Primary Health Care

THEORY AND PRACTICE

Trisha Greenhalgh

Department of Primary Care and Population Sciences
University College London
UK

Blackwell Publishing

BMJ Books

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To my students, who expected me to write this book.

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Preface

In 1999, the editor of the *Lancet*, Dr Richard Horton, threw down this gauntlet:

> *'Primary care is the subject of more charters, declarations, manifestos, and principles than any other medical discipline, except perhaps its similarly plagued cousin, public health. Yet this efflux of ruminations from worthy experts and respected bureaucracies has contributed hardly anything to the daily practice of family medicine'*.[1]

Horton's words were met with outrage from primary care academics worldwide, and I certainly shared that outrage. But his editorial revealed two important things. First, that the academic foundations of primary care, if not weakly developed in themselves (and perhaps they were), had been poorly articulated by academics within our discipline. Second, that these foundations were, as a result, widely and profoundly misunderstood by people in powerful positions in academia and medical publishing. It was Horton's shot across the bows that prompted me to take on the task of producing a completely new, single-author textbook on the academic basis of primary health care.

The case for such a book was not difficult to make. Remarkably few academic textbooks in this field have ever been written – and to my knowledge, no new first editions have been published in the past 15 years. The giants on whose shoulders I stand include Britain's William Pickles (*Epidemiology in Country Practice*, originally published in 1939[2]) and Julian Tudor Hart (*A New Kind of Doctor*, 1988[3]); Hungary's émigré to Britain Michael Balint (*The Doctor, His Patient and the Illness*, 1956[4]); America's Barbara Starfield (*Primary Care*, 1992[5]) and Robert Rakel (*Textbook of Family Medicine*, 1973[6]) and Canada's Ian McWhinney (*A Textbook of Family Medicine*, 1986[7]).* I have also been inspired by Gillian Hampson's excellent textbook for nurses, *Practice Nurse Handbook*, first published as Bolden and Tackle's Handbook in 1980.[9]

Apart from more up-to-date reference lists, what does this book offer that goes beyond what the greats of a generation ago came up with? First and

*I should also mention John Noble and team's *Primary Care Medicine*, the leading US textbook, which is an excellent overview of the clinical problems seen in primary care practice, along with a guide to evidence-based decision making.[8] This is an outstanding reference tome for doctors in clinical practice, but does not attempt to cover the breadth of interdisciplinary territory addressed here. Another comprehensive textbook written for a US audience is Rakel's *Textbook of Family Medicine*, first published in 1973 and now in its 7th edition.[6] While mainly centring on clinical problems, it includes sections on evidence-based medicine and also covers the important work of McWhinney.

foremost, I have deliberately devoted a large section of the book to disentangling the diverse disciplinary roots of primary health care. Pickles, Fry and Starfield took an almost exclusively epidemiological perspective and showed how such a perspective could both emerge from and serve to inform the work of the primary care team. Balint focused on the psychodynamic perspective and showed how this could illuminate the study of the doctor–patient relationship. Tudor Hart linked epidemiology with political science and drew links between social inequalities and health outcomes. McWhinney, to whom I owe a particular intellectual debt,[†] drew on a range of disciplines including epidemiology, psychology and moral philosophy, but did so in a way that produced a unified, multi-level theory (patient-centred medicine; see Section 5.4) rather than – as I have chosen to do – setting out a menu of different disciplinary and theoretical perspectives as possible 'options' for cutting the cake of primary care. It is on McWhinney's important early work, and with the advantage of the last decade in which primary care has matured considerably as an academic field in its own right, that I seek to build.

I have called Chapter 2 'The "ologies" of Primary Health Care' because I believe that no single 'ology' (be it basic biomedical science, epidemiology, psychology, sociology, anthropology or philosophy) can alone underpin either practice or research in primary care. What is needed is not a single, 'minestrone' discipline that primary care can call its own, but a greater recognition by practitioners and researchers that different primary disciplines provide different theoretical lenses through which the complex and multifaceted problems of primary care can be studied. As I explain in Chapter 2, identifying the right 'ology' for a particular primary care problem is one of the key skills of the academic practitioner.

