I was born in Dundee, possibly inheriting an interest in psychiatry from my grandfather who was, for more than forty years, superintendent of Dundee Royal Mental Hospital, and from my father who divided his fifty years of practice between institutional psychiatry and general practice in this city.

Educated at Dundee High School and St Andrew's University, I graduated in 1938. Following tenure of posts as resident surgical officer at Dundee Royal Infirmary, and assistant medical officer at Dundee Royal Mental Hospital, I spent six years in the Royal Naval Volunteer Reserve at sea, and latterly in the departments of psychiatry at the Royal Naval Hospitals at Barrow Gurney and Kingseat, Aberdeen.

In 1947 I held an appointment at the York Clinic, Guy’s Hospital, and attended postgraduate instruction at the Maudsley Hospital, but convinced that my interests lay outside hospital practice, I thereafter returned to general practice in Dundee. I obtained the Diploma in Psychological Medicine in 1947 while in general practice, and proceeded M.D. in 1950.

Since 1948 I have carried on an industrial practice in Dundee, with a part-time appointment as assistant psychiatrist with the Eastern Regional Hospital Board (Scotland), and hold a clinical

J. COLL. GEN. Practit., 1963, 6, 546
assistantship in the department of psychiatry of St Andrews University Medical School.

The National Health Services Act (1948) divides my professional life exactly in half, giving me equal experience before and since that measure. Interests and circumstances have also divided my work in another way, as I have been able to carry on family care in combination with specialist work in the field of psychiatry.

When I heard that I had had the good fortune to be awarded this fellowship, I saw an opportunity of comparing National Health Service practice in both fields of family care and psychiatry, with that in a country where illness is still a personal responsibility and not one to be shared by the community. In particular, knowing the tremendous problem of mental ill-health, with its resulting calls for psychotherapy, often of long duration, I was interested in studying how this was provided for under a system of private payment or personal insurance.

A personal letter to the dean of one of the senior American medical schools brought the following reply:

I am afraid you will find that the rank and file general practitioners in this country are neither trained nor interested. Little time was devoted to psychiatry in the curricula of American medical schools until about 1950, and only recently have teaching hospitals had psychiatrists available for consultations on patients who were not obviously psychotic.

A colleague who visited North America for a limited period recently, reported that all but 10 per cent of patients outside hospital suffering from psychiatric illness did without any treatment whatever, as they could not afford it (Fulton, 1961).

On the other hand I had heard that "American medicine is the best in the world", and I was quite familiar with the many criticisms, some well founded and others not so, of our National Health Service—or "socialized medicine" as it is known across the Atlantic. I went with an open mind, but hoping to find that general practice, or its successor family practice, was not doomed to extinction as predicted by so many people.

**General Itinerary and Method**

My object was to visit a cross-section of family practitioners in their work, to visit departments of psychiatry of medical schools with the aim of seeing what was being done for the family doctor as an undergraduate and as a graduate in the field of psychiatry, and to try to assess how well the results of modern teaching were being applied to the average patient.
With a view to covering as much ground as possible, both in large centres and in country districts, my wife and I decided to travel most of our journey by road.

Montreal was our port of arrival and a week was spent there, mostly with the staff of the Allan Memorial Institute of McGill University. From there we flew to Toronto where Dr W. V. Johnston, Executive Director of the College of General Practice of Canada, was inexhaustible in his help and hospitality. After ten days with the practitioners in and around Toronto, our journey took us by car north round the Great Lake, calling on local practitioners wherever we passed, through Sault St Marie, Winnipeg, to Saskatoon. Here we spent a most profitable ten days with Professor D. G. McKerracher and his colleagues in the department of psychiatry of the medical school of the University of Saskatchewan, visiting local practitioners, and having the opportunity of speaking to medical undergraduates.

Thence we passed several enjoyable and instructive days at Edmonton before reaching Vancouver where I met a representative sample of local family doctors, and also learned something of the teaching of psychiatry and family care at the University of British Columbia.

This completed two months study in Canada, and our route took us from there south into the United States where the general pattern was continued, with stops at the University of Washington, Seattle, and on to San Francisco.

My original plan was to return from California across the centre of the United States to Kansas City, but having been repeatedly advised to visit the southern states if possible, we continued our journey through country areas south through New Mexico and Texas to New Orleans. It was essential then to visit Kansas City where the headquarters of the American Academy of General Practice is situated, and where I received much helpful advice on my further journey. I took the opportunity at this point of visiting the Menninger Clinic which is a short distance away in Topeka. From there we continued east through Missouri and Ohio, calling at St Louis, Cincinnati, and Columbus, to Cleveland where I visited Western Reserve Medical School. In each of these centres both general practitioners and medical schools received us with extreme kindness. Ann Arbor with its University of Michigan was our last call in this phase of our schedule, before crossing the border back to Canada and Toronto. After a week’s respite in Toronto, we flew to New York to complete our travels in the eastern states. During this time some days were spent in Boston, where I was shown the Family Care Programme of Harvard University Medical School, and our final days were passed in seeing the wonders, both medical and otherwise, of New York City.

