PRIMARY CARE—IS IT HERE TO STAY? THE IMPLICATIONS FOR MEDICAL EDUCATION*

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A national preoccupation with primary care, perhaps as part of an "obsession"[1] with the subject of health itself,[2-4] is evident in many previous meetings sponsored by the New York Academy of Medicine[5] and other symposia and publications of the health-care establishment.[6-12] The academic community is in the center of the turmoil, attempting to maintain its traditional mission of teaching and research[13-15] yet "stressed" in these attempts by the impact of financial and social pressures[15-17] and a growing insistence that it move toward new forms of medical education[18] and assume unfamiliar roles in the delivery of health-care services[19,20] characterized by "humanism and social welfare."[21]

What is primary care that it should have stirred such controversy and been identified as among the greatest single issues or problems facing medicine in America today?[10,22-24] McWhinney has taken some degree of responsibility for the introduction of the term in a paper entitled "The Primary Physician in Comprehensive Health Service: Further Reflections After a Visit to the United States."[25] Primary care has been discussed at length in numerous publications.[26-30] These emphasize a collective approach termed also the "generalist functions"[10,31] of a physician, to include in particular first contact, accessibility, continuing care, comprehensive management, encouragement of the individual's own growth[32] and maintenance of health, and "commitment to people above commitment to technology."[25] "This is a stunningly (some might say impossibly) broad mandate."[33] Yet the problems are much more complex than the definition, and relate to why primary care has become a national concern and matter of contention: What kind of physician should provide it, what is the

*Presented at a meeting of the Committee on Medical Education held February 8, 1979.

appropriate preparation, how and in what setting is it best delivered, what are the reasons for its present inadequacies, and what is its long-term outlook?

The title suggested for this paper has two parts: the first asks whether primary care is here to stay. The answer would seem to be in the affirmative to meet more appropriately and adequately than in the past broad health-care needs based on newer demands. The second part of the title, Implications for Medical Education, raises major unresolved issues and problems centering around primary care, particularly as they concern the role of the department of medicine.

Departments of medicine today reflect the dramatic changes in American medical schools during the past six decades, spurred by the Flexner Report in 1910[34] and by the achievements in medical research during the era after World War II, and subsequently supported by the National Institutes of Health. The scientific discoveries that brought new drugs, technologies, and insights into human biology and medicine are well known and have been described by a number of authors.[1,17,35-38] With such a heritage, it is understandable that the cause and potential cure of disease, especially where it could be understood at the molecular level, became the highest priority, and faculty were selected for their concern with and creativity in research.[39] The curriculum was a continuum from the basic sciences to the clinical setting on the wards. Postgraduate training continued this orientation within the same framework of teachers in a hospital setting, and the highly specialized and sophisticated techniques created for the diagnosis and management of overwhelming illness reinforced such training as the appropriate and perhaps sole responsibility and goal of a department of medicine.

As Hogness and Akin have noted, the profound changes after World War II "combined to cause extraordinary modifications in the schools of health sciences, their interrelations and their relations with the rest of the university and society in general.... There has been unparalleled expansion of budgets, physical facilities, and programs, coupled with rapidly growing numbers of faculty, students and staff."[40] But gratification with such growth, which the academic community regarded as its main reason for existence, was shared neither by the public at large nor by their legislative representatives, who voiced widespread dissatisfaction with health-care services,[41] which came to be well summarized by the title of a recent symposium: "Doing Better and Feeling Worse: Health Care in the United States."[7]

The growing demand that the academic community assume responsibilities for primary care services to a larger segment of the population arose from many sources.

First, comparisons were made between our system of health care, which emphasizes diagnosis, with that in the United Kingdom, where the stated objectives have been continuity and home-based care supported by a nationwide network of paramedical and social services.[42]

Second, health care came to be regarded as a right,[43,44] although it is not clear how this was to be interpreted: i.e., providing accessibility,[37] meeting costs,[2,18] or responsibility for the individual to maintain his own health.[12] Pellegrino viewed primary care as a "universal human need, a relative right," indeed, a "moral imperative in our times and in our society,"[3] which raised the issue to the level of a "human bill of rights."[45] Yet a sharply divergent view expressed concern that medical care as the right of the patient could entail force or the "threat of violence by the state" upon physicians to enforce it, which would thus be "immoral."[46]

