Conflicts between personal and public health care:
can one GP serve two masters?

General practice has always been placed between personal care and public health duty. But the latter has not been an integral part of general practice for very long and is still poorly integrated in countries like Germany, Austria, and France. But even in those countries, working as a GP often includes a public health approach, and GPs' role — in the language of social science — is defined by public health, as well as by the requirements of personal care.[1,2]

During the past few years GPs have experienced a shift from performing a personal care role to a public-health function. For instance, in the pursuit of public health we are paid for treating a percentage of our patients in areas such as raised blood pressure, screening for a variety of conditions, and immunisation programmes. Such programmes, more or less, make it possible not to inform patients of the primarily public-health function of most of the screenings and most of the treatments in low-risk groups. Informing patients would reduce participation, and obstruct the public-health goal.

At the same time we are told to give only evidence-based treatment or none at all, although we know that evidence-based medicine only gives answers for selected groups in studies that are not always applicable to our individual patients.

There are other examples where GPs, sometimes unwittingly, start to follow a public-health approach. For instance, treating cystitis with trimethoprim instead of a quinolone is following a public-health approach, focusing on limiting bacterial resistance and reducing costs for society. For the individual patient, at least in Germany, quinolones would slightly increase the chance of successful treatment.[3]

Treatment of mild hypertension or mild hyperlipidemia in patients with no history of a cardiovascular event, especially those under the age of 65 years, will reduce the risk of such an event in the future only marginally.[4] However, from a public-health point of view, the major burden of these diseases stems from those with low risk but who are also the majority.[5] Most obvious is the situation of bringing people to join screening programmes. The absolute risk reduction for the person taking part is extremely small,[6,7] but the reduction in the burden of disease seems to be large enough for society.[5] Treatment is primarily based on a public-health approach, but the individual patient is rarely aware of how far this approach is applied in his/her own case.

Public health has even changed our way of thinking. Evidence-based medicine is supported by studies that represent groups of patients and, therefore, provide answers on a population level. When applying their results to personal care, we should realise that the patient will often differ from the group studied. The original proponents of evidence-based medicine recognised this from the outset, but in the reality of care this knowledge may be lost and partly supported by systems of payment for the way we care.

Furthermore, there is always the possibility of a benefit for a small subgroup which, due to the group's size, is diluted within the whole group studied. I may be tempted to try a treatment not supported by randomised controlled trials if an evidence-based treatment has not been successful, or even to try a placebo when everything else fails.[8,9]

The public-health approach is legitimated for different reasons: limited resources (the goal is to have a healthcare system free for all, still affordable), and the knowledge that individuals gain from better public-health. Therefore, our actions as 'agents' of public health are also legitimated.

The public-health approach is not wholly new. GPs always have to think of everything that is possible, but usually only do the things that are necessary in that situation, and for that very patient, to prevent over-treatment.[10] In doing so, we often fulfil the public-health approach. However, our intention is different: GPs following an approach of personal care generate low costs only because, as a rule, patients often do not need more treatment and could even be placed at risk by it. GPs are still primarily driven by the orientation of doing the best for their patients.

This also applies to the opposite way of handling problems. GPs sometimes do even more than is purely medically indicated. For some patients it can be very important to use an additional diagnostic tool to allow the patient more certainty that they do not have a particular disease, even when it is quite obvious to us as doctors without additional reassurance. For another patient, it may be very important to obtain an additional remedy to the medication he/she already has, which is over-treatment seen from a public-health perspective.

Personal care is still what the public wants us to provide.[11–13] Perhaps most of us see ourselves continuing to act within that approach: the good doctor who cares for the one patient at any one time, and the patient who expects that the best will be done for him or her.[14] The function of general practice can still be described as caring for people with common diseases, selecting those who need secondary or tertiary care, and being in charge of all the problems patients or people in care encounter. Additionally, the foundation of general practice is a stable (often long-lasting) patient–doctor relationship based on trust,[15] which is interpreted as 'the doctor is doing the best for me'.[16]

As these examples show, GPs have always followed two principles: doing the best for the patient, and doing the best for society.[2] Now, at a time when the emphasis is shifting from the first to the second principle, we should analyse the conflicts between the two principles and reflect on what we are doing when caring for a certain

patient, which principle we follow, and if this is adequate for that patient in that situation. We also need to ask ourselves if the move towards the public-health principle is the best for us and our patients.

In wealthy countries patients regard their GP as the person who looks after their personal interests. This helps to produce a strong patient–doctor relationship. This is reflected in the high priority for personal continuity of care.[11–13,15,17,18] Even in countries such as Germany, where patients have direct access to a specialist without a waiting list, nearly 90% of the patients still consult their GP.[19] Therefore, we should remember that prioritising public health care as a GP would devalue the expectation of patients, and could contribute to the end of general practice as traditionally understood.

In poor countries there is a different imperative. The prioritisation of personal care could endanger the whole system or push it into private payment — the end of an orientation towards equity. In such countries, GPs are right to follow primarily the population healthcare approach, but they will find that patients also expect personal care. This can make working as a GP more difficult in these countries.

Whenever these two principles are in conflict we should reflect on what is possible under the circumstances in which we work, and then decide — transparently for ourselves and our patients — which approach to follow. Any divergence between the expectation for personal care and the experience of public-health medicine challenges the foundation of general practice, namely a trusting patient–doctor relationship. We should be particularly wary when we are offered higher incomes for more public health. In the short run we profit from it, in the long run it will threaten the basis of our professional existence and ignore the needs of those trusting us: the ill and diseased.

Heinz-Harald Abholz
Professor, Abteilung für Allgemeinmedizin, Universitätsklinikum Duesseldorf, Germany

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ADDRESS FOR CORRESPONDENCE

Heinz-Harald Abholz
Abteilung für Allgemeinmedizin, Universitätsklinikum Duesseldorf, Moorenstr 5 — Geb. 14.97, 40225, Duesseldorf, Germany
E-mail: abholz@med.uni-duesseldorf.de