In addition to visiting general practitioners and medical schools, I also made a point of calling on drug stores (on introduction by a physician), and inspecting samples of prescriptions, which, from experience at home, might reflect the standards of practice of the average physician. Wherever possible we talked to the potential patient—the man in the street—and gained his opinion of medical practice.

In all, more than a hundred family practitioners were interviewed, more than half that number of psychiatrists, and many other specialists of all kinds. I visited five of the Canadian medical schools, and sixteen in the United States. Even so, in six months it was obvious that many centres would have to be missed. In particular I did not see Los Angeles or Chicago, and, visiting the mid-west
states, I missed the south eastern regions. This was inevitable, but I found no reason to think that the pattern of practice would differ from what I had seen. Perhaps when one considers that the area covered, transposed to Europe, would extend from the United Kingdom to the Caspian in the east, and to North Africa in the south, my omissions are excusable.

**Country and People**

In going to North America, I had been warned that I must remember that I was not visiting a British community, in spite of the common language. Even considering Canada alone, it was soon apparent that the country was continental. Our first contact was with predominantly French Montreal—both language and custom was Gallic. As we went west we passed communities and provinces each of which differed from the last. Polish, Italian, Ukrainian, and German, to mention a few, interspersed a general Franco-British matrix.

Each province in Canada, and state in U.S.A., is autonomous in many respects, including health matters, and all resent and resist pressures from the Federal Government. The central authority however has found an effective way of guiding provincial policy by offering financial support for certain projects, subject to the province raising equal funds from its own resources. This arrangement accounts for the fact that one province could be well ahead in the provision of state supported medical services, while another has only recently taken initial steps in a similar direction.

Another reason for differences in social policies in various parts of the country, is greatly differing sources of economic wealth. Taxation may vary from province to province, from state to state, and the allocation of public moneys is a matter for local politics.

Distances are measured in hundreds of miles, and I can remember asking one practitioner where his nearest psychiatric consultant was, to be told—two hundred miles away! For all this, I learned that health authorities were, in some regions sending out specialist help to rural areas in the form of visiting teams who make regular calls to isolated communities.

In the United States these differences were even more marked, and going either way over the border one was quite conscious of entering another country. Racial differences became more complex; wealth and poverty became more extreme. Each state had its own problems of climate, natural resources, political and social pressures,
These are factors, which will make the organization of a centrally planned health service so complex in the North American continent, perhaps impossibly so.

And what of the patient? I took the opportunity, wherever it presented, of sitting in an office practice, and of seeing what problems the average patient brought to his doctor. One of the first things which impressed me was the sociability of the average American. This was reflected in the friendly relationship between patient and doctor. As in all personal contacts in America, christian names are used on both sides, and there is little of the authoritarian in the physician. The patient, although of no higher intellectual level than his British counterpart, is completely conversant with his illness in the most technical terms—"what is my [blood] count today, Doc?"; "Perhaps you'd better do my pressure—I feel it is up and it was 160/100 last time".

This state of affairs is due not only to the lay press and radio, as many of the organized medical bodies keep the patient well informed on signs of illness, and encourage him to visit his physician. "Well medicine"—the term for extension "check-ups", take up a large part of many practitioners' time, and some set aside part of the day for this alone. Two hours are spent in history taking and examination. In Montreal I learned of an experiment in providing a public health service related to mental, rather than physical health, in which the citizen was offered a routine, periodic check-up on his mental health! There are other features of the social pattern which have a noticeable effect on medical practice. The telephone plays a much greater part in the life of the American than it does in Britain. While visiting doctors I invariably heard cases being diagnosed and prescribed for in this way. Patients seem to accept this without protest—whether from faith in the practitioner or faute de mieux I do not know.

Another feature of transatlantic life is the automobile, in which one moves, eats, is entertained, banks, shops, and visits one's doctor. Everyone has access to a car, and so all patients can be brought to the physician's office. For this reason much iller patients are seen in the office, and relatively few home calls are made. This situation is rationalized by the practitioner in saying that he does much better medicine in his office than he could do in the home, where he would lack his technical equipment. However, when one sees the traffic problems involved in the larger cities, it becomes obvious that no practitioner could do more than one or two home
calls unless he did them on his feet—and no one walks in America.

I was to find also that the insurance paying bodies, both in Canada and U.S.A., tend to frown on any doctor who does excessive home calls, as it is considered unnecessary in most cases, and draws excessively on funds.

