CHAPTER 1

Introduction

Summary points

1 Primary health care has many definitions. Most of them include the following dimensions: first-contact care; undifferentiated by age, gender or disease; continuity over time; coordinated within and across sectors; and with a focus on both the individual and the population/community.
2 In the twenty-first century, traditional academic skills (the ability to think logically, argue coherently, judge dispassionately and solve problems creatively) must be supplemented by contemporary academic skills (communication, interdisciplinary teamwork, knowledge management and adaptability to change).
3 Primary care is an applied (secondary) discipline and its study is problem-oriented. It does not have a discrete scientific paradigm to call its own. Rather, it draws eclectically on a range of underpinning primary disciplines (which will be discussed further in Chapter 2).
4 Different problems in primary care require different perspectives, based on different conceptual and theoretical models. It will never be possible to come up with a single 'unifying theory' that explains all aspects of primary care. Studying different theories can help illuminate why different people look at (and try to solve) the 'same' primary care problem in different ways.
5 There is a tension between the typical 'textbook definition' of primary care (concerned with a tidy disease taxonomy, evidence-based treatments and a compliant patient in a stable family and social context) and its practical day-to-day reality (fragmented and changing populations, unclassifiable symptoms, absent or ambiguous evidence and mismatch of goals and values between clinician and patient). The academic study of primary care should not focus on the former at the expense of the latter.

1.1 What is primary (health) care?

We hear increasingly of a 'primary care led health service', 'primary care based research', 'capacity building in primary care' and 'primary care focus' for healthcare planning. But when we talk about primary (health) care, what exactly do we mean? Is primary care anything that occurs outside a hospital? What about a hospital-based walk-in service for minor illnesses? Is voluntary sector care (such as that provided by self-help charities) part of primary care? If a general practitioner (GP) or family doctor (or a general internist in the

USA) provides specialist services, does that still count as 'primary' care? And, frankly, does it matter? Instead of chasing a tight definition of primary care and enforcing it across all countries and healthcare systems, would we be better off with flexible parameters that can be applied with judgement in different contexts?

Let's start with a working definition and see how it stands up to closer scrutiny.

> *Primary health care is what happens when someone who is ill (or who thinks he or she is ill or who wants to avoid getting ill) consults a health professional in a community setting for advice, tests, treatment or referral to specialist care.*

An obvious primary care contact is a visit to the general medical practitioner or GP (referred to in some countries as the family practitioner or family doctor),* for example, with an episode of acute illness, for ongoing care of a long-term health problem or for a check-up or screening test. But primary care in the UK – and in many other countries – also includes pharmacy services, community-based nursing services, optometry and dental care. It includes not merely the acute care that sick persons might receive *before* they enter hospital with a serious illness (such as a stroke or diabetic emergency), but also the care they receive *after* discharge – rehabilitation, ongoing education and support, and continuing surveillance of their chronic condition.

Until about 1980, the focus of most writing about primary care was the work of the individual GP in treating and preventing illness. Take, for example the following definition produced by the Leeuwenhorst working party in 1974:

> *'The general practitioner is a licensed medical graduate who gives care to individuals, irrespective of age, sex, and illness. He will attend his patients in his consulting room and in their homes and sometimes in a clinic or hospital. His aim is to make early diagnoses. He will include, and integrate, physical, psychological and social factors in his considerations about health and illness. . . . Prolonged contact means that he can use repeated opportunities to gather information at a pace appropriate to each patient and build up a relationship of trust which he can use professionally. He will practice in co-operation with other colleagues, medical and non-medical. He will know how and when to intervene through treatment, prevention and education to promote the education of his patients and their families. He will recognize that he also has a responsibility to the community'.*[1]

This definition reflects some undoubted strengths of primary care: closeness and continuity of the clinician–patient relationship, broad scope of care and embeddedness within the wider healthcare system. But it still seems old-fashioned

*Throughout this book I will use the term 'general practitioner' unless I am specifically drawing a distinction between the subtly different roles represented by these different titles. I will also use the term 'primary care' to mean 'primary health care', though I acknowledge that in other contexts primary care includes social as well as health care.

Box 1.1 Examples of primary health care encounters.

- A 63-year-old woman with a sticky eye asks her high-street pharmacist if there is anything she can buy over the counter for it.
- A dentist finds a suspicious white lesion while doing a routine check-up of a 72-year-old woman smoker and offers to refer her urgently to an oral surgeon.
- A 15-year-old schoolgirl visits an evening family planning clinic for a repeat prescription of the contraceptive pill.
- A mother brings her 3-month-old baby to a community centre to be weighed and immunised.
- A 24-year-old HIV-positive gay man attends for a routine blood test and a repeat prescription for his antiretroviral medication.
- A 78-year-old man with diabetes and leg ulcers receives regular visits from both the district nurse (to bandage the ulcers) and the community diabetes team (to monitor the diabetes).
- A 19-year-old single mother attends the accident and emergency department with a sore throat.
- A community psychiatric nurse visits a 53-year-old woman with schizophrenia every 2 weeks to assess the illness, administer a depot injection of medication and provide support.
- A multi-disciplinary community team including doctors, nurses, social workers and health advocates provides a 'health bus' offering a range of services to refugees and asylum seekers on an inner city estate.
- An 82-year-old woman with fading vision and a strong family history of glaucoma visits an optometrist for a routine check-up.
- A 50-year-old man with migraine that has not responded to medication from his GP attends an alternative health centre for a course of cranial osteopathy and aromatherapy.

and stereotypical, not just because it appears to assume that the doctor is male, but also because it places 'him' very centrally in charge of the service and responsible for deciding what is best for the patient.

