Primary Care – Whose Responsibility?

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The increasing recognition of the importance of the primary care concept which has taken place in the past ten years has been accompanied by the rapid and successful development of family practice as a major response to marked deficits in primary care. More recently we are seeing more varied and fragmented approaches to this need by other specialties which have previously concentrated their efforts on secondary and tertiary care. Instead of competing for the primary care banner, the medical profession should give high priority to better understanding the nature of primary care and specifically training primary care physicians with a sufficiently broad range of knowledge and skills to provide primary care of high quality for patients of any age and their families.

During the past ten years, the concept of "primary care" has risen from virtual obscurity to become one of the most important issues facing American medicine. The Millis Commission and Willard Committee Reports in 1966 were primarily responsible for putting the plight of American medicine into proper perspective, and focusing our attention on achieving a more organized primary, secondary, and tertiary health care system.[1,2] The secondary and tertiary systems had been growing rapidly for many years, and they had reached a level of size and sophistication far out of proportion to the primary care base which was needed to sustain them. Prestige and greater financial rewards were available to the physician who chose to practice within the secondary and tertiary systems; and consequently there appeared little likelihood of reversing this trend. However, the Millis and Willard Reports pointed us in the right direction, and since then the federal government – along with the entire public sector – has encouraged us toward rapid change.

During this period, the specialty of family practice was born. The birth was complicated and there were gestational difficulties. Few specialties were willing to admit parenthood and accept full responsibility for this fledgling. Many doubted that family practice would ever be a desirable and respected member of the medical fraternity and achieve the status necessary for long-term viability. This unwillingness on the part of existent specialties to accept responsibility for primary care was noted by the Millis Report when it stated, "Few existing specialists consider comprehensive and continuing medical care to be their responsibility."[1]

Parenthood was finally shared by a consortium of established specialties (plus the American Medical Association and the American Academy of Family Physicians), each recognizing the need for a primary care effort, but none willing to accept sole responsibility. By contrast, it is amazing (and amusing) to note that today these same specialists are clamoring to be recognized as primary care physicians. To the non-medical public this new development seems a self-serving effort arising from financial insecurity and competition for the federal dollar. The jostling for position in the federal funding line is all too reminiscent of organized medicine's habit of responding only at crisis points rather than taking action based on a thorough evaluation of the problem and a unified approach to the most efficient solution. I fear that too often we appear to the public to be more concerned with what is better for the physician than what is best for the patient.

Although the Millis and Willard Reports did approach the health care delivery problem with sufficient planning and forethought, their recommendation that a single, well-trained physician in primary care be developed has not been universally accepted. Instead, we again appear to be approaching the issue in a fragmented fashion, with several disciplines competing for the primary care banner. This is reminiscent of the same disorganized system which was initially responsible for the problem. To quote the Millis Report, "It is time for a revolution, not a few patchwork adaptations."[1]

The British Medical Association approached this same problem in a similar but more thorough manner in 1970 through its Working Party on Primary Medical Care, which combined the reports of seven different committees in an attempt to synthesize an ideal system of primary care.[3] The final report recommends that the present British system be remodeled by establishment of a specialty of Primary Medicine. The specialty would require five years of graduate training and the physician-graduate would be incorporated into a modern system of health care, utilizing allied health professionals while maintaining the present secondary and tertiary components as purely consultative services.

Dr. Charles Edwards has emphasized the need for American medicine to assume a leadership role in de-

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signing and implementing an efficient system of health care delivery which would offer optimal medical care at a reasonable cost to all people. He states, "I am convinced that the pluralistic health care system as we know it in the United States is moving steadily toward its own destruction, not by design but by default."[4] This is a result of medicine's unwillingness to heed the directive of the Millis Report and devote a unified effort toward defining and training a single primary physician who could relate effectively to our present secondary and tertiary medical care system.

