

Primary care, community medicine and prevention: a convergence of needs

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SUMMARY. Both general practitioners and community physicians practise a range of activities along a spectrum from health care to prevention, but increasingly they have come to regard preventive medicine as the key to their respective future roles. This convergence of goals is deceptive because the primary care model of prevention is individual-oriented while that of community medicine is population-oriented. Since an effective preventive strategy is likely to require the use of both these approaches, community physicians and general practitioners should acknowledge the complementary nature of their skills and work towards the integration of their preventive efforts.

Introduction

PRIMARY care is largely concerned with the first-line clinical management of individual patients while community medicine tends to view the whole population as its patient. The two specialties also differ in their history, organization, financing and training.

Yet as well as differences there are similarities: both are relatively new specialties and are striving to establish a secure professional identity, both have responsibilities to defined populations, and both appear to regard prevention rather than care (or cure) as the key to their future role. This paper attempts to trace the origins and development of this convergence of goals and to argue that neither discipline can succeed in developing effective preventive programmes without recognizing its dependence on the skills and orientation of the other.

Primary care and prevention: towards anticipatory care

The National Health Service Act 1946 laid the basis for the provision of primary care services as we know them today in the UK. General practitioners were required to provide medical care for defined populations, but prevention was not explicitly stated in their contract. On the other hand, local authorities were obliged to provide preventive primary care for mothers and children but were debarred from providing treatment services. As the Court report pointed out,

'the allocation of responsibilities itself helped to create the belief and practice that primary health care ... could be divided into the separate components of prevention and cure.'¹

The periodic reorganization of the health service since 1948 has not altered this position substantially, and general practitioners have continued to deliver mainly therapeutic primary care while clinical medical officers have practised the lion's share of clinical prevention, often in collaboration with a third element in the primary care system, the health visiting service.

This schism of primary care into prevention and cure prompted little protest in the earlier years of its operation. Following the foundation of the Royal College of General Practitioners in 1952, general practice set itself the task of improving training and encouraging research at a time when morale,

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professional status and remuneration were low relative to hospital medicine. Davies has argued that the College was the principal route through which new rationales for general practice began to emerge, including the holistic or biographical approach, the strong influence of Balint, and notions of the primary care team and its responsibility to provide comprehensive, family-centred care.² In 1970, the first hints of a reorientation towards prevention were discernible in the College report on the future of general practice.³ Here, the general practitioner was characterized 'as doctor, as teacher, as health educator, as research worker', but his primary role was to remain 'the provider of medical care for all sections of the community.' Shortly afterwards, the Davis report summarized the new role of the general practitioner as:

'(1) The diagnosis and management in or near the home of undifferentiated illness in a defined population of individuals or families to whom he is directly accessible and for whom he accepts a continuing responsibility. (2) The prevention of disease and the maintenance of health both physical and mental including the detection of the earliest departure from normal in the individuals and families of this population.'⁴

In 1977, the College took up the cause of prevention in general practice at a time when the Department of Health and Social Security had also embarked on a preventive initiative.⁵ A series of College reports on the subject placed prevention firmly at the top of the agenda for the development of primary care,⁶⁻¹⁰ and by 1981 the idea of anticipatory care was being promoted as

'the main direction of growth for the primary medical services in the foreseeable future. "Anticipatory care" implies the union of prevention with care and cure — "prevention" including both the promotion of health and the prevention of diseases.'⁶

Community medicine and prevention: towards a new public health

Although its roots lie in the nineteenth century public health movement, community medicine was perceived by its founders primarily as a means of bringing epidemiologically based management and planning to bear on the newly integrated health service following the 1974 reorganization. As early as 1960, Sir John Charles, Chief Medical Officer to the Ministry of Health, urged that the Medical Officer of Health should 'increasingly regard himself as the community physician' who should link the three arms of the health service.¹¹ Sir George Godber, in his corresponding report for 1967, gave the screw a further twist in a more explicitly administrative direction:

'It will be lamentable to the future of social medicine and gravely limiting to the development of our services if the present generation of administrative doctors does not seize the opportunity now opening before it, of providing in every district the community physician who will promote the organisation of medical care in all its curative and preventive aspects and in larger areas the essentially medical part of better administration.'¹²