Third, primary care was cited as an area "where medicine fails."[45] Increasing concern was expressed about high costs,[47] limited accessibility to care,[41] and the continued existence of two classes of care,[48] reflected by overcrowded emergency rooms and clinics, particularly in municipal hospitals in New York, where the "poor, elderly, dependent and foreign born" obtain health-care services,[49] and in teaching outpatient clinics for the financially and socially underprivileged, often existing side by side with private diagnostic clinics.[50]

Fourth, a series of reports called upon the medical community to make changes. The Millis Report of the Citizens' Commission on Graduate Medical Education recommended continuing and comprehensive care as the "central focus of medical school organization, planning and clinical teaching."[51] The Willard Report recommended the establishment of family-practice residencies in line with the change in name of the American Academy of General Practice to the American Academy of Family Practice.[52]

Fifth, federal legislation and financing had perhaps the widest impact.[41] Legislation such as the Health Professions Education Act and the Comprehensive Health Manpower Training Act led to the development of family practice and primary care residencies and to expansion of medical and other health-professional schools. Federal financing policies estab-

lished the Medicare program to meet the special health and economic problems of the elderly, and the Medicaid program was designed to reduce the economic impact of health-care services for the poor. Legislation also provided a network of neighborhood health centers to serve the poor under a program of the Office of Economic Opportunity, as well as child and youth projects and Health Maintenance Organizations.

To expect that federal legislation imposed on medical schools and their teaching hospitals can remedy the perceived inadequacies of present-day primary health care is as unrealistic and unfair as to insist that medical research and directed federal grants cure the disease under inquiry. My view is that academic medical centers have a responsibility to address health-care issues as they do research in biomedical science. To oppose doing so because it is not compatible with the missions of teaching and research places restrictive limitations on these very areas of development in primary care which are admittedly more difficult to approach. In fact, within academic institutions this apparent unresponsiveness on the part of departments of medicine and particularly their chairmen has led to the enormous countergrowth of educational and residency programs in family practice[25,30,37,53-55] with a great deal of creativity that has challenged a time-honored dogma that the best graduates continue to enter internal medicine residencies.

More recently, internal medicine has responded by restructuring its organization and training programs. The American Board of Internal Medicine has defined criteria for the training of the general internist,[56] and departments of medicine have established sections of general internal medicine,[57,58] increased the time residents spend in ambulatory care,[59] set up separate tracks for them to do so,[60-63] or worked cooperatively with related medical residency programs.[64,65] Part of the problem is that departments of medicine are often urged to include *both* the formulation of educational goals of primary care and the implementation of health-care delivery by faculty as well as residents, even the "major onus for redressing physician manpower imbalance."[66] Education and health-services delivery should be more closely integrated to be mutually supportive, but the problems are so formidable that in my limited time I would prefer to deal with the issues of education and training.

The responsibility to define the educational programs that should constitute primary care teaching and training is not limited to internal medicine. Indeed, a chairman of a department of family practice observed that the

"scholarly endeavor necessary to develop further the academic base of primary care is severely deficient in each of the three disciplines," i.e., general internal medicine, general pediatrics, and family medicine.[53]

The spectrum of opinion concerning a role for departments of medicine in primary care education is certainly more diverse than in these other disciplines. Some academic leaders view the medicine of the future as organized into specialized[67] although not overspecialized[68] disciplines concerned principally with disease as it can be understood at the molecular level,[35] while at the other pole of the argument[69] are those who propose that departments of medicine pool their resources with departments of family practice in training primary care physicians, but that the latter should take the lead because "family practice comes much closer to fulfilling the public need than does general internal medicine."[70]

If departments of medicine appear indecisive about their roles in education and postgraduate training for primary care, there are reasons for them to be apprehensive about changing a system that has worked so well. Emphasis on in-hospital care has brought great benefit to the severely ill and has been recognized as a decisive factor in producing well trained practitioners able to care for such patients.[10,16,22] If medicine has neglected teaching in the ambulatory setting, this has been in part because of the great difficulties of doing so there compared to the wards.[26] Meyers has commented on the difficulties of analyzing a clinical problem in the ambulatory setting: "Decisions have to be made on incomplete information. Sometimes decisions cannot be made. Intuitiveness is involved. Uncertainty is involved."[71]

