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EDITORIAL

Motherhood, Apple Pie, and COPC

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The dramatic progress of the Human Genome Project during the last decade has highlighted the strength of the reductionist approach to biomedical science. In essence, by reducing human disease to a matter of mistaken DNA and the resulting amino acids, we may be able to greatly increase our means to prevent, diagnose, or treat that disease.

Even as we celebrate the successes throughout

medicine of the reductionist scientific approach, we must also acknowledge its limitations. Reductionist scientific methods have led to a detailed understanding of the pathophysiology of type 2 diabetes, for example, and to a range of medications for treating it. Yet despite this new understanding, the prevalence of type 2 diabetes increased by 50% from 1994 to 2001.[1] Similar detailed understanding of the pathophysiology of tobacco effects has had no impact on the rates of smoking during the last decade.[2]

The limitation of the reductionist approach to health and illness, of course, is that it fails to account for the fact that we are more than the sum of our parts. Though we are indeed a collection of amino acids and other such molecules, we are also products of our environment. As chronic and behaviorally based illnesses become ever more important mediators of health in our society, this relationship of a person's health to psychological, familial, community, and societal contexts becomes increasingly obvious. Engel, with his biopsychosocial model, has emphasized the importance of a broader view of these contexts to successful treatment of the person.[3] Those of us in family medicine can justly argue that our field, by specifically including the family in its view of the health of the individual, has taken this broader view.

Community-oriented primary care (COPC) is an approach to primary care that takes this relationship view a step further.[4,5] It is a model of primary care which puts into practice the idea that community context plays a role in the health of the person. Through a systematic process of identifying health needs and acting on those needs, COPC links efforts in the primary care practice and in the community. In bridging the divide between clinical care and public health, COPC offers a new vision for health care.

The article by Plescia and Groblewski in this issue of the *Annals* shows both the best and the most challenging aspects of COPC.[6] In an ongoing partnership between a primary care practice and members of the community it serves, an iterative process is being followed to develop and refine efforts to improve health. These efforts, based on a shared understanding of the major health concerns in the community, have led to targeted interventions both in the community and in the primary care practice. Plescia and Groblewski report a level of sophistication beyond most published examples of COPC in their work to understand how to structure interventions. Even more exciting is their description of how they are applying what has been learned to programs to improve health.

Their work exemplifies much of what has attracted the health care community to the COPC model in the last half century. COPC offers to target scarce resources to high priority health care needs, and to extend health promotion outward from the primary care practice into the community. Linking preventive care activities in both settings makes intuitive sense—it must be more effective than the disconnected system under which we so often function. Who can argue with the logic on which COPC concepts are based? It's like motherhood and apple pie.

In addition to its role in enhancing preventive care, COPC is a democratizing concept that can reduce barriers between health care providers and community residents. There is moral as well as practical value to involving the community in the planning and delivery of personal health care, as described by Plescia and Groblewski. Perhaps for this reason examples of COPC have been most often described in low-income, medically underserved or cross-cultural settings, where barriers between health care providers and community residents can be highest.

Reports such as that of Plescia and Groblewski and others which periodically appear in the literature confirm at least parts of these hopes of COPC. Bayer and Fiscella[7] described how a COPC approach in an inner-city community increased community acceptance of a range of preventive care services, improved measures of diabetes control, and facilitated tobacco cessation efforts. Epstein et al[8] have described the results of extended COPC work in Israel that resulted in increased rates of breast feeding, decreased rates of anemia, improved hypertension control, and decreased rates of smoking.

While confirming part of the vision of COPC, these examples of its application leave unanswered some challenging questions that have plagued this model of primary care delivery. Plescia and Groblewski paid $61 apiece (or $78 per household) to survey 492 residents of their practice catchment area, for a total of about $30,000. We do not know whether this figure also includes the opportunity costs of planning and interpreting the questionnaires or of writing the grant that supported the interview costs. Plescia and Groblewski were able to obtain a major grant from the Centers for Disease Control and Prevention to allow them to conduct this survey; they are to be commended for recognizing the value of the information that could be gained from the survey and for the effort taken in obtaining the grant. Even so, the question remains—how many practices can afford to take this approach to COPC or have the time to do so?

Therein lies one of the rubs with COPC. Without exception, COPC has taken root only where there has been substantial outside funding or an energetic advocate or both. The reasons are simple. Whereas it seemed for a short time that managed care might push

health care delivery into a population-based perspective that would value the linkage between primary care and community in health promotion, this support has clearly not materialized. If anything, the prospects for routine financing of COPC activities seem dimmer now than 10 years ago.

Just as importantly, those of us who have been proponents of COPC have failed to show convincingly 2 other elements of the model: (1) how it can routinely and feasibly be done in the context of a busy primary care practice without substantial added resources or a committed leader, and (2) evidence that it does result in better health. Too often we have focused on historical examples of COPC and relied on the motherhood and apple pie rightness of COPC concepts as sufficient justification for its wider application without doing the hard work and research needed to bring it forward into the health care environment of the 21st century. Until methods of putting the concepts into action are developed that are inexpensive and feasible for busy clinical practices, and that have results that are useful for practices and communities, COPC will remain little more than an attractive but rarely used idea. Without those practical methods, there will be no way to show that health outcomes can be improved using a COPC approach. Without proven evidence of its effectiveness, COPC will not gain a broader base of acceptance and application.

New developments in information technology and applications of qualitative assessment methods offer hope that rapid, practical methods for carrying out the ideas of COPC are on the horizon.[9] Reconceptualizing COPC as a collaborative process involving multiple interested parties will be important. Formation of partnerships between key stakeholders in the health care arena and the community, all of whom stand to benefit from the goals of health promotion, can help to break down the old idea of COPC driven by the primary care physician working in relative isolation. The critical demonstration of improved outcomes is complex and harder to achieve, but it can be done. Innovative approaches for molding interventions to a community, such as Plescia and Groblewski have done, together with focused planning and new concepts for assessing outcomes, can set the stage for providing the needed evidence for evaluating the effectiveness of COPC.

The ideas behind COPC make as much sense now as they ever have. It is time to move forward into the 21st century by finding ways of adapting these concepts to everyday practice.

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