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General Practice

Primary care: core values Core values in a changing world

This is the first in a series of six articles reflecting on the core values that will underpin the development of primary care

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In 1920, the Dawson report advocated a population based approach to the organisation of health services, the allocation of resources, and the training of health care staff.[1] It also introduced the concepts of primary and secondary levels of care and of primary care health centres. For several decades these ideas lay dormant, until medical specialisation, fragmentation of health services, and the introduction of publicly funded healthcare made their logic inescapable. The term "primary care" became common coinage, and in 1978 its fundamental importance was recognised by the World Health Organisation.[2] In the same year, the US Institute of Medicine identified the four essentials of good primary care as accessibility, comprehensiveness, coordination, and continuity.[3]

For most of this century, the typical primary care professional has been a generalist practitioner,[4] usually practising close to the population served by the practice, alone or in a small group, and supported by a small staff. (Generalist practitioners include practitioners from nursing and from general paediatrics or internal medicine.) The key relationship for most of these practitioners is with individual patients who consult about problems they have identified themselves. Until recently, screening for risk factors and early disease in asymptomatic patients has been unusual. But practitioners have often forged strong community links, especially in small towns and rural areas. For all its limitations, generalist practice has represented a strong tradition of personal care, comprehensive in its response to the needs of the people and reasonably accessible in their neighbourhoods and homes. It is on this living tradition that primary care should build as it evolves into new forms.

Traditions are the bearers of values. In a living tradition, there is a perennial debate about how the inherent goods of the tradition are to be realisd. The debate takes on a special poignancy when there is a conflict between one good and another. Alastair Macintyre distinguishes between the internal and external goods of traditional practices and institutions.[5] The external goods are those for which the institution competes, such as prestige, money, market share, power. The internal goods are those that enable members of the institution to practise in accordance with their ideals and to attain fulfilment in their work. Conflicts between these two goods are a perennial issue for all traditions. The relentless pursuit of one good can destroy the other and ultimately bring down the whole institution. The continuing strength of a tradition is the best assurance that these conflicting goods will be reconciled.

Summary points

All key relationships in primary care—with patients, with colleagues in practices and in the wider health service, and with local communities—are underpinned by basic, core values passed down by tradition

Primary care practitioners must guard these values, recognising that values may be affected by evolution in health care and its delivery

Primary care must, however, ensure that this is a conscious and explicit evolution, rather than an erosion left too late to remedy

The practitioner and the patient

Traditionally, the commitment of the generalist practitioner is to the person, not to "the person with a certain disease." General practice defines itself in terms of relationships, not in terms of diseases or technologies. The commitment is open ended. The relationship is ended only by retirement, removal, death, or a decision by either party to end it.

The key role of the generalist practitioner is responding to the initial presentation of illness, through responding to suffering and making a clinical assessment. How events unfold is profoundly influenced by this initial response. Responding to suffering is a moral obligation. Compassion is not, as some have suggested, conditional on evidence of its effectiveness.[6] Although a practitioner or a practice may enter into a contract with a paying agency, the relationship with a patient is better described as a covenant.[7] A contract sets out the limits of what can be expected of the parties. It says: "I am committed to doing so much, but not more." A covenant is an undertaking to do whatever is needed, even if it goes beyond the terms of the contract. Sticking with a person through thick and thin is hard work: an act of love, not in the affective sense, but in Dostoevsky's sense of active love: "hard work and tenacity and for some people perhaps ... a whole science."[8]

The healing relationship between practitioner and patient can take its place beside others in which there are strong moral obligations and mutual commitments, such as those between parent and child and teacher and student. Although continuity is important in all of them, it is not simply a matter of chronological time. There are inevitable breaks of continuity in any relationship. No practitioner can be available to patients at all times. A good relationship, however, requires continuity of responsibility. Responsible practitioners will want to provide a deputy who can give care as close as possible to the care they can provide, and they will want to be present at times of great need. We seem almost to have forgotten the importance in medicine of presence. Of course, this faces us with many conflicting moral choices between obligations to different patients, to our families, and to ourselves.

Continuity in relationships builds trust, creates a context for healing, and increases the practitioner's knowledge of the patient, much of it at the tacit level.[9] Since it concerns responsibility and commitment, it is a moral issue for practitioners of all professions in primary care, and for their patients. A relationship with one doctor is strongly preferred by most patients and doctors, but some patients view it as continuity with a practice, and others give a higher value to accessibility.[10] Patients can have strong feelings of continuing care from a familiar doctor, practice nurse, and receptionist working together.[11] The preconditions of continuity are ready access, competence of the doctor, good communication, and a mechanism for bridging from one consultation to the next.[10]

Continuity is a mutual commitment by patient and practitioner. [9] [10] A practitioner's sense of responsibility increases with the duration of the relationship and with the number of contacts.[9]

Obstacles to continuity

Some obstacles to continuity, such as long distance commuting and population mobility, are features of modern industrial societies. Others lie in the management of the healthcare system, in communication between primary and secondary sectors, in management of the practice, and in the operations of the primary care team.

