Editorial

The paradox of the parts and the whole in understanding and improving general practice

The book reviewed in this issue of the Journal [1] epitomizes the state of the art of quality measurement in general practice. Currently available quality indicators are based on a mix of scientific evidence and expert opinion. Indicators assess processes of care that have been found to be associated with markers of patient outcomes.

Quality of care measures and clinical indicators are typically criticized for the limitations of the scientific evidence on which they are based and for their strong reliance on what can be measured [2–4]. However, an even more fundamental issue is important to developing indicators of the quality of general practice. This larger issue is the problem of the parts and the whole—that is, indicators of the quality of care for specific diseases may not adequately represent the quality of care for the whole person.

This is a particular issue in assessing general practice, in which patients often present for care of multiple problems [5] that span different acute and chronic illnesses, prevention, mental health, and family care [6]. The illness presentations in general practice are often non-specific and undifferentiated [7], and much of the quality of practice involves defining the problem to be addressed. In addition, general practice often requires prioritizing the most important issue(s) to address within the context of personal knowledge and an ongoing relationship [8]. Quality indicators, as currently configured, are helpful with aspects of primary care that relate to the care of an individual disease or problem, once it has been defined, and once it is prioritized as the most important issue to address with a particular patient at a particular time. As a result, current quality indicators may be a more fitting representation of the quality of specialty practice, which typically focuses on providing care for specific diseases.

Current quality measures indicate that generalists tend to provide inferior disease-specific care compared with specialists [9]. Yet, general practice is about more than the care of specific diseases. ‘Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community’ [7]. These prioritizing, integrating, relationship-centered functions may explain why generalists use fewer resources while producing similar health outcomes for patients with chronic disease [10,11]. The added value of the generalist approach may also explain why health care systems that emphasize primary care have better health status among their populations than specialist-dominated systems [12–14].

Most currently available disease-specific quality indicators do not capture the added value [6] of these generalist functions. Fortunately, measures are now available that begin to assess the processes of generalist practice [15–22]. Several of these are based in part on the Institute of Medicine definition of primary care [7]. These processes include the domains of comprehensiveness, coordination, continuity, accessibility, communication, advocacy, family, and community orientation and integration of care. They also comprise the quality of the relationship, as assessed by trust, accumulated knowledge, duration of relationship, and the patient’s preference for the regular clinician. A growing body of inquiry shows the effect of these domains on the process and outcome of care [15, 17,23–26].

In order to capture the quality of general practice, both disease-specific indicators and measures of the integrative, prioritizing, relationship-centered functions are needed. Focusing quality measurement and improvement efforts only on disease-specific measures misses much of what is uniquely important about general practice, and may have unintended detrimental consequences by devaluing fundamental aspects of the generalist approach that are essential to its success.

Quality indicators are likely to foster optimal quality of care only if disease-specific and general processes of care are assessed and valued. This dual focus will minimize unintended negative consequences of the application of quality indicators, and will stimulate additional research on the prioritizing function of general practice, which is not adequately assessed by currently available indicators. It is necessary to simultaneously focus on both the parts and the whole.

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References


