

# The Importance of Primary Care (Part 1)

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I recall casually getting snacks at a pastor's house a decade or so ago. A gentleman approached me and asked what I did.

*I'm a family doctor.*

*Oh, you're one of those people who sees coughs and colds and sore throats all day.*

And with that, he soon moved on!

My Anabaptist heritage prevented me from doing what the Old Man wanted to do! But seriously, I attempted to tell him what I *actually* do, but he didn't seem all that interested.

I was aware that if he could have spent just a few days with me, his analysis would have dramatically changed. Let me give you just a few snapshots from what I did this past week in my office:

- Gave two patients cancer diagnoses.
- 10 school physicals.
- 2 preoperative physicals (one for eye surgery and another for neck surgery)
- Wrote a letter to justify prior medication use to obtain an airman's certificate.
- Addressed chest pain which was rooted in stress and overload syndrome.
- Dealt with burning urination in a child and constipation in another.
- Treated a red eye.
- Treated a swollen cheek (likely parotid gland swelling).
- Treated Lyme disease.
- Discussed prostate cancer and treatment options versus no treatment.

These were really just in the past two days! Coughs and colds and sore throats? Yes, there was a cough in one of the above visits! But the span of family medicine goes far beyond that.

## Definition

A family doctor is a *primary care physician*, sometimes known as a *PCP* for short. What exactly does that mean? The American Academy of Family Physicians defines *primary care* as:

*The provision of integrated, accessible health care services by physicians and their health care teams who are accountable for addressing a large*

*majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. The care is person-centered, team-based, community-aligned, and designed to achieve better health, better care, and lower costs.*

*Primary care physicians specifically are trained for and skilled in comprehensive, first contact, and continuing care for persons with any undiagnosed sign, symptom, or health concern...not limited by problem origin...organ system, or diagnosis.*

*Additionally, primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings...Primary care is performed and managed by a personal physician who often collaborates with other health professionals and utilizes consultation or referral as appropriate. Primary care provides patient advocacy in the health care system to accomplish cost-effective and equitable care by coordination of health care services. Primary care promotes effective communication with patients and families to encourage them to be a partner in health care [emphasis added].<sup>1</sup>*

The three branches of medicine that provide primary care have historically been *family medicine*, *pediatrics*, and *internal medicine*. (The latter two are divided into multiple *subspecialties*, such as pediatric cardiology or adult cardiology.) These three provide care of the entire age of the population, from birth to death. Each of these is considered a specialty in its own right. Family medicine became the 20<sup>th</sup> medical specialty in the United States in 1969. Family medicine trainees (known as *residents*) receive three years of training after medical school in pediatrics, obstetrics and gynecology, internal medicine, psychiatry and neurology, surgery, and community medicine. This “apprenticeship” prepares the doctor for a board certification exam in family medicine at the end.

I am grateful to have done my residency training at Penn State Health Milton S. Hershey Medical Center, which founded the first department of family and community medicine at an academic medical center in the United States in 1967. We define our specialty as one of breadth and not depth, because you need to know a fair amount about most branches of medicine rather than a lot about a narrower segment.

Family medicine was also the first branch of medicine to move away from a strictly *biomedical* focus to a broader model of *biopsychosocial* care which emphasized the emotional and social impacts on our physical health. A very important fourth component—spiritual—was later added to create a *biopsychosociospiritual* model, the one that guides my practice. In this definition, *spiritual* didn’t automatically mean Christian, but rather

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<sup>1</sup> <https://www.aafp.org/about/policies/primary-care>; written in 2019.

how matters of faith and religion impacted one's health. Of course, I practice from a Christian worldview as a Christian who "happens" to be a doctor rather than a doctor who "happens" to be a Christian—but that's a subject for another time!

You may be familiar with the "GPs" of yesteryear. These were general practitioners who often set up practice immediately after medical school or possibly with one additional year of internship. While the GP still exists in places like Britain, they were crowded out by the insurance world in the US as third party payers required their participating physicians to be board-certified, and hence GPs couldn't fill that role (because they had not completed the required residency).

Unlike a pediatrician who sees children up to age 18 or an internist who sees them from age 18 on, a family physician is qualified to see anyone in the age spectrum. Family medicine uniquely combines the best of both worlds.

