Family Medicine Should Shape Reform, Not Vice Versa

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If the PCMH represents good primary care, why isn’t it defined by the criteria of good primary care?

The burgeoning of interest in primary care in the United States provides the family medicine community with an opportunity that should not be missed, but one that we are close to wasting.

Family medicine is person-focused, not disease-focused; i.e., the rationale for the discipline is based on the health of people and populations, not the one-by-one counting of diseases, their diagnosis and their management. This puts the specialty in conflict with most of academic medicine, its affiliated teaching hospitals and specialty societies, which consider “health” to be the absence of diseases and “ill health” to be the sum of individual diseases.

Diseases are professional constructs without inherent meaning. They can be and are artificially created to suit special interests. Diseases do not exist in isolation from other diseases and are, therefore, not independent types of illness but, rather, varied manifestations of ill health. What were once considered “diseases” are merely syndromes: common manifestations of diverse processes set in motion by interacting influences on health.

The challenges in medical care today are vastly different and much more complex than they were a half century ago. The great successes of technological medicine in the last half of the 20th century resulted in saving lives and increasing life expectancy. People who otherwise would have died are now vulnerable to a host of other conditions that threaten their well-being. In consequence, most people, particularly as they age, now have multimorbidity: the simultaneous presence of more than one type of illness.

Classifications of cause of death and disease have not kept pace with the multifactorial nature of illness causation and the phenomenon of multimorbidity. Categorizations based largely on organ systems make little sense pathophysiological; they serve primarily to justify the division of medical practitioners into “specialties.” A more theory-driven classification would be more consistent with the etiology and manifestation of various health states, which would aid in the devising of interventions that take variability into account.

In clinical practice, making a diagnosis does not necessarily assure appropriate or useful treatment, even though the purpose of making a diagnosis is thought to be to drive more appropriate interventions. Family physicians have differed from other types of physicians in applying different treatments for the same diagnosis. Moreover, different physicians behave very differently when faced with a patient with the same presenting symptoms, presumably due to differences in training and the context in which they work. Neither diagnoses nor their management can be reduced to universal “truths” that will predict health outcomes of people or populations. The World Health Report 2008, Primary Health Care – Now More Than Ever, indicates that this requires a renewed universal emphasis on primary health care – i.e., person-focused care over time, not disease-focused care.

The medical home and primary care

Family medicine appears to have acceded to the concept of the “patient-centered medical home” (PCMH), but proposals for the PCMH are not very patient-centered. They are justified on the basis of evidence regarding the benefits of primary care, but the criteria for assessment of PCMHs, such as those promulgated by the National Committee for Quality Assurance, concern organizational...
features such as electronic health records, computerized guidelines and amorphous “teams,” none of which have been demonstrated to be pursuant to good primary care.

By contrast, the facets of primary care that, in combination, constitute its essence are these:

- **First contact care**, which requires accessibility and responsibility for reducing unnecessary specialist care,
- **Person-focused care over time** delivered by the patient’s chosen physician, who assumes responsibility over long periods for all health care,
- **Comprehensiveness of care**, and
- **Coordination of care** when people have to go elsewhere for problems outside the competence of the primary care practitioner.

Good primary care requires all four functions. The United States performs relatively poorly on all four but particularly poorly on person-focused care over time and comprehensiveness. Primary care in the United States has less breadth of coverage than in most other countries. For example, in New Zealand and Australia, primary care physicians manage a much wider variety of problems than in the United States, presumably because of the inclusion of general internists and pediatricians in the U.S. primary care pool and because of limitations set by payers on what they deem to be the province of primary care.

The proposed system of qualification of the PCMH lacks any measure of person-focused care over time and comprehensiveness of services available and provided. Why would family medicine sign onto a system of evaluation that lacks its hallmarks? The challenge of family medicine is to set the tone for a reorientation of the U.S. health services system to high-level primary care. To do so, family medicine must mobilize in the following ways:

1. Require that qualification of PCMHs be based on achievement of the four essential features of primary care: first contact care, person-focused care over time, comprehensiveness of care and coordination of care. (Community orientation, cultural competence and family-centeredness all ultimately derive from the four features.)

2. Insist that evaluations of primary care quality use measures of overall health, at least in addition to disease-specific measures.

3. Reject pay for performance (P4P) in primary care unless it is tied to generic improvements in patient health that are attainable and directly measurable. Support disease-oriented P4P in specialty care, where it is more appropriate.

4. Advocate for governmental and private policies that build a strong infrastructure for primary care practice. This means taking an active stand on issues that influence the supply of primary care physicians and that provide for more and better training of such physicians outside the hospital (so they learn to deal with problems as they present in the community, not as they are referred to academic teaching centers) and advocating for training that goes beyond the diagnosis and management of specific diseases to deal with ill-defined syndromes that never result in formal diagnoses but need attention in people’s daily lives.

5. Insist that the essence of good primary care is care of patients in the context of the community and the population. This involves doing the following:

- Being responsive to patients’ problems, needs and symptoms as they experience them, not as they are reformulated by professionals,
- Assessing the quality of care based on improvement of patients’ problems, both as experienced and as manifested by fewer symptoms (including those from adverse effects), improved functioning, resilience to threats to subsequent health and delayed progression of ill health.

To their credit, family medicine participants in a discussion of the PCMH in late 2008 expressed “apprehension that the PCMH remains ‘in the belly of the beast’ – not radical enough to escape from old ‘medical’ models and provider-centeredness into the concepts of health and community linkage.”14 The family medicine community needs to heed their concerns for family medicine to survive with intact principles.

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