Resident Continuity Clinic: An Oxymoron?

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The management of patients with chronic illnesses is widely regarded to be a major weakness of 20th century primary care, perhaps its most glaring deficiency.^{1,2} We have much to learn about how best to care for such patients, but we have even more to learn about how to teach residents and students the skills they will need to do a better job of this than their teachers have done. Thus, it is timely and appropriate that this supplement of the Journal of General Internal Medicine is devoted to a series of papers addressing how chronic disease care might be taught more effectively in primary care residencies. The reports from the University of California, San Francisco, and San Jose-O'Connor Family Medicine Residencies relay encouraging evidence regarding chronic disease management in the context of a residency practice, but they also highlight the persistent challenge faced by all primary care residency programs.^{3,4} How do we teach residents to care for patients over time when the length of the residency is short and the availability of residents to these patients is sporadic? The typical patient with diabetes or hypertension will live with their illness for decades. Residents are with us on a part-time basis for only 3 years. Even in those residencies with the greatest focus on ambulatory care, residents still spend less than half of their time in such settings. Is it inherently contradictory to describe the outpatient activity of our residents as "Continuity Clinics," when this activity is usually anything but continuous for either the resident or the patient?

Primary care in America is experiencing a period of rapid transformation. While we have a pretty good idea about the general themes of this transformation, we know astonishingly little about the detailed attributes of a new model of care⁵. Understandably, we tend to focus on primary care's weaknesses in our attempts to make it better and chronic disease management is surely such a weakness. But we also have nearly 50 years of evidence about the strengths of primary care,^{2,6} and we must be careful not to damage what we do well in our efforts to address what we do badly. We know that successful primary care requires trusting relationships between patients and those who care for them, and we know that this is even more important for people with chronic illness^{7,8}. This trust, or "interpersonal continuity," lies at the heart of traditional

primary care^{2,6} and is also a cornerstone of patient-centeredness⁹. Traditionally, interpersonal continuity has implied a longitudinal relationship between a patient and his or her personal physician, which we assume to be strengthened by sequential visits involving these two individuals over time¹⁰. By our current definition, this "continuity equation" is heavily dependent on the primary physician's availability for office visits and presence in the clinic. It requires a type of availability that is incompatible with resident physicians' schedules and leaves the patient without access whenever the physician is unavailable. It is focused on the doctor and not focused enough on the patient—a deficiency most apparent when the patient has a chronic disease. Perhaps the old model of continuity has not been all that good for the doctor or the patient.

Is it possible that in the new model of care such interpersonal continuity might evolve independent of visit frequency between a patient and his or her physician? In his recent essay, "Continuity Matters," Bruce Guthrie, MD, wrote: "Continuity in its broadest sense will always depend on individual clinicians *taking responsibility* for the longitudinal care of patients."¹¹ Regular office encounters may facilitate familiarity, but we propose that the new math of interpersonal continuity depends on the patient's perception that their physician is fully engaged as a partner and willing to assume responsibility for their care. Herein lies the opportunity for training programs to positively affect the continuity experience of those patients cared for by resident providers, and for the residents themselves. Primary care residencies must equip resident physicians with the tools to assume and communicate their *professional responsibility* for the care of their patients. First, we cannot expect residents to feel accountability or longitudinal responsibility for patients to whom they are not explicitly linked by name. We should entrust residents with their own patient panels, and provide them regular summaries on the evolving health and demographics of those panels. Early in their training, we should acclimatize residents to efficient strategies for managing information and hold them accountable for timely follow through on items that require their input. Second, there is no reason that primary health care characterized by personal responsibility need be limited to a single provider. As illustrated by Johnson and colleagues' qualitative evaluation of the Academic Chronic Care Collaborative reported in this supplement, we are learning that teams of professionals can collectively take responsibility for patients.¹² Such teams may actually deepen the patient's sense of confidence and trust. It is imperative that we train residents how to effectively work within teams to coordinate the care of their patients. Last, we should have policies in place that not only allow, but also encourage resident providers to be present with their patients during critical life events such as hospital admissions, family conferences, and end of life care. Teams are not about diffusing responsibility or watering down intimacy; they are

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about expanding responsibility and building in redundant systems of accountability.

"ResidentContinuity" is not an oxymoron, it is an achievable goal. As we proceed into an era where many physicians are opting for less than full time work, what we learn about improving and sustaining interpersonal continuity between residents and their patients may very well inform a much broader audience. Thankfully, proximity is no longer a prerequisite for building strong relationships, but a deep sense of professional responsibility remains essential.

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