The list in Box 1.1 shows some examples of primary health care problems. It is taken from a seminar in which some of my postgraduate students (GPs, community nurses, pharmacists and managers) told of the last encounter they had in primary care. It illustrates a number of features of contemporary primary care that challenge the Leeuwenhorst definition.

1 *A multi-professional team.* Most so-called GP surgeries or family practices include several doctors, as well as practice and community nurses, dieticians, physiotherapists and counsellors, and there may be close links with an interpreting or advocacy service for minority ethnic groups. Dentists, high-street optometrists, community pharmacists and sexual health clinicians (e.g. family planning) are part of the primary care service but usually have their own list of patients and keep separate records. Whilst in some countries (e.g. Germany),

single-handed GPs ('office-based physicians') remain the norm, in others the primary care organisation is a complex social system in which teamwork and coordination are essential.

2 *Proactive as well as reactive care*. Some primary care contacts are patient-initiated (someone feels unwell or worried, so they seek advice), but an increasing number are initiated by a clinician, perhaps via an automated recall system. Clinician-initiated consultations may be for the care of chronic illness (e.g. diabetes, asthma, arthritis, depression), management of risk factors for future disease (e.g. low bone density), prevention (e.g. immunisation) or screening (e.g. cervical smears). In such circumstances, good care is not so much about making clever diagnoses but about the 'three R's' (registration, recall and regular review), as well as supporting self-care (see Section 4.4). It is also about what Julian Tudor Hart once called 'doing simple things well, for large numbers of people, few of whom feel ill'[2] – a task that depends crucially on both continuity of care and high-quality administrative systems.

3 *Population as well as individual focus*. The primary care practitioner is increasingly seen as responsible for health at a population level. Modern IT systems in primary care enable individual patient data to be aggregated (i.e. anonymised and added together) to produce a picture of the overall health of the practice population that can inform the planning of primary care provision and the commissioning of secondary care services. The adverse health impact of poor environments (damp housing, dangerous streets, junk food outlets, sexually explicit media) and, conversely, the positive health benefits of social support and healthy communities are important contributors to the overall disease burden in primary care.

4 *The social and cultural context of illness*. A major advance in primary care over the past 30 years has been the recognition that biomedical models of diagnosing and treating illness (see Section 2.1) are inadequate. Both the social origins of disease and the cultural dimension of the illness experience and self-management are increasingly taken account of in planning services and the advice offered to patients. GP surgeries in multi-ethnic communities often develop positive links with public, religious and voluntary sector organisations who may be able to address the patient's wider social needs and/or provide 'cultural brokering' for ethnic minorities.

5 *The centrality of the patient in his or her own care*. The days of 'doctor's orders' are long gone. Particularly in chronic illness, it is now seen as essential for the individual to understand the nature of the illness and take an active role in monitoring and treating it – often with lifestyle changes as well as (or instead of) medication. All this needs motivation, skills and practical support. Different people have different personalities, learning styles and support needs. 'Empowerment', 'self-management' and 'shared decision making' are different ways of conceptualising the active involvement of the patient (see Section 4.4).

6 *An advocacy role*. According to one definition, an advocate is 'someone who represents the views of another, without judgement, regarding a situation that affects them, in order to influence others'. This role is of course particularly crucial when the patient is vulnerable or disadvantaged in some way (e.g.

learning difficulties, limited language skills, lacking information or social capital). In healthcare systems that rely heavily on the 'empowered' patient engaged in 'self-care', advocacy is increasingly essential to reduce inequities.

7 *Multiple service models*. The examples in Box 1.1 suggest that there is probably no universal formula for organising primary care. Rather, the service must be responsive to local needs, priorities and ways of working. New models of primary care such as drop-in clinics in high-street locations (such as NHS Walk-in Centres) and telephone advice services (such as NHS Direct in the UK), as well as private GPs, alternative practitioners and the voluntary sector (self-help groups and charities), often make an important contribution to the mixed economy of provision. Imaginative local schemes (e.g. travelling health buses) may be developed to make health care more accessible to hard-to-reach groups. An increasing proportion of hospital attenders in reality belong neither to accident nor emergency cases, but are people seeking advice on illness or perceived illness in areas where the primary care sector is underdeveloped or not trusted; some hospitals employ primary care clinicians to deal with these individuals. All these models increase choice for patients but add to the complexity of the system and the difficulty of studying it systematically.

8 *Multiple interfaces*. As Box 1.1 shows, many primary care problems are mild and self-limiting, while others are long-term and/or potentially serious, and require cross-referral within the primary care team (e.g. to a nurse or counsellor) or external referral (typically to a hospital specialist or perhaps to a social worker). In these days of evidence-based practice (see Section 2.2), many such conditions are managed by protocols and care pathways that incorporate the different input of multiple professionals and that transcend the primary–secondary care interface. Consistency of care wherever care is delivered, and close liaison across interprofessional, interorganisational and intersectoral boundaries, and the effective use of new technologies, is essential for a 'seamless' experience by the patient.

