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CHAPTER 1

DEFINING PRIMARY CARE

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Primary care has been described in many ways: by provider type, by specialty, and by care provided. In 1978, the World Health Organization described primary care as "first level contact. . . . address[ing] the main health problems in the community" and with a variety of clinicians including midwives "suitably trained socially and technically to work as a team."[1] One commonly accepted definition was developed by the Institute of Medicine's (IOM) Committee on the Future of Primary Care in 1994:

> *Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.*[2]

In explicating this definition, the IOM avoided specifying the type of provider or location of service required to provide primary care. Instead, the statement emphasized characteristics of clinicians and systems, such as the ability to provide care that addresses health and social needs as well as illness management, cultural competence, and ability to work in the context of an individual's social network. Other structural aspects of care were also emphasized such as the provision or coordination of care for most of an individual's needs, acting as a point of entry to the healthcare system, and the persistence of relationships over time.[2]

The importance of identifying oneself, or one's profession, as able to offer primary care services can easily be seen in the economic consequences of direct patient access as opposed to requirements for referral or restrictions on authority to treat. For clinicians such as midwives and other women's health practitioners, the recognized ability to treat an expanded range of conditions affects state and institutional scope of practice, prescriptive authority, third-party reimbursement, and a host of other pragmatic business survival factors. A small study published in 2002 indicated that midwives identified lack of reimbursement, institutional policies, state laws, and public perception of scope of care as barriers to their providing primary care.[3] And as Phillippi and Barger pointed out in 2015, state limitations on scope of practice, uneven and incomplete recognition as primary care providers by the federal government, and insurance reimbursement continue to be barriers.[4]

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A growing body of literature has examined quality and cost issues when midwives or nurse practitioners provide primary care. Although each of the studies has flaws, they have consistently demonstrated overall equivalence in quality and possible cost savings.[5-8] The factors that attract many women to midwifery care, such as longer visits or more time for discussion, may offset financial savings. However, to the extent that interventions in primary care decrease the impact of chronic disease, that money may be well spent.

Midwifery Scope of Practice

Regardless of the credentialing or financial benefits that might accrue from midwives' identification as primary care clinicians, the traditional scope of midwifery (maternity cycle care) did not meet the definition. Whether midwives could reasonably act in this role was addressed by the American College of Nurse-Midwives (ACNM) in its 1992 position statement, "Certified Nurse Midwives and Certified Midwives as Primary Care Providers/Case Managers."[9] Appropriate populations for midwifery primary care were identified as healthy women and newborns, and the focus on health maintenance was emphasized. In 2012, following enactment of the Patient Protection and Affordable Care Act (ACA), the ACNM reaffirmed the role midwives can play in the position statement, "Midwives Are Primary Care Providers and Leaders of Maternity Care Homes."[10]

The "Core Competencies for Basic Midwifery Practice"—a document defining the scope of basic midwifery education—include the knowledge and skills required to assess, diagnose, and treat conditions beyond the maternity cycle and well women's gynecologic concerns.[11] The expected scope of practice includes health promotion and disease prevention, immunizations, diagnosis and treatment of common self-limited health problems, and management of mild to moderate chronic conditions such as asthma or obesity.[11]

Women's Health as Primary Care Practice

Clinicians whose focus is on women's health care are often de facto primary care providers. Many healthy women choose to see their gynecologic provider for primary care on a regular basis, where prenatal care and ongoing reproductive health care have established a trust relationship. Even as recommendations around management of cancer screening have changed, consultation regarding contraceptive and procreative plans, the effects of hormonal changes during menopause, and sexual health remain integral parts of providing care for women. Midwives already provide health screening, preventive health recommendations, and counseling about lifestyle changes to women. In addition, during pregnancy, many clinicians defer to the obstetric provider for the management of many health concerns, probably because the "extra patient" complicates choices of therapy or medication.

A key component of primary care is health maintenance. This is accomplished in several ways: through counseling and education to decrease lifestyle risks and promote health, disease prevention, and regular general healthcare examinations. But beyond health maintenance, how are midwives active in primary care?