The Royal Commission on Medical Education (1968) pursued the theme of the need for coordinators of services and defined community medicine as

'the specialty practised by epidemiologists and by administrators of medical services.'¹³

These and other pronouncements of the time began to mould the embryonic community physician. As well as forging the

administrative link between the three previously divided arms of the old National Health Service, his skills as a doctor would be put to constructive use, with epidemiology providing his diagnostic tools and administrative-cum-managerial expertise offering him his therapeutic regimens. His patient, of course, would be the community. The concept of a community physician with legitimate 'medical specialist' functions was attractive to the advocates of community medicine. They were determined to emulate their general practitioner colleagues in establishing a discipline with a recognized professional medical status. These ambitions were realized in 1972 with the creation of the Faculty of Community Medicine under the auspices of the Royal Colleges of Physicians. The Faculty set about defining the specialty in terms which would emphasize its essentially medical content:

'Community medicine is that branch of medicine which deals with populations or groups rather than individual patients. In the context of a national system of medical care, it therefore comprises those doctors who try to measure accurately the needs of the population both sick and well.'

The specialist knowledge which the community physician would offer included:

'the principles of epidemiology, of the organisation and evaluation of medical care systems, of the medical aspects of the administration of health services and of the techniques of health education and rehabilitation which are comprised within the field of social and preventive medicine'.¹⁴

In practice, community physicians were to be faced with multiple frustrations. The results of a postal survey of the 154 district community physicians in post six months after reorganization of the NHS revealed widespread concern about 'roles in general' and the large proportion of time spent attending meetings.¹⁵ Some years later, a diary survey of 471 community physicians in England indicated that 60% of their time was taken up with administration. A further 14% was devoted to planning and only 9% to preventive medicine. The authors called for a shedding of some of this administrative load to enable the community physician to

'apply his skills in areas where they are urgently required, such as the promotion of health, assessing needs, setting priorities and evaluating services'.¹⁶

Around this time, a reappraisal of the progress of community medicine began to take place and dissatisfaction was almost universally expressed. In particular, the neglect of epidemiology and prevention was bemoaned,^{17,18} and demands for a revival of the spirit of 'public health' were and are being voiced.^{19,21} Partly in response to these demands, the Faculty of Community Medicine established a Health Promotion Committee in 1982 and the President of the Faculty identified the development of preventive strategies as the 'particular if not exclusive responsibility' of community medicine.²² By this stage, the specialty appeared to be expressing a collective desire to move in a distinctly preventive direction, and this was inevitably reflected in the Faculty's revised assessment of its role:

'Community medicine is concerned with the promotion of health and the prevention of disease, with the assessment of a community's health needs and with the provision of services to communities in general and to special groups within them'.²³

The renaissance of the public health ideal was under way.

Converging aspirations, diverging skills

Superficially, both primary care and community medicine have therefore staked out an enormous area of common ground. Both, it has been argued here, have identified prevention as their goal

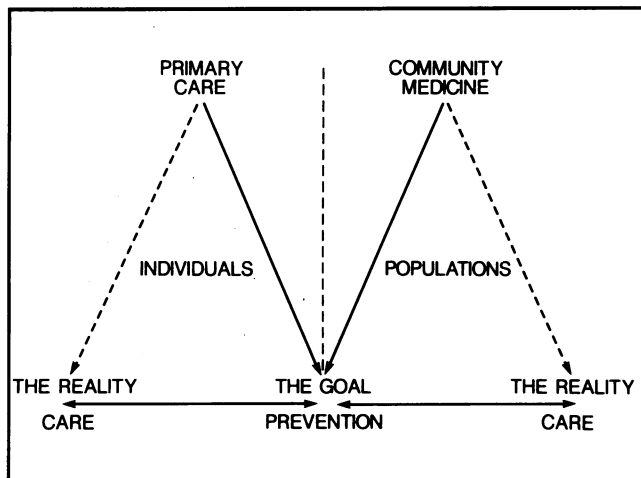


Figure 1. Converging goals of primary care and community medicine.

for the future, and in doing so, have expressed a sense of dissatisfaction at their overwhelming preoccupation with care (clinical treatment in the case of general practitioners and organization of services in the case of community physicians). Their aspirations are apparently identical (Figure 1).