These eight features characterise what might be called 'the new primary health care'. Here are some further definitions of primary care and general practice, which capture this more contemporary perspective:

> *'Primary care is first-contact care, delivered by generalists, dependent (increasingly) on teamwork, which is accessible (both geographically and culturally), comprehensive (interested in old as well as new problems), co-ordinated, population-based (there is responsibility for 'the list' as well as the individual patient), and activated by patient choice'*.[3]

> *'Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients and participating in the context of family and community'*.[4]

> *'The general practitioner is a specialist trained to work in the front line of a healthcare system and to take the initial steps to provide care for any health problem(s) that patients may have. The general practitioner takes care of individuals in a society,*

irrespective of the patient's type of disease or other personal and social characteristics, and organises the resources available in the healthcare system to the best advantage of the patients. The general practitioner engages with autonomous individuals across the fields of prevention, diagnosis, cure, care, and palliation, using and integrating the sciences of biomedicine, medical psychology, and medical sociology'.[5]

'General practitioners/family doctors are specialist physicians trained in the principles of the discipline. They are personal doctors, primarily responsible for the provision of comprehensive and continuing care to every individual seeking medical care irrespective of age, sex and illness. They care for individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. They recognise they will also have a professional responsibility to their community. In negotiating management plans with their patients they integrate physical, psychological, social, cultural and existential factors, utilising the knowledge and trust engendered by repeated contacts. General practitioners/family physicians exercise their professional role by promoting health, preventing disease and providing cure, care, or palliation. This is done either directly or through the services of others according to health needs and the resources available within the community they serve, assisting patients where necessary in accessing these services. They must take the responsibility for developing and maintaining their skills, personal balance and values as a basis for effective and safe patient care'.[6]

I find all these definitions useful to some extent. They are, for the most part, both factually accurate and morally inspiring. They implicitly convey the multiple roles played by today's primary care practitioner – including clinical expert (in the diseases and symptoms seen in the community); professional carer (of individuals with chronic disabling conditions); witness (to the illness narrative and the experience of suffering or loss); gatekeeper (and coadministrator of limited resources); member (and perhaps manager) of a multi-professional, interagency team and educator (of colleagues, patients and people at risk).

But I also find the definitions above rather dry. Some of them come from a previous era, written as they were before the major social changes – set out in Box 1.2 – had occurred. In addition, these worthy definitions lack the passion that I feel for my own clinical work in primary care, and some of them seem to skirt round the essence of what primary care actually *is*.

I would like to find a definition of primary care that expresses the pride I felt when, as a newly qualified hospital doctor, a patient first said to me, 'I wish you were *my* doctor' and which encompasses the missing piece of the professional jigsaw that I had found so lacking in the organ-specific hospital specialties I had studied in my youth (see Table 1.2). I want a definition of primary care that incorporates the mixture of elation and terror that I felt when I got my first 'list' (i.e. a list of some 2000 people, most of whom were not currently ill, but for whose care I was now responsible) – and the ethical and legal responsibilities that went with it. And finally, I want a definition

Box 1.2 Social changes that have influenced the scope and direction of primary health care in the past 25 years.

Demographic changes

Globalisation and mass migration, leading to multi-ethnic communities and language/cultural barriers in the consultation (Section 7.1)
Ageing population (Section 7.1)
New family structures, especially growth of single-occupancy households (Section 7.1)
Changes in patterns of poverty and social exclusion (Section 7.4)

Changes in disease patterns and understanding of their aetiology

Increase in chronic incurable illness and comorbidity (Section 10.1)
Increased recognition of the interplay between genetic risk, lifestyle choices and environment in the genesis of chronic illness (Sections 4.3, 7.3 and 8.4)
Increased recognition of the importance of healthy communities (Chapter 9)

Changes in delivery of health care

Emergence of evidence-based medicine, replacement of 'clinical freedom' with standardised guidelines/protocols (Section 5.2)
Shift from treating established disease to early detection (screening) and prevention (Section 8.3)
Shift of place of care from hospital to community for chronic conditions (Section 10.1)
New and diverse roles for nurses and professionals allied to medicine (Section 10.4)
Increase in organisational complexity of care, especially across the primary–secondary care interface (Section 10.2)

Changes in social roles and expectations

Increased emphasis on patient autonomy, dignity, self-determination and informed consent; decrease in 'doctor's orders' (Section 4.4)
Decline in traditional sick role and rise in 'self-management' and 'expert patient' (Sections 4.1 and 4.4)
Rising expectation that society should change to accommodate the ill and disabled (Section 4.1)
Changing role of women – decline of the full-time wife and mother (Section 7.2)
Decline in public trust in doctors and nurses (Section 5.6)
New definitions of professionalism (Section 5.6)

Technological changes

Increased dependence on technology for administering and coordinating care (Section 10.3)

Standardisation of clinical categories and terms for electronic coding and record-keeping (Section 10.3)
Capacity to generate powerful, population-wide epidemiological data from aggregation of routinely collected clinical data in primary care (Section 8.1)
Universally available medical information (e.g. via Internet) leading to greater questioning by patients of medical advice (Section 8.2)
Growth in high-technology medicine (but not necessarily in the accessibility of such options to everyone)

Changes in the role of the state

Challenges to professional self-regulation, shift from voluntary 'quality improvement' to compulsory 'quality control' (Sections 11.1 and 11.2)
The 'new public management' – with emphasis on accountability, targets and centralised standards and protocols (Section 11.2)

Social movements

Rise of consumerism, leading to increased expectations of health professionals and decreased tolerance of quality gaps (Chapter 11)
Growth in complementary and alternative medicine and re-emergence of humanism as a reaction to over-rationalist models of care

of primary care that does not merely assert the importance of teamwork but which conveys the impoverished contribution invariably made by those who insist on flying solo.[†]

To get a handle on these intangibles, we need to move from descriptions of what happens in primary care to a consideration of why these things are important – that is, we need to shift our focus from the *structure and process*

[†] That is not to say that being a 'single-handed' practitioner is a bad thing. There is considerable evidence that patients prefer their primary care to be provided on a small scale and that benefits such as 'a personal service' and continuity of care are seen as a worthwhile trade-off for a more limited range of clinics.[7,8] But single-handed practitioners will usually be the first to tell you how much they value and depend on their professional friendship networks, their links with colleagues outside their own small practice and the refreshment they get from regular educational meetings, learning sets and so on. Good single-handed practitioners also tend to be especially adept at working in partnership with nurses, physiotherapists, pharmacists and so on. When I talk about 'the impoverished contribution made by those who insist on flying solo', I am drawing attention to the real dangers of refusing to acknowledge the limitations of one's own past training, present knowledge or professional role and those of failing to draw judiciously and creatively on the skills and expertise of others. As I emphasise in the section *What is academic study?*, 'teamwork' is one of the eight essential skills of the academic primary care practitioner, and Chapter 10 considers how this plays out in the complex health care systems of the twenty-first century.

