The Importance of Being Comprehensive

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Along with accessibility, continuity, and care coordination, comprehensiveness has been considered one of the core pillars of primary care since the days of general practice. The Institute of Medicine's 1996 definition of primary care states that the primary care provider should be accountable for "addressing a large majority of personal health care needs" in the community being served. These days, the literature of family medicine is filled with papers about improving access and understanding continuity. We certainly hear about the challenge of improving care coordination every day from the chronic disease model to "hot-spotting" high-cost patients. Somehow comprehensiveness has become an ignored stepchild. We would never admit that it isn’t important, but we never really want to talk about it either. Perhaps this is because comprehensive competence is really hard to attain and maintain. We know that outcomes of most procedures tend to improve with the frequency with which they are performed. So how do we prepare family physicians to have outstanding clinical outcomes when there is almost always a narrowly trained specialist standing in the wings to question our skills? How can we do as good a job as someone who does only one thing over and over again? And yet we know that access to care in rural communities, community health centers, and international health depends on generalists who can competently care for whatever comes through the door. We also know that cost effective care requires a primary care system that is much more than a referral factory. If the comprehensiveness of our skills narrows, referral rates increase, and so goes the cost of health care.

In this issue of Family Medicine, we publish five papers that directly or indirectly address the scope of services offered by family physicians. Our lead article describes how digital photography of retinal vessels can improve screening for diabetic retinal disease in a medical home. Papers by Daly and Walker examine endoscopy services in primary care. Koppula and colleagues report on obstacles to obstetric training in Canadian family medicine, and Firnhaber and Kolasa present a brief report on procedural training in a community health center. These papers are particularly timely, because there is growing concern that the comprehensiveness of American primary care might be weakening. We are putting so much energy into transforming our practices and building interdisciplinary teams, and we are experiencing so much pressure to see more patients that it is often easier to simply refer patients for procedures rather than providing this care on site. Each time we do this, we risk making care less efficient and convenient for our patients. Each time we do this, we lose a small measure of the comprehensive competency we once had.

Traditionally, our debates about procedures have tended to be about their financial benefits to our practices or about our professional prerogatives and interests. It is time we talk about comprehensiveness as a critical domain of patient service. Referrals cost our patients time, and they increase the likelihood of communication errors. Sending our patients to the emergency department whenever it is inconvenient for us to see them has real human costs in addition to real financial costs. Our practices may save on overhead, but we forfeit an opportunity to build our patients’ trust in us.
when we send them elsewhere for services we can safely provide. Furthermore, it demeans the best traditions of our discipline and undermines how the public views family medicine in general. Family physicians are trained to care for sick people, not just preserve wellness and screen for diseases.

Building a comprehensive scope of skills for residency graduates may be the most challenging demand on a family medicine residency. There is precious little time in the curriculum, and there are no shortcuts. Political challenges are abundant in dealing with specialists at academic institutions. Residents actually have to do things to become competent, but improving simulation technology can make this process more efficient. The Advanced Life Support in Obstetrics (ALSO) course is a good example of how this can be done. In addition, there are plenty of obstetricians, cardiologists, and surgeons in academic medicine who understand that everyone does not live near an academic health center and that the poor, in particular, are cut off from specialty and procedural care.

Comprehensiveness is essential to competent family medicine. We cannot continue to be who we are without it. Electronic health records can allow us to accurately track referral rates and indications. We should measure these for each practice and each provider. Our goal should be to provide every possible service that we can safely provide in the Patient-centered Medical Home and to rigorously measure and improve the quality of these services. If we don’t do this, it might not matter how many family physicians we are able to produce.

References
2. Gawande A. The hot spotters: can we lower medical costs by giving the neediest patients better care? New Yorker 2011;January 24.