Continuity in medical-student clerkships is becoming a thing of the past. There is little continuity between students and teachers, between students and patients, and between specialty-based components of the curriculum. Although block rotations in clerkships have been used for more than 100 years, in Abraham Flexner’s day, patients, teachers, and students were together in the hospital for extended periods on medicine, obstetrics, and surgery services, which provided excellent opportunities to learn in a relatively relaxed and longitudinally mentored environment. Not so today.

Faculty members struggle to meet clinical productivity quotas while maintaining teaching and research responsibilities. Attending physicians are on service for shorter and more intense periods of time, so there is much less opportunity to get to know students and residents. Most faculty members have even less time for substantive involvement in curriculum development and implementation. As a result, mentoring relationships either are fragile or do not exist, and the progressive advancement of student competencies is not well guided across the curriculum.

Students complain about having to start all over again with each new specialty-specific rotation. The constant churning of people and sites leaves students feeling overwhelmed by what they do not know about each specialty and struggling to understand their new roles, new tasks, and new coworkers. Unfortunately, we chronically underestimate the powerful influence of these changing contexts on learners’ thoughts, actions, and values. Context matters, because learning from experience accrues from being immersed in and acculturated to a community of practice, and experiential learning is strongly influenced by issues such as the patient census, time sensitivity in the environment, and multiple and conflicting commitments of participants.

Discontinuity creates an inefficient and disjunctive system that produces great frustration and anxiety in learners and great challenges for teachers. Perhaps it is time to return to the best aspects of our past and create new models of apprenticeship that offer greater continuity and provide faculty members with protected time for teaching and mentoring.

In this issue of the Journal, Hirsh and colleagues describe various forms of continuity in clinical education, advancing our understanding of the strengths and challenges of longitudinal relationships in clinical settings. They identify key components of educational continuity (con-
tinuity of care, curriculum, and supervision) and describe multiple models of clerkships organized in various ways to enhance continuity. This article is being published as a Sounding Board article rather than as a regular article in the medical-education series because it strongly advocates for continuity as an organizing principle for medical-education reform and because there is relatively little published literature in this area. Yet it addresses a major design principle for clinical education.

The lack of sustained relationships among students, teachers, and patients is a major problem in medical education. Fortunately, a growing number of medical schools recognize this problem and are creatively addressing it. New models of longitudinal relationships are required to make clinical education more effective and efficient. Hirsh and colleagues take us back to our Flexnerian roots and help us imagine how this redesign of clinical education might be achieved.

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