The Two Faces Of Primary Care

by Eric J. Cassell

Among the cost cutters who are overseeing the rapid and often thoughtless restructuring of the American health-care system, "primary care" medicine has become a panacea. To the executives and physicians who run the managed-care organizations that increasingly dominate America's health-care landscape, primary care seems to offer promising solutions to many of the problems of modern high-cost medicine. They see the primary care physician as a combination low-cost general practitioner and "gatekeeper" to the rest of the health-care system, reducing the flow of patients into more specialized and expensive forms of medicine.

Within medicine, however, primary care has long had a different meaning. While its name suggests simplicity, primary care is in fact a very sophisticated response to problems created by high-cost, high-technology, highly specialized modern medicine. It has been evolving as a distinct field for several decades. Primary care emphasizes a more comprehensive view of patients and their treatment than does today's standard medicine. It seeks to aid the vast majority of patients who are not best served by the high-technology, superspecialized medicine at which the American health-care system excels, especially the poor, the chronically ill, the aged, and the disabled. Consider the plight of a poorly educated 58-year-old woman, a diabetic for 20 years. Her mother and her son both died of the disease, and she lives in constant fear of its complications. Yet she seems almost completely unable to follow the regimen of diet, exercise, and medications prescribed by a specialist. Without the added attention to the psychological and social elements of her illness that primary care provides, there is little hope of helping her.

The cost cutters tend to see only the financial and organizational advantages of primary care, and there is no question that these are considerable. Primary care is inexpensive relative to high-technology specialist care. Because most care is administered by one physician, it makes the task of administration relatively uncomplicated. And since primary care physicians do not need to operate out of high-technology hospitals or medical centers, this kind of medicine can be brought close to the places where people live, at relatively low cost—an especially useful characteristic in providing for the poor of the inner city and rural America. And, of course, there is the fact that primary care physicians can act as gatekeepers, aiding in the more rational use of resources.

It is a common and destructive error, however, to assume that the medicine itself is simple—as if primary care is concerned only with the treat-

The Clinic *(1944), by Ben Shahn*

ment of colds, sprains, and other simple ailments, and with determining who is ill enough to require the attention of a specialist. In fact, primary care is a more effective medicine not only for people with simple ailments but for those with illnesses that are serious and complex.

Specialists and specialism put the focus of medicine on an organ system or a disease; primary care medicine makes the *patient* its subject and object. It understands functional impairment and disease to be processes that enter into the patient's life story, and its interventions are chosen with the course of that story in mind. Diseases such as diabetes or even cancer unfold over such a long time that the nature of the person has an enormous impact on the evolution of the disease and its treatment. This focus on the patient rather than the disease is what makes primary care unique, and what makes it as well suited to prevention as to treatment, to children as to adults, to the well as to the sick. It is especially well adapted to the care of people with chronic illnesses, who make up the largest number of the sick.

The primary care doctor is not just an updated version of the storied general practitioner of old (who was, in any event, more storied than real for most people). Primary care physicians are generalists schooled not only in the intellectually and technically exacting realm of medical science but in communication skills, principles of behavioral science, and methods of developing the doctor-patient relationship. With these skills they can, for example, help patients become more involved in their own treatment, change harmful kinds of behavior, and stick to their therapeutic regimens. About one-third of each year's roughly 16,000 medical school graduates go into fields that are classified as primary care—family medicine, pediatrics, and general internal medicine—but only a minority of these new doctors receive such special training in primary care. The newer medical schools of the Southwest have been quicker to embrace primary care training than the more traditional citadels of the Northeast and West (although Pennsylvania State University's Hershey Medical Center

has one of the nation's exemplary primary care programs).

The rise of primary care is one of the expressions of a fundamental intellectual shift that has been taking place within medicine during the 20th century. For almost 200 years, health has been defined as freedom from disease, and medicine has been thought of as a world of disease—peopled by those who have an acute disease, are being prevented from having a disease, are being cured of their disease, or are being rehabilitated from the effects of a disease. But with the aging of the population and the growth in the number of people suffering chronic illnesses such as diabetes, arthritis, and heart disease, the idea that health is simply freedom from disease has become increasingly inadequate. Is a person with diabetes ill even if the disease is under control and he is able to live as others do? Among the elderly virtually everybody has one disease or another. Are all people who have a disease unhealthy?

Primary care has its roots in the effort to find definitions of health that accommodate these new realities and help patients meet their social, emotional, and economic goals despite illness, impairment, and functional limitation. It has links to two somewhat older movements in medicine, family medicine and hospice and palliative care (the specialized care of the dying), and shares with them the imprint of American society's growing emphasis on individual choice and dignity and its recognition of cultural diversity.

The innovative primary care that has been evolving within medicine and the kind of primary care commonly envisioned by the leaders of the new managed-care juggernaut are not necessarily mutually exclusive. There is much talk of reducing the number of specialists produced by the nation's medical schools and increasing the number in primary care fields. But if money for medical education and residency training is held back by corporate and government cost cutters, the development of true primary care and the training of primary care physicians—and specialists—will be slowed. If physicians are treated as part of the nation's health-care problem rather than part of the solution, over-regulation and declining income and morale among doctors will hamper change. This would be especially hurtful, because the eventual triumph of primary care medicine seems assured. For the older, more demanding, and more cost-conscious America of the 21st century, it is the only choice that makes sense.

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