The second unique feature of this book is that it is (to my knowledge) the first general, single-author academic textbook to take an explicitly multiprofessional perspective on primary health care (as opposed to general practice or family medicine). The shift from uniprofessional to multi-professional focus reflects changes in the organisation of primary care over the past 20 years and in the diverse roles associated with its delivery – particularly the growth of primary care nursing. It also reflects, I guess, the increasing role of the person who is ill in his or her own care, since the 'expert patient' (see Section 4.4) is also a member of the multi-professional team. Only around half the students on my MSc course in International Primary Health Care (www.internationalprimaryhealthcare.org) are medically qualified; the remainder have backgrounds in nursing, health policy, pharmacy, social work, physiotherapy and management. As I emphasise in Chapter 10, illness in the

[†] That is not to say that I regard the contribution of the other authors listed here as less intellectually significant, but that my own take on academic primary care aligns most closely to that of McWhinney and his team.

twenty-first century is characterised by complexity, comorbidity and the need for coordination. In this context, textbooks aimed exclusively at a single professional group are increasingly anachronistic.

The third unique selling point of this book is that every word has been written by a single author. There is a touch of irony here. If primary care is so intellectually diverse, so clinically and organisationally complex and its practice necessarily multi-professional, surely it would be better to include an appropriate range of individuals as chapter authors, each of whom would cover a particular area of expertise. There are certainly some advantages to such an approach – for one thing, the subject matter would be covered more evenly and comprehensively. As it is, this textbook is biased towards my own areas of interest and expertise (sociological aspects of illness and healthcare, ethnic health, electronic records) and somewhat superficial on other areas (such as epidemiological databases). But the upside is – I hope – that this book offers a holistic overview of the field along with consistency of style that simply cannot be achieved in a multi-author textbook. Incidentally, a massive, multi-author reference textbook on primary health care has recently been published in the UK,[10] and an equally weighty *European Textbook of Family Medicine* has recently rolled off the press. I do not seek to compete directly with these tomes, but to supplement them with one woman's take on the parameters of our discipline.

Having said that, I make no claim to comprehensiveness. In a field as diverse and rapidly changing as primary health care, any attempt at encyclopaedic coverage of its multitudinous themes in a single volume is doomed to failure, and in any case the academic journals make a much better job of covering all the latest topics. Like McWhinney before me, I have sought to produce a 'territory map' of academic primary care along with some illustrative examples of how theory and method may be applied to the huge range of potential research topics. Though necessarily incomplete and distorted by my personal interests and prejudices, I hope this map will prove sufficiently coherent to convey the breadth of what counts as the 'normal science' of academic primary health care and sufficiently flexible to accommodate perspectives and theories that I have missed (or which are yet to emerge).

What, then, is my intended audience for this book? To paraphrase John Van Maanen, any book that aspires to the status of academic work has three potential audiences:[11]

1 Scholars in the field. This book is written primarily for people who are already working as academics in primary health care or who aspire to enter the field as researchers or teachers. These are the people who, by and large, see the subject matter of primary health care through similar eyes to mine, who already know (or are learning) the jargon, who share (or are coming to share) the assumptions and are familiar with the main theories and methods used in primary care research. Included in this group are students (PhD, MSc and ambitious undergraduates) who seek to define, with a view to extending, the margins of knowledge in primary care.

