act as intermediaries or liaisons who could transport the tangibility, as well as the idea, of continuity of care from the hospital setting into the community setting (Deakers, 1972; Jowett & Armitage, 1988; Marquez, 1980; McNulty, 1973). The role that is attributed to the liaison nurse and the representation of a continuity of care event are not unlike that of a social worker.

Titles for liaison persons come in various forms; from continuing care coordinator (Beatty, 1980b; Dake, 1984; Zarle, 1987), discharge planner (Buckwalter, 1985; Guthridge, 1973), home health care coordinator (Marquez, 1980), liaison nurses (Deakers, 1972; Jowett & Armitage, 1988), hospital nurse coordinator (Guthridge, 1973),

to discharge planning coordinator (Fenerty, 1993). The liaison nurse is believed to be "a valuable link to fulfilling the hospital's commitment to the concept of continuity in [patient or] family care" (Deakers, 1972, p. 91). A liaison's key role of intermediation ties in with nursing's desire to provide continuity of care by ensuring complementary or appropriate services between hospital and community care (Chezem, 1980; Dake, 1984; Deakers, 1972; Guthridge, 1973; Hartigan & Brown, 1985; Kruse, 1985; Neidlinger et al., 1987; Packard-Helie & Lancaster, 1989; Parsons, 1980; Pennington, 1969; Smeltzer & Flores, 1986).

Subsumed under discharge planning, continuity of care between agencies is further linked specifically to the activity of patient referrals (Ciambelli & Sauve, 1980; Dake, 1984; Deakers, 1972; Fenerty, 1993; Gikow et al., 1985; Guthridge, 1973; Hartigan & Brown, 1985; Jowett & Armitage, 1988; Kruse, 1985; Neidlinger et al., 1987; Packard-Helie & Lancaster, 1989; Pennington, 1969; Rusch, 1986; Skidmore & Mitchell, 1980; Ziegler, 1974). As early as the 1940s, continuity of care through referrals was viewed as a "responsibility for nursing service beyond the hospital into the home and from the home to the hospital, without any break in its continuity" (Carn & Mole, 1949, p. 343). The concept of continuity of care originated as a concern for those patients needing post-hospital nursing care and was eventually seen as a concept that could be applied within the hospital walls as well.

In their survey, Carn & Mole (1949) found that some hospitals had had a formal referral system since 1910. This seems to indicate there was a concern for continuity of care from hospital to the home as early as the 1900s especially for those who required

long term care. Farrisey (1954) explained, "for patients to receive continuous nursing care, communication through referral is needed between hospital nurses and community nurses" (p. 449). Although not every care recipient is seen as needing a referral, to ensure care continuity, every care recipient is believed to need assessment for a possible referral (Bernstein, 1974; Hartigan & Brown, 1985; Pennington, 1969).

Referral or the transfer of care recipients for care to other providers or agencies for further therapeutic procedures, seem to fall within the category of intermediation. Referrals to appropriate agencies are considered important nursing actions for continuity of patient care (Haynes, 1962; Jowett & Armitage, 1988; Kruse, 1985). According to Pennington (1969), continuing nursing care involves planning which begins with an assessment of present needs of the care recipient, the development of a care plan to meet the present needs, followed by anticipatory evaluation of future needs and when indicated, proceeds to actually referring care recipients to the appropriate agencies to meet the identified needs (p. 14).

At first glance, there appears to be no difference between nurses as intermediaries and social workers as linking elements in a continuity of care event. A focus on the care process as consisting of involved care provider-care recipient interchanges reveals that the nurses' deeper immersion in such a process is what differentiates them from social workers who basically have an ancillary position. Put another way, although social workers and nurses perform similar tasks of discharge planning or referral, the nature of involvement in a care process is what distinguishes the two disciplines in a continuity of care event. For example, Goggans (1964) insists that "what needs to be passed on to

whoever is going to assume the responsibility for nursing care is not a flow of paper but the thinking of the nurse who understands the needs of the patient, wherever she happens to be" (p. 85).

The attribute of nursing intermediation provides a visual representation of continuity of care as an occurrence consisting of articulated components with junctures (rather than gaps) at the points of articulations, simply by virtue of the depth of the involvement of nursing in the care of a given recipient within and between transitions.

Antecedents

Goggans (1964) argues, "Continuity begins whereever [sic] we begin to give nursing care or nursing services--whether in the hospital, the clinic, or the home. To provide continuity of anything requires a beginning. It is not possible to continue something we don't have" (p. 84). Goggans idea of first contact with a nurse as the beginning of a care continuity event is comparable to the medical view. It differs only in who the provider is at first contact between a care provider and a care recipient. After the first contact, it is believed that the expanse and contents of a care process is dependent on the extent of availability and accessibility of resources that allow encounters between a care provider and recipient (Chezem, 1980).

Availability and accessibility. Accessibility and availability of information, care providers, and certain programs are some of the examples found in the literature which can be considered necessary for care and its continuity. Ciambelli and Sauve (1980) propose that "continuity of care can be strengthened by the ready access to previous records" (p. 69) as well as previous providers. In this regard, they encourage the

admission of care recipients, specifically mentally ill patients, to the hospital they have been admitted on previous occasions for continuity of care to be enhanced because "the current nursing staff may have worked with the patient in the past" (p. 69).

Some authors report that as a result of a perceived need for continuity of care, their department or institution developed and/or revised documentation methods and/or records to make the information regarded as necessary for patient care available, accessible, retrievable and useable (Case & Jones, 1989; DiBlassi & Savage, 1992; Foard et al., 1977; Pobojewski et al., 1992; Turnbull & Hodges, 1983). In hospice care, Demi (1980) asserts that unavailability of hospice inpatient units for temporary care and unavailability of caregivers at home act as barriers to care continuity.

Kotthoff (1980) gives an indication of the impact accessibility and availability can have on the health care system in general. She reports that nurse practitioners emerged to alleviate inaccessibility and unavailability of health care resources which became too expensive in the 1960s. She narrates, "In the midsixties, consumers and government officials began to analyze the reason for these high costs. Although many causes were found, no single solution was apparent. The nurse practitioner movement was an attempt to expand services traditionally provided only by physicians" (p. 106). Therefore, it can be argued that if the service or providers of needed services are not accessible or available to a care recipient, care cannot exist much less continue.

As in the other three domains, not only are availability and accessibility depicted as precursors to a care process in nursing but also as attributes in that the elements are deemed necessary within or during the care continuity event itself. In addition, in

nursing, availability and accessibility for continuity of care is expanded to include access to documentation or records and to certain services or programs like hospice care.

Consequences

Self-care. There is general agreement in nursing that the ultimate aim of continuity of care is to enable care recipients to care for themselves (Chezem, 1980; Corkery, 1989; Dake, 1984; Ensfield, 1971; Hartigan & Brown, 1985; Leach, 1991; Peters, 1989; Rusch, 1986; Stillar, 1962).