Perhaps of greatest concern is the perception by medical faculties of the altered definition of an internist[72] from one dealing with disease as it can be understood, diagnosed, and treated, to a physician who must cope with the "medicalization of social problems."[4,16,35] By this is meant the shifting of social ailments to the internist, who until now has been trained to deal neither with these nor with those problems which have "their roots in profound social and cultural disarray and over which medicine cannot be expected to provide remedies."[35] As Renée Fox has put it: "Because a greater proportion of deviance in American society is now seen as illness, the medical profession plays a vastly more important role than it once did in defining and regulating deviance and in trying to forestall and remedy it."[4] Conflict and controversy [30,54,73] between internal medicine and family practice exist in these areas as both disciplines strive to define their long-

term objectives for the education and training of primary care physicians in the academic tradition: [37,55,74,75] in particular, the nature and duration of in-hospital training, and the means to deal effectively with the social and psychological problems that accompany illness. This broader approach toward the whole person, also termed "holistic"[76] or "patient-centered medicine,"[77] has been advocated as part of health care with more social implications as compared to the more sharply defined and traditional role of the physician to provide medical care[15] for those with manifest disease.

I believe that a traditional department of medicine must examine these issues carefully and build on existing strengths to provide a response. The diversity and depth of its skills can support primary care development in a constructive and rigorous way with expectations of high academic standards. Particularly the obligation and commitment of its chairman can be no less to the many outstanding younger members of the full-time faculty who have been recruited to meet primary care needs of the department and who should aspire to the same creative scholarship and advancement as those engaged in biological research, although there are more formidable problems in comparable achievements in primary care. These are some of the recommendations I would make:

1) A basic or pathophysiologic orientation to teaching can be incorporated in the ambulatory setting with more difficulty than on the wards, but nevertheless effectively.

2) Educational and training programs in primary care should begin with medical students within the first few weeks of their curriculum,[78-80] and the teaching site should be the clinic where primary adult and pediatric care is provided.[81] Continuity of clinic experience should be maintained during the four-year curriculum. This should not be construed as sacrificing the existing major part of a student's time in the basic sciences, for such a primary care program can be given one afternoon a week (or at times every other week) during the first two years. In the third and fourth year it is already part of the curriculum in most schools.

3) Within the clinic or on the wards, interchange between internists and family-practice physicians should take place, particularly in teaching students and residents and in combined clinical conferences.

4) Liaison with psychiatry both on the inpatient[82] and ambulatory services should be developed with psychosocial issues being viewed as inseparable from medical practice. A supportive environment must be created in which residents receive help and guidance so that they feel

comfortable in dealing with these problems of ambulatory patients, and a curriculum needs to be developed to help them do so.

5) In a three-year residency program, rigorous inpatient exposure should continue to form the basis for the training of the general internist, but with a continuity of experience in the ambulatory setting as well as a block of intensive time there.[59]

6) The structure of the primary care experience should include continuity of care for residents working within a clinic setting of full-time faculty members and other health professionals. A medical curriculum and a precepting system should be established whereby house staff are directly observed and evaluated in their interaction with patients. For this purpose, communication skills must be defined and taught and precepting faculty must be relieved of patient-care responsibilities during this time.[83,84]

7) Primary care faculty in medicine should work with those in community medicine trained in epidemiology, sociology, and evaluation, to begin to examine costs, quality of care, and therapeutic outcome. Some of the research issues of primary care are likely to be derived from these areas of exploration.[33,37,85]

8) Those in the practice of general internal medicine in outlying facilities affiliated with the teaching hospital must continue to have an identification in ongoing education with the department. Ways must be sought to provide meaningful continuing education for those general internists in the community who are unaffiliated with the hospital.

9) Fellowships should be established in primary care medicine to provide a realistic alternative to specialty fellowships and to encourage an academic basis for faculty development for the future.

Summary

This article reviews the issues that have raised primary care to one of the central concerns facing the academic community today. The challenge is particularly important for departments of medicine which have traditionally regarded teaching and research as their dominant obligations and are now called upon to reappraise their role in relation to training and education for primary care. This means that the preparation of the internist in the future remains to be clarified in relation to the extent of in-hospital training, the time spent in the ambulatory setting, the degree of specialty training, and, in particular, the response to medicalization of social problems of patients as this becomes a more and more prominent feature of our society. A

number of recommendations are provided for departments of medicine to meet the educational and training challenges posed by primary care.

ACKNOWLEDGEMENT

I thank Dr. David Duffy for helpful discussions.

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