Instead, we see recommendations for a fragmented approach to primary care, such as the recent suggestion by Pearson that obstetrician-gynecologists be considered the primary care physicians for women.[5] This certainly may happen if we continue to train an excessive number of residents in the traditional specialties rather than primary care. Should this be the case, however, it will also become necessary for the neurosurgeon – and all other consulting specialists – to deliver primary care as well!

Just as physicians trained in the surgical specialties require an adequate volume of surgery in order to remain most effective, so must the primary care physician see sufficient numbers of patients who require his broad diagnostic and management skills. Quality and effeciency are sacrificed when physicians straddle levels of care and diminish activity in their primary area of training and expertise.

Primary care, to be done well, requires special training. The expanding body of knowledge and skills required to offer excellent primary care belies the old notion that all physicians are equally capable of providing good primary care. Early specialty tracking in many of our medical schools, while preparing physicians to be more competent consultants or secondary level practitioners, leads them away from adequate training in primary care. The audit techniques that are being rapidly developed to measure competence and quality in outpatient settings will soon make it possible for us to identify poor performance in office practice as easily as we do in hospital practice.

Rather than competing for the primary care banner, the medical community should be analyzing the knowledge and skills required to deliver modern, high-quality primary care in a manner consistent with present social and economic realities. Our combined energy should be directed toward training individuals ideally suited to this task. The curriculum for training these physicians should be designed on the basis of careful analysis of those problems which the primary care physician will deal with in practice. Such an approach, based upon practical necessity and actual need, would be a great improvement on the present effort of numerous specialties to design curricula based on their individual identities.

A balance must be sought which allows for maximum comprehensiveness (giving greatest cost-effectiveness) without sacrificing high-quality care. The balance probably lies somewhere between the extreme comprehensiveness of the general practitioner-surgeon of the past and the multispecialty approach to primary care existing in some settings today, involving the internist, pediatrician, obstetrician, and other supporting specialists.

Numerous studies have analyzed the practices of physicians delivering primary care, and they reveal that respiratory, dermatologic, musculoskeletal, psychiatric, and gynecologic disorders make up a large proportion of the problems seen. Family practice is the only medical discipline whose training programs include all of these areas as major components of their programs. All other medical disciplines are characterized by their emphasis on consultative or surgical skills. The areas mentioned above have not been given emphasis – or even exposure – in most of the other specialty training programs which claim to produce physicians competent in primary care. Only in the past few months has the American Board of Internal Medicine agreed that the disciplines of dermatology, office gynecology, musculoskeletal medicine, ophthalmology, otolaryngology, and psychiatry be included as components of general internal medicine training programs.[6] The inclusion of these disciplines was a rarity in internal medicine training as recently as two years ago.

In addition to the skills listed above – all of which have been among the essential components of family practice teaching programs since the Board's inception in 1969 – family practice training emphasizes interpersonal skills and the management of factors which disrupt the well-being of an individual, a family, or a community. The knowledge of family dynamics and the early identification of interpersonal problems are also important skills of the family physician.

The emphasis upon ambulatory skills in family medicine does not imply that the family physician has no role in hospital medicine. Many common problems treated by hospitalization are within his level of competence as a result of the extensive nature of the family practice training programs. The family physician is also the professional best prepared to coordinate care for patients when the skills of a large variety of consultants and allied health professionals are necessary. Involvement in hospital care maintains continuity of the relationship between the physician and the patient, ensuring the best possible overall care.

Primary care, then, would appear to be best provided by a physician trained in the broad range of ambulatory skills already available in family practice residency programs. The medical profession can and should provide support for the training of these physicians. If we fail to do so, the public sector – primarily the federal government – will become increasingly dissatisfied with our efforts to organize an efficient health-care delivery system. Without our agreement on a workable plan, they may insist on a plan based not on high quality of medical care but on accessibility at the lowest cost. This would, in effect, be the result of our "default" in accepting the leadership proposed by Dr. Edwards.

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