As a dimension of a care process, continuity is believed to consist of a beginning phase (which may start from any point and in any setting in the health care system), proceeds from there, and terminates when the goal of self-care or independence of care recipients from care providers is reached (Corkery, 1989; Deakers, 1972; Ensfield, 1971; Peters, 1989; Smeltzer & Flores, 1986; Stillar, 1962; Waters, 1987a, 1987b).

At the conclusion of care continuity and in a state of self-care, "individuals or groups [of individuals] take control of their lives" (Zarle, 1987, p. 2). This state is reflected in the care recipient's ability to perform procedures for their medical and/or surgical conditions, no longer needing the help of a professional (Ensfield, 1971; Dake, 1984; Rusch, 1986) when a treatment plan is completed, or when the patient and his or her family fully understand the patient's illness (Peters, 1989). Chezem (1980) expands the idea of self-care by positing that illness is a state whereby responsibility for getting well is shifted from the individual to the physician and other health providers and wellness is a state whereby responsibility is shifted back to the individual. Chezem further adds, "as the availability of hospital beds decreases and the cost of hospitalization

grows larger, the emphasis on self-care at home becomes not only philosophical but imperative" (p. 117).

Therefore, while continuity of care remains in existence, a care recipient stays in a provider-dependent state and upon completion of continuity of care, a person becomes completely independent from the provider assuming that the goal of self-care on the part of the care recipient has been successfully reached.

Surrogate terms and related concepts

Discharge planning. The term continuity of care is, from time to time, used interchangeably with the term discharge planning (Haddock, 1991; Urbanic & McKeehan, 1985). Although discharge planning is used as a surrogate term for continuity of care, descriptions of discharge planning indicate that it can be considered a related term and, at best, is a mechanism which may contribute to continuity of care rather than an embodiment of continuity of care. While discharge planning may be applicable when hospitalizations occur, it is difficult to associate discharge planning with continuity of care when hospitalizations do not occur.

Urbanic and McKeehan (1985) note that "terms like continuing care and continuity of care are replacing discharge planning in the literature" (p. vii). They add, "Although the terms are used interchangeably, they differ in 'tense.' Continuing care refers more to a present process, whereas continuity of care refers to a future goal" (p. vii) with emphasis on transitions in the substance of care from one agency or provider to another rather than transitions of care recipients.

Summary

In nursing, continuity of care appears to consist of ideas involving the precepts of singularity, planning, and intermediation as well as availability and accessibility. It is believed that in order for continuity of care to even begin and then proceed, needed health services have to be accessible and available at the starting point and throughout a care process. In addition, care itself is viewed as a premeditated process, therefore, requires planning. Thus, care continuity can be viewed in two ways: as a consequence of care planning and as a phenomenon consisting of actual care actions or it can be narrowed to the occurrence of a congruous previous, current, concurrent and eventual interventions or substantive care which are based on the care recipient's needs and which culminate in self-care as an endpoint.

Care recipients' perspectives on continuity of care

Literature specifically addressing continuity of care from the care recipient's perspective is virtually nonexistent. Care recipients' perspectives regarding continuity of care that are included in some of the literature reviewed for the four domains reflect the provider's interpretation of continuity of care rather than that of the care recipients. For example, in the medical domain, continuity of care is viewed as usual-physician continuity or longitudinal care. So too is the care recipient's perspective evaluated from the same point of view. This approach is based on the contention that continuity of care "is an expression not well understood by layman" (Hjortdahl & Laerum, 1992, p. 1288).

To capture the qualitative component of continuity of care, Hjortdahl and Laerum

(1992) translated the meaning of continuity of care to patients as having a personal doctor on a long term basis. The results and conclusions are naturally related to usual-provider continuity rather than continuity of care itself. Using personal doctor as the basis of continuity of care, the investigators concluded that "unsatisfied patients who often change doctors have short patient-doctor relationships. After trial and error the patient may find a doctor fitting his or her own style and standard, causing the significant increase in satisfaction found with longitudinal care" (p. 1289) or more appropriately usual-physician continuity. Another example is Kibbe et al.'s (1993) study. The researchers compared the preferences of patients on continuity of "familiar" physician over the convenience of being seen the same day by an unfamiliar physician.

In their study, Moore and Busing (1993) concluded that "the nurse or receptionist was believed to provide the greatest continuity to patients" (p. 533). This conclusion was based on the finding that the "nurse or receptionist who coordinates the team was frequently identified as the most important person from the patient's point of view" (p. 532). What exactly constituted continuity of care from the care recipients' perspective was not apparent. However, on the basis of how the concept was used in the study, it can be misconstrued that constant contact with a familiar person, even a receptionist, represents care continuity. Approaches like these beg the question of whether continuity of usual-provider rather than continuity of care is what is being evaluated. The confusion is also reflected in a study conducted by MacKinnon and MacKenzie (1993).

MacKinnon and MacKenzie (1993) found that 72 - 85% of 252 women wanted their primary nurses to be present during their labour and birth. This finding was

translated to indicate that to some care recipients such as maternity patients, continuity of care meant "having a caring relationship with the birth centre nursing staff throughout the child-bearing year; that is, from pregnancy through the first months after childbirth" (p. 10). The focus was on the presence of primary nurses as representing continuity rather than on the "caring relationship." This interpretation demonstrates the tendency for investigators to confuse continuity of care with continuity of a familiar provider. The assumption that guides these studies is that when the component of usual-provider continuity is present, the component of care and caring behaviours on the part of the providers are also present. Literature specifically on care and caring indicate that this assumption can be problematic.

Perspectives on care and caring

Because care or caring has been a subject widely discussed in the nursing literature, this section relies heavily on care as addressed by nursing authors. Although it is impossible to address all there is about care or caring, inspection of some of the discoveries and insights on care and caring provides help in ascertaining where or how continuity fits within the context of care.

Nightingale (1957), whose name is almost synonymous with nursing, did not specifically define her concept of care. However, from her writings, inferences can be made regarding her idea of what patient care should consist of. Focusing on the care recipient rather than the disease, she strongly recommended the manipulation of the environment to provide conditions that will effectively allow or promote the patients' self-

healing process. For the nurse to be of any benefit to those under her care and to the doctors, she firmly believed in the sharpening of the nurse's observational skills for collecting accurate information. She professed that "sound observation, ... [was] for the sake of saving life and increasing health and comfort" (p. 70). Nurses, therefore, had to be constantly attentive to the changes in the care recipients' health status so that they might provide the appropriate care in conformity to the change in the care recipients' condition.

