Primary Care and the Community

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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.[1]

This 1996 Institute of Medicine definition of primary care differs from the 1978 definition,[2] which emphasized the role of the clinician in caring for individuals. The revised definition extends the role of the clinician to consider the family and community when providing health care services.

As described by Pathman et al[3] in this issue of the *Journal*, there is wide variability in primary care physicians' involvement with their communities. The authors identify four distinct activities or dimensions through which physicians interact with their communities. When considering these four activities, only one ("identifying and intervening in the community's health problems") requires active outreach and expertise by the physician. Those physicians who do take a proactive role in addressing specific community health problems have the opportunity to affect morbidity and mortality for a larger number of people than those physicians who are not engaged in active outreach. The second and third dimensions ("responding to the particular health issues of local cultural groups when caring for patients" and "coordinating local community health resources in the care of patients") describe skills all primary care physicians should aquire. It could be argued whether these two dimensions relate to a heightened community awareness or are essential for the provision of quality primary health care. The fourth dimension ("assimilating into the community and its organizations") is a desirable goal for physicians that may take several years to attain. There is no guarantee, however, that those physicians who do assimilate into the community do so with the result of improving the health of the people residing in that community.

Pathman and colleagues make an important point that needs to be emphasized: community-oriented primary care (COPC) involves a specific set of activities. Practicing in and assimilating into a community, responding to local cultural health issues, and coordinating local resources do not constitute COPC. Educators of medical students and residents need to realize that simply providing health care in a specific community is not the same as practicing COPC.

So where does this leave us? Greenlick[4] describes the need for future physicians to be able to practice population medicine; that is, the unit of care represents groups of people either registered in the clinician's practice or residing in the community. This paradigm contrasts with the traditional role of physicians, which has been to practice medicine one individual patient at a time. If the health care system of the future is to have physicians working with populations in their communities, then medical schools will need to equip future physicians with the skills to practice population medicine.[5]

A recent national survey distributed to 142 US allopathic and osteopathic medical school curriculum leaders examined the expectations that each institution had for their students to learn specific skills in community dimensions of medical practice (Garr DR, unpublished data, 1998). Preliminary results from this survey reveal that 90% of respondents (43/48) expect their students to appreciate the effect of language and culture on health care services. Eighty-eight percent (42/48) expect their students to identify community resources that can assist with the care of patients. Only 58% of respondents (28/48), however, expect their students to know how to provide community-responsive care. Considering these early results, it is not surprising that Pathman et al found a low response to the question about self-efficacy and the activities involved in intervening in the community's health problems. It is understandable that those surveyed by Pathman and coworkers are not confident about their abilities to provide community-responsive care if the medical educators who taught them did not expect their students to learn those skills.

An encouraging finding in the study by Pathman and colleagues is the positive association between the respondents' community health care interests in medical school and their subsequent confidence in

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three of the four community dimensions. If medical educators in the future place greater emphasis on the community dimensions of clinical practice during medical school, perhaps more students will develop an interest in addressing the health needs of populations, pursue that interest throughout their education, and use their skills in the future as confident, community-responsive physicians.

Pathman et al imply that "identifying and intervening in the community's health problems" requires physicians to focus on broader health issues within the surrounding community. Although such involvement would certainly be commendable and is one of the fundamental principles of COPC, it may not be essential for a primary care physician to look beyond his or her practice to address a population's health problem.[6] For example, physicians can take a much more active role in caring for those people registered in their clinical practices who have chronic problems such as diabetes or hypertension. Primary care physicians in the future may be expected to monitor the health status of the "community" of patients within their practices and implement outreach programs with the goal of helping their patients take better care of themselves. In the evolving age of managed care, COPC has been suggested as a paradigm for addressing the challenges of the cost, access, and quality of health care services.[7]

The increased availability of electronic medical records and infrastructure support provided by managed care organizations can assist in identifying those people at risk within a physician's clinical practice and facilitate the initiation of active outreach and prospective management of people with chronic diseases. The National Committee for Quality Assurance has already instituted its Health Plan Employer Data & Information Set (HEDIS) guidelines,[8] which are receiving attention from managed care organizations and clinicians throughout the country. Such prospective monitoring of quality of care can potentially improve the health of all people registered in physicians' practices, not just the health of those who come to their offices for health care services.

The COPC literature implies that physicians are expected to lead the effort in identifying and intervening in the community's health problems in order to become involved with broader community populations. This perception that physicians need to initiate and direct such activities is one of the obstacles that has slowed the utilization of COPC. Although the input and guidance by physicians is certainly important, other health care agencies, health professionals, and community members must all contribute to the implementation of community-based interventions. Interdisciplinary health care teams will likely be an important resource for developing and implementing community-oriented health care programs that address the future needs of specific populations.[9]

The study by Pathman and coworkers does raise some important issues. Certainly, the finding that physicians who work with minority patients lack involvement in three of the four community dimensions raises a specter of concern that warrants further study. Similarly, the finding that physicians with more capitated patients reported less community participation and assimilation needs additional exploration.

The health care delivery system in the United States is changing rapidly, and its future remains uncertain. If managed care continues to grow at its present rate, it is likely that physicians and the health care delivery systems with which they are affiliated will need the expertise and systems to work more effectively with populations and communities. It is likely that the medical education system in the future will need to change to prepare clinicians to practice community-oriented primary health care. Dr Pathman and his colleagues have made a valuable contribution by identifying and examining a range of activities that compose the interface between primary care and the community.

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