Teaching the fundamentals of primary care: a point of view.

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In the United States today major forces in society and within medicine are coming together to support an increase in the number of primary care physicians and an enlargement of the place of primary care in medical practice. The drive toward universal health insurance coverage and efforts at cost containment are playing an important part in fueling the movement toward primary care (Nutter et al. 1991; Budetti 1993). A shortage of physicians in rural and other underserved areas is also an impetus to the production of more primary care physicians (Young 1990; Riley et al. 1991; Roberts, Davis, and Wells 1991; Jecker and Berg 1992; McElmurray et al. 1992; Roberts et al. 1993). Medical schools and medical educators are rethinking the traditional curriculum and training of physicians (Kar 1990; Finberg et al. 1991; Stimmel 1992; Bryant and Morgan 1993).

Observing at the present moment, one might conclude that contemporary economic and political forces had selected primary care over specialty medicine as the solution to some of the problems of access and economics that now afflict American medicine. A historical perspective not only clarifies what primary care is and provides further understanding of its rise to prominence, but it also points up dangers that primary care training programs must overcome. Educational programs for primary care physicians have three goals: First, they must prepare physicians for the care of patients in the twenty-first century. To accomplish this they must develop the new knowledge base for this training. Finally, they must develop teaching methods that will overcome the obstacles against which previous attempts have foundered.

In Great Britain, in 1920, not long after national health insurance was instituted, primary care (the primary health center) was distinguished from the secondary consultative center and the teaching hospitals. The idea that primary care is the most general, entry-level medical care and that it is to be contrasted with referral centers that contain specialist care and with teaching hospitals has become widespread in the world. Primary care has been a central mode of medical care in many nations for a long time, providing an international body of varied experience (Bufford 1992; Blumenthal 1992; Whitcomb and Desgroseilliers 1992). The concept was further developed by the World Health Organization's search for health care systems that could advance the social goal of member governments for "the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life." The World Health Assembly, in subsequent deliberations, defined primary health care as follows:

Essential health care based on practical, scientifically sound, and

socially acceptable methods and technologies made universally

accessible to individuals and families in the community by means

acceptable to them and at a cost that the community and the country

can afford to maintain at every stage of their development in a spirit of

self-reliance and self-determination. It forms an integral part of both the

country's health system of which it is the central function and the main

focus of the overall social and economic development of the

community. It is the first level of contact of individuals, the family and

the community with the national health system, bringing health care as

close as possible to where people live and work and constitutes the first

element of a continuing health care process. (World Health Organization

1978)

At first glance it seems to be describing a kind of medicine that is ideal for dealing with the most common problems in the poorly defined fashion that they often show themselves. As Barbara Starfield points out, "It addresses the most common problems in the community by providing preventive, curative, and rehabilitative services to maximize health and well-being. It integrates care when more than one health problem exists, and deals with the context in which illness exists and influences people's responses to their health problems" (Starfield 1992, 4). Similar concepts mark a statement on the generalist physician by the American Boards of Family Practice and Internal Medicine (Kimball and Young 1994). When the implications of these definitions are elaborated, primary care takes on a complexity that is a far cry from the purpose delineated for it by the British National Health Service.

Two other movements in medicine and widespread social changes of the last generation further define what is asked of primary care. The family practice movement gained force in the 1960s. Decrying specialty medicine's concentration on the disease rather than the patient, it sought to focus the doctor on the patient in a special way. In G. Gayle Stephen's words:

Family physicians know their patients, know their patients' families,

know their practices, and know themselves. Their role in the health care

process permits them to know these things in a special way denied to all

those who do not fulfill this role. The true foundation of family medicine

lies in the formalization and transmission of this knowledge. (Stephens

1982, 8)

Increasingly apparent in the 1970s, the hospice movement became another force toward care of a patient as a sick person within a family and community matrix. It is the sine qua non of palliative care that disease-oriented medicine has failed to cure the patient or meet the needs of patient and family. Palliative care is often associated with symptom control, but hospice physicians know that symptom control cannot be adequate in the absence of a much broader understanding of dying patients -- suffering is an affliction of persons, not bodies, and can occur in relation to any aspect of a person: physical, psychological, social, or spiritual (Cassell 1982).

The family practice and palliative care movements were born during a period in the United States marked by a great expansion of our understanding of the concept of person. The civil rights and women's movement, the embrace of difference and diversity leading to the disappearance of the melting-pot metaphor, and the rise of bioethics, all celebrated the emergence of an enriched concept of person. For medicine, this translated into care not merely of an individual or a bearer of rights, but of "me, [as in] Doctor -- treat me, not just my lungs or liver!"

The family practice movement grew rapidly in the early years after its official designation as a specialty in 1970, but then faltered. Palliative care continues to struggle to gain acceptance within mainstream medicine. And, as