EDITORIAL

In This Issue: Local + Familiar = Healthier

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A number of reports in this issue of the *Annals* connect the thread running from patients[1] to place[2,3] that affects quality, cost, and care. Three studies infer, from large regional or national data sets, that having access to primary care clinicians when it is more convenient for patients improves continuity and cost.[4] If those patients have access to organized care on the correct scale of physician and nonphysician team members,[5] then one could reasonably expect such outcomes as those regarding earlier detection of breast cancer, less-invasive cancers, and lower mortality reported by Roetzheim.[6] In addition, the prospective study by Jean-Jacques and colleagues[7] demonstrates that outreach through the mail to low-income minority patients regarding colon cancer screening with fecal occult blood substantially increases adherence to preventive protocols in a high-risk population. Operationalizing availability insists on new definitions of relationships that model communication and teamwork. We know that prevention yields long-term benefits, but turning knowledge into action is the challenge of our times.

These reports look at different aspects of the same issues that are at the heart of a national discussion on rethinking primary care. In particular, the discussion of suitable panel size has been a source of debate as the United States moves toward a more population-based rather than fee-for-service structure for primary care. Whether through open-access scheduling, extended hours, outreach, or house calls, the image of family doctors as people who are available when and where patients need them is a compelling one. Thus, whatever the changes, continuity[8-13] and connectedness[14-16] are essential to the positive outcomes we strive for. Haggerty and colleagues[17] create a complex instrument that captures the many components of continuity but, in essence, affirms 3 long-held conceptual aspects of primary care: coordination, comprehensiveness, and confidence.[18,19]

Two articles raise inconsistencies between what family doctors think patients want and what, when asked, patients say they want.[20] When Hudson and colleagues[21] inquired about the role primary care physicians should play in cancer care, they found that patients feel primary care is less central in their cancer care than physicians might believe. "Get us to our oncologist fast and often" might be a summary of their findings. If primary care physicians seek to focus on the person, cancer patients seem to want to focus on the cancer. Similarly, if aggregating data into large health information networks holds the promise of population health with targeted interventions on high-risk populations, patients in a region of New York don't seem to see it that way.[22] While countries like the Netherlands are using nationally aggregated data to understand health and health care delivery, the United States is plagued by a longstanding public suspicion of collective information being of positive use to patients or communities. People appear to trust public health less than Google, which continuously collects data on where you are and what you buy.

Gillam and colleagues,[23] in their systematic review of the Quality Outcomes Framework[24,25] in the United Kingdom offer a sobering analysis of benefits and problems. As in any large and widely adopted attempt to change primary care practice, they find reason for optimism as well as cautionary findings. Although showing modest progress in achieving measurable targets for quality, the effects on cost and patient and clinician experiences of the process, which might be characterized as teaching to the test, has been more problematic. In this regard, Hunt and colleagues raise some unsettling questions about the nature of the relationship between the expanding definition of chronic illness and the explosion in pharmaceutical use in the United States.[26] By showing the potential for more income for clinicians by using more drugs for increasingly stringent measures of questionable clinical significance, they observe that physicians spend more time adjusting drugs than taking into account the burdens that polypharmacy places on patients' lives. This finding confirms Kafka's line, "To write prescriptions is easy, to come to an understanding with people is hard."[27]

Finally, the article on stroke narratives by White and colleagues[28] describes the real trajectory of recovery and healing and the characteristics of the stages

that recovery entails over long periods, as well as the mix of depression, anxiety, and hopefulness that our patients experience from such a life-changing event as a stroke.

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