Look for Opportunities to Increase Continuity of Care in Medical Education

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As a geriatrician, many of my patients struggle to navigate the "discontinuity crisis": the disconnected and complex network of primary care, outpatient specialists, emergency department, hospital, skilled nursing facilities, home care providers, and the many of the other components of our so-called healthcare *system* (1). Despite the name, these components often function far more separately than interconnected, making continuity difficult for patients and clinicians alike. This discontinuity is not only a challenge for patient care but is also detrimental to medical education. Research shows that a lack of continuity in training environments leads to weaker clinical skills, patient centeredness, and lower learner satisfaction.

Continuity in medical education includes learners having longitudinal relationships with patients. (Other types of continuity include informational, management and educational continuity.) Many forces contribute to rising discontinuity, including changes to ambulatory teaching structures (e.g., X+Y models); resident duty hours leading to work compression; increasing complexity and specialization of medical care; changes to attending schedules and reimbursement structures.

The Tufts Maine Track Longitudinal Integrated Clerkship is at the forefront of addressing this challenge by thoughtfully building continuity into the clerkship year. For educators teaching in more traditional block-rotation curricula, however, the situation can feel like an uphill battle. Below are several strategies to help mitigate discontinuity at the microsystem level:

- **Banish discontinuity from the hidden curriculum.** When discontinuity becomes normalized, its harms fade into the background. Explicitly name discontinuity when learners encounter. Encourage reflection on ways it impacts their education. Brainstorm together ways to increase continuity within the constraints of the current system.
- **Assign learners tasks that increase continuity.** Trainees working on inpatient services can call or send messages in the EMR to outpatient providers; this can be invaluable to patient care as information flows in both directions, and models seeking out opportunities for continuity. For medical students, consider opportunities for them to follow the same patient across multiple care settings whenever possible.
- **Provide follow-up updates for learners.** Although actual continuity with patients may not be possible, we can encourage learners to take an active role and interest in their learning by following up on results or consultations they are involved in ordering. When working with students in my clinic for a brief period, I set reminders for myself to send them a message to let them know about results or a patient's outcome.

- **Advocate for system-level change.** There are many forces at play that lead to discontinuity in medical education and patient care, from the program to the institutional to the policy level. When opportunities present themselves, look for ways to build opportunities for continuity into trainee schedules.

Discontinuity in medical education is deeply intertwined with the discontinuity that patients experience – the patients who might say, "Do I have to tell my story again?" or "I have so many providers; I can't keep them all straight." System-level changes are necessary to address the discontinuity crisis in our health care system, which impacts learners, patients and providers. Nonetheless by naming and looking for opportunities to increase continuity for learners, we can take practical steps toward improving the experience for everyone.

Reference

1. Warm EJ, Desai SS, Bowen JL. *Navigating the Discontinuity Crisis in Medical Education.* N Engl J Med. 2025;392(24):2447–2457.

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