The task analysis undertaken periodically by the American Midwifery Certification Board evaluates congruence between education and practice to support the certification examination's validity. Apart from these periodic assessments, there is little literature that directly evaluates the participation of midwives in primary care. Data collected from midwives attending the ACNM

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Annual Meeting in 1993 identified obesity, anemia, and upper respiratory and gastrointestinal infections as primary care diagnoses managed by more than 80% of midwives.[12] Murphy has reported that for gynecologic patients seen by midwives, blood pressure evaluation and assessment of medication use were common; cholesterol assessment and determination of rubella immunity were provided by more than half of the clinicians.[13] Those services provided to the fewest women included other immunizations. About half of the midwives asked women about other sources of primary care. Midwives identified lifestyle and psychosocial issues as counseling issues commonly addressed in their practice. The counseling services least often reported as provided included injury prevention, seatbelt use, and work-related risks.[13]

Midwives surveyed by Stuart and Oshio most commonly reported that their formal education included material related to acute respiratory, gastrointestinal, and genitourinary problems and hematologic and metabolic conditions.[3] Knowledge of behavioral, psychosocial, and sexual conditions was also reported by a large majority of the respondents. In each case, a somewhat smaller percentage managed these conditions independently.

A 2011 report on community health centers included a small number of midwives and nurse practitioners.[14] While the midwifery care provided was predominately for reproductive needs, 42% reported serving as a primary care provider for their patients, of whom approximately 18% had one or more chronic conditions.

The 2012 Task Analysis by the American Midwifery Certification Board found that almost half of recently certified midwives were providing primary care and managing most conditions that were diagnosed either independently or collaboratively.[15] More than 50% of respondents indicated they provided independent management for concerns ranging from anemia and asthma to skin infections, respiratory infections, and common gastrointestinal complaints.[15]

The Clinical Scope of Primary Care

Reviewing the commonly identified problems, screening tests, and counseling during primary care visits helps to establish a basis for deciding when and to whom midwives can offer primary care services. Adult women on average have more than four office visits per year.[16] Women are seen more frequently than men, whites more often than blacks, and elderly women more often than young women (excluding pregnancy).[17] In contrast, African Americans have more visits to hospital outpatient departments than do whites, and those between 45 and 64 years of age are more likely to be seen there than those over 65 (who presumably have a source of care through Medicare).[18] Approximately 40% of visits by women are for acute care, 30% for management of a chronic condition, and 23% for preventive care.[19]

The federal government regularly reports on common diagnoses seen in ambulatory care. The National Ambulatory Medical Care Survey (NAMCS) reports comprehensive access and diagnosis data every 5 years in addition to yearly summaries.[17] These reports help identify the "substantial majority" of health problems a primary care clinician should be able to identify and manage or refer appropriately. However, data for nurse practitioner and midwife visits include only 1.2% of reported primary care visits.

Common symptoms described as reasons for office visits include cough; pain, whether specified or general; fatigue; and malaise. **Table 1-1** lists some of the most commonly identified diagnoses for women during an office visit, outside of reproductive care.[17,20,21] Obesity is rarely

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Table 1-1 Common Diagnoses During Office Visits for Women

Acute upper respiratory infection (URI), sinusitis, pharyngitis
Asthma
Lower respiratory infection, bronchitis, pneumonia
Essential hypertension
Headache, migraine
Diabetes mellitus
Depression, anxiety, other mental health
Joint pain
Back pain
Urinary tract infection
Lipid abnormality
Hypothyroidism
Viral infections
Skin lesions or rashes

Data from National Center for Health Statistics. National Ambulatory Medical Care Survey: 2012 State and National Summary Tables. Available from: http://www.cdc.gov/nchs/data/ahcd/namcs_summary/2012_namcs_web_tables.pdf. Accessed February 11, 2016; St Sauver J, Warner DO, Yawn BP, Jacobson DJ, McGree MF, Pankratz JJ, et al. Why patients visit their doctors: assessing the most prevalent conditions in a defined American population. *Mayo Clin Proc*. 2013;88:56-67; Wändell P, Carlsson AC, Wettermark B, Lord G, Cars T, Ljunggren G. Most common diseases diagnosed in primary care in Stockholm, Sweden, in 2011. *Fam Pract*. 2013;30(5):506-513.

included on a list of reasons for visits, although in 2010 the majority of American women were either overweight or obese; this includes 27.9% who were classified as overweight (body mass index [BMI] of 25.0-29.9) and 35.5% who were classified as obese (BMI of 30.0 or more).[22]

Among the screening or general evaluation services provided during office visits, weight measurement and blood pressure evaluation are by far the most common. The NAMCS reports on selected examinations during primary care visits. For women, the most commonly reported were skin (16.4%), pelvic (10.7%), and breast (7.8%); of note, depression screening was performed less than 2% of the time.[17] Selected educational topics included nutritional counseling (7.1%), exercise (4.9%), tobacco cessation, and injury prevention.[17] When one considers the obesity rate among US women, the fact that nutritional information was provided only 7% of the time, and exercise recommendations of all types made < 5%, the need for increased counseling appears evident. The ACA has additionally mandated a series of preventive services specific to women's health.[23] These are shown in **Table 1-2**.