To a smaller extent in Canada, and perhaps a larger in the United States, we found other important differences in community life in relation to that in Britain. Religion plays a more prominent part in the life of the average North American—although he can turn a blind eye, and a short memory, to much blatant dishonesty in his political system, where "payola" is an accepted fact of life. On the other hand many hospitals in the smaller communities are built and financed entirely by voluntary effort, and it is amazing how quickly and efficiently the necessary funds are raised in this way.

A depressing fact was obvious—and it had spread into the field of medical practice to a noticeable extent—that social value was measured invariably in terms of worldly wealth. Repeatedly, a question on progress in medical practice was answered in terms of dollars, cars, country homes, and foreign travel. These answers left our way of practice in Britain looking in a very sorry state. Few practitioners could see that one could do reasonably good quality medicine without a constant financial incentive, and many were too willing to damn a colleague simply because he had accepted salary remuneration.

In spite of this however, and contrary to the policy of organized medicine, which is to uphold private enterprise and fee for service at all cost, many practitioners are disturbed by the present situation, and privately at least, are looking forward to progress towards a health service which will provide good comprehensive medical care to the community on a pre-paid insurance basis.

In speaking to the average patient I had no doubt that he is dissatisfied with the present state of affairs, and will eventually make his demands felt in the political field.

A final influence in the physician’s life is the constant threat of litigation, which hangs over his head. This is quite a factor in determining a practitioner’s line of treatment. Some told me that they expected to be sued twice in a life time. Premiums for defence were at a level of $200 per annum, rising to double this figure if surgery, anaesthetics, or convulsive therapy were included in the risk. One of the first things I was told, when we set out on the road,
was to turn a blind eye to accidents, as if I stopped and offered assistance, I would be laying myself open to a suit for malpraxis. Fortunately I never had to make this difficult decision.

**General Practice as a Whole**

It has been repeatedly stated that the general practitioner is becoming extinct in North America, and I was told that I would have difficulty in making contact with him.

The College of General Practitioners of Canada has recently attempted an estimate of practitioners engaged in general practice (defined as including certificated specialists doing family care and excluding non-certificated practitioners who limit their practice to some special field). The results show that 10,537 of 20,981 registered practitioners could be called general practitioners. In U.S.A. the corresponding figures given to me by the American Academy of General Practice were 67,200 of a total of 214,050 practitioners—a much smaller proportion at first sight, though I found later that it was not a true reflection of the situation.

Perhaps it is necessary here to try to define what is meant by a general practitioner, as the term can have several connotations. It can mean a physician who does not limit his practice to a special field; one who practices family care; one who has direct and continuing responsibility to the patient for his overall medical care; a personal physician; one who practices undifferentiated medicine, and so on. There are many derogatory definitions.

In Britain we have tended towards accepting the general practitioner as the physician who accepts continuing responsibility for the overall supervision of the medical care of the patient in the home and within the family group. In this he has gradually dropped all but the most minor surgery, a large part of gynaecology, and an increasing part of obstetrics—though there is still considerable resistance to this latter trend. He is no longer a general practitioner, if by general one means a practitioner in all fields of medicine and surgery. Perhaps it is time that this term, in spite of tradition, should be dropped and replaced by that of family physician.

In North America the term general practitioner or "generalist" is more apt, as he sees himself a complete physician and surgeon, limiting his activities only to his own estimate of his capabilities. He is Jack (or master)-of-all-trades, and this has brought him into some disrepute with his specialist colleagues, and thence with the undergraduate and also the patient. This "general" practice was
graphically brought to my notice when on one occasion in a ten minute office call I witnessed a speculum examination of the cervix, followed by manipulation of a cervical disc under hypnotic anaesthesia, with some psychotherapy thrown in for good measure—all in the same patient. In spite of the fact that such extensive treatment might be dismissed as of poor quality, I personally could not fault any of it from gynecological, orthopaedic, or psychiatric viewpoint. Only a general practitioner could have carried it out!

While for many clear cut complaints the American patient goes direct to the specialist, there is no doubt that he wants, and often lacks, a family physician. Many people to whom we spoke bemoaned their present lot—"I have a doctor but I haven't found out yet what his line is—he always passes me on to someone else". Those who can't afford private care attend hospital outpatient clinics, and, while they appreciate the care they get there, complain that they get a different doctor every few months when the staff changes. Much of this hospital care, though free or at nominal charge, is carried out by students or practitioners in training and cannot be of first quality.

It is customary in both Canada and U.S.A. for "Physicians and Surgeons, M.D. " to be classified in the telephone directory under headings of general practice, internal medicine, paediatrics, surgeons, etc., and the prospective patient must often indulge in some self diagnosis before choosing his doctor. The telephone directory was in many places my first reference, and I often found less than ten per cent of practitioners called themselves general practitioners.