Box 1.3 Core values of primary care.

Holistic. Primary care embraces the complexities and interactions of bodily systems, mental responses, family, community and sociocultural context. It also seeks continuity of care through time.

Balanced. Primary care seeks a middle ground between breadth and depth of knowledge, between lay and medical models of illness and distress and between active intervention and 'leaving well alone'.

Patient-centred. Primary care sees each patient as an individual and seeks to offer personalised rather than standardised packages of care.

Rigorous. Primary care seeks to draw judiciously on multiple sources of evidence (the patient's unique predicament, the relevant research literature and the wider family and social context) when considering the action to take in relation to a particular problem.

Equitable. Primary care takes responsibility for social justice in the allocation of scarce resources; hence it works proactively with, and plays an advocacy role for, the disempowered, inarticulate and socially excluded. This may include challenging the educated worried well when they seek a disproportionate share of healthcare resources.

Reflective. Primary care is always practised in conditions of ignorance and/or uncertainty. It requires a questioning attitude, willingness to revise provisional diagnoses in the light of emerging findings and the humility to defer to higher authority (the specialist, the parent, the patient) when appropriate.

Developed from various sources.[9,10–15]

of primary care to the *core values* of primary care. Values are defined by the Oxford English Dictionary as 'principles, standards or qualities considered worthwhile or desirable'. The core values of primary care are those aspects of our practice which we hold dear, which give us satisfaction, for which we seek to perform especially well and for which we are disappointed if we fail to deliver on. Box 1.3 shows some core values of primary care.

Table 1.1 summarises some important changes in the scope and organisation of primary care in the past 30 years, and Table 1.2 shows the implications of these changes for how illness and its management are approached, using one condition (diabetes) as a worked example. You can see that there has been a fundamental reframing since the 1970s (when diabetes was a relatively rare condition treated in hospital by specialists who focused on lowering the blood glucose level) to the present day (when it is seen as a multifaceted condition affecting both the patient and the wider family and requiring active self-management and a coordinated and individualized package of multiprofessional support). Table 1.2 should not be taken to imply that primary

Table 1.1 Trends in the scope and organisation of primary health care.

Feature	*Traditional general practice*	*Modern primary health care*
Core business	Diagnosis and treatment of acute illness	Prevention, surveillance and support of chronic illness
Typical encounter	Reactive (patient-initiated)	Increasingly proactive (clinician-initiated)
Focus of care	Uniprofessional (doctor-focused)	Multi-professional (team-focused)
Place of care	Most encounters occur in the GP surgery	Diversity and choice in place of care
Principle of resource allocation	'Health for me': resources allocated by patient demand	'Health for all': resources allocated by population need
Basis of clinical decision making	Clinical freedom (sometimes idiosyncratic)	Evidence-based (often directed by guidelines and protocols)
Nature of clinician–patient relationship	'Doctor's orders': paternalistic advice with limited information	Patient preference: shared decision making based on informed choice
Purpose of record-keeping	Paper-based and constructed as aide-memoire for individual doctors	Electronic and designed to organise the work of multiple professionals around the patient's illness and provide aggregated data for monitoring disease trends

care has driven these changes. Quite the contrary, it was hospital specialists (both diabetologists and diabetes-specialist nurses) who first recognised the need for these changes and worked to achieve them across the primary–secondary care interface.[16] Profound shifts in the attitudes of GPs and practice nurses were needed, as well as education, improved administrative systems and new models of care across the interface (e.g. the introduction of advice hotlines, open-access appointments and 'fast-track' foot clinics). But once the sea change had occurred in how diabetes was conceptualised and managed, it ceased to be a disease that could be comfortably accommodated in a hospital setting.

All this began to happen in the mid 1980s, when I was training to be a diabetologist and undertaking my first research project – into the kinetics of insulin absorption in patients with 'brittle diabetes'. I did not know at the time that my lack of fulfilment from my research project (and the feeling that I wasn't getting anywhere despite collecting vast numbers of blood samples from poorly controlled patients) reflected the exciting paradigm shift shown in Table 1.2, nor that my decision to change career and enter general practice in 1989 marked the imminent shift in the care of a substantial

Table 1.2 An example of primary care principles and values: a new model of diabetes.

