Paradoxically the increasing ability of medical science to change favourably the course of illness and, therefore, to bring about what Morris (1975) referred to as ‘the unnatural history of disease’, has substituted a wealth of new problems for those it has solved. Among these are effects on primary care. It is not many decades since the general practitioner could do little more than ease pain, offer comfort, and hope that nature would do the rest. Now that many powerful and effective treatments are available to him, how has the general practitioner’s view of his own role changed, encouraged by a system of medical education which is still heavily biased towards hospital medicine? How in particular have the expectations of the patients changed and for what reasons do they initiate a consultation with the doctor? (Banks et al., 1975).

In this issue we publish reports from two studies of the behaviour of women who consider themselves to be ill and of their use of primary care in two very different cultural settings. Fabrega (1977) has been concerned with a town in south-eastern Mexico, where beneath a thin veneer of Western values and practices, the cultural influences of the extinct indigenous Mayan empire conflict with those of seventeenth and eighteenth century Spain, where a system of state medicine exists but is not comprehensive. In contrast, Beresford et al. (1977) have studied women in south London, living in a decaying inner suburb of a metropolitan city, who have access to a highly developed and freely available health service.

Although the objectives of the studies differ, both show vividly, to use Fabrega’s words ‘the multiplicity of factors which influence health status and judgements of perceived illness’. Neither study makes any attempt to diagnose the illnesses which provided the consultations nor indeed do they even classify them in medical terms, although in both studies it is clear that most were of a minor nature.

In both studies social factors influenced perception of illness, and behaviour in response to it, in unexpected ways. The aboriginal Mexicans (indigenas) reported illness less frequently than those whose cultural characteristics are primarily Spanish (ladinos); the reported duration of symptoms was shorter among the indigenas and they resorted to nature doctors less often than did the ladinos. As Fabrega points out the more deprived and socially stressed aboriginal group might have been expected on biological grounds to report the higher morbidity rate; he suggests that one explanation for the difference may be that the ladinos may have social expectations that they can or ought to indulge in the ‘luxury’ of being confined to bed by a call for medical care, whereas the indigena does not have such an expectation.

Beresford and her colleagues in London found that the frequency of general practitioner consultations by women was also influenced by social factors—such as, the ease with which a woman can get away to see the doctor, the length of time she has lived in the neighbourhood, her attachment to the neighbourhood, the physical amenities of her home, her ability to find privacy, and the ease with which she can run her home. Marital state almost always has a complex role to play; among married women those who have least difficulty in being free to consult a doctor do so more frequently, yet the opposite is true for single women among whom consultation rates are highest for those who find it most difficult to get away.

In neither investigation do the authors attempt to provide data which explains the ebb and flow of the response to illness which they observe; nevertheless, there is a clear implication in both papers that a need is felt by the women for medical advice concerning problems which are not strictly medical and that this need can be aggravated, assuaged, or repressed by clearly definable aspects of the women’s daily life, by the structure and values of the society in which she lives, and by her relationship to that society.

This raises questions related to the management and prevention of these episodes of illness. When objective evidence of disease cannot be obtained, how can we tell whether the illness does or does not exist. Does it constitute a social problem or does it require medical care? Have we given sufficient thought to the ways of meeting the needs of the
multiple users other than by letting them make their frequent pilgrimages to the doctor's surgery? Perhaps if their world were modified their needs would no longer be felt. But can this be done? If they really need to consult, should it be a general medical practitioner? If not who should substitute for him? How should substitutes be trained? And how can patients (or clients) be persuaded to consult such substitutes?

These questions will seem banal to some and perhaps provocative to others. Nevertheless, they have seldom been asked and they certainly have not been answered. The World Health Organisation is committed to the promotion of primary medical care in the developing world on the grounds that more can be achieved to improve the health of the total community by working at this primary care level, than by developing large hospitals which can be accessible only to a small proportion of the population. Everywhere such community programmes rest heavily on auxiliary health workers. Britain boasts a comprehensive primary care system based entirely on qualified medical care, yet whether the general practitioner and his team are playing the most appropriate roles for the needs of the times is a question seldom asked.

Is the day of the medically qualified general practitioner, family physician, or primary care doctor passing even in Britain, as it has already passed in many other highly developed societies? Is the future for all medical care to be dispensed by doctors based upon hospital supported by properly organised community health services manned largely by health workers without medical degrees? We are not in sympathy with this view, but a pattern of hospital-based medicine is extensively followed in Europe and in the United States of America. It is being introduced in several developing countries. It is clear that if a resolution is to be found, the function of primary medical care requires far more attention than it has received in the past from investigators; what is the need, what is the demand, how does it arise, how should it be met? 'We must simply state what we can do, so that all can understand and then help to design a service based upon society's values and with a human face' (Mahler, 1975).

References


Primary medical--whose responsibility?

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