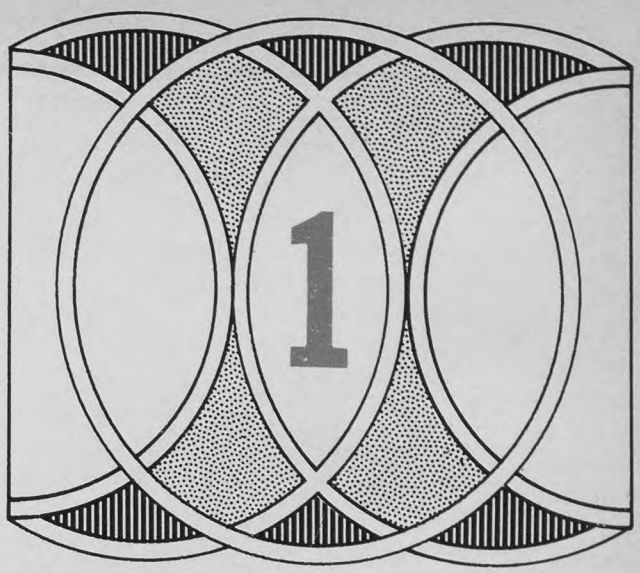
Family Practice Forum



Primary Care Physician —Whose Job?

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The past decade has seen an intense interest in the development of a health care system which is comprehensive in scope and humanistic in application. The flourishing family practice movement derives its impetus from the demands of the population, as reflected through legislative bodies, as well as from students and some academicians. Janeway[1] has pointed out the impact of the Flexner Report on medical education and its by-product, medical care, in producing the unexpected effect of excessive specialization. Great emphasis on biomedical research, which this reform brought about, has resulted in tremendous strides in the management of disease. The preoccupation of medical schools with this fruitful orientation, together with the prestigious NIH programs following World War II, naturally influenced medical students to enter fields of narrow specialization. Only recently has the medical establishment felt the obligation to concern itself actively with the provision of health care emphasizing more comprehensive and patient-oriented health care delivery. As pointed out by Farley,[2] the vague notion that skillful primary care of patients involves only concern for their well-being and the "art" of medicine, which physicians intuitively (or osmotically) acquire, is no longer tenable. The primary care of patients must be taught as an academic discipline.

Concurrently with recent attempts to address the problem of training in primary care, the various specialties are examining their roles in primary care. Legislative bodies providing funds for this purpose generally mention family practice, internal medicine, and pediatrics as the disciplines involved. In a recent commentary, Pearson[3] presented the obstetrician-gynecologist as the legitimate primary care physician for women. Cited in support of this view is the not uncommon practice of women utilizing the Ob-Gyn specialist as their physician of first contact. Because of his principal orientation and training toward the reproductive tract, it is difficult to envision the Ob-Gyn specialist functioning adequately in this role. His willingness to do so in the absence of adequate numbers of broadly oriented primary care physicians is commendable, but the need for him to do so represents the "spin-off" of the preoccupation with biomedical research and resultant overspecialization of the post-Flexner era. To say that any physician of first contact can function as a primary physician augments the problem of fragmentation of medical care as applied to families.

There is a growing consensus that a family orientation in health care is optimal, utilizing the family-oriented physician as the leader of the health care team. This physician acts as the family's advocate within the health care system, focusing on family members and their interactions in health and disease. This model optimizes economy of health care personnel as well as the health care dollar. The less broadly oriented physician, such as the obstetrician-gynecologist, does not achieve these objectives.

The main emphasis in training of those physicians entering primary care should be in the area of primary care, and not in another area of specialization with primary care as a secondary or collateral consideration.

Primary health care, as epitomized in the discipline of family medicine, has been recognized as the substratum of all health care. It possesses a fundamental scientific base and is worthy of "primary" emphasis in the process of medical education. In a healthy competitive atmosphere, various modalities of primary care are being defined, developed, and tested. It is important that specialties with principal emphasis elsewhere not be cast in the role of primary physician.

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References

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3. Pearson JW: The obstetrician and gynecologist: Primary physician for women. JAMA 231: 815-816, 1975