More than 50% of women take one or more medications. The most common prescriptions among nonpregnant women of childbearing age include oral contraceptives, levothyroxine, albuterol, acetaminophen, hydrocodone, and selective serotonin reuptake inhibitors (SSRIs). Pregnant women are less likely to take prescription medications other than prenatal vitamins, but 1 in 4 reported taking medications that included treatment for asthma, allergies, and diabetes; antibiotics; and levothyroxine.[24] In one study in Minnesota that worked from pharmacy records, women age 19-29 years were prescribed antibiotics, contraceptives, antidepressants, opioid analgesics, and antiasthmatics most commonly; women age 30-49 received antidepressants and antibiotics most frequently, followed by opioids, antiasthmatics, and medications for gastrointestinal disorders.[25]

While the preceding data identify a number of conditions that preclude the midwife or other women's health clinicians from acting as the primary source of medical care (e.g., insulin-dependent diabetics may require endocrinologist supervision), these women can be identified on history and physical examination, and then referred as necessary. Far more women need health

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Table 1-2 Preventive Services Specific to Women Mandated by the ACA

Type of Preventive Service	HHS Guideline for Health Insurance Coverage	Frequency
Well-woman visits	Well-woman preventive care visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception care and many services necessary for prenatal care	Annual, although several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.
Screening for gestational diabetes		In pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
HPV testing	High-risk human papillomavirus DNA testing in women with normal cytology results	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for STIs	All sexually active women	Annual.
Counseling and screening for HIV	All sexually active women	Annual.
Contraceptive methods and counseling	All FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity	As prescribed.
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence		Not specified.

FDA = Food and Drug Administration; HHS = US Department of Health and Human Services; HIV = human immunodeficiency virus; HPV = human papillomavirus; STI = sexually transmitted infection

Modified from Health Resources and Services Administration. Women's preventative service guidelines. Rockville, MD: US Department of Health and Human Services; 2011. Retrieved from: http://www.hrsa.gov/womensguidelines/

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education, preventive services and screening, and general examinations that fall well within the midwife's scope of practice. The use of tools such as the *Choosing Wisely* campaign by the American Board of Internal Medicine and the US Preventive Services Task Force Guidelines can assist midwives and other health practitioners in effective decision making and counseling.

Chronic Diseases and Cause of Death

Prevention of chronic disease is a key component of primary care. Chronic diseases are linked to 7 of the "Top Ten" causes of mortality in the United States; about 50% of American adults have at least 1 chronic disease.[26] Women generally report an increased number of days of feeling physically or mentally unhealthy compared to men, and rates are higher among minority, low socioeconomic status, and poorly educated groups.[27] Increasingly, attention is paid to the role of modifiable risk factors—poor nutritional habits and physical inactivity (linked to overweight and obesity), tobacco and alcohol use, uncontrolled hypertension, and hyperlipidemia—in affecting the burden of chronic illness. It is unlikely that the overall disease burden can be reduced without improvements in these factors.[28]

Monitoring for causes of death from chronic diseases uses Centers for Disease Control and Prevention (CDC) indicators linked to key topics such as cancer, cardiovascular disease (CVD), diabetes, asthma, chronic obstructive pulmonary disease, renal disease, arthritis, and mental health. Lifestyle factors including nutrition; exercise; tobacco and alcohol use; oral health; and the "overarching" factors of poverty, education, and insurance status are also followed for their contribution to the development of diseases.[29]

Causes of death can be viewed in two ways, and most people are used to the report of disease states, grouped into typical categories, such as "cancer" and "unintentional injuries" (**Table 1-3**).[30,31] These groupings allow for the comparison of relative contributions from broad categories; at the same time, they do not provide specifics. For example, if "malignant neoplasm of the trachea, bronchus, and lung" were a stand-alone category, rather than part of the broader category cancer, it would be the number 3 cause of death for some population groups.[30] Another way to consider the burden of disease is to show the contribution of factors that promote disease. Mokdad and colleagues reported on underlying factors that contributed to the official diagnostic cause of death, the "actual" cause, in 2000.[32] They found that lifestyle factors such as tobacco, alcohol, and drug use; poor diet and lack of exercise; and toxic agents including pollutants were direct contributors to more than 40% of all-cause mortality. Krueger and colleagues documented lack of a high school education as a contributor to mortality equal to current tobacco use, with a particular link to cardiovascular death.[33]

