

Continuity: A Central Principle of Primary Care

Mary N. Hall, MD

I recall the story of a patient from a war-ravaged Balkan country who presented her posttraumatic stress through somatic symptoms. Whenever she was seen by other physicians, or in the emergency department, costly and unnecessary tests and referrals were ordered, which led to surgery more than once. Over time, through regular visits with her primary care physician, she learned more effective coping strategies for her anxiety symptoms. Both she and her primary care physician were happier, and her utilization of specialists and imaging decreased. Continuity of care is a central principle of primary care that can improve quality, physician and patient satisfaction, and cost reduction.

In this issue of the *Journal of Graduate Medical Education*, an article by Fortuna et al¹ dives into the timely issue of continuity in resident primary care practices. The authors found reduced continuity in 4 resident primary care practices when compared to nonteaching practices, with varying levels of continuity found among the resident teaching sites. They then isolated specific factors most strongly associated with increased continuity, primarily increased clinical faculty time, scheduling protocols, and the absence of advanced care providers. This is useful information for educators looking for specific tactics to move the needle in this area. The authors also provide further evidence for the connection between continuity and high-quality outcomes and highlight additional benefits of continuity of care, including improvement in patient and provider satisfaction. This article makes valuable contributions to the conversation on continuity of care in primary care education.

A precursor to any intentional work to increase continuity of care is the foundational belief that it matters. We must first agree as an academic community that this is a high priority. We then need to acknowledge and understand the real world challenges that we face, and work toward strategies to overcome the barriers. In an ideal world, access and continuity are not a trade-off, and we are available for patients 24/7. As this is certainly not the case, especially in resident practices, we need data to support the value we place on continuity. It is encouraging that this study showed an association

between improved continuity and improved rates of diabetic control, hypertension control, screening colonoscopy, and mammography. Armed with this information, we are more likely to get the buy-in necessary to implement strategies that will improve continuity.

Many physicians know intuitively that we are more attentive to and successful with chronic disease management, risk factor modification, and prevention parameters with our own patients versus those of our colleagues. Our understanding of our patients in the context of their lives enables us to identify and manage the psychosocial factors that may be getting in the way of their success. Another benefit of continuity not addressed in this study is the potential for an ongoing relationship to limit inappropriate testing and referrals. In the advent of high-deductible health plans and an increased focus on “consumerism,” continuity can be seen as a benefit. A trusted primary care physician can help a patient determine the necessary and evidence-based tests and referrals to enable them to spend their health care dollars wisely.

I also propose that continuous, meaningful relationships contribute to physician wellness in many subspecialties, not just primary care. The topic of physician wellness, and conversely physician burnout, is ubiquitous and permeates our literature, work conversations, and even the lay press.² Burnout among family physicians in particular is among the highest of all physicians, and has continued to increase in recent years.³ In their 2014 article “From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider,” Bodenheimer and Sinsky⁴ challenge us to expand the triple aim to include attention to improving the work life of providers. Only in this way will we achieve better care for our patients.^{4,5}

So, why did we choose medicine in the first place? For me, it was and continues to be the deep and genuine relationships with patients, families, and learners that give me the greatest joy and meaning. When we are feeling burned out, the absence of these relationships can cause added stress. Focused educational time on teaching reflection about and management of the physician-patient relationship can build resilience in our learners as well.

Continuity of care is an increasingly difficult principle to achieve in the current health care

landscape. In addition to the inherent challenges to resident continuity (eg, inconsistent schedules) that are mentioned in this article, there are many other barriers.¹ As health care systems grapple with the transition from a volume-based to a value-based world, an increasing focus on access and on-demand care threatens the physician-patient relationship. To survive and thrive, health care systems are driven to prioritize growth of the primary care market share over the nurturing of established physician-patient relationships. The drive toward primary care redesign and “sameness” may move schedulers to a central location away from the practices and contact with those who know the patients, resident schedules, and importance of continuity to resident education. An understanding of these threats will enhance our ability to communicate the value of continuity to administrative colleagues and to work collaboratively to create practical solutions.

As we move forward in our transformation from volume to value, it will be essential to protect and champion this central tenet of medical care: the continuous physician-patient relationship. We need to be flexible as we adapt to the rapid pace of change in our health care environment, but we must hold on to that which nurtures us and our patients. The voices of physician educators must be heard to make sure that continuous relationships remain at the center of primary care and other residents’ training experiences.

References

1. Fortuna RJ, Garfunkel L, Mendoza MD, et al. Factors associated with resident continuity in ambulatory training practices. *J Grad Med Educ*. 2016;8(4):532–540.
2. Oaklander M. Doctors on life support. *Time Magazine*. September 7, 2015:42–51.
3. Shanafelt TD, Hasan O, Dyrbye LN, et al. Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clin Proc*. 2015;90(12):1600–1613.
4. Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. *Ann Fam Med*. 2014;12(6):573–576.
5. Hall MN. To be well, or not to be well, that is the question: what will we choose? *Fam Med*. 2015;47(10):819–820.



Mary N. Hall, MD, is Chief Academic Officer and Senior Vice President, Division of Medical Education, Carolinas HealthCare System.

The author would like to thank Renee E. Miller, MHA, for her review of this manuscript.

Corresponding author: Mary N. Hall, MD, Carolinas HealthCare System, PO Box 32861, Charlotte, NC 28232-2861, 704.446.9252, mary.hall@carolinashealthcare.org