Conceivably, care as advocated by Nightingale, could be considered a beginning in the conceptualization of continuity of professional care. However, the role of women in the health care system in the era in which she practised might have led her to relegate "the patient to a passive role, essentially infantile, with every want and need provided by the nurse" (deGraaff et al., 1989, p. 71). Consequently, her contribution, in terms of continuity of care, may be to the over-accentuation of provider-focused approaches.

Watson (1985, 1988) is a nurse theorist who is frequently cited in the nursing literature. She claims that her views about care are based on biophysical, behavioral, social sciences, and especially on the humanities. She contends that human caring is a moral ideal which allows transpersonal caring-healing, a necessity in managing a care recipient's physical illness. Like Nightingale, Watson (1985) portrays the person as having the capability of self-healing, but unlike Nightingale, Watson (1985, 1988) believes in both the caregiver and care receiver as co-participants in the caring-healing process. She uses the term "carative factors" and proposes that "carative factors aim at helping the person attain (or maintain) health or die a peaceful death" (Watson, 1985, p.

7). To Watson (1985), care involves a transpersonal, intersubjective, and transactional relationship that is "grounded on a set of universal human values - kindness, concern, and love of self and others" (p.10). In this regard, human care can be deemed to transpire between people in any setting and as Vezeau and Schroeder (1991) point out, human care is not exclusive to the discipline of nursing.

Vezeau and Schroeder (1991) argue that "in nursing literature, the term 'caring' is freely used and often discussed as if it has only one meaning, unique to the domain of nursing .... [In actuality], the term caring is used in many disciplines and can have multiple meanings which stem from very disparate assumptions" (p. 1). But, even if care is not unique to nursing, nursing appears to be the only discipline which can claim "human care" as the chief reason for its existence. Nursing as a human care service, "exists to serve people who need ... care in a personalized and intimate way with direct comfort, support, compassion, empathy, listening, touching, and trusting. Without human care people cannot fully recover, maintain well-being, nor survive" (Leininger, 1988, p. 20).

The work of Vezeau and Schroeder (1991) presents a broader perspective of care which seems germane to the understanding of continuity of care. They examined seven descriptions of caring which reflected variability in the approaches of caring in nursing, philosophy, and in narrative literature. Descriptions included caring as the preservation of whatever a caregiver decides is inherently good, as a form of nonverbal and verbal dialogue between individuals to establish a mutual relationship, and as a relationship arising out of one's freedom to relate and the need to relate to others in order to survive.

In addition, some viewed caring as an end in itself demonstrating commitment in its perfect form and some viewed caring as an affective process based on receptivity wherein the caregiver feels for and receives the care recipient completely.

Vezeau and Schroeder (1991) also propose that the differences in caring approaches are the result of the differences in their underlying assumptions. Some caregivers may hold assumptions about reasons why individuals care, about balance of power between caregiver and care receiver which can be expressed in various ways (e.g., shared, reciprocal, egalitarian, or mutual), and assumptions about conceptualization of the mind and body such as self-body dualism versus self-body unity. Others may subscribe to the assumption that time and space are multidimensional, that time is directional and linear where the past evolves into the present which then evolves into the future--a process of continuity, that space and time are absolutes, or that experiences consist of everchanging patterns. Vezeau and Schroeder postulate that all these assumptions are capable of affecting a caregiver's caring method. Even so, these authors determined that, "approaches to caring can be differentiated by whether caring is a means to an end, or an end in itself. When outcome is primary, the nature of the relationship is directed toward that goal, whatever it may be; caring becomes an instrument" (p. 14).

When the views on care as presented by Nightingale (1957), Watson (1985, 1988), Leininger (1988), and Vezeau and Schroeder (1991) are synthesized, care emerges as a phenomenon that is simultaneously instrumental and expressive and its continuity means a past to present to future evolution. The view that continuity of care comprises both instrumental and behavioral components is also endorsed by some authors in the

medical domain as it relates specifically to physician-patient relationship (Kaplan et al., 1989; Korsch et al., 1968; Moore & Busing, 1993; Starfield & Borkowf, 1969).

There is evidence that the dichotomizing, either advertently or inadvertently, of the instrumental and expressive nature of care/caring contributes significantly to the limitations in grasping the concept of continuity of care leading to difficulties in its implementation. This is exhibited in the overemphasis on procedural and structural changes in organizations (e.g., organizational redesigns) and quantitative approaches when modifying care modalities or introducing programs (e.g., discharge planning). Meanwhile, the value and maintenance of caring relationships or interactions between care providers and care recipients within and between transitional stages of care are underemphasized.

The need for a balance in emphasis of the expressiveness and instrumentality of care when conceptualizing care and thus, its continuity, to guide health care professionals in their actions is acknowledged by Valentine (1989). She proposes an "Integrated Caring Model." Supported by quantitative and qualitative data, she presents a model of care that represents caring as an integration of affective, cognitive, and interactional elements. This need for balance is also evident in some of the results of studies on patients' perspectives on nursing care. In a qualitative study by Brown (1986), patients were asked to describe experiences in which they felt "cared for." Brown (1986) concluded that the patients in her study spoke "clearly to the importance of the nurse meeting their treatment needs (instrumental activities) and doing this in a way that protects and enhances the unique identity of the individual (expressive activities)" (p. 61).

From a review of the literature, Mayer (1986) asserted that "patients may not be receptive to the expressive caring behaviors [of nurses] until basic physical needs have been met through instrumental activities. [For example,] listening to the patient may not be perceived as caring if the nurse is not also skilled in starting a needed intravenous infusion or in administering needed analgesics" (pp. 66-67). In the study she conducted, Mayer (1986) found that patients valued instrumental, technical caring skills more than the nurses and expressive behaviour was ranked higher by nurses than the patients. The weight of this finding is equalized by the finding of a significant correlation between nurses' and patients' perceptions in general. As a result, Mayer (1986) posits that expressive activities by the caregivers cannot be understressed. This postulation is supported by other research findings (Brown, 1986; Drew, 1986; Marck, 1991; Pauly, 1993; Riemen, 1986; Swanson-Kauffman, 1986).

In Pauly's (1993) study, the findings indicated that "patients perceived the nurses' way of being and doing as caring" (p. 183); "patients described the nurse as caring when she was in tune with their experience" (p. 184); and patients perceived caring as doing "more that they expected or went beyond what they believed to be the requirements of the job" (pp. 187-188). These findings are comparable to the research findings of Riemen (1986), Brown (1986) and Swanson-Kauffman (1986). Similar findings, with gender difference in patients' perception of care further identified, were also reported by Jackson (1991) in her study on dimensions of care in a nursing home.