Disparities in Health Care

Having looked at common components of primary care visits and areas where health education and preventive measures can improve long-term health, midwives must also consider how disparities in health and access to health care can affect practice. One difficulty in studying the disparities found between racial and cultural groups is that US studies have historically used race as a marker for class or socioeconomic status.[34] Disparities in services sought and provided can be found across ethnic groups, age groups, rural versus urban locations, and economic strata. The World Health Organization states, "the social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries."[35] The first National Healthcare

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Table 1-3 Leading Causes of Death for Women, 2013*

Rank	15-19	20-24	25-34	35-44	45-54	55-64	65+	65-74	75-84	85+	All Ages
1	Unintentional injuries 40.4%	Unintentional injuries 40.3%	Unintentional injuries 29.9%	Cancer 24.6%	Cancer 33.3%	Cancer 38.3%	Heart disease 24.6%	Cancer 35.6%	Cancer 23.2%	Heart disease 28.7%	Heart disease 22.4%
2	Suicide 14.6%	Suicide 11.8%	Cancer 13.0%	Unintentional injuries 18.1%	Heart disease 14.8%	Heart disease 16.6%	Cancer 18.9%	Heart disease 18.2%	Heart disease 21.8%	Cancer 10.1%	Cancer 21.5%
3	Cancer 9.6%	Homicide 8.1%	Suicide 9.2%	Heart disease 12.0%	Unintentional injuries 9.7%	Chronic lower respiratory diseases 5.8%	Chronic lower respiratory diseases 6.6%	Chronic lower respiratory diseases 9.0%	Chronic lower respiratory diseases 8.2%	Alzheimer's disease 8.0%	Chronic lower respiratory diseases 6.1%
4	Homicide 6.2%	Cancer 7.7%	Heart disease 7.5%	Suicide 5.8%	Chronic liver disease 4.2%	Unintentional injuries 4.1%	Stroke 6.5%	Stroke 4.4%	Stroke 6.5%	Stroke 7.3%	Stroke 5.8%
5	Heart disease 3.9%	Heart disease 4.2%	Homicide 4.9%	Chronic liver disease 3.3%	Chronic lower respiratory diseases 3.6%	Diabetes 3.9%	Alzheimer's disease 5.7%	Diabetes 3.8%	Alzheimer's disease 4.6%	Chronic lower respiratory diseases 4.8%	Alzheimer's disease 4.6%
6	Birth defects 2.6%	Pregnancy complications 2.8%	Pregnancy complications 3.1%	Stroke 2.8%	Stroke 3.4%	Stroke 3.6%	Diabetes 2.7%	Kidney disease 2.1%	Diabetes 3.1%	Influenza & pneumonia 3.1%	Unintentional injuries 3.8%
7	Pregnancy complications 1.5%	Birth defects 1.4%	Diabetes 2.0%	Diabetes 2.8%	Diabetes 3.2%	Chronic liver disease 2.6%	Influenza & pneumonia 2.6%	Unintentional injuries 2.0%	Influenza & pneumonia 2.2%	Unintentional injuries 2.4%	Diabetes 2.8%
8	Influenza & pneumonia 1.2%	Diabetes 1.2%	Chronic liver disease 1.7%	Homicide 2.1%	Suicide 3.2%	Septicemia 1.9%	Unintentional injuries 2.2%	Septicemia 1.9%	Unintentional injuries 2.1%	Diabetes 2.0%	Influenza & pneumonia 2.3%
9	Stroke 1.0%	Influenza & pneumonia 1.0%	Stroke 1.6%	Septicemia 1.6%	Septicemia 1.6%	Kidney disease 1.6%	Kidney disease 2.0%	Influenza & pneumonia 1.7%	Kidney disease 2.1%	Hypertension 1.9%	Kidney disease 1.8%
10	Chronic lower respiratory diseases 0.8%	Septicemia 1.0%	Influenza & pneumonia 1.4%	Influenza & pneumonia 1.6%	Influenza & pneumonia 1.4%	Influenza & pneumonia 1.5%	Hypertension 1.6%	Alzheimer's disease 1.3%	Septicemia 1.8%	Kidney disease 1.9%	Septicemia 1.6%

*Percentages represent total deaths in the age group due to the cause indicated. Some terms have been shortened from those used in the National Vital Statistics Report. To learn more, visit Mortality Tables at http://www.cdc.gov/nchs/nvss/mortality_tables.htm or http://www.cdc.gov/nchs/deaths.htm (HHS, CDC, NCHS).

