STARFIELD SUMMIT

...where primary care research inspires policy and practice

4Cs of Primary Care: Comprehensiveness

Why this is important (brief description):

Comprehensiveness is a cornerstone of primary care, but perhaps it's least elucidated element and a subject of broad definitional debate. Barbara Starfield describes comprehensiveness in the following way: "*Comprehensiveness means that all problems in the population should be cared for in primary care (with short-term referral as needed), except those that are too unusual (generally a frequency of less than one or two per thousand in the population served) for the primary care practitioner or team to treat competently*."[i]

Since Starfield, many in the primary care community have debated whether comprehensiveness refers to the breadth of the conditions a physician cares for, or the depth of their ability to take care of each condition. Despite debates over how to define and measure comprehensiveness, we know that the ability to provide comprehensive care is a key factor that often differentiates primary care physicians from specialists. While specialists may be subject-matter experts on specific body systems and illnesses, the primary care clinician must be the subject-matter expert of the patients themselves. Comprehensive care has been shown to reduce medical costs and decrease hospitalizations and family physicians who provide more comprehensive care have reported lower levels of burnout[vii]. Yet, comprehensiveness among family physicians is decreasing, with fewer FP's reporting obstetrical care or pediatrics as part of their regular practice. As we work towards training the future family physician, we need to understand what we mean by a comprehensive physician, and develop residencies that train physicians who demonstrate competence in comprehensive care.

What We Think We Know (Bulleted evidence + Seminal references):

- Comprehensiveness is considered a core feature of generalism and central to Family Medicine's self-identity, dating back to its creation[i,i], and reiterated in recent national discussions of FM's future[ii,iii]
- Comprehensiveness has different meanings to different Family Physicians, characterized for some by breadth vs depth, care of various populations (pediatric patients, pregnant patients, geriatric patients), care in various settings (inpatient, outpatient, nursing home) and provision of a multitude of services (medication-assisted treatment, mental health, casting, outpatient procedures)[iv] or a "Basket of Services"[iii]
- Comprehensiveness can be measured at the clinician & practice levels using administrative data[v,vi]
- Increased comprehensiveness of primary care physicians is associated with lower Medicare costs and hospitalizations, and lower rates of physician burnout[vi,vii]
- By some definitions, comprehensiveness is decreasing in family medicine[viii] with fewer physicians providing inpatient[ix], procedural[x], obstetrical[xi] and pediatric[xii] care, though scope remains broader among rural family physicians[xiii] and those working with NPs and PAs[xiv].
- There is some evidence that intended scope of practice of family medicine graduates is broader than actual practice suggesting it is not training, but perhaps market forces and clinical options upon graduation driving a decrease in comprehensiveness[xv,xvi]

Questions for Group Consideration at the Starfield Summit:

- What do we mean by comprehensive physician? Does this/should this vary by community need?
- How do we train a comprehensive physician given all the competing demands in residency?
- What should our approach be in training for comprehensiveness when multimorbidity and complex care drive most morbidity and cost?
- What role does continuing education play in allowing primary care physicians to expand the scope of their practice? Does continuing education strengthen the patient's sense of their physician's competence?
- With increasing group practice, how important is it that an individual clinician provide comprehensive care vs. comprehensive care being available through team based care in their practice - "collectively comprehensive"? And if it is more feasible to be collectively comprehensive, how can we train residents to work as part of a comprehensive team?
- How will we define a comprehensive family physician upon graduation?
- Comprehensiveness has many definitions and communities have different needs. How can we support residencies in being flexible to the needs of their community while still training a family physician who is considered comprehensive?
- What other measures can be made to better understand the health and economic effects of comprehensive care among physicians?
- Are there measures that can be made to assess perceived value of the patient (comparing primary physicians and other specialists)? What strategies can be used to educate the public on the costs saved by contacting their primary care clinician prior to enlisting the help of a specialist?

References:

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