In her research, Riemen (1986) also discovered that the physical presence of the nurse with a patient for the sole purpose of accomplishing a task is considered a non-

caring action. She explicates that caring involves existential presence, wherein the caregiver is "truly present in thought, word, and deed" (p. 35), which does not necessarily involve extensive time and which gives both care recipient and caregiver a feeling of worth. In agreement with Riemen (1986) and expounding Nightingale's (1957) thoughts, Peplau (1989) states, "A professional encounter--whether the nurse-patient contact is for a duration of ten or one hundred minutes--is a very fluid interaction in which the professional uses observation, then interpretation of observed phenomena, and then responds with theory-based interventions" (p. 23). According to Riemen (1986) and reinforced by the results of Drew's (1986) study, it is the rushed or abrupt manner of nurses and their emotional distancing that make patients feel helpless, dehumanized, angry, and afraid. However, in contrast with Mayer's (1986) findings, Riemen found that clumsily performed technical procedures were not raised as instances of non-caring.

The instrumental and expressive nature of a caring relationship are also reflected in the results of studies by Swanson-Kauffman (1986) and Marck (1991). Swanson-Kauffman (1986) identified five caring categories which were extracted from women's perspectives regarding their unexpected early pregnancy. To the patients, caring consisted of knowing, being with, doing for, enabling, and maintaining belief. In her thesis on women's experience of unexpected pregnancy, Marck (1991) discusses the importance of recognizing pedagogic moments when they present themselves in a caregiver-care recipient interaction. That is, the caregiver questions "what an experience is for someone ... to better grasp the meaning of it for that person" (p. 4) and from this expressive experience, is able to respond or act appropriately.

Although there is a variety of approaches to care, it has been established that caring does not occur in isolation rather it always occurs in a caregiver-care recipient involvement. Benner and Wrubel (1989) declare:

> Caring ... means that persons, events, projects, and things matter .... Care sets up a world and creates meaningful distinctions, and it is these concerns that provide motivation and direction for people .... Caring ... places the person in the situation in such a way that certain aspects show up as relevant ... [enabling] people to discern problems, to recognize possible solutions, and to implement those solutions .... The same act done in a caring and noncaring way may have quite different consequences. A caring relationship sets up the conditions of trust that enable the one cared for to appropriate the help offered and to *feel* cared for. (pp. 1,4)

Benner and Wrubel (1989) touch on a point that needs further reflection: If the same act can be done both in a caring and noncaring way resulting in different consequences, the question of who decides whether or not a particular caregiver-care recipient interaction is a caring experience is crucial. It is then essential for congruency to exist among caregivers and between caregivers and care recipients in their perceptions of the recipients' needs (Brown, 1986).

According to Brown (1986) "in most situations the nurse cannot assume that a *well-intentioned nursing act* [italics added] will be experienced as care" (p. 62). Like Brown (1986), Pollack-Latham (1991) notes that "best intentions and actions cannot be considered 'caring' unless there is a 'completion of caring' in the recipient .... [which is manifested in] the recipient having a feeling or inner recognition of being cared for by the caregiver" (p. 192). In an earlier study, Larson (1984) also concludes that "nurses ... [cannot] assume that *intended* caring is always perceived by the patient as *caring*" (p.

50). In her phase two research report, the author adds, "Caring requires mutual perception by the enactor and the recipient" (Larson, 1987, p. 187). If this is so, one cannot dismiss the impression that congruency in perceptions among all the participants in the care process of a given care recipient may in fact be integral to the implementation of continuity of care.

When attempts are made to relate the process of care to the work place, the question of how to differentiate between caring for one's loved ones and caring as a professional caregiver invariably becomes an issue. In her investigation to clarify the unique role of care in nurse-patient relationships, Pollack-Latham (1991) uncovered three overlapping interpersonal components that contribute to the caring of patients by nurses: personal, social and professional. Personal caring relates "to the health of the other [and] is an explicit, close, intimate relationship involving family and friends; social caring includes caring for strangers and usually involves less intensity and intimacy than personal relationships ....; [and] professional caring ... implies a responsibility on the part of the caregiver to use knowledge and skills to help the recipient after a need is determined" (Pollack-Latham, 1991, p. 185). This approach to care provision was similarly observed by Jackson (1991) in her study. Albeit, all three components play a part in varying degrees depending on the caregiver's approach to caring, according to Greenleaf (1991), more is required in professional caring. She states: "In employment situations, ... carework .... [or] caring acts, performed in the context of a job ... carries with it a contract that calls up standards of care and hold the worker accountable for maintaining these standards" (Greenleaf, 1991, p. 73).

Professional caring relationships appear to be based on an implied contract whereby accountability or responsibility is the motivating factor that drives nurses to work towards the achievement of common objectives. The relationship is said to begin with an identified patient-focused objective or need and end with the care recipient recognizing the accomplishment of that objective or fulfilment of the need (Bishop & Scudder, 1991). To this sequence of events Kitson (1987) adds:

> Of vital importance is that the professional carer ... is able to assess the effectivenss of the service they are providing .... [and] to judge the quality of the care provided, not in terms of the length of time taken, but rather in relation to whether her commitment to the patient is such that it ensured continuous and sustained nursing care; whether the particular needs of the patient were identified and met. (p. 161)

In disagreement with Peplau (1989), Kitson (1987), Benner and Wrubel (1989), and Bishop and Scudder (1991), Pollack-Latham (1991) views the lack of continuity of professional provider-recipient relationship and the short term interactions as barriers to professional caring by nurses. However, Bishop and Scudder (1991) explicate that in "actual practice, when a particular nurse resumes her relationship with a particular patient, their dialogue and development of trust continues within a common nursing practice shared with other nurses who are also caring for the patient" (p. 22).

It seems that the dialogical aspect of care, development of trust, congruency in needs perceptions, caregivers' sense of accountability, responsibility or commitment, and other attributes of caring relationships can be viewed to function as linkages among nurses in providing care. This should also hold true across disciplines and agencies if the endpoint is a goal common to all those involved in the care of a given care recipient.

These assumptions are counter to the position of those who maintain that the number of care-providers or the length of contact between caregiver and care receiver are barriers to professional care as well as its continuity.

In light of the various perspectives on care and caring, another dilemma can be noted when one attempts to articulate the concept of continuity of care. Continuity appears to be a component of care itself and the term "continuity of care" becomes redundant. That is, the expressive-instrumental nature of care requires the element of continuity especially when the concern revolves around care-recipient outcomes. For example, although Pollack-Latham (1991) did not identify "continuity" as one of the critical attributes of care, the critical attributes themselves seem to have an aspect of "continuity." The attribute of accurate perception is described as an "attempt to 'know' the other [using] both subjective and objective methods to focus and understand another person in a holistic sense .... Becoming acquainted with someone may involve a process of attunement, piecing daily perceptions together to obtain a whole picture" (p. 189). Add to this the idea that time is directional and linear, where there is an evolution of the past into the future (Vezeau & Schroeder, 1991), and a picture of care's aspect of continuity emerges.