Modified from Centers for Disease Control and Prevention. Leading causes of death in females 2013. Retrieved from: http://www.cdc.gov/Women/lcod/2013/WomenAll_2013.pdf. Accessed February 11, 2016.

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Disparities Report noted, "there are complicated interrelationships between race, ethnicity, and socioeconomic status that may result in health-care disparities."[36(p8)] Those disparities remain more than a decade later, as evidenced in a 2014 report on health disparities and quality, which found that many measures of access and quality were unimproved or worsening.[37] Within racially and ethnically defined groups, those with less education, lower incomes, and working class jobs fare more poorly.

An illustration of the intertwining of risk factors and worsened outcomes can be seen in the case of CVD, the most important overall cause of death for women. Rates of CVD are higher among African American women than whites or Hispanics.[31] Multiple studies have documented that the factors associated with increased risk of cardiovascular death—obesity, uncontrolled hypertension, and diabetes mellitus—are increased among African Americans.[38-40]

Barriers to accessing care fall into categories that include structural/logistical, financial, and knowledge of available resources.[41] Among structural obstacles, including issues such as transportation and office locations and hours open, poverty and race both have been shown to negatively affect access. The issue is worse for women than for men. Financially, as many as 28% of uninsured women delayed seeking care as a direct result of cost in 2011, although that number drops precipitously to 8.8% among publicly insured women and 3.9% among those with private insurance.[22]

Having a usual source of care (defined as an office or health center) is also associated with improved access to services. Almost 90% of all women report having such a source of care. The percentage rises with age, influenced by Medicare access in the elderly, and is lower for Hispanic women.[22] The group most directly affected includes those ineligible for insurance under the ACA, of whom only 54% reported having a usual source of care.[42] The ACA extended health coverage to approximately 14 million previously uninsured women through a combination of tax credits and Medicaid expansion. However, 20 states have not accepted federal money to expand Medicaid as of 2015, with the result that about 3 million women living in those states fall into a gap where they are neither covered by Medicaid nor are eligible for financial subsidies to purchase insurance.[42] They also do not have guaranteed access to the women's health services provided under the ACA.

Disparities in education about health needs and in treatment exist. Little change has occurred over time in the knowledge among members of an ethnic group about relative risks of specific health problems within their own group,[43] suggesting lack of health information provided by clinicians. Patients in racial/ethnic minorities have been shown to receive less information about their diagnoses and possible treatments compared to whites.[44]

> *The costs of health disparities are not just to the individual or their families. One study estimated the economic burden of health disparities to be greater than 1 trillion dollars between 2006 and 2009 in the United States. This included direct medical costs, indirect societal costs from chronic illness, disability and missed workdays, and premature death.*[45]

Health equity has been defined as

> *attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.*[46]

Anyone who is interested in improving health-care equity should consider these goals in evaluating their own clinical practice and ask questions such as: Have I asked all of my patients about

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immunizations? About violence? About substance abuse? How can I make my practice more accessible to women in the community? Am I treating my patients with as much respect as I would want to be treated? Am I listening to the women I serve? And, am I helping them work toward better health?

Cultural Competence in Practice

Simply knowing about disparities in health access and health care is not enough to make one an effective provider. Awareness of and respect for the diversity among women can help remove a common barrier to care. Culture has been defined as "a socially transmitted design for living which includes traditional values, beliefs, rituals, and behaviors."[22] Within groups there is diversity and change over time; cultures are not monolithic. Dunn describes the characteristics of any culture as dynamic, shared, learned, and integrated.[47] Other authors have suggested that healthcare providers form a culture based on a common set of knowledge and behaviors, including a use of language that is not common in the community,[48] and that medicine sees itself as culture-free, while identifying anyone with a different perspective as being "cultural."[49]

Several terms are used to describe the effort to function effectively as a caregiver for a woman of differing race or ethnicity. Whether it is called cultural awareness, cultural sensitivity, cultural humility, or some other term, cultural competence is the skill of learning, accepting, and appreciating cultural differences and similarities between groups, and being able to act on that understanding. Nunez suggested that the term *cross-cultural efficacy* is more appropriate than cultural competence, because it represents an understanding of equalities between cultures.[50] Whether one uses efficacy or competence as a goal, the first barrier for many healthcare providers is recognizing that persons from different communities have different practices and belief systems, and that their reality, their truth, is based in those practices and beliefs. Lack of understanding on the part of the clinician is a barrier to care, both because it decreases the chance that data are collected, and because the patients can identify this as bias against their cultural or racial identity.

