# Values and Roles in Primary Care

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Discussions about research priorities and criteria for quality assessment in primary care are confusing when the differences in the underlying models and value systems are unclear. This article presents a simple grid that can facilitate discussions involving the roles of primary care physicians.

One axis of the grid includes three value systems that are important to the understanding of different goals in primary care. The second axis includes three practice roles that are important to the evaluation of the actual delivery of primary care. Examples are used to illustrate how the grid can be used in discussions about the mission of primary care.

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The Institute of Medicine (IOM) Committee on the Future of Primary Care worked diligently, both on the interim report on the definition of primary care[1] and on its final report.[2] The Committee has 19 members with very different professional and organizational backgrounds and is supported by IOM staff with equally different backgrounds. This circumstance could easily result in some confusion in discussions about the content, structure, research priorities, and quality assessment in primary care. The participants rely, often implicitly, on rather different utility or value systems and on different models, or paradigms, in the delivery of primary care. Thus, it can be especially difficult to formulate the similarities and differences in the roles of different primary care clinicians, ie, family physicians, general internists, pediatricians, and nurses. It is therefore necessary to be precise and explicit about the frame of reference of each participant. Doing so was certainly important during the conference in January 1995 on the scientific base of primary care. At this conference, a simple grid was used: one axis with three different utilities, or value systems, and the other axis with three models, or practice roles, for the delivery of health care (Figure).

Two publications form the basis for the grid: Toon's philosophical essay "What Is Good General Practice?"[3] which gives a thoughtful overview of the biomedical model, the preventive or public health model, and the holistic or teleological model; and the discussion of different utilities in medicine by Wulff and coauthors,[4] which distinguishes so-called rule-utilitarian, act-utilitarian, and deontological values and norms. *Rule-utilitarian* values imply that the utility of a certain intervention is optimized for a group of patients, resulting in the best effect for the lowest price for most patients. *Act-utilitarian* considerations are necessary to optimize the choice of a certain intervention for an individual taking into account his or her specific preferences. *Deontological norms* refer to the important driving force in medicine to be a good physician and a good person.

The simultaneous use of the Toon and Wulff approaches to primary health care helps clarify discussions about the essence of primary care and the role of primary care physicians.[5] Each of the six elements represented on the grid are, in principle, important to every physician, but how they rank in importance can be quite different. All elements belong to the frame of reference of medicine at large and, as such, are recognized by physicians. These elements, however, have varying appeal to individual providers and provider groups in the medical community.

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**Practice Roles**

| Values | Biomedical | Public health | Holistic |
|---|---|---|---|
| Act-utilitarian | | | |
| Rule-utilitarian | | | |
| Deontological | | | |

Figure. The multiple missions of primary care. On the Y axis are the the three value systems that are important for the understanding of divergent goals in primary care. On the X axis are the three practice models that are important to the evaluation of the actual delivery of primary care.

When it is unclear which elements are considered most important, discussions about the mission of primary care, research priorities, and criteria for quality assessment can become confusing.

## The Grid

In the grid, the classic model, or paradigm, is biomedical: state of the art in medicine reflected in education, research, and publications. The medical model is strong, stable, and generally acknowledged as a cornerstone of modern society. The development of the medical model strongly depends on the introduction and assessment of new diagnostic and therapeutic interventions. The decision of how much good and how much harm results from an intervention is usually based on its average utility for a group, or its *rule-utilitarian* value. This principle is illustrated by the participation of a primary care physician in a randomized controlled trial of a new treatment for urinary infections. The physician includes in the trial all eligible patients during a certain period. If the trial is successful, the resulting rule will be to treat similar patients in the future with the new treatment.

On the other hand, consider a 70-year-old man who suffered a severe stroke 6 months ago from which he has only partially recovered. He has an enlarged prostate, lives alone, and over the years has had several urinary infections. This patient may well be better off with a less optimal treatment that has suited him well in the past and is easy to apply. Understanding the preferences and circumstances of the individual patient requires the use of *act-utilitarian* values: what is good for a group is not necessarily good for an individual. The cultural values and ethical principles in a given community in part define which doctor is a "good doctor" for a specific patient, along with compassion, genuine interest in the patient's ability to cope with difficult conditions, use of other than medical solutions, and the continuation of a friendly and open relationship over time.

In the day-to-day application of the biomedical model, the three utilities consequently meld together in a varying mix depending on the physician, the patient, and the clinical problem. Sufficient knowledge and skills to

apply rule-utilitarian norms are essential before the individual physician, whether working in the community, an outpatient department, or a tertiary care hospital, can balance those norms with what is best for the individual. The choice of treatment for a myocardial infarction in a 55-year-old woman with a pancreatic malignancy will depend on the patient's condition, her preferences, and the situation at home. True compassion with the suffering patient and the anticipation of death within the next few months implies focusing on act-utilities and may also involve a deontological approach. This balancing process is characteristic of family practice because it implies the responsibility of a family physician to accept its consequences by providing continuity and comprehensive care.

The preventive or public health model implies the incorporation of rule-utilitarian considerations for a population or risk group. In public health, well-designed prevention and health maintenance programs are key issues. Norms in society about the common good, cost, accessibility, and egalitarianism coincide with the notion that prevention is better than treatment. Consequently, a certain authoritarianism is accepted in prevention and public health: the denominator is the population or a group of persons, which implies less emphasis on the autonomy of the individual included in a prevention program. An individual who does not want to participate can put others at risk, as for example, occurs in communities in which diseases such as poliomyelitis, whooping cough, and measles have disappeared because of the vaccination program. In such a situation, however, it is acceptable to have a small number of nonvaccinated children who belong to a religious community that rejects vaccinations.

The holistic or teleological model implies a perspective on the meaning of disease in a person's life and on the way it may affect his or her potential to grow. In this model, coping with illness, pain, and limitations in function can provide opportunities to have a richer life. A physician can, for example, interpret lower abdominal pain in a 20-year-old woman as the result of a very difficult family situation. The patient, however, may not acknowledge an association between her abdominal pain and the violent and antisocial behavior of her family members, and consequently merely expect treatment of her complaint. From the physician's perspective, symptomatic treatment does not eliminate the cause of the complaint and could even make it more difficult for the patient to solve her real problem.

A similar situation can occur with a 40-year-old man who tests positive for the human immunodeficiency virus (HIV). His family physician may not want to be limited to finding the balance between act- and rule-utilitarian considerations, but rather prefer to help the patient make the most of his remaining time in a teleological sense. Inherent to this approach is the need to make certain that the provider's personal preference sufficiently coincides with the patient's philosophy of life. As a consequence, this model has met equally strong defenders and opposers over the years.

The elements of this grid are not mutually exclusive. Strong emphasis on the need for good relations with the patient does not preclude the need to be a fully competent clinician. The need to maintain liaison with public health and mental health agencies does not diminish the urgent need to provide personal and continuous care to the very sick. Setting the research priority in family medicine on the development of episode-oriented morbidity studies does not diminish the need for better diagnostic or counseling strategies. The explicit formulation of the mix of models and utilities that represent varying frames of reference in complicated discussions may make it easier to reach consensus, or, if not, at least to more precisely articulate real differences in opinion that preclude consensus.

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