Discussion and implications

If one accepts the proposition that the delivery of care begins with an identified care recipient-focused objective; occurs over a period of time; involves the expressions of both instrumental and emotive attributes of care, as what nursing researchers and theorists report; and involves multiple providers/agencies, then, continuity of such care

must be necessarily described within the framework of complementarity. A care process viewed from beginning to end, disregards all boundaries and all care provider-care recipient encounters (previous, current, concurrent and eventual) must correspond according to the final outcome. In keeping with the importance placed on care recipient outcomes, the target must be a care recipient-focused goal and the goal of self-care appears to be an endpoint on which all four disciplines under study agree. It is on this foundation that the following discourse is presented.

For clarity and ease of presentation, the earlier categorization and inclusion of data in each domain of medicine, administration, social work and nursing is discussed according to the re-categorized grouping below.

Recognition of needs and first contact as antecedents

Medical authors assert that care recipients must first recognize they need professional help before they enter the health care system and then proceed into caregiving/care receiving interchanges with professional care providers (Banahan & Banahan, 1981; Hennen, 1975; Lansky, 1992). Physicians identify this stage as "first contact" with the health care system (Alpert et al., 1976; Gonnella & Herman, 1980; Hennen, 1975; McWhinney, 1975a). Nurse theorists like Orem (1971, 1991), go beyond the structural format and attach care recipient-focused significance to the first contact episode. She considers the very act of seeking professional help by a care recipient to return to normalcy or competency in meeting his or her own needs, as an act of self-care.

While the first professional contacted by a care recipient is usually a physician

(Donabedian, 1968; Hennelly & Boxerman, 1979), first contact with the health care system can also occur through nurses and other health care providers (Kotthoff, 1980; MacPhail, 1991b; Smith et al., 1985). The disciplines of medicine and nursing each view first contact with its members as the beginning of continuity of care. Immediately, it gives the impression that care and its continuity involve two completely separate continuity events, one that follows a medical path and another following a nursing path, when in reality the activities performed with or for a given care recipient overlap considerably.

If the concept of continuity of care is to be generalized across disciplines and perceived from the care recipient's position, does it really make a difference who the first contact professional is as far as care, its progression and eventual completion is concerned? Evidently, it makes a difference if the motive behind a claim, such as the one doctor:one patient dogma, is to perpetuate one's "egotism and infallibility" (Aylett, 1976, p. 51) which results in a power struggle among disciplines rather than accord needed to bring concept and practice closer.

Availability and accessibility as antecedents and as attributes

The idea of availability and accessibility are applied both as antecedents to and as attributes of continuity of care. It is suggested that if availability and accessibility are not present at the outset, care cannot start and if these elements are not present at each juncture sites, a breakdown is said to occur in the progression of care and a dead-end is reached; that is, patients have difficulty progressing or do not progress on to the next

phase of care (Beatty, 1980a, 1980b; Kruse, 1985; Zarle, 1987). Whereas physicians, nurses and social workers all view themselves as agents of the components of availability and accessibility, administrators view the organization as the agent that makes all three disciplines available and accessible to care recipients.

Availability and accessibility have been researched in medicine but only within the context of usual-physician continuity (Arber & Sawyer, 1981; Breslau & Haug, 1976; Breslau & Reeb, 1975; Freeman & Richards, 1990, 1993; Miller, 1973; Roddy, 1980; Roos et al., 1980; Starfield et al., 1976; Steinwachs, 1979; Ware & Snyder, 1975; Wasson et al., 1984) which does not help clarify the concept of continuity of care. For example, from their study findings, Breslau and Haug (1976) concluded that "restricted access to one's 'own' doctor and the arrangements of doctors' schedules ... brought about a rise in the number of visits for acute illness care and a decline in [usual-physician] continuity" (p. 350). Conclusions like this speak for usual-provider continuity and not necessarily continuity of care.

In all four domains, availability and accessibility are associated not only with providers functioning as entryways into and passageways of the health care system but extend to other access situations: Access to documentation, other resources, other services, as well as double access to resources resulting in duplication. The subject of accessibility and availability usually brings other factors, such as organizational designs, work schedules and cost containment strategies into play when attempting to articulate the concept of continuity of care. In describing continuity of care, these structural elements are transformed into expressions of care or care operations as exemplified by the patient-

focus hospital model and integrated community services models.

Responsibility shifts as an attribute

Responsibility is not conveyed as an attribute of continuity of care in the literature reviewed except as a subcategory of usual-physician continuity in the medical domain. However, responsibility is the usual rationale given for each of the four discipline's claim of guardianship for continuity of care. The identified attributes of longitudinal care, knowledge base of providers, intermediation, linkages and inclusiveness, including availability and accessibility, are all directly and indirectly associated with the element of responsibility. Conflicting views centre around the question of which discipline or professional should remain the principal provider who will bear the burden of responsibility for care and its continuity.

In medicine, Roddy (1980) argues that family practitioners "assume longitudinal responsibility whether the patient is ill or well, and provide the integration with other resources for physical, psychological, and social aspects of health care" (p. 355). Presumably, a usual-provider will "pull out a little extra for a patient for whom he feels responsible .... When more that one professional is looking after a patient the boundaries of responsibility can become blurred and a gap in care emerges .... [and] the patient can slip through the net" (Gray, 1979, p. 675). The idea that longitudinal responsibility belongs to the usual-physician is supported by other authors (Alpert et al., 1976; Aylett, 1976; Becker et al., 1974a; Fox, 1960; McLeod & Meagher, 1993; McWhinney, 1975a, 1975b; Roddy, 1980). It is argued that usual-physician continuity fosters personal

responsibility for continuity of care (McWhinney, 1975a; 1975b).

Becker et al. (1974a) describe continuity as exemplified by the feeling of responsibility by the physician and assert that the feelings of personal responsibility grow as continuity of care improves. Fox (1960) is adamant that care recipients need a "personal doctor who will take continuous responsibility for him, and, knowing how he lives, will keep things in proportion-protecting him, if need be, from the zealous specialist" (p. 752). McAuley (1993) insists, "Physician, not an anonymous team or even the team nurse, is responsible for his or her own patients" (p. 1723). However, "There is no established evidence ... that the physician's feeling of responsibility leads to better care" (Rogers & Curtis, 1980, p. 122).

In contrast, some argue that if continuity of care is to take place, there should be shared responsibility between physicians and care recipients (Tarlov et al., 1989) and others argue there should be shared responsibility among physicians (Geyman, 1975; Hansen, 1975). While there are competing ideas regarding responsibility belonging to one doctor versus a team of doctors, or physician versus other disciplines, according to Crittenden (1983), "nurses and social workers have had involved discussions about their relative professional merits to handle discharge planning" (p. 5) as it relates to continuity of care. Social workers claim primary responsibility for the "coordination of community support systems which enable the patient to return home, and ... relocation of the patient and coordination of support systems or transfer to another health care facility" (SHSWD, 1986, p. 76). In addition, social workers view themselves as individuals highly qualified to hold "supervisory responsibility for hospitalwide continuity of care" ("Discharge

planning," 1991, p. 16).