Race, education, source of care (defined as having a regular provider), and other variables all play a role in the patient's perception of bias from his or her providers, and that racial identity is a more powerful factor when asking about system bias. Regardless of education or financial status, non-white groups tended to perceive system bias based on cultural identity and use of English.[51] Among the specific factors suggesting a lack of cultural sensitivity to patients were a failure to provide ethnically sensitive office materials, such as illustrations or reading materials, and office staff behavior.[52] In this study, the language barrier was more important to Latinos, while environmental factors that suggested respect for African American culture were more important to African Americans. Other factors are also sources of potential bias in provider-patient encounters. Religious group, financial or educational status, obesity, substance use, or even sexual preference can lead to withdrawal and distancing by providers.

Other factors that primary care patients have identified as indicators of culturally sensitive care include people skills and effective communications, individualized treatment plans, and technical skill. Positive characteristics used to describe physician behavior in one study included listening, demonstrating concern, and good communication skills.[52] Beck and colleagues' review of the literature on patient-provider relations

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identified more than 20 nonverbal and verbal behaviors that had positive associations.[53] Among these were friendliness, courtesy, and empathy, which are behaviors that suggest acceptance of the person.

In medicine, providers also need to be respectful of the traditions and "folk illnesses" of their patients.[48] These issues may cause women to delay coming for care, utilize parallel care (medical plus traditional healers), or cause behaviors that the provider interprets as noncompliance when in fact the patient is following his or her own script for healing. Some illnesses do not fit a Western biomedical model, but are deeply rooted in cultural beliefs. Awareness and responsiveness to different cultural expectations can help to identify instances of parallel treatment, practices, and therapies that may be harmful, and to improve communication.

Having said all this, is cultural competence enough? There is limited evidence that cultural competence can erase the barriers to health quality caused by poverty, race, and lack of education.[54-56] Recall the definitions of primary care with which this chapter began and think about how to create a patient-centered care setting. It is often difficult for providers to actually listen and hear what the underlying barriers to adherence to treatment, or even attendance at a clinic, really are. True primary care requires not only awareness of one's culture, but of the family and community influences that impact the individual. Care has to begin where the woman is.

It has been recommended that an anti-racist approach needs to be taken, rather than one of cultural competence, and that white providers need to acknowledge and address issues of privilege and bias that affect perceptions of patients who are not similar in either ethnic or socioeconomic background.[57-59] Recent studies have found that particularly when white providers are working with black patients, implicit bias among providers is a factor in quality of communication and patient satisfaction.[59,60]

Conclusion

Primary care is a complex construct. It requires that care be available and that a clinician take the responsibility for paying attention to the whole person, not only one organ system or disease. It is best provided when the clinician can see across the divides of race, education, culture, and financial status, working to understand the individual and community network to provide care that works for the woman. Outreach and intervention strategies need to be tailored to each community, just as healthcare interventions are targeted at the individual to be most effective.

Many women rely on their midwife or other gynecologic caregiver to recognize and address all of their healthcare needs. Although the public perception of midwives is closely tied to birth and to care of healthy women, since the earliest days of Frontier Nursing Service American midwives have cared for women at risk from poor nutrition, poverty, and other socioeconomic problems. Midwives have continued to care for a population that is disproportionately adolescent, of color, immigrant, and poor.[61] When considering the focus on education, empowerment for shared decision making, psychosocial interventions, and lifestyle changes to improve health that are components of primary care, it is not surprising that midwives can be considered primary care providers. Because midwives are skilled at being "with women," they can evaluate the needs of women under their care, provide high-quality services, and refer women requiring more in-depth care to the appropriate consultants. Fulfilling that expectation—and triaging those who are not appropriate for midwifery primary care to a different clinician—requires knowledge. The basics of that knowledge are in the following chapters.

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