

Editorials

Primary Medical Care: A Riddle And A Parable

For most of 2 days I listened to a bevy of earnest speakers describe both the problems and potential solutions for access to primary health care in the United States (The Second National Conference on Primary Health Care Access, Beaver Creek, CO, 11-14 April 1991). They were a diverse and distinguished group of professionals who work in government agencies, universities, private foundations, and local organizations; and all had direct experience in serving needy populations.

They spoke about chronic underfunding, personnel shortages, stultifying health policies, fragmentation of care, rural obstetrics, urban AIDS, and medical student debt that mitigates against choosing a primary care specialty. But they also spoke about local and regional experiences with imaginative plans to solve some of the problems in both urban and rural settings for ethnic minorities, the poor, and other disadvantaged persons. They offered more than a litany of complaints, but it was plain that the solutions were incommensurable with the problems.

The sense I got of the group was that they were committed but weary warriors; not so much weary of serving the underserved but weary of resisting and trying to outwit the intractable forces, attitudes, and higher priorities that appear to be arrayed against primary care — forces that abort or subvert workable plans. It seemed that they had encountered a Hydra-like monster having the genetic capacity to grow new heads and to transform itself into a thousand disguises.

Sometime during my listening I dredged up from a dim corner of memory a riddle from my childhood:

Upon the hill is a big red bull,
He eats and eats and never gets full.

The first answer I learned, betraying my age and rural roots, was a threshing machine. It huffs and puffs and clatters away, consuming all the

shocks of grain that a gang of laborers can gather and stuff into its mysterious innards. A second answer, perhaps less provincial, was a fire burning out of control — maybe a forest fire or a blazing building.

Whatever the tortuous relevance of the riddle to the problems of primary care, the metaphor of the big red bull stuck in my mind and took on the character of a parable, which in its own way could be a third, more contemporary, answer to the riddle.

Parable of the Big Red Bull

Once there was a big red bull, a magnificent beast with enormous power — a prize-winning creature, coddled and nurtured since birth — and capable of unimaginable fertility. He was a syndicated bull, owned by rich investors who expected an exorbitant return on their money. He was no mere goose that laid a few golden eggs for an impecunious and ordinary farmer, but the master of his breed who could populate thousands of farms with his offspring. Everyone who saw him marveled at his perfection and dreamed of owning his progeny. It was unthinkable to butcher him.

He was amoral in his animal perfection, with no conscience about what he inseminated. He brooked no rivals in his pasture and cared not a whit about the expenses of his upkeep or the price of grain that went into his insatiable maw. He existed for himself alone, uncaringly unaware that his demands were outrageous.

Moreover, he was cranky, ill-tempered, and intimidating. One never thought of petting him — he needed no affection. One swipe of his gigantic horns could disembowel an unwary intruder, and his hooves could crush a score of victims if he stampeded. He was untouchable. A small army of caretakers controlled him from a distance. They built higher and stronger fences, more palatial barns, and reserved for him an endless supply of greener pastures. He could be lured to move only in the company of cows in estrus. He was, in his domain, King of Beasts.

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The bull's registered name was High-Tech Medicine, out of Empiricism by Experimental Method. His remote ancestors included Superstition, Nurture, Traditional Wisdom, Caritas, and Placebo; but later breeding selected sires named Secularization, Quantification, Somatification, Instrumentation, and Chemicalization.

The dominance and penetrance of these newer gene pools produced big, beautiful herds, which were impossible to domesticate. They rushed headlong through ordinary fences and crashed through standard barns, devastating neighboring farms. They could be corralled only in huge new feedlots, where they consumed extraordinary amounts of grain from millions of acres of the best land.

The meat from these herds was heavily marbled with fat and was considered a delicacy by those who could afford it. In Japan it was said to sell for \$180 per pound, and in the United States the cost of its production was 12 percent of the gross national product. The Producer's Association squelched rumors that the meat caused atherosclerosis among its habitual consumers — mainly the middle and upper classes. Milk from the herds was scant and poor in nutrition, unsuitable for the children of the poor.

Nevertheless, the owners of High-Tech Medicine and his descendent blood lines became rich and powerful and insisted upon their dominance in the cattle industry, even though they could not feed all the people and might have caused harm had they succeeded. They became adept at securing government subsidies and corporate contracts to maintain their herds and resisted other subsidies (which they contemptuously called welfare) to feed the poor. When the poor complained about not having enough meat and milk, the owners spoke of rationing and devised a food stamp plan, which was never fully funded.

Reformers arose among the hungry and disenfranchised, who tried to breed animals more suitable to their needs; but the Bull Registry regulations and breeding policies made it impossible for new breeders to become licensed, accredited, and certified. The monopoly was able to prevent the development of a promising new breed, Low-Tech Medicine, which was leaner and gave much more milk. It was dismissed as inferior,

even though it was successful on the few farms where it got a fair trial.

Finally, there was a great famine in the land that decimated all the herds. The big red bulls were protected to the end, but they were eventually butchered by their owners, who ate marbled meat until they too starved.

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A "New" Standard For The Diagnosis Of Mild Hypertension?

More than 60 million persons in the United States have hypertension, including 3 million children.¹ A diagnosis of hypertension must be accurate because of the high costs of treatment and follow-up. The 1992 US treatment costs for persons with hypertension is estimated at \$15 billion.¹ Treatment of hypertension can be associated with metabolic or other side effects, including physical symptoms or a decrease in the quality of life. In addition, the benefits of treating mild elevations of blood pressure (systolic 140 to 150 mmHg or diastolic 90 to 95 mmHg) remain controversial because of a borderline risk-benefit ratio, the effects of labeling, and the high cost of newer antihypertension medications.²

Routine office blood pressure measurements are the current standard used to diagnose and monitor hypertension. Office measurements, however, can have limited validity as the result of measurement errors and the phenomenon of clinic or "white coat" hypertension (elevated clinic blood pressures that are normal at other times).³ Approximately 7 percent of the general

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