2 Thinking practitioners. This book is also intended for general practitioners, practice and community nurses, and other primary care professionals who wish – for personal fulfilment or career progression – to go beyond the multitude of books on the shelves that promise 'ten tips for better consulting' or 'how to organise your practice.' The examination for the Membership of the Royal College of General Practitioners (www.rcgp.org) now includes an understanding of research and the academic basis of general practice in its syllabus. But be warned: I did not set out to write a textbook for the Membership of the Royal College of General Practitioners, nor have I consulted or collaborated with its Board of Examiners, so do not take my word for what will come up in the exam or what the 'right' answers will be deemed to be.
3 General readers. Finally, this book is intended for people – especially in other academic disciplines – who have not the faintest idea what primary health care is and have even less clue about its academic basis. Primary health care is (like education, human resource management and in-flight catering) an applied field of study. Its main subject matter is not a unique set of abstract premises and theories nor a set of observations made in the pure environment of the laboratory, but the messy reality of the real world with all its complexity and situational contingencies. As the opening quote of this Preface illustrates, the academic basis for applied fields is harder for outsiders to grasp, not least because so many practitioners within those fields are unclear about the concepts and theories that inform (often implicitly) the work that they do. It follows that those of us who hold tenured professorships in applied fields must spend at least some of our Sunday afternoons setting out our stall in a way that academics from the traditional 'ologies' can begin to take this seriously. I hope that, in this book, I have begun to address that task.

One final comment about the intended audience for this book: I live and work in the UK, and many (though by no means all) of my examples are taken from my own direct experience. This means that this book will perhaps be more meaningful to readers who are based in the UK. But this book is also intended as the course textbook in an international Masters course that takes students from (so far) four continents and 17 different countries. Whilst I use local examples at both micro level (e.g. the primary care consultation as it generally happens in the UK) and macro level (UK health policy or funding arrangements), I have presented these *as examples*, and have deliberately tried to select ones that provide transferable insights for students from other countries. I hope, therefore, that this book will prove useful to an international audience, and I would be especially keen to receive suggestions for meeting the needs of this wider audience should the book run (dare I say it) to a second edition.

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March 2007

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Foreword

In 1974, as a working GP in what was then still a functioning colliery village, I was invited to lecture on primary care at Johns Hopkins University Hospital in Baltimore. This was an awesome responsibility. Johns Hopkins was the place where Sir William Osler and William Henry Welch added Rockefeller's oil fortune to German laboratory science, thus realising in practice Abraham Flexner's dream of medical education founded on hospital specialism and scientific evidence.[1] This set a world gold standard pattern for medical education which even today remains largely intact.

True, I was only invited by the Department of Public Health, which, though distinguished in its own right, was still considered by all other faculties as only a minor adjunct to clinical medicine and surgery. And of course there was no department at all for general practice, family medicine, or any other concept of primary health care. However, the phrase "primary care" itself had suddenly become fashionable. Kerr L. White, then at Chapel Hill, North Carolina, had shown that in one average month, out of 1000 adult US citizens at risk, 750 had some sort of illness, 250 consulted any sort of doctor, 9 were admitted to any sort of hospital, and only 1 actually reached a teaching hospital to provide case-material for learning. He originally got this idea from John and Elizabeth Horder's referral data, from the James Wigg practice in Kentish Town.[2] Consultants in teaching hospitals ignored at their peril mounting evidence that existence of cost-effective generalists was a precondition for their own survival as real specialists, rather than "specialoids" – doctors claiming specialist fees but without effective hospital support. That useful term was coined by John Fry[3], one of the first to recognise this truth. It was confirmed by a report from the American College of Cardiology, which found that though in Boston, Miami and New York there were more than 10 cardiologists per 100,000 population, 70% of these had office-based rather than hospital-based practices, and half were not specialist Board-certified.[4] In a market economy, health workers closest to technology make the most money, and nobody wants either to be a generalist, or to provide continuing care.