Family physicians will have either MD (Doctor of Medicine) or DO (Doctor of Osteopathy) behind their names. (It's beyond the scope of this article to flesh out the differences.) Their offices will often employ both physician assistants and/or family nurse practitioners to assist in the care of patients. As physician extenders, they will usually have their own independent panel of patients.

Let's unpack the above definition by *briefly* exploring some of the highlighted (underlined) portions—understanding that each of these sections could be book chapters in themselves!

## Large Majority Of Personal Health Care Needs

I've already given you a flavor of the breadth of family medicine in my two-day scenario above. Never underestimate your PCP's knowledge. But neither should the PCP ever underestimate what he or she doesn't know! I had a family doctor mentor in Harrisonburg, Virginia who told me thirty years ago, "Don't be afraid to say, 'I don't know, but I'm willing to help you find the answer.'"

I saw a patient recently for diabetes follow-up. He mentioned something about shoulder pain, paused, and then said that was probably out of my field. Not exactly! Your PCP should be your first point of contact for these needs. With the internet and now AI, patients are seeking their own diagnoses prior to coming to the doctor. But the information output is only as good as the information input. And this is where patients have a distinct *disadvantage* over their PCP. (Their advantage is their awareness and description of their own symptoms, and PCPs certainly must attentively listen to those descriptions.) This will occasionally lead to patients ordering their own labs, which often results in tests ordered that weren't needed or information obtained which isn't relevant.

## Sustained Partnership and Person-Centered

One of the absolute jobs of primary care is developing long-term relationships with patients. I was aware of this recently when I realized that the grandmother of a newborn I was seeing was one of my seventh-grade students many years ago!

This partnership is part of the “social” aspect of the *biopsychosocial* definition, and the PCP has a unique advantage in understanding how the “family dynamic” impacts patient health. A PCP may have to tell a minister that he needs to step away from ministerial responsibilities for a period of time for his own emotional health or a farmer that he has to stop milking to permanently address his pain.

Person-centered care focuses on what is best for the patient, not what is best for the insurance world or a third party. I always tell my patients that my goal is to help them walk productively through any period of their lives using whatever modality (medical or otherwise) that is morally and ethically permissible.

## Better Health & Better Care

There are multiple metrics and analyses over the past number of decades which consistently show that PCP-driven and specifically family medicine-driven care has a significant impact on improved quality of life, lower mortality, and significantly reduced costs. For example, the 1997 National Medical Expenditure Survey showed that patients using PCPs as opposed to specialists for their personal physician had a 33% lower annual health care cost as well as a 19% lower adjusted mortality risk.<sup>2, 3</sup>

PCPs need to know when it’s time to seek specialist care, but they should be the ones determining that. A patient should not self-refer to an ENT for an ear flush, for example! Unfortunately, large health care systems prefer to keep patients within the system, so a PCP may refer a diabetic patient to the endocrinologist down the hall or to the nephrologist due to slightly abnormal kidney function, resulting in significantly more expensive care.

## Disease Prevention

One of the criticisms of modern medicine is its focus on sick care rather than well care, or keeping people sick rather than helping them to be well. It’s very rewarding as a PCP to help prevent illness or even to reverse disease states by lifestyle changes such as diet and exercise. (I just saw a patient today who has lowered his blood sugar average two percentage points simply by changing his diet.)

## Effective Communication

This begins by listening to the patient. Studies have shown that the average physician lets the patient talk for around twenty seconds before beginning to talk! The patient must feel heard. Medical terminology must be translated, as most “medical jargon” is certainly not household language for the average patient. It is less than helpful for a patient to leave an encounter without understanding what was said. My physician wife—who used to be a first-grade schoolteacher—almost always sketches some simple diagrams for patients to take along from their visit. It’s low tech but high yield!

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<sup>2</sup> Franks P., Fiscella K., Primary care physicians and specialists as personal physicians. Health care expenditures and mortality experience. *J Fam Pract.* 1998 Aug; 47(2):105-9. PMID: 9722797

<sup>3</sup> Analyzed via <https://alter.systems/c/fdaec624-dao8-4738-9520-ad9f7f1f9f4a>.

Part 2 will address the cost factor.

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