	Traditional biomedical model	*New model informed by primary care principles and values*
Diabetes conceptualised as	Disease of the pancreas (absolute or relative insulin deficiency)	Multifaceted disorder arising from metabolic defect, which leads to imbalance in multiple embedded systems (biochemical, endocrine, physiological, psychological, family/community, society)
Cause seen in terms of	Damage to pancreatic cells and/or cellular resistance to insulin	Complex interaction between nature (genetic risk), nurture (environmental mediators and moderators) and culture (behaviours, norms and expectations of the group)
Management focused on	**a** Correcting the deficiency with insulin injections or medication **b** Ensuring compliance	Multiple dimensions and levels of care: **a** Developing a partnership for care **b** Drawing up a personal management plan that reflects the patient's goals and priorities **c** Providing culturally appropriate education and resources for self-care **d** Supporting positive lifestyle choices **e** Managing overall cardiovascular risk **f** Regular structured surveillance ('annual reviews') for early complications **g** Judicious referral for specialist assessment or management
Main goals of management	Near-normal blood glucose control Avoidance of hypoglycaemia	Understanding, confidence, self-efficacy, well-being Reduction in overall cardiovascular risk Prevention of secondary complications (amputation, blindness) Social integration Personal goals of patient (e.g. pregnancy, marathon run, renewal of driving licence)
Main model of care	Doctor-driven	Self-management supported by multi-professional team
Main indicators of success	Blood or urine testing Patient's HbA1c level	Complex risk profile including HbA1c level Lifestyle choices, e.g. smoking cessation, exercise Well-being
Quality failures detected via	Critical events, e.g. hospital admission, death	Surveillance at patient level Regular, multidimensional audit at system level including process measures (e.g. data capture) and outcome measures (e.g. proportion of patients with blood pressure adequately treated) Structured review of critical and near-miss events

proportion of people with diabetes in the UK from hospital clinics into primary care.

Here is one final definition that reflects not only a description of what happens in primary care, but also the core values listed in Box 1.3. You will see that it is a refinement of the initial back-of-envelope that I proposed on page 2.

> *Primary health care is what happens when someone who is ill (or who thinks he or she is ill or who wants to avoid getting ill) consults a health professional in a community setting for advice, tests, treatment or referral to specialist care. Such care should be holistic, balanced, personalised, rigorous and equitable, and delivered by reflexive practitioners who recognise their own limitations and draw appropriately on the strengths of others.*

Box 1.4 summarises what I personally believe to be the defining characteristics of primary care and what I have called the 'four pillars of professionalism' in this field of practice. Later chapters in this book address these four pillars in more detail.

Box 1.4 Definition and scope of primary health care: a summary.

Primary health care has 10 defining characteristics:

1 It provides the patient's first point of contact with the health care system.

2 It deals with both acute and chronic health problems regardless of age, sex or disease type.

3 It provides person-centred care to the individual, taking account of his or her family and the wider community.

4 It considers health problems in their physical, psychological, social, cultural and existential dimensions.

5 It is ideally delivered via an ongoing clinician–patient relationship, built over time and characterised by high levels of communication and trust.

6 It is proactive as well as reactive, promoting health and well-being by supporting healthy lifestyle choices and offering interventions to manage risk.

7 It takes responsibility for the health of the community as well as of the individual.

8 It has a particular role in the early stages of potentially serious illness when symptoms and signs are mild or non-specific.

9 It assumes an advocacy role for the patient when needed (and/or works flexibly with others who take on this role).

10 It strives to make efficient use of health care resources through coordinating care, working with other professionals and managing the interface with other specialities.

To practice this specialty, the primary care practitioner must be competent in three areas:
- Clinical care
- Communication
- Management

Professionalism in primary care rests on four pillars:
- Ethical: drawing on core values, principles and virtues
- Scientific: adopting a scholarly and reflective approach to practice, including (but not limited to) the use of best up-to-date research evidence in clinical decisions
- Organisational: addressing issues such as access, equity, relevance to social need, efficient use of resources and so on
- Educational: taking ongoing responsibility for continuous professional development of oneself and one's staff

Developed from various sources[6,9,10–15]; see text for further discussion.

1.2 What is academic study?

All the definitions in the previous section point to an important conclusion: primary health care is not itself an academic discipline. In the eyes of the people writing these definitions, primary care is a practice rather than a theory, based on 'doing something' rather than 'thinking in the abstract'. For those with the time and inclination to take an academic perspective, we might say that primary care is a problem-oriented field of study that draws variously on a range of concepts and theories drawn from different disciplines. If you study primary care from such a perspective, you may initially be frustrated at the intellectual fuzziness in this field of study compared to (say) the kind of well-demarcated subject areas that are taught in universities (e.g. biochemistry, mathematics). Before the end of this chapter, I hope to have persuaded you that primary care has (or *could* have) a robust academic basis. But before I take on that argument, I would like to consider in more detail what 'academic study' actually means.

The German academic, philosopher and educationist Friedrich Wilhelm von Humboldt (1767–1835), who founded Berlin's first university and who was once described as 'the last universal scholar in the field of the natural sciences', believed that there are four core skills that the graduate of academic training will display. He or she will be able

1 To think constructively
2 To argue coherently
3 To judge dispassionately
4 To solve problems creatively

As well as these *traditional academic skills*, I would further add four essential skills for the academic scholar in the twenty-first century. I have called these

contemporary academic skills:
5 To communicate ideas and concepts to the non-expert
6 To work effectively and efficiently[‡] as a member of a multi-disciplinary team
7 To manage knowledge – that is to find, evaluate, summarise, synthesise and share information
8 To adapt appropriately to change
If these eight core skills (four traditional, four contemporary) are taken as the defining features of an *academic* approach, such an approach is entirely congruent with the core business of primary care and with primary care as a fundamentally practical (and inherently fuzzy) field of enquiry.[§] Others might define academic study as to do with abstract thoughts rather than real-world problems or practical action, and I guess those are the people who believe that primary care has no academic basis! I return to contemporary academic skills in Section 5.1 when I consider the nature of generalist knowledge.

In order to unpack academic study further, we need to consider the notion of an academic discipline. If you ask your children what 'discipline' is, they would probably say 'punishment for breaking the rules' or (as self-discipline) 'behaving according to a particular set of rules'. In the world of academia, a discipline is a body of knowledge that has a well-defined set of intellectual conventions and rules.