On the other hand I found that a majority of the specialists did not limit their practice to their chosen field, and many were quite willing to advise on family care in addition. Some admitted that limitation to their specialty was tedious and bad for their general medical outlook; others were frank in admitting that some family practice was necessary to achieve the desired standard of living.

The greatest intruders into the field of family medicine however, are the internist (or medical specialist as we would call him), the paediatrician, and to a lesser extent the obstetrician. In some areas I was told that the generalist was being replaced by the internist, who by our standards is a well qualified physician who does general medicine with the exclusion of all surgery, paediatrics, and obstetrics. In other words, apart from the exclusion of child-care he would fit in well with our best type of general practitioner. Both the obstetrician and paediatrician in turn gain access to the family with a pregnancy, and often assume thereafter full responsibility
for care of the family, in spite of their obvious defects due to specialization. In other words, although relatively few practitioners advertise themselves as family physicians, it seems that more and more are quietly entering the field, which far from diminishing, is if anything expanding. There is certainly an unsatisfied public demand for such care, and I found that many medical schools are actively teaching the subject and all are giving lip service to it.

The important question for the future is that of who is to carry out this essential phase of medical care more efficiently. The duty of the family physician is to deliver to his patient the fruits of medical research and experience. To my mind it is best done by one who makes it his whole interest, and is of broad enough experience and training to view the person as a whole. The specialist, in limiting his field of practice has abrogated his right to personal or family practice.

This overlap between family doctor and specialist, though very real in North America, does not exist in British medicine, where both halves of the National Health Service are to some extent protected from each other by the administrative structure. Neither general practitioner nor specialist feels threatened by the other as he does in America. In Britain we accept the fact that the specialist can perform his scientific techniques more efficiently than the generalist, and I do not think that any of our specialists would presume to be good family doctors. Even the concept of the team of specialists, working together in a clinic, did not suggest to me a desirable successor to the general practitioner of the past. It lacks the essential personal rapport with the patient, and I found that many such clinics in North America had found it necessary to employ traditional family physicians on their staff.

**Conditions of Practice**

The transatlantic family physician works under very different conditions from his counterpart in Britain. In the first place, the country as a whole is grossly under-doctored, especially in country districts. A few of the larger cities are, on the other hand, over staffed with specialists who are driven to do family care. The lack of general practitioners has allowed competing "professions" to flourish. In one city I found "Physicians and Surgeons" listed under four headings. Certainly the first was "M.D.", but this was followed by headings of "osteopathic", "chiropractic", and "Christian scientist". There is a current movement to have the
first of these integrated with the orthodox physician.

In Montreal I found it customary for a practitioner to list his special interests under his name; elsewhere a practitioner might proclaim that his practice was limited to this or that field. In New York on the other hand there was none of this, practice being much as it is in Britain with doctors advertising nothing more than their name.

The American generalist works entirely in office and in hospital. His office consists usually of a small consulting room where patients are interviewed, and this may have from one to three examination rooms off. Some have a special baby room where babies are weighed, measured and examined in routine monthly visits.

All have a receptionist and nurse; only rarely did I find either of these duties being carried on by the doctor's wife. The receptionist deals with appointments and telephone, the nurse does much of the laboratory work, blood examinations, injections, and so on. According to the business acumen of the practitioner, this general set up is expanded to include x-ray room, physiotherapy room, laboratory, dispensary, and I even encountered kitchens (for coffee), and laundry. A car park for the office is desirable.

The practitioner starts work early—at 8 a.m. or before, and goes to hospital where he sees his bed-patients. In Britain this would correspond with our morning round of home visits. Few practitioners do more than one or two house calls—and these only in emergency. I met some practitioners who had not visited a home for years, and one who was prepared to send an ambulance to bring the case to his office if no car was available. Many requests are postponed by telephone diagnosis and prescription, and while we heard of blunt refusals to visit, this was probably rare.

Record keeping, as far as the individual practitioner goes is of high order, but, with a greater tendency for the patient to shop around from doctor to doctor, I felt that there was much unnecessary duplication of investigation and examination. I realized the value of our system, whereby the patient's record follows him around on change of doctor. Few practitioners had any idea of how many patients they had at risk, but I was repeatedly told that practitioners saw 50 and more patients a day (an oft repeated criticism of our way of practice). On this point I heard that the film "On Call to a Nation" which was being shown throughout the country, caused great amusement, with the picture of a National Health Service general practitioner coping with an unending stream of patients
with the aid of no instrument other than a pen! On the other hand I felt I could cry quits when a patient told me that when she went to see her doctor she first over-ventilated, because if she stopped for breath during the interview she was on her way out.