Recognizing that in the present system of delivering health care, no one provider or agency can provide all that a care recipient needs (Hartigan & Brown, 1985; Skidmore & Mitchell, 1980) and believing that care recipients should take responsibility for their health, some authors have taken the position that responsibility for care should shift among providers and between providers and recipients of care depending on the care recipient's problem or difficulty (Chezem, 1980; Kotthoff, 1980). Based on the problems encountered with the issue of responsibility (e.g., turf battles), there is a cry in all four domains for the establishment of clearly defined roles for all those involved in the care process, including both providers (Clouten & Weber, 1994; Feather, 1993; Kruse, 1985; Leach, 1991; McKeehan & Coulton, 1985; Peters, 1989; Short, 1993; Wood, 1993) and care recipients (Donabedian, 1968; Hansen, 1975; Kotthoff, 1980; Kruse, 1985; Leach, 1991; Rehr, 1986; Stillar, 1962).

According to Feather (1993), her finding on discharge planning's effectiveness, "suggests that the model of discharge planning is less important than having ... clarity in roles, responsibilities, and procedures .... If discharge planners have ... clarity, almost any model of discharge planning can be effective" (p. 11). Fletcher et al. (1984) also suggest that "whether patients receive care from one or many providers may have relatively little effect on the outcomes of care as long as some entity, either an individual or team, knows that it is responsible for coordinating patients' total care and is in a position to exercise that responsibility" (p. 410).

Some authors note there is a wide discrepancy between responsibility as an idea

and responsibility in practice. Authors like Fairbanks (1980) assert that care planning in which care recipients actively participate, is a responsibility of the nurse. However, in a case study on nursing staff perceptions of the delivery method of nursing care, McCormack (1992) found that although nurses stressed the importance of involvement of care recipients in their care, formal discussions of care plans with the patients and involvement of patients did not occur indicating that "knowledge in itself does not guarantee action" (Goggans, 1964, p. 83).

Some of the reasons for the inconsistency between knowledge of one's responsibility and acting out the responsibility can be explained by some research findings. Morse et al. (1990) noted divergent concepts of care, such as care as an interaction process versus care as an intervention, tend to compete for the nurses' allegiance. Nurses are caught between administrators' demands for the performance of nursing tasks in an efficient and economic manner and the demands of lack of time and shortage of staff. They assert, "even in their own arena, bedside nurses do not have professional control of their own practice, consequently they may be forced to resort to deviant behaviors to maintain minimum staffing levels and a safe caring practice" (p. 12). This implies certain responsibilities are neglected or responsibility shifts do not occur because factors like administrative strategies prevent certain responsibilities from being exercised by providers like nurses who have employee status.

In her study, McCormack (1992) discovered a power struggle occurring between nurses and doctors. She deduced that this struggle arises from nurses greater knowledge of the patients while at the same time retaining a "handmaiden image" restricting

nursing's initiatives in care planning and implementation. These realities exemplify the restrictions some disciplines, intentionally or unintentionally, impose on other disciplines in their attempts to carry out what is perceived as its responsibility in a care process. Therefore, certain questions have to be settled: Exactly what do or should care provider and care recipient responsibilities entail, who decides when the shifting of responsibilities should occur, or under what circumstances does responsibility shifts occur among the providers and between providers and recipients?

If the factor of accountability affects continuity of care, the problem of who should be accountable for what and to whom in the real world becomes an issue that needs resolution for the further development of the concept of continuity of care. For example, concern over the controversy of turf and blurring of professional roles in a patient-focused model hospital have led Clouten and Weber (1994) to pose some fundamental questions: "If any team member is able to respond to patients' needs, who is ultimately responsible? What regulations define what nurses and other professionals can or cannot do? ... Is nursing accountable for problems encountered by all team members?" (p. 35).

While arguments regarding responsibility among care providers persist, little attention has been given to the assumption of responsibility by care recipients. If the care recipient is to assume responsibility, at some stage or stages of a care process, should not he or she require certain knowledge and skills? Kaplan et al.'s (1989) study findings show evidence that when care recipients are taught early in a series of physician visits the "techniques for improving question asking, negotiating skills, and medical care 'focus'

during conversations [with physicians], along with techniques for decreasing barriers such as embarrassment, anxiety, and intimidation" (Kaplan et al., 1989, p. S113), at follow up, health status of patients was found to be superior compared to those patients who did not receive training in appropriate behavioral strategies (Kaplan et al., 1989). The implications of this finding go beyond each of the domains of nursing, medicine, social work and administrative work and extend across the disciplines as a whole, as well as into general public education.

Another question which needs answering is, "To what extent should care recipients themselves be accountable and under what circumstances?" Kruse (1985) provides a partial answer:

> Dysfunctional interdisciplinary interaction results from a lack of understanding of the unique contributions of the various health professions. Consequently, overlapping of services in some areas and gaps in others may emerge .... Problems may be precipitated by a lack of consensus among the professions about the content and process of preparation for discharge. One such problem is disciplinary differences regarding who has responsibility for decision making: The client and family or the health professional. Whereas legal reasons may be given for a health professional's presumptive authoritarian stance. Timing may be the acknowledged basis for limiting the level of involvement of the client. (p. 73)

McKeehan and Coulton (1985) add, "Most experts involved in designing health care delivery system envision personal health as primarily the responsibility of the client. If this is true, the rightful owner of the territory of health is the client; yet, with the acceleration of technological advances and the increase of knowledge in all areas, the client clearly needs the support of health care providers who, in turn, need one another" (p. 85). There is a need for "health providers ... to assist the client in recognizing and

accepting responsibility for those areas where choices can be made" (McKeehan & Coulton, 1985, p. 87) and to provide an atmosphere where care recipients can feel free from the fear of possibly "being labelled ... manipulative and uncooperative ... [when the definition of their health] state does not coincide with that of the professional" (Armitage, 1981, p. 391).

Therefore, responsibility within the context of continuity of care consists of three major considerations: Care provider responsibility, care recipient responsibility and a combination of both. If continuity of care involves a complementarity of all care provider-care recipient encounters, critical is the question of who is responsible for what and when, and who decides.

Singularity as an attribute

From a provider-focused approach, single provider, single agency or one administrative body strategies are held to preserved care continuity in a complex, multiprovider health care system and a system riddled with transitional phases. However, there is evidence that variations functioning as transitional points or junctures can be found not only among providers and between providers and/or agencies but also within a single provider. In their study, Morse et al. (1990) attempted to discover if caring is "a constant and uniform characteristic, or ... [if] caring ... is present in various degrees within individuals" (p. 9). The investigators concluded "there is little evidence that caring is a uniform state .... [and that if] caring is conceived to be learnable, then caring skills can be acquired, practiced, perfected, demonstrated, and taught" (p. 9).