Management's drive for efficiency can threaten relationships by rigidly defining professional roles and by penalising practitioners who step outside their role. No doubt it is inefficient for a doctor to attend to an old person's callosities and toenails, but it is through such little services that relationships are built. Some doctors and nurses may have special expertise in managing asthma, diabetes, or advanced cancer, but this does not mean that every one of these patients has to be transferred to their care. A patient's relationship with the primary care practitioner may be broken if there is poor coordination between primary, secondary, and tertiary care sectors. The organisation of a practice may itself be an impediment to continuity.

Relationships with colleagues

Teamwork enhances primary care, but it requires wise leadership, attention to team relationships, and a change in traditional professional values. The growth of teams has been rapid in the past two decades as doctors and nurses have often been joined by social workers, psychologists, counsellors, physiotherapists, and pharmacists. Breaks in continuity, poor coordination, and blurring of responsibility are among the faults attributed to the primary care team.

The evolving nurse-doctor relationship is the key to the future of primary care. Each profession has its central role, but there is much overlap, and the roles should be allowed to evolve over time with minimal direction. The value of teamwork is in the diverse perspectives of the professions. From their integration emerges a new level of care, different from each of the individual perspectives. We have so much to learn from each other, but we can only learn if we approach teamwork with what Wilber calls an aperspectival frame of mind.[12] This means valuing all perspectives, but regarding none as final—not even our own. It requires in us a capacity to step out of our own perspective and to view it from outside, as we view those of others. In the same way, the patient-centred clinical method aims to integrate the perspectives of doctor and patient.[13] "No perspective is final," however, is not the same as the moral relativism of "all perspectives are equal."

In a well functioning team the members meet together regularly, learn from each other, and care for each other as well as for their patients. When discussions about patients result in decisions, the responsibility for implementation is clearly defined. Whether it is a longstanding team or one assembled for a particular patient, a team needs a leader. Leadership should be open to any of the practitioners in the team. This is difficult if some team members are in an employer-employee relationship.

Clinical freedom and managed care

The freedom to practice in accordance with the highest standards is highly valued by all professions. Constraints are always present, but clinical freedom allows practitioners the flexibility to make difficult choices between competing priorities. The choices may range from decisions about how much time to spend with a particular patient to the allocation of the practice's resources among preventive, clinical, and managerial functions. With this freedom goes the moral obligation to do everything needed for the individual patient and to use the least resources necessary to attain this end. Family physicians are notable for their restraint in using resources without impairing the quality of care.[14] At the same time they strongly resist measures designed to limit services at the point of care in the name of efficiency. To clinicians, efficacy—and not efficiency—has the higher value.

Under managed care in its various forms, restrictions on clinicians have now become commonplace. Modern information systems make it possible for managers to monitor and control practitioners' behaviour by such measures as utilisation review, incentives and disincentives, and preauthorisation for procedures and referrals. This is so destructive of professional morale that it may become self defeating. If limits to resources are established by society they can be subject to public scrutiny. The transfer of financial risk to practitioners gives practices the freedom to make their own decisions about the distribution of resources. Self-imposed limits are more tolerable than those imposed from above, but if we stand to gain from the decisions ourselves, our interests are potentially in conflict with those of our patients.[15]

The practice and the community

The population perspective, ensuring that the services of the practice are made available to the whole practice population, has a long tradition in general practice.[16] Information technology has made it easier to maintain the necessary records. But if a practice is going to offer preventive services for asymptomatic patients it must ensure that such services are strongly supported by evidence.[17] The population perspective is also an attitude of mind, a looking beyond the individual patient with head injury, lead poisoning, or salmonella infection to other people at risk from the same health hazards.

Community oriented primary care takes this perspective a step further through systematically identifying health problems in the community, modifying practice procedures, and monitoring the impact of changes.[18-20] Such care is said to require a new kind of hybrid practitioner with competencies in primary care, prevention, epidemiology, ethics, and behavioural science. These roles may be conflicting, competing for time and resources and causing tension in individual practitioners and practices. For the practitioner, community oriented primary care could usurp essential clinical skills. However, the principles of such care can be applied in other ways, such as by collaboration between all practices in a community or geographical locality for purposes such as deputising arrangements, hospital discharge planning, or shared care schemes. A group of community practices could also collaborate with a health unit or social agency to address problems such as homelessness, child poverty, and malnutrition. The Divisions of General Practice in Australia are moving in this direction.[21] In Britain, general practitioners are, increasingly, working together in locality groups, rather than as individual fundholders. They commission (and sometimes purchase) the secondary care for their communities, based on local epidemiology and needs assessment. New legislation will oblige all general practitioners, from 1999, to work together in large primary care groups. These will work with health authorities and local authorities to commission all health care.

The human scale

General practice has traditionally been carried on in small units located close to the homes of patients. Primary care should continue this tradition, continuing to be accessible to patients and avoiding the anonymity and intimidating atmosphere that tends to go with larger institutions. Embedding the practice in the community that it serves helps the staff to form links with the community and to learn about its resources.

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