I had borne in mind the fact that I might be seeing only the best type of practitioner, and occasionally I tried to see the other side of the penny which, it was admitted, did exist. I decided however, that I would learn nothing from seeing bad work, and so did not persist very much in this direction. Once or twice I did manage to see practitioners who were considered by their colleagues to be doing a poorer type of work, and I found that they were supplying a need which exists in every community. This practice was not all bad, and in many ways I found features which brought back memories of home. I saw cough bottles being demanded and supplied with only a gesture of examination; I saw chronic compensation neuroses, and even in the "best" practices I saw vitamin and cytamen given, without any reference to need or blood picture.

There is a tendency, perhaps deriving from the patient's wishes rather than that of the doctor, to give "shots" of one kind or another. At certain seasons of the year antisenstivity injections are a major business, and the pollen count is reported daily in the press. School health examinations and immunizations, are carried out in the office without public health authority intervention, and the patient is well educated in these matters. The good and bad effects of the fee-for-service system of remuneration were at times very apparent.

The North American family physician engages in more of the technical clinical investigations which his British counterpart delegates to the outpatient departments of the hospital service. This is, I think, good in so far as it keeps him more au fait with the scientific progress of medicine, but at the same time it may restrict his interest in the family and social aspect of his patient's illness. My overall impression was that the patient gets very much the same standard of medical attention in the average surgery, as he does in Britain; differences in training, equipment, and practice make very little impression on the service finally received by the individual patient. It is perhaps needless to add, that as far as the practitioner is concerned, the American seems to have far less grounds for discontent and frustration than has his British colleague, the National Health Service being geared more to the patient's satisfaction than that of the physician.
General Practice and the Hospital

One of the essential differences between our ways of practice, is the custom of the family doctor in both Canada and America, of admitting and personally treating his cases in hospital. In order, therefore, to practise, it is necessary for the practitioner to have access to hospital beds. I feel that this is a constant stimulus to better clinical medicine on the physician's part, but it is inevitably an expensive way to treat illness, even allowing for the fact that hospitals are not staffed so extensively by specialists. However, in teaching centres the trend is to staff hospitals by full time specialists as it is in this country.

In the hospitals with general-practice wards, the practitioners' "privileges" in the hospital are governed by a committee of his peers, who decide, on his past experience and present practice, what he may do in the various special fields. As specialists gain increasing representation on these committees, it is inevitable that the generalist is gradually finding his privileges cut. In the scheme of things this threatens his whole existence as a practitioner, and one can well understand the tensions existing within the profession. Perhaps the highest form of clinical control in the hospital is the system of accreditation. Under this system the status of the hospital is decided by a centrally appointed committee which reviews standards of record keeping, research, and equipment, and it is approved or otherwise. Only accredited hospitals can attract suitably qualified professional staff.

These factors bring a constant pressure to bear on the staff, who are clinging desperately to the control of medicine, and this is reflected in the exacting degree of self criticism which is applied by the practitioners themselves. Each hospital has a "tissue committee", which is elected by the staff itself, which inspects records, results of work, and makes an actual study of all tissue removed, for comparison with the evidence of the "work-up". Bad and unnecessary work is thereby controlled. A surgeon, whether certificated or general practitioner, who is removing excessive normal tissue, or who is operating without sufficient work-up is called to account for his actions, and if he does not mend his ways, may have his privileges reduced or withdrawn. Self-criticism through these committees is severe, and was quite shocking to me at first sight, but it is the profession's defence against control by political and other forces. They feel that if they do not control themselves, the government will.
After the initial shock, I realized that this is a healthy form of self-discipline, but it made me ponder on the fact that the worst of us in our National Health Service never fear direct censure of our clinical work, which must at times be justifiable. A general practitioner may have to answer for costly prescribing, but there is no judgment of his clinical acumen. Similarly within the hospital service, there is no system of control on unnecessary or poor clinical work, and one cannot imagine such control being tolerated.

Criticism is often made, on both sides of the Atlantic, of excessive bureaucratic control within the National Health Service, but in comparing the two systems I felt that if criticism was justified, it was in the uncontrolled and often extravagant methods of British practice. Our greatest freedom is from interference, by financial considerations, in treatment. This makes our service a costly one, but it is one of the few aspects of National Health Service practice which were envied by many of my American hosts.

**General Practice and the Specialists**

In America, just as the specialist has intruded into the field of general practice, so has the generalist refused to withdraw from the specialist field. There is little in general medicine for which the general practitioner will not assume full responsibility. Cardiovascular disease is very prominent in the average office practice. Many practitioners have their own electrocardiograms and after some postgraduate instruction, read their own tracings. Anticoagulant therapy is instituted, and controlled by laboratory test, without specialist help. Blood chemistry and B.M.R. investigations are just part of office routine, and even when these are not carried out on the premises, they are arranged direct with a laboratory without specialist intervention. The benefit of direct access to laboratory facilities was very apparent here.

