From Washington

The Scope of Research in Family Practice and Primary Care

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From its inception in late 1989, the Agency for Health Care Policy and Research (AHCPR) has been committed to supporting research in primary care. The Agency's Division of Primary Care has focused attention on the need for a research base for family practice and primary care through a variety of mechanisms. Two national conferences led to better communication, the development of an initial research agenda, and examining the various methods that can contribute to research in primary care.[1,2] A Task Force on Increasing the Capacity for Research in Primary Care was established in November 1990 and will produce a report with recommendations during the final quarter of 1991. Finally, a recent AHCPR publication summarizes many critical areas of primary care research that deserve attention.[3] Elements of that research agenda that should be of particular interest to family physicians are discussed here.

The scope of research in family practice can be described in eight components. At the very core of primary care are the *patient,* the *physician,* the *problem,* and the *clinical process of care* by which patient and physician deal with the problem. The process of care occurs over time and involves successive contact with the family physician and other health professionals as needed. The patient and the physician do not, however, deal with the problem in isolation, and the environment of health care exerts important influences. The patient is part of a *social system* (often a family) that functions within a larger aggregate of individuals at the *community* level. Similarly, the physician is part of a *practice or program,* which in turn is part of the larger *health care system.* Although there is a great deal of overlap, research on issues involving the problem and the process of primary care is likely to be characterized as clinical, while research in the other six components have many features of health services research.

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The Problem

In primary care, patients present with clusters of ill-defined symptoms, such as fatigue, headache, sleeplessness, and arthralgia, as well as fully developed and easily labeled diseases. The important task of the family physician is to differentiate self-limited from more serious disease, provide the patient with prognostic information, and develop a plan to deal with the problem appropriately. To add to the challenge, this must be done efficiently, without overuse of the large and expensive arsenal of diagnostic tests available. Unfortunately, the bulk of medical knowledge is focused on the diagnosis and management of fully developed disease, and is largely silent on approaches to the undifferentiated illnesses, problems, and concerns with which most patients present most of the time. Research is needed to better understand the basis and natural history of primary care problems and the normative management approach to common problems employed by family physicians. For example, what is the optimal therapeutic approach to vaginitis, uncomplicated urinary tract infection, low back pain, or carpal tunnel syndrome? Why does one person facing situational stress develop headaches, while another develops an irritable colon?[2]

The Clinical Process of Primary Care

Family practice presents a tremendous challenge resulting from the broad range of clinical problems, the need to communicate effectively and to use communication as a therapeutic adjunct, and the challenge of information processing required to select therapies (either directly or through referral) that are of proven effectiveness and

consistent with the patient's informed choices of lifestyle. The clinical processes of primary care occur at the front line of the health care system and form the interface between self-care on the one hand and medical specialism on the other. The complexities of this process are still not completely understood. When is a given symptom a benign, self-limited phenomenon, and when is it the first clue to serious illness? How can the distinction be made more precisely and without undue expense or risk to the patient? Among all the clinical prevention activities that may be appropriate for any given patient, how does the clinician decide which should be done first? What are the common types of physician-patient discordance in decision making and how can they be resolved? How much of the variation in the use of diagnostic tests can be explained by the provider's or the patient's discomfort with uncertainty? How do practitioners and patients agree or disagree on which problems should be addressed, or for that matter on the definition of a problem?

The Patient

The patient brings to the primary care setting a variety of problems that include symptoms, chronic illnesses, lifestyle issues, medication effects, problems of living and interpersonal relationships, behavioral and other risk factors, and administrative problems such as physical, disability, and return-to-work examinations. The patient's central role in the health care process is slowly gaining recognition, yet important questions remain unanswered. What leads a person to become a patient? Why does a patient seek care for a particular condition at a particular time? How do patients decide which problems to take to their primary care provider? What factors explain the variation among individuals in the value placed on levels of function, discomfort, and distress? Why do patients with the same condition and identical treatment experience different outcomes? What is the patient's expectation of care? What leads a person to stop being a patient? How do patients evaluate a physician's advice?[1,2]

The Physician

Primary care practice requires assimilation and processing of large volumes of information while maintaining personal communication with the patient. More research is needed to understand how family physicians deal with the unavoidable uncertainty that surrounds their clinical decisions. How do physicians balance cost, financial incentives, patient preferences, medicolegal considerations, ease of adoption, and the weight of scientific evidence in their decisions to modify their practice pattern? How is the information flow during a consultation useful as a learning strategy for the primary care physician? In which instances does the physician become an integral part of the treatment? What characteristics contribute to the physician being viewed as effective and desirable by patients? What strategies can the family physician use to coordinate care provided by multiple practitioners?

The four categories that make up research on the environmental influences on primary care contain research questions that should be of great interest to family physicians as well. As the *social system* most critical to the patient, the family has the potential to produce, sustain, overcome, and cure illness. Not enough is known about how this occurs to permit primary care physicians to intervene on behalf of troubled patients. Within the *community* a number of vulnerable populations exist for whom improvements in health care will require a great deal of additional knowledge. Of particular importance are health and health care issues for mothers and children, the homeless and underserved populations, individuals with HIV and AIDS-related illnesses, the elderly, individuals with disabilities, and those living in rural areas. The *practice or program* environment of primary care is changing rapidly, and research on the effect of the various strategies for "managed care" continue to be promulgated by those footing the nation's medical care bill. Finally, within the larger *health care system,* research is needed on the effect of medical liability on the pressures, incentives, and behavior of family physicians and patients. Physician payment reform will likely have a profound effect on family practice that deserves the research perspectives of family physicians.

The research agenda and the conference proceedings (referenced below), as well as other AHCPR publications, are available from AHCPR through the Division of Information and Publications, Room 18-12, 5600 Fishers Lane, Rockville, MD 20857; telephone (301) 443-4100.

References

1. Primary care research: an agenda for the 90s. Rockville, Md: Agency for Health Care Policy and Research, 1990.
2. Primary care research: theory and methods. Rockville, Md: Agency for Health Care Policy and Research, 1991.
3. A research agenda for primary care: summary report of a conference. Rockville, Md: Agency for Health Care Policy and Research, 1991.