Care, therefore, is rendered in various skill and ability levels of a provider. Additionally, in some circumstances such as in burnouts, "caring as an emotional state may dissipate .... [and] as a therapeutic intervention ... physical exhaustion may reduce the nurse's ability to continue to provide care" (Morse et al., 1990, p. 9). If all these are true, then care itself comes in various degrees and must be taken into consideration when determining continuity of care. Moreover, the question of reliability negates the use of the one-provider or one-agency as the ideal measure for continuity of care.

In a multiprovider system, the attribute of singularity is reflected in the postulation that for continuity of care to occur, congruency is needed in thoughts and behaviours among providers (Goggans, 1964; Buckwalter, 1985) and especially between providers and care recipients. The emphasis is on the premise that although the care recipients' needs and providers may change along a continuity pathway, the common thread that guides the thoughts and behaviours of all those involved in the care process is the achievement of a care recipient-focused objective (Bishop & Scudder, 1991). However, "What happens if there is a discrepancy among care providers and between care providers and recipients in their paradigms of what is care?" Ostensibly, it becomes a matter of who manages to convert whom.

Presence of care/caring attributes

The current approach to viewing continuity of care tends to portray movement or transitions of care recipients from one provider or setting to another. In contrast, Urbanic and McKeehan submit (1985) that it is the substance of care that is transferred

from one agency or provider to another rather than the care recipient. Although both views adhere to the idea of movement, Urbanic and McKeehan's (1985) proposition is in keeping with the idea of care that is in continuity rather than the provider.

If care or caring consists of a combination of instrumental and expressive behaviours such as knowing, being with, doing for, enabling, and maintaining belief (Swanson-Kauffman, 1986), recognizing pedagogic moments to respond appropriately in a given care provider-care recipient encounter (Marck, 1991), or if care is a human trait, moral imperative, an affect, therapeutic intervention, or possibly an interpersonal relationship (Morse et al., 1990), then in a continuity of care event, the presence or absence of these characteristics should be taken into consideration when measuring continuity of care.

Unfortunately, since there is no agreement as yet on what care and caring consist of, the concept of care or caring is in dire need of maturation. After analysing various concepts of caring totalling 35 authors, Morse et al. (1990) concluded, "There is no consensus regarding the definitions of caring, the components of care, or the process of caring .... [The] different perspectives appear contradictory" (p. 2). Morse et al. (1990) insists that "conceptualizations and theories of care and caring must be debated, queried and clarified so that the concept, when developed, will be applicable to the art and science of nursing" (p. 12). If continuity is viewed as a basic element of care or caring, it should follow that the development of the concept of continuity of care might very well be in direct proportion with the development of the concept of care and caring.

Planning and unidirectionality as attributes

Some authors suggest, "Joint planning among the various practitioners involved in the care of patients, would be easier to achieve if there were a perceived need to achieve common goals" (Starfield et al., 1977, p. 938). This view supports the idea that deliberate planning (in the form of care plans and discharge plans) is needed to provide care and to complete a care process. However, discussions about care planning and discharge planning as part of care planning, indicate they are mechanisms to achieve continuity of care rather than attributes of continuity of care. Clear distinctions have to be made between mechanisms to achieve continuity of care and abstractions of continuity of care itself. In addition, discrimination between planning for care and actual implementation of the plans as they relate to continuity of care must be performed if the concept of continuity of care is to be pursued as a viable concept.

Unidirectionality, as an attribute and the manner in which it is linked with continuity of care such as through readmissions, does not take into account deliberate readmissions (e.g., repeat diagnostic or surgical procedures) where care recipients are required to have several admission episodes as part of a therapeutic plan and intervention. Further, unidirectionality as a demonstration of a forward movement of a care recipient through the health care system and its subsumption under discharge planning limits the concept of continuity of care to hospital-posthospital transitions.

In agreement with social workers, some nursing authors also subscribe to the idea of readmissions as an outcome of lack of continuing care (Beatty, 1980a, 1980b; Deakers, 1972; Guthridge, 1973; McKeehan & Coulton, 1985), but, they do not place

emphasis on readmissions to the extent wherein unidirectionality is portrayed as an attribute of continuity of care. For example, Deakers (1972) contends that readmissions can be prevented if public health nurses are involved and who are capable of identifying certain problems that confront care recipients after discharge; McKeehan and Coulton (1985) associate readmissions to unhealthy personal habits and lifestyles implying that readmissions may not be related to a breakdown in transition between hospital and home.

Self-care as a consequence

The majority of the authors agree that the ultimate purpose for a care process is for the care recipient to return to a state of self-care (which includes care by family members and others). However, the meaning of self-care also differs among the disciplines. In medicine and administration, self-care means compliance with medical regimens and independence from care providers except physicians. Geden (1985) considers this view as having "a potential of being incongruent with self-care theory ... [with] outcomes ... quite misleading if the researcher fails to consider whether the patient made a deliberate choice to engage in this therapy .... [In which case], their compliance levels would be quite low, but their self-care agency may be quite high" (p. 268).

Nurses and social workers view self-care as a state in which patients have regained "as much of their determination and sense of independence as possible" (Simmons, 1986, p. 68) which implies independence from the supervision of all health professionals including physicians. Although self-care is emphasized in social work, the idea is not well explicated. Whereas in nursing, Orem's theory of self-care helps to explain self-care

or more appropriately, a return to self-care as a consequence of care continuity.

According to Orem (1971), "When a change in health state brings about total or almost total dependence on others for the needs to sustain life or well-being, the person moves from a *position of self-care agent* to that of *patient or receiver of care* .... Evidence of health deviations leads to demands for determining what should be done to restore normalcy" (p. 29). This is compatible with the idea of continuity of care as a phenomenon in which individuals experience a change from self-care to receiver of care and back to a self-care state, an idea supported by both nurses and social workers. Orem's (1991) description of self-care as "the practice of activities that individuals initiate and perform on their own behalf in maintaining life, health, and well-being" (p. 117), in effect, allows one to view care and its continuity as the care recipients' rightful territory and should be under his or her control.

Conclusion

After decades of use, continuity of care as a concept remains at the fetal stage of development and is viewed primarily from a provider-focused point. The provider-focused stance remains prominent in the Federal/Provincial/Territorial Subcommittee's (1992) vision of the future health care, specifically of continuing care, in Canada. The Subcommittee speaks of a need for a single entry system along with a "one-stop shopping" model of service "so clients do not have to contact multiple providers to meet their needs" (p. 17). This suggestion coupled with the classification of a segment of society as "continuing care clients," demonstrates a view that is influenced and continues

to be influenced by the medico-centric application of the concept of continuity of care.