Other investigations which he cannot carry out in his office, he can order in his hospital, and he takes great pride in being able to do this. One of his commonest criticisms of our way of practice is that of our lack of access to hospital beds. It is felt that we “lose the case” on its admission to hospital, and show very little interest thereafter. One reason for this belief is that in the United States the case would certainly be taken over by a specialist, who would not in every case refer it back after discharge. My only defence of our system was that I believed that a full time specialist would carry out technical investigations much more efficiently than I could myself,
that I always had access if I wanted, and always received a full report when the patient was discharged. It is my opinion that the family physician has very little place in inpatient hospital care, and has more than enough to do outside the hospital, but it cannot be denied that the hospital practice carried on by the American general practitioner does much to raise his standards of clinical work and professional status.

It is in the field of surgery that this overlap between generalist and specialist has produced most heat, and at the time of my visit this had resulted in open warfare. An eminent member of the American College of Surgeons declared publicly that the general practitioner had no place in surgery, even in the role of an assistant, and the resulting ill feeling was apparent wherever I went. Most general practitioners have very definite ideas about their prowess in the surgical field. This was most obvious in the west and country areas, and less so in teaching centres, in some of which general practitioners' surgical activities had been curtailed almost to that in this country. Circumcision, which is routine in all male babies, and tonsillectomy are almost the generalist's bread and butter. In many regions "simple" appendicectomy and herniotomy are considered well within his capabilities. I met many family doctors who did not draw the line at cholecystectomy or hysterectomy, even when certificated surgeons were available.

In one smaller community I found a certificated surgeon who was forced to carry on family care in addition to surgery in order to make both ends meet, though there was plenty of work for him to do in his own field, if it were referred to him. He spent some time covering his generalist colleagues as assistant, not always receiving the appropriate fee. I heard of this elsewhere as I travelled, but it is probably rare.

One reason for this excessive surgical zeal, is, of course, the fact that the public's image of the successful doctor is the surgeon, and he must live up to his patient's expectations—"My patients expect me to do it, they certainly expect me at least to assist at the operation". Another reason to which I shall refer later, is that the insurance bodies pay very good fees for surgery and so upset natural evolution of medical practice.

For all this, I must say that all the work I saw done by these family doctor surgeons—especially by those of the older generation—was of high quality. This generation is however dying out, and there is little doubt that, apart from remote regions, all surgery will
soon be the prerogative of full-time specialists. It is unfortunate that respected academic bodies should enter into such a violent dispute when future trends are so obvious and inevitable.

While I did meet family practitioners who were tending to exclude obstetrics from their practice because of its ties, the vast majority do a great deal in this field. Domiciliary care, of course, is quite extinct, and every case is delivered in hospital. Even in country districts where the patient may live up to a hundred miles away, she is admitted to hospital a few days prior to the expected day of delivery. I had the opportunity of being present at deliveries and saw that standards are as high as our hospital practice. Spinal anaesthesia at the hands of a specialist is popular, and instrument delivery common. The missing figure here to me was our trained midwife—and this is possibly the reason for the disappearance of domiciliary midwifery. The physician carried out the delivery personally in every case. While there has been recently some suggestion of training midwives on a large scale, especially for the country districts, this had met with strong resistance from the medical profession, many of whom still see the midwife as a nineteenth century Mrs. Gamp. Only ten per cent of babies are breast fed, this being one of the few instances in which the American patient does not respect her physician’s advice. All premature babies are immediately taken under the wing of the paediatrician.

Much gynecology is done in the office, and without exception every office I visited was fully equipped for such work. Manual and speculum examination are part of every routine “check-up”, and most practitioners could mention one case of pre-clinical carcinoma which they had spotted by their routine office cervical smears. The patient expects such examination when she consults her family physician, and does not like to be referred to a specialist on every occasion. It seemed to me that most practitioners performed such examinations with a frequency which would bring a high standard of care, for indeed I saw almost as much clinical gynecology in my visits to generalists’ offices in America as I saw in my undergraduate instruction in the late 1930s.

I was very disappointed to find that the generalist incursion into the specialist field was not pursued in psychiatric illness. Making special inquiry wherever I went, I found that family doctors could be divided into three rough groups. As in Britain, there is a small group who are prepared to recognize and treat their neurotic patients in a positive way, no matter what the cost in time and effort. They
carried out psychotherapy even though they were not paid for it. Another group admitted spending time listening to the psycho-
neurotic, but stated frankly that they overcame the difficulty of remuneration by making essentially false returns to the paying bodies, disguising neurosis as organic illness, or unnecessary investigation in order to qualify for payment. A third group, and this was the majority, said that they had no training or time for such patients. They spent much time and effort, however, in the exclusion of organic disease and tentatively treated with sedation. When this failed to solve the patient’s problem they referred the case to the psychiatrist. That this is not simply a question of lack of training, was illustrated by the predicament of one young practitioner I met in Canada. A recent graduate, he had an excellent training in comprehensive medicine and psychiatry, and was interested in the subject. Having to make a living however, he was unwillingly forced to turn to minor surgery, and was starting up the ladder by learning to do tonsillectomies.

