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Early editions of *Primary Care Medicine* began by defining the tasks of primary medical care to include the following: (a) medical diagnosis and treatment; (b) psychological diagnosis and treatment; (c) personal support of patients of all backgrounds in all stages of illness; (d) communication of information about prevention, diagnosis, prognosis, and treatment; and (e) the prevention and care of chronic disease through risk assessment, health education, early disease detection, and behavioral change. The integrated performance of these five clinical tasks defined the essential work of primary care clinicians when this text was conceived and written, does now, and will continue to do so in the future. From its conception, *Primary Care Medicine* has been designed to support clinicians in achieving the highest level of performance in these tasks.

Chapters 2 to 5 address technical aspects of the clinical tasks that operationally define primary care medicine. Respectively, each provides a framework for the use and interpretation of diagnostic tests, health maintenance including screening for disease and risk, estimating and communicating prognosis, and making and implementing decisions about therapy. The condition-specific content of subsequent chapters is organized accordingly. But there is a strong relational component to these clinical tasks as well. Taken together, these frameworks support clinicians to work with patients in making high-quality decisions in the face of the uncertainty and complexity that characterize frontline clinical practice.

DEFINING PRIMARY CARE: THE PAST, PRESENT, AND FUTURE (1–35)

In addition to the enduring definition based on the clinical tasks of primary care medicine, other definitions derive from its place in organizational models of health care, from its functions within systems of care, from the academic contributions made by practitioners to education and applied research, and from primary care practitioners' vocational purpose and professional identities. These definitions and the historical circumstances of their emergence provide important context for understanding the challenges and opportunities of primary care practice—to learn from the past, to understand the present, and to create its future. These five definitions of primary care are summarized in Table 1-1.

Organizational Definitions of Primary Care

Early references to primary care were in policy documents written in the early 20th century in response to the recognition that specialized knowledge and technical skills were becoming

essential to medical care. Increasing prominence of science in medical education and milestone advances in diagnosis (e.g., x-ray imaging in 1885) and treatment (e.g., the discovery of insulin in 1922) raised challenging questions about distribution and access to specialized technologies and treatments. In 1920, the Dawson report in the United Kingdom argued for “primary health centers” staffed by general practitioners who would refer to secondary health centers when need for specialized care exceeded local availability. Tertiary centers were those aligned with medical schools. The primary–secondary–tertiary organizational structure became blurred when diagnostic and treatment technologies were decentralized from hospitals to community settings for both primary and specialty care uses. Nonetheless, primary care has continued to be defined by many as the nontechnical first level of care with referrals made when greater specialized knowledge or technical skill is needed. This definition positions primary care practitioners as “gatekeepers,” especially when access to secondary and tertiary care is otherwise restricted. This role can be seen positively—as a gateway to valued care—when patients are in a trusting relationship with clinicians who are visibly committed to supporting them in maintaining health and well-being. Clinicians are more likely to be seen negatively as an obstacle to needed care when there has been insufficient time to build a trusting relationship by working with patients to make decisions that reflect their concerns and preferences.

There was early recognition that social circumstances had a profound effect on the health and well-being of patients beginning with those recovering from acute illnesses. At the beginning of the 20th century, social workers were employed and then organized in departments of leading hospitals in the United Kingdom (St Thomas’ Hospital) and the United States (Massachusetts General Hospital [MGH]), where the earliest deployment was in the hospital’s outpatient clinic).

The integration of public health and social circumstances with primary medical care took form in community-oriented primary care centers (COPCs) in South Africa in the 1940s and in the United States in the 1960s. The South African model relied heavily on community health workers as did China’s Rural Cooperative Medical Scheme implemented in the late 1960s. The success of integrated models that reached into impoverished communities to identify and leverage their assets spurred the Declaration of Alma Ata, issued at a WHO conference in 1978, which included a recommendation for investments in primary health care systems everywhere as a means of achieving health care as a basic human right.

System-Function Definitions of Primary Care

During significant attempts at health care reform, the passage of the Patient Protection and Affordable