There are two sorts of academic discipline. The first – primary or theoretical disciplines – comprise the traditional academic 'subjects' that have been offered at universities for decades. Examples of primary disciplines include physiology, immunology, sociology, statistics, philosophy, history, geography and so on. In Chapter 2, I will refer to these as 'the ologies'. Each of these has an agreed body of knowledge (we can generally say that X is or is not part of the discipline), an agreed focus and set of concepts (the 'stuff' that is deemed worthy of study by experts in the discipline), a theoretical model of how these concepts

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[‡] *Effectiveness* is sometimes defined as 'doing the right thing' and *efficiency* as 'doing things right'. The former is essentially a clinical dimension; the latter is largely an economic one. If I make a tasty and nutritious meal, dirtying only the minimum of pots, for someone who is not hungry, I have done something efficient, but not effective. If I jump into water to rescue a drowning person but ruin my expensive watch in the process, I have been effective but not efficient since I could (perhaps) have achieved the same outcome by removing the watch first.

[§] If you are interested in seeing how these academic skills link to an official policy map of the practical skills and 'know-how' needed for delivering primary care in the twenty-first century, take a look at the 2004 report from the US Society of General Internal Medicine on 'The Future of General Internal Medicine'.[9] As well as expertise in providing comprehensive long-term care to an unselected population, this national task force identified the following skills as essential for the general internist practising in a community setting: effective communication with patients and colleagues, evidence-based practice (including critical thinking and knowledge management), reflection and lifelong learning, leadership and team working, professionalism and adaptability to a changing world.

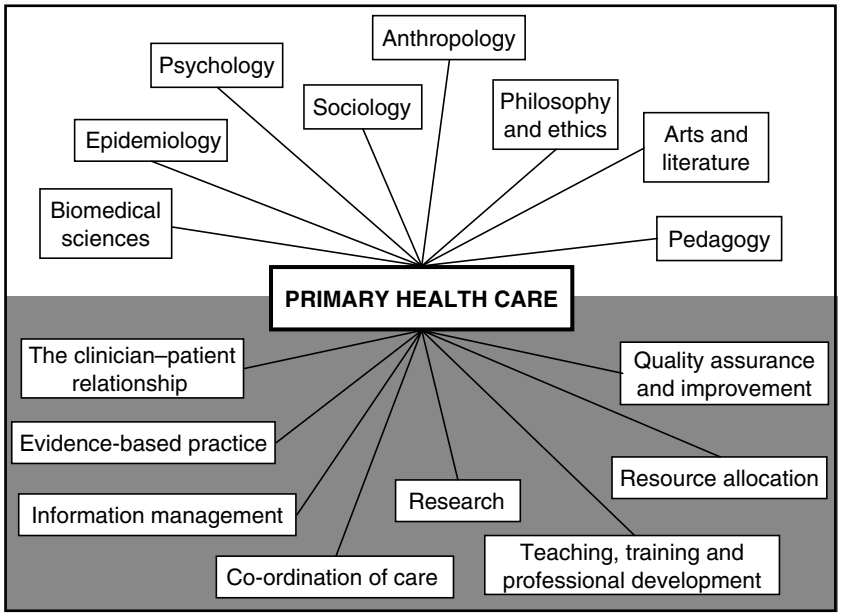

Figure 1.1 Primary health care: underpinning disciplines (upper half) and key themes in contemporary practice (lower half).

fit together (see Section 1.3) and a more or less agreed approach to research design (immunologists, for example, do experiments on rabbits, whereas historians study ancient manuscripts and philosophers discuss premises and what can be deduced from them). Within each theoretical discipline, scholars generally agree about the main research questions and about what counts as good (or poor) research. Until recently – with a few notable exceptions – scholars from different primary disciplines rarely exchanged ideas with one another.‖

The second sorts of discipline – secondary or applied – focus on problems rather than concepts and theories. Scholars in secondary disciplines consider real-world issues from many different angles, drawing eclectically on the different primary disciplines to address different dimensions of the problem. Examples of secondary disciplines include business studies (which draws on economics, marketing, anthropology and organisational theory), education (which draws on learning theory, linguistics and psychology) and primary health care, whose underpinning disciplines are illustrated in Figure 1.1.

‖ Philosopher Thomas Kuhn introduced the concept of a *paradigm* (a particular scientific approach characterised by four things: concepts, theories, methods and instruments).[17] If you are interested in the philosophical basis of different approaches to primary care, I recommend Kuhn's book, which is short, inspiring and easy to follow.

Table 1.3 Primary care: textbook versus gritty reality.

The textbook	*The reality*
Diagnoses	Non-specific conditions
Families	Unsupported individuals
Housing	Homelessness
Continuity of care	Episodic care
Evidence and guidelines	Pragmatic solutions
Compliance	Compromise
Predictability	Uncertainty
Healthy lifestyle choices by individuals	Structural and practical barriers to healthy choices

Adapted from Murdoch.[18]

Figure 1.1 raises an important question: Given the number of different underpinning disciplines relevant to the academic study of primary care, where should one start? The answer is, with a real-life problem. The theoretical literature often only makes sense when *applied to* a practical problem; the different theoretical perspectives represented by the 'ologies' can be thought of as different 'lenses' through which to view real-life problems. Strictly speaking, secondary disciplines such as pedagogy are not 'disciplines' at all but 'applied fields' – since a discipline in the pure sense is a single conceptual framework with its own conventions and rules. But in practice, the word 'discipline' is now used for both theoretical and applied fields of study.