Finance

In Canada, but not in the United States, the problem of cost of hospital care has been faced by the government. Hospital care is now provided in all provinces under a government sponsored scheme financed partly by local taxation and partly by federal grant. This provides for accommodation, nursing, and investigation, but does not include doctors’ fees or drugs, which are still the responsibility of the patient.

The importance of this scheme is that it is the first major step towards a health service, and the patient is already finding it less costly to be treated in hospital, and is bringing various pressures to bear on the practitioner to make full use of it. I was told that in some places hospitals had suddenly become full as they have in this country, relatives finding it more convenient to have invalids removed from the home.

The question of physician’s fee has also been partially solved in Canada, by various provincial insurance schemes such as Physicians’ Services Incorporated (Ontario), Medical Services (Alberta) Incorporated, etc. These are non-profit making insurance projects, originated by the profession itself in each province, which provide for limited medical care by the family doctor. Premium varies according to coverage. These schemes are admitted to be another defence against state financed medicine. The profession feels that it can provide an efficient service of pre-paid medical care,
and that there is no need for government interference. On the other hand it is admitted that what is provided is not a comprehensive health service but only medical care.

Under these schemes the physician, generalist, or specialist is paid an agreed fee for service rendered. Great emphasis is put on organic disease, and surgery especially is well remunerated. Some examples may be of interest:

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office consultation and examination</td>
<td>$8</td>
</tr>
<tr>
<td>Repeat office visit</td>
<td>$3</td>
</tr>
<tr>
<td>House call</td>
<td>$5</td>
</tr>
<tr>
<td>House call (emergency)</td>
<td>$10</td>
</tr>
<tr>
<td>Appendicectomy—general practitioner</td>
<td>$100</td>
</tr>
<tr>
<td>Specialist</td>
<td>$100</td>
</tr>
<tr>
<td>Confinement—general practitioner</td>
<td>$75</td>
</tr>
<tr>
<td>Specialist</td>
<td>$100</td>
</tr>
</tbody>
</table>

Sometimes fees for general practitioner are the same as for specialist; sometimes specialist receives more. These schedules of fees make interesting reading to those of us whose capitation fee converted to fee for service, amounts to not more than 5s. gross. The Canadian physician renders his account for services to the paying body, and receives payment, less a small percentage for collection and normal default.

I had the privilege of visiting the offices of two of these organizations, and had the administration explained to me. Every process is mechanized and each doctor's work can be analysed at any time for cost and frequency, with an efficiency which is terrifying when compared with the working of our prescribing cost committees. If a practitioner appears to be doing excessive home calls, or any other procedure out of normal incidence as compared with his fellows, he can be asked to explain or correct his ways. It was explained that excessive cost in any direction would result in reduction in general fees, as the schemes run at a very narrow margin of profit.

In his hospital care, as previously mentioned, the practitioners' work is continually under review by tissue committees, and excessive unnecessary work as shown by records and pathological check is brought under control. A high proportion of appendicectomies showing no pathology leads to censure. In spite of this, I was assured that there had been no rise in mortality from acute appendicitis.

My chief interest was in psychotherapy, and I was surprised and disappointed to find that this was the only field in which the family
doctor was not paid for his work. In one province I found that while a practitioner was paid $10 for circumcision, $100 for appendicectomy, not to mention cholecystectomy and hysterectomy, he was paid nothing for the most minor efforts in psychiatry. In some areas a fee of $10 had been recommended, but it was rarely paid. I saw an admonition to the practitioner that claims for such a fee should be given careful thought before being rendered. Long term psychotherapy by the family physician has no financial reward whatever, and even in the hands of the specialist is limited. The psychiatrist is paid what seems to be an adequate fee of $15—20 per hour, but there is a ceiling figure to therapy. I was told that this had brought about an increase in the number of patients receiving maximum treatment, and I feel that one might be forgiven doubting the sincerity of the psychotherapist who accepts patients for treatment under these limiting conditions. If then, a practitioner rendered an account with a diagnosis of neurosis, and treatment psychotherapy, he would not be paid—or at most only for an office call.

This was the main weakness of the scheme to my mind. Explanations by the paying bodies varied from, "These neurotics don't need any treatment anyway" to "We should pay for this, but psychotherapy is too nebulous to define for actuarial assessment". However, they have no difficulty in assessing specialist psychotherapy, even though it is limited, and so the latter argument is not tenable. It was also pointed out to me that a very large proportion of the cost of these prepaid plans is made up of first and second office calls, which must be taken up with psychotherapy in any case, irrespective of what returns were made. It might well be that if the paying authorities were prepared to face the incidence and proper treatment of psychoneurotic illness, and to pay for it, there would be a drop in incidence of apparent organic illness and investigation which could be more than compensatory.