Some authors even reject the idea of continuity of care or its usefulness either due to the complexity in the concept's application or the misrepresentation of the concept. Nevertheless, focusing on the contents of care and care as a process, the attributes that best describe care continuity within the framework of complementarity, are *responsibility shifts, singularity* and *presence of care or caring attributes* from one encounter to the next, as providers and a given recipient strive towards the achievement of the common goal of self-care. From this perspective, the number of providers involved in a care process and the duration of contact between any one provider and recipient become irrelevant assuming that "all health care professionals care about the client and therefore his or her needs .... [Continuity of care] exists when the health team spirit is one of caring about those needs being met rather than about who meets them. At the same time, the health team members and the client must agree on what those needs are and how they can best be met" (Chezem, 1980, pp. 117-118).

Expressions of care, therefore its continuity, as identified by nursing authors, are possible only when providers use facilitating methods for accurate perception, methods to demonstrate caring, and continuous validation and evaluation of caring outcomes (Pollack-Latham, 1991). These strategies require knowledge and skills, on the part of the providers, beyond that what is needed for straightforward or routine procedures and tasks. Knowledge and skills, on the part of the recipient, are also needed if they are to assume some responsibility for their health and play an active role in the care process.

The synthesis of the various perspectives on care and continuity of care needs

further development. For example, the attribute of responsibility shifts is deeply entangled with the problems of disciplinary and agency boundaries, role delineation, knowledge and skills of both providers and recipients and the prevailing belief that physicians bear total responsibility for patient care. The attribute of singularity requires consensus among care providers and between care providers and recipients in their paradigms of what is care. In view of a lack of research, the idea of singularity remains open to the question of discrepancy in paradigms among providers and between providers and recipients of care. The attribute that captures the presence of substantive care from one encounter to the next, calls for more care recipient focused studies to arrive at some consensus in approaches to care. After all, in the end it is the recipients who make the ultimate decision whether or not care rendered by any one provider is relevant to their specific circumstance.

Although theories and studies on care or caring exist, studies specifically on continuity of care that reflect their perspectives and discoveries are non-existent. It is only from visualizing a complete picture --a coherence of a past, present and eventual state of a care recipient, that one can truly describe continuity of care, differentiating it from continuing care. Because of the number of possibilities in the variety of pathways in which continuity of care can take, especially in care recipients with multiple health needs, a longitudinal qualitative study of perhaps five years or more might be required to establish a firm foundation for the concept of continuity of care.

Moreover, although there are several obstacles restricting further development of the concept of continuity of care, the most conspicuous are identified by Sutherland and

Fulton (1992). They state: "The idea of nonhierchical teamwork (teams made up of equal members) is not part of the education of most professionals, especially physicians, and role models are scarce .... [It] is a particularly difficult challenge if the semantic and technical communication problems are worsened by interprofessional rivalry or negative perceptions" (Sutherland & Fulton, 1992, p. 221). This suggests that if care continuity is to be effected, models of care and their application must have at their core the idea that care recipients are ultimately responsible for their own health care. Consequently, emphasis on measuring care recipient-focused outcomes to determine the effects of care giving-care receiving activities becomes crucial. Care recipient outcomes measurement in areas involving self-care as an endpoint should assist in redirecting movement towards developing complementary strategies (administratively, intra-disciplinary and inter-disciplinary) in structure, process and context that embrace care with continuity as one of its components rather than co...uity with care as nothing more than an all-purpose designatory term.

At present, what is most critical in care provision as a whole is that in the search for solutions to what is perceived as a fragmented health care system, nursing itself is being redefined within the current conceptualization of continuity of care. Nursing is being redefined based on tasks, functions and cost containment strategies and is most noticeable by the emergence of multiskilled generalists within the increasingly popular patient-focused model of hospital care and at a time when care recipients are most vulnerable due to the rapid and draconian changes in the health care system. To defend nursing's stance within and to those outside the profession that "care" is at the core of

its practice, therefore the profession's area of expertise, much has to be done with very little time in the area of research on care, including its characteristic of continuity.

Researchers must bore beneath the superficiality of the claims that collaboration among disciplines, integration of services, new care modalities, restructuring of organizations, and restructuring of the health care system as a whole, represent or effect continuity of care if the notion of continuity of care is to evolve from the ideal or jargon to the praxis level.

Definition of terms specific to this investigation

Care mode or care modalities - closely knitted with work design; a label given to the organizational type of care being employed by care providers.

Functional nursing care mode - based on industrial engineering principles of division of labour and mass production. Responsibilities are allocated according to tasks such as the task of giving medications or bathing. Each nurse is responsible for each task (Young et al., 1980, p. 4).

Midrange theory - "theory that deals with a relatively broad scope of phenomena but does not cover the full range of phenomena that are of concern within a discipline .... Midrange theory tends to cluster around a concept of interest" (Chinn & Kramer, 1995, pp. 216, 40).

Primary Nursing - a patient is assigned to a nurse throughout his or her hospital stay; the primary nurse can have more than one patient and has 24-hour responsibility for ensuring that care is delivered by herself or by other nurses (Smith et al., 1985; Closs & Tierney, 1993).

Primary Care - the health care system as a whole can be viewed as a pyramid of care services divided into primary (broad base), secondary (middle) and tertiary (apex) levels of care. Primary refers to a patient's first contact with the health care system and the care provider (primary care worker) first contacted provides direct patient care and follow-up (Smith et al., 1985; Sharp, 1993).

Self-care agent - "the provider of self care" (Orem, 1991, p. 117) who deliberately acts on his or her own behalf; actions are "self-initiated, self-directed, and controlled in regard to presenting [environmental] conditions and circumstances" (Orem, 1971, p. 31).

Team Nursing - a patient is assigned to a team of caregivers; A registered nurse acts as the team leader and who supervises aides, orderlies and license practical nurses; a team can have more than one patient (Lyon, 1993). Some of the care is delegated to the nonprofessional members of the team while the nurse performs the highly skilled tasks, and also trains and supervises the team members (Young et al., 1980).

Appendix A

Table 1. Continuity of care: Comparison of medical, nursing, social work and administration domains.

	Domains			
	Medical	Nursing	Social Work	Administration
Antecedents	(1) Recognition of need for professional help by patient (2) Accessibility	Availability; accessibility	Accessibility	Availability; accessibility
Attributes	Usual-physician continuity (a) Longitudinal care (b) Responsibility (c) Knowledge base	(1) Singularity (2) Planned (3) Intermediation	(1) Linkages (2) Unidirectionality	(1) Inclusiveness (a) Tasks inclusiveness (b) Services inclusiveness (2) Longitudinal contact
Consequences	Undetermined	Self-care	Self-care	Self-care
Surrogate terms/related concepts	Longitudinal care Care over time	Discharge planning	Continuing care Discharge planning	Continuing; continuous care

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