So before my lecture I was shown around Johns Hopkins Hospital. Like most large hospitals, its ground floor was built around an exhausting and apparently endless corridor, with a network of pipes and cables running along its ceiling. As we approached somewhere about halfway along this corridor I saw a roughly cut cardboard sign hanging from bits of string looped around the pipes. And this is what it said:

DEPARTMENT OF PRIMARY CARE →

My guide was intrigued – he had never noticed it before. We followed the arrow, and found ourselves in the Emergency Room. It was heaving with the sort of events one sees on television doctordramas – children with acute severe asthma whose parents had never been told the difference between a 'preventer' and 'reliever'; diabetic patients in ketoacidosis whose medication had not been reviewed for years; overweight men rigid with low back pain who had never received advice or physiotherapy; elderly people whose undetected hypertension had led to a massive stroke; and smokers whose unchecked habit had finally caused them to cough up blood. These everyday 'emergencies' would occur very rarely in a country with a developed primary care system accessible to the whole population. The barbarism of the scene was confirmed by the presence of several heavily armed policemen. The doctors and nurses confirmed that their work had indeed just been renamed, in tune with fashion. New words, unchanged resources.

I tell this story first to establish two points, and then to draw an important conclusion for the many thousands of students who will use this book, in this first edition and the many others which surely will follow.

First, even in the USA, things have moved on since then, as is the nature of market economies. Specialoids have not been eliminated, but they have been pushed back – by the mighty force of corporate investors in health care, whose profits depend on rationalising the processes of commodity production, and have no interest in maximising doctors' incomes. So *things* get rapidly better, and even if *people* get worse, more and more *things* can be done to repair them. In Britain, where until 1979 the National Health Service, and the medical schools producing its doctors, all operated as a gift economy outside and above the market, both *things* (medical and nursing knowledge and resources) and *people* (staff and patients) steadily improved, even though both service and teaching functions were always grossly under-resourced. In USA in the early 1980s, one single department of family medicine in Worcester, Massachusetts, employed more staff than all the UK departments of primary care and general practice put together. Our health professionals learned how to listen and talk to patients as if they were friends, neither customers to be flattered nor sheep to be herded. Among their most impressive teachers was Trish Greenhalgh, in her frequent columns in the *British Medical Journal*. More than any other medical journalist, she spoke to her fellow GPs in the language of experience, but never without linking this to our expanding knowledge from the whole of human science.

When I compare the outlines of primary care so lucidly presented in this wonderful book, obviously derived from rich experience of real teaching and learning, with the *grand guignol* theatre of London medical schools when I was a student 1947–52, the advance is stunning. Young health workers today are incomparably better educated than they were in my immediately postwar generation, and from what I see of mature students entering medicine at Swansea Clinical School, they are now moving ahead faster than ever before. They know more of what really matters, the body of knowledge from which they draw is larger, simpler, and much more effective, and their attitudes to patients are hugely more sensitive and better informed.

But here we reach my second point. Students in every advanced economy now face an imminent future in which technology will certainly go on improving, but human relationships are rapidly getting worse. In 1996, even before we got incontrovertible evidence of approaching environmental crisis, the United Nations report on human development showed that the world then contained 358 people with one billion or more US dollars. Their total wealth equalled the combined incomes of the poorest 45% of the world population.[5] Disproportionate wealth on this scale creates equally disproportionate power. Health care systems in almost all countries, whatever their stage in economic development, have been conscripted to a single market-oriented pattern determined by the World Bank, which now has a far bigger health budget than the United Nations' World Health Organization.

Students of anatomy will not find what has become the most potent of all human organs, the wallet. The market decides. Even if all these 358 billionaires were angels, determined to address the needs of all people rather than such wants as are profitable, they must maximise their cash returns on investment. If they do not, their corporations will be devoured by competitors.

So the irresistible force of advancing scientific knowledge collides with the immovable object of a global economy in which meeting global needs is allowed to proceed only as a byproduct of making very rich people richer still.[6] They say our world began with a big bang. Unless your generation recognises the difference between natural laws, which cannot be changed, and human laws (including those of economics) which arise from human decisions and behaviour, that may be how it will end. Students today will have to learn, and later to apply their learning, within contexts of crisis no less profound than that from which my generation only just managed to emerge in 1945. Some of the social relationships already established in the pre-"reform" NHS, which were a precondition for developing the ideas and practice outlined in this book, could still provide foundations for rebirth of the honesty and hope we now desperately need.

Julian Tudor Hart

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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 health-care 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.