Please do not assume that the only disciplines relevant to primary health care problems are the ones shown in Figure 1.1, nor that all the disciplines shown will be relevant to all primary care problems. Table 1.4 sets out the definition and scope of some key underpinning disciplines of primary care, some of which for clarity, are not shown in Figure 1.1. You might like to modify Figure 1.1 by adding and subtracting different disciplines in a way that allows you to make sense of particular problems in the context of your own work in primary health care. Like the rest of this book, Figure 1.1 is intended to set the scene for further reflection and discussion, not to be memorised as 'fact'.

Traditionalists often bemoan the fact that universities are offering their students an increasing array of secondary disciplines from in-flight catering to Frisbee throwing and (probably rightly) argue that the main task of a university is to introduce its undergraduates to bodies of theoretical knowledge and the rules and conventions of the primary disciplines. It is certainly true that one can (and some universities do) approach practical subjects in a superficial, unrigorous way and that all applied fields of study (including primary care) have a continuing responsibility to demonstrate their academic rigour if they are to be considered credible. Whilst non-academic (e.g. continuing professional development) courses can offer useful tips and tools for the primary care practitioner, the academic study of primary care problems is impossible unless students have a sound theoretical grasp of the main underpinning

Table 1.4 Underpinning academic disciplines for primary health care.

Discipline	*Definition*	*Contribution to the study of primary health care*
Primary disciplines		
Anthropology	The study of human cultures and how they have evolved and influenced each other	Culture, values and identities (includes organisational culture, professional culture and so on as well as the ideas and practice of different ethnic groups)
Biomedicine	The study of the structure and function of the human body, its disease processes and treatment	Diseases and how to treat them
Epidemiology	The study of disease patterns in populations	Prevention and management of diseases and risk factors in populations (both infections, e.g. HIV, and non-infectious, e.g. obesity)
Health economics	The study of the production, distribution and consumption of goods and services in health care	Models of payment for primary care. Issues of affordability and access
Law (strictly, jurisprudence)	The study of the body of enacted or customary rules recognised by a community as binding	Legal rights of patients, legal obligations of health professionals. Informs the study of medical ethics
Philosophy	The study of the nature of knowledge (ontology) and how it is used in practice (epistemology). Also, moral philosophy or ethics which concerns what is the right way to live and behave	The nature of knowledge, e.g. differences between scientific knowledge and experiential knowledge or know-how
Psychology	The study of mind and behaviour. Factors that influence human beings to act, particularly cognitive and emotional influences	Motivation, incentives, rewards, emotional needs. Influence (e.g. impact of 'medical advice' vs. 'lay advice' on patients' decisions)
Social psychology	The study of social influences on human behaviour	Interpersonal influence, roles, modelling, norms
Sociology	The study of human society and the relationships between its members, especially the influence of social structures and norms on behaviours and practices. Includes medical sociology (the study of the norms, behaviours and social networks of health professionals)	Organisational, family and peer structures. Group norms and values. Social influences on clinician behaviour (e.g. adoption of guidelines)

(*Continued*)

Table 1.4 (*Continued*)

Discipline	*Definition*	*Contribution to the study of primary health care*
Secondary disciplines		
Pedagogy	The study of learning – in particular, how knowledge can be understood, used and valued	Acquisition and application of knowledge by both patients and professionals
Health promotion	The study of strategies and practices aimed at improving the health and well-being of populations	Disease prevention, healthy lifestyles
Organisational studies	The study of the structure and function of organisations	Organisational factors influencing accessibility, process of care, financial efficiency and health outcomes
Political sciences	The study of government structures and their function in developing and implementing policy	Impact of different political structures on the effectiveness of policymaking (includes 'modernisation' of urban bureaucracies, citizen involvement)

primary disciplines such as the biomedical subject areas (physiology, pharmacology, epidemiology and so on), social sciences (sociology, anthropology) and psychology.

For this reason, I believe that primary care is a particularly difficult subject to study. It should be considered as a postgraduate (advanced) discipline by people who recognise its complex foundations, and not as 'the easy bits' of biomedicine. For this reason also, I believe that the study of primary care is best accomplished through open and pluralist discussion in learning groups that are both *multi-disciplinary* (i.e. comprising individuals who studied different theoretical disciplines as undergraduates) and *multi-professional* (i.e. comprising individuals who have a wide range of roles in their working lives – and hence different perspectives on primary care problems).

Professor J. Campbell Murdoch has drawn attention to the difference between the primary care of most textbooks and the reality with which most of us deal in our daily practice (Table 1.3).[18] As Murdoch pointed out, most of us spend our first few years in clinical primary care 'unlearning' the tidy theories and taxonomies of textbook biomedicine and becoming more or less comfortable with the 'grey zone' of practice we have found ourselves in. We learn, more or less, to manage without the things we expected to find (the left-hand column in Table 1.3) and to cope with what we actually find (the right-hand column). We also learn that the knowledge base of primary care is potentially infinite and that however hard we try, we cannot ever get on top of everything.

Much of primary care is characterised by *untidiness*, *uncertainty* and many different potential approaches to a single problem. The notion of uncertainty, and the gap between theory and reality, will be recurring themes throughout this book. The academic study of primary care includes the theoretical study of 'grey areas' and uncertainty in clinical method. It also includes the use of multiple theoretical perspectives to build up a rich picture of a complex and contested field of study. You can probably begin to see why the contemporary academic skills of teamwork, knowledge management, communication and adaptability to change are going to be particularly critical to the study of primary care.