But a closer look at the common goal reveals a fundamental flaw in this analysis. While the terminology is similar, the meaning is not. General practitioners usually use the term prevention as a synonym for individual-oriented, clinically-mediated anticipatory care. Davies traces the development of this view of prevention from the antecedent ideologies of family-centred and holistic care.² Community medicine, on the other hand, has rediscovered its public health roots and is expressing them in terms reminiscent of the nineteenth century,²⁰ when the environmental approach to prevention proved so effective. Consequently, the old conceptual and practical barrier between clinical prevention and mass prevention has yet to be breached.

The future: a convergence of needs

Rose²⁴ and Forwell²⁵ have recently argued that effective prevention calls for a combination of individual-based and population-based strategies. Each of these strategies has its strengths and weaknesses and their relative importance will depend upon the target disease or problem. It is hard to conceive of the successful prevention of cardiovascular disease, for example, without the use of clinical techniques for the detection, treatment and follow-up of high blood pressure, alongside mass strategies of public education and price control to bring about a reduction in tobacco consumption. By adopting both methods simultaneously, the chances of success are likely to be greater than by the reliance on either one alone.

Few would dispute the claim of the Royal College of General Practitioners that family doctors are uniquely placed to undertake clinical prevention, or the assertion of the Faculty of Community Medicine that community physicians have the prime responsibility for population-oriented health promotion. What is needed, if effective preventive programmes are to be developed, is a recognition by both disciplines of the complementary nature of the clinical and mass approach. Neither anticipatory care nor a reviving public health movement represents the sum total of prevention. If general practitioners and community physicians genuinely aspire to preventive medicine, they will need to bring their divergent skills together in pursuit of this common goal. The integration rather than assimilation of the preventive approaches of the two specialties should be the long-term aim.

Some progress has already been made in this direction. The Royal College of General Practitioners and the Faculty of Community Medicine have established a Liaison Committee to examine issues of common concern and this could serve as a forum

for more wide-ranging discussions. Some community physicians have a specific primary care remit, although their role has tended to be organizational rather than preventive. Several academic departments comprise both community medicine and general practice within a single administrative unit, and in some cases the relationship appears to have been mutually beneficial.

The obstacles should not be underestimated, however. Ideologically, the worlds of general practice and public health remain firmly separated and occasionally in conflict. Administratively, the two fields are organized and funded differently, and there is little geographical contiguity. And because both specialties are relatively young, a kind of intellectual jostling for position is inevitable. As with newly formed nation states, new specialties are liable to defend their defined territories vigorously, regarding any attempt by others to encroach upon them as suspect.

Conclusion

The central theme of this paper, that there is a need for a combined clinical and population approach to the control of disease in a primary care setting, is not new. General practitioners such as Pickles,²⁶ Fry,²⁷ Hart²⁸ and Mant and Anderson²⁹ have argued for an epidemiological and even for an explicitly public health dimension to primary care, while Kark³⁰ and others³¹⁻³³ have emphasized ways in which integration can become a practical reality. However, these initiatives have been confined to a tiny if growing band of enthusiasts. Their ideas are ripe for large-scale implementation given the evolving convergence of the ideological perspectives of general practice and community medicine in the UK today. Both specialties ought by now to have achieved sufficient maturity, self-confidence and intellectual independence to be able to meet jointly the challenge of a fully integrated preventive strategy for the future.

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Fellowship

There must be lots of good chaps,
Who are sober most of the time,
Who even passed the membership
At the first attempt, in their prime.

They are very polite to their elders —
And patients (if not too tired) —
They know they must be holistic,
And can be pompous if required.

Their jargon always impresses.
Self-auditing like mad,
They've mastered quality initiative,
Which surely can't be bad.

They'll have an age/sex register,
Try to keep it up to date;
Some floppy discs invest in,
(An expense they deprecate).

Should they attend a workshop,
Or cure the President's flu?
Is this the way to academia
And a key to the Fellow's loo?

Anon. 1985