

# Letters to the Editor

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## More on Primary Care

### *To The Editor:*

The July/August issue of the *Journal* was an excellent review of the origins of the concept of primary care. In response to the Institute of Medicine's definition, a study was undertaken in North Carolina by the Health Services Research Center at the University of North Carolina (now the Cecil G. Sheps Center for Health Services Research) to determine if the proposed model agreed with the perceptions of practicing physicians and was applied in practice. North Carolina primary care physicians, selected by random sample of all active practicing family and general practitioners, general internists, general pediatricians and obstetrician-gynecologists, were surveyed and asked if they agreed with the elements of the IOM checklist as being more or less important to the practice of good primary care. The physicians were also asked to describe their normal practice of medicine and how it reflected the checklist attributes.

Not all of the elements on the checklist were rated as essential to primary care by the 169 respondents; for example, "maintaining a cross-reference system of patients by age, sex and disease" and "advising and seeing patients in community agencies" were rated as less important (2.07 and 2.15 on a scale of 5) compared to "seeing medically urgent cases within one hour" and "receiving feedback from physicians to whom you refer patients for work-up, diagnosis, or treatment plan," which were ranked 4.85 and 4.63 on the same scale. The responses to the questions revealed a range of perceptions of what specific elements were important within the five main attributes, although there was agreement that at least some parts of all five attributes were very important. The components of primary care that these primary care physicians felt were normatively important to their practice were also most often followed in practice. There were attributes that respondents felt were not essential to primary care, such as "maintaining a cross-reference system of patients by age, sex, and disease"—but 66% of the respondents were able to retrieve records in all three ways and another 22% by two of those criteria. Some attributes, such as having "office hours available after patients' work hours," were not seen as important to good primary care (rated 2.29 on a scale of 5), and

most (84%) physicians did not offer office hours on evenings and weekends. Primary care physicians also reported mixed agreement with attributes such as "periodically reviewing medical records for quality of care"; half reported doing this, and the score for this attribute (3.05 on a scale of 5) was right in the middle of the scale for its importance.

The study, conducted in 1978 and 1979, showed that certain specific indicators of the IOM definition of primary care were considered by practicing primary care physicians to be more or less important to the idea of good primary care, and that many but not all of those attributes could be used to characterize their practices.

Primary care at the end of the 1970s was a complex construct that reflected wishes and ideals as much as the actual practice of medicine. It was not likely then, nor is it today, that when definitions of this concept are proposed they will closely reflect the realities of practice. The question that remains is whether the ideals of primary care as embodied, in part, in the 1978 IOM definition substantially changed medical practice.

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