1.3 What are theories – and why do we need them?

Theories are conceptual models that help us make sense of reality.[19] Look at the example of Dr Begum and her colleagues in Box 1.5. The clash of approaches between these three health professionals results from the fundamental way they conceptualise the problems they deal with in their work. Dr Begum's conceptual model of primary health care is one where patients suffer from diseases, which have causes (and risk factors) and which respond to a greater or lesser extent to specific treatments, which in turn have been tested in randomised controlled trials. In other words, she uses the biomedical model (see Section 2.1) – a rational, scientific model that underpins anatomy, physiology, biochemistry, cardiology, immunology and so on. If Dr Begum were to conduct a research study, it would probably be a randomised controlled trial or a survey of symptomatology in a particular disease.

Box 1.5 Different perspectives on primary care problems.

A young GP, Dr Begum, works in a busy group practice. She is a keen proponent of evidence-based medicine. She considers every problem in terms of 'diagnosis', 'prognosis', 'therapy' and so on. She searches for research evidence on the Internet. She carefully evaluates the research evidence and draws conclusions that she believes are rational and logical. But she cannot understand why the other doctors in her practice (who are older and more experienced) do not share her enthusiasm for exploring the research literature and applying the results in practice. Her practice nurse, Mrs Perkins, suggests, 'The best thing to do is spend a bit of time listening to the patient, and getting to know their family and their situation, so you can view their illness from their point of view and in its proper context'. One of the older doctors, Dr Brown, has a different piece of advice, 'My dear, when you have accumulated as many years of experience as I have, you won't need to rely quite so much on your super-scientific research evidence. You'll be able to improvise like the rest of us. When people come in asking for some new fangled medication, you'll be able to get them out the door believing they never wanted it in the first place'.

Mrs Perkins has a different model – based centrally around the achievement of empathy through shared experience and active listening. The question for her is not 'what is the diagnosis?' but 'who is this patient and what is he or she going through?' Note that Mrs Perkins views her work not as *doing something to* the patient but as *being there for* the patient. Her work is built around a 'care' relationship, not a 'cure' relationship, and the mental model for the former is not a rational (scientific) one but an experiential (phenomenological) one (see Section 11.5).[20] If Mrs Perkins were to do a research study, it might take the form of an in-depth case study, written up as a detailed narrative, of a patient whose illness was an epic struggle for survival or quest for meaning.[21]

Dr Brown's model of primary care problems is different again. Like Dr Begum, he is interested in influencing the course of the illness, but his ideas about treatment are not primarily biomedical. He uses the word 'improvise' – a term more frequently used in relation to jazz music or unscripted theatre. This suggests that his mental model is based on the view of general practice as an art – where the demonstration of a bit of priestly authority and mystical divination might just help the healing process. The conceptual world of artistic improvisation has little place for 'causes' and 'effects', but has much to do with the performative relationship between the 'actor' and his or her 'audience', the roles they assume and the games they play. Dr Brown might even take a psychodynamic model of his work – the notion that in general practice, trivial illness is the vehicle through which painful subconscious (emotional) issues are brought for discussion (the so-called hidden agenda – see Section 6.3).[22] If Dr Brown were to conduct a research study, it might be a series of reflective discussions between him and his fellow GPs, in which they work through a series of challenging patients and how they attempt to use their professional position (what Balint called 'the doctor as the drug' – see Section 6.3) to promote emotional (and thereby symptomatic) healing in their patients.[22]

If you have a conventional hospital-based medical training, you will almost certainly feel most comfortable with the rational, scientific model. If you come from a nursing background, the 'care' model might make more sense to you, because much of your undergraduate training would have been based on it (and because much of your work is to do with caring). However, nursing curricula throughout the world vary considerably, and scientific models are increasingly privileged (perhaps reflecting the emergence of the extended role of the nurse in diagnosis, treatment and so on). If you are a British GP, or come from a comparable health care system (such as the Netherlands or New Zealand), you may well be most comfortable with an 'artistic' model of general practice and/or with models that consider subconscious, as well as conscious, influences on behaviour. Which model is correct? Think about this for a little before you read on.

If you believe that any one model is the 'correct' way to conceptualise every problem you encounter in primary health care, you have probably not seen very many real-life problems or listened to many people from other professional (and lay) backgrounds. You have probably also not understood Section 1.2 about the multiple underpinning disciplines of primary care! But

if you are an experienced generalist, and especially if you work a lot in multidisciplinary teams, you will almost certainly know that different conceptual models help us with different sorts of problems – and allow us to have multiple 'takes' on the same problem. A rational, 'evidence-based' model helps us when the problem can be couched in the taxonomy of a specific disease (or a differential diagnosis), whereas the 'improvisation' model might become dominant when the problem is best expressed as 'Mrs Jones making yet another appointment after all those negative tests'.

Different primary disciplines are generally based on different conceptual models, though most of the hospital-based medical disciplines share a common biomedical model (in which problems can be analysed at different levels including the molecule, the cell, the organ and so on). There are many other conceptual models relevant to primary care that I have not yet mentioned. If you work in a managerial or executive role, your mental model of primary care is probably one of a complex organisation and you will see problems in terms of appropriate skill mix, effective teamwork, efficient project management and so on. You will have a natural tendency to analyse problems at the level of the team (e.g. particular project groups). And if you work in social services, you are more likely to view problems in terms of the social structures, norms and relationships that produce particular behaviours – that is, your conceptual model will be the social system and your unit of analysis will be the social group (e.g. teenage mothers).

Take another look at Table 1.4, which illustrates the diversity and scope of academic primary care. You will probably return to it (and perhaps add to it) when you begin to conceptualise and theorise about the primary care problems you meet in your own practice. Once you begin to do that, even if you do not find any easy answers, you can call yourself an academic primary care practitioner.

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