Though the above may be over critical of Canadian practice, it must be admitted that conditions under our N.H.S. are little better. All that might be said is that while the British practitioner is also not paid to undertake psychotherapy and has no incentive to do it, there is at least no incentive to be doing other, possibly unnecessary surgical and medical procedures.

One cannot again but be envious of the industry produced by the fee for service system, and of course of the financial return, but to some of us it must appear too open to abuse, and too much an influence on the mode of practice of the family doctor. It was
reassuring to find that some sections of the Canadian profession were quite conscious of these defects and I quote Dr J. Wendell Macleod, whom I met as dean of medicine, at the University of Saskatchewan, and who says (Macleod, 1960):

On the North American continent—the quality of medical care is threatened by two major hazards. One is the overtly technical approach to the problems of the sick person. The second hazard is the upswing—of preoccupation with the financial aspects of medicine—including emphasis on dollar success—our naive faith—in the adequacy under all circumstances of the fee-for-service method of paying the doctor. . . .

Practice in the United States differs from that in Canada in many ways, but the overall picture is much the same. In general practice, although 60-70 per cent of the population may be covered by some form of insurance, there are no schedules of fees, and the practitioner can charge what he likes; the difference between coverage and the actual bill is made up by the patient himself. As a rule all fees are higher than those in Canada, and there is less clinical control on what the physician does. More well-medicine is done in the United States, and regular check-ups are more fashionable.

Hospital care remains a matter for private provision, either from personal resources or through privately financed schemes such as the Blue Cross organization. Physician’s services must be covered by separate insurance, and again medical practice is sometimes guided by the amount of insurance coverage, e.g., a patient might have to forego an electrocardiographic examination which would have been carried out if he had had coverage.

Many industrial organizations, unions, and similar bodies have initiated their own schemes of prepaid health insurance, but few of these are prepared to meet psychiatric illness. Of those brought to my notice which do the St. Louis Labour Health Institute gave most extensive care. In New York two large health insurance bodies have made a move in the direction of covering mental health, but both of these are limited. The Health Insurance Plan of Greater New York provides for one psychiatric consultation only, but no treatment. Another, Group Health Insurance Incorporated, has gone further, and for an experimental period has offered coverage of up to 15 days psychotherapy, and 30 days hospital care. This experiment has proved successful to date and results of two years’ work are expected shortly. Some plans, such as the Kaiser Foundation Health Plan in California, sell their clients low cost psychiatric care as a separate item, and there are similar schemes elsewhere, but these are only drops in the ocean of uncovered mental ill-health.
There is no doubt about the increasing demand for comprehensive health insurance within the community, and the provision of an age-limited health service, tied to Social Security, is part of the present administration's proposals for the current year. This step is vehemently opposed by organized medicine, which, by self imposed blinkers, can see, hear, and say nothing but evil about "socialized" medicine. The situation reminded me vividly of that in this country in 1946-48 before our National Health Service was introduced. I found that practitioners would listen with interest when I spoke of the many faults in our service, but turned a deaf ear to any of the benefits. Of course, when I read articles on conditions under which I was supposed to work at home, written by "Refugees from the N.H.S.", I could understand this attitude.

Prescribing Trends and Drugs

The results of my visits to drug stores were instructive and surprising, and I am grateful to those who gave me access and spent time in discussing trends in prescribing.

I had expected to find large quantities of sedative and tranquillizer in use, but this was not so. Approximately 20 per cent of all prescriptions were of this type, but this figure is no greater than the proportion in our own prescribing. The surprising thing was that the commonest prescription, especially in teaching areas, was for phenobarbitone $\frac{1}{2}$ gr., which I would class as almost placebo in action. On questioning practitioners as to why they had not advanced from this, I was informed that they had on the whole returned to this drug, as the newer drugs had not lived up to their early promise. Of the latter, meprobamate was perhaps the most commonly used in neuroses, with chlorpromazine and other phenothiazine derivatives used sparingly in the psychotic illnesses. The antidepressant drugs appeared very rarely indeed, and all are used in very small quantities. I seldom saw more than 50 tablets prescribed, and often saw prescriptions for 36 or less.

On the whole I found the standard of prescribing high. Anti-histamine drugs were relatively common, reflecting the preoccupation of public and profession with allergy. Strict control is kept of narcotics. A further striking feature was how seldom antibiotics were used, even allowing for the fact that I may have visited in a period free from epidemic. Oral penicillin was the standard drug for both children and adult, and I hardly ever saw a prescription for tetracycline, chloramphenical, or any of the more potent agents.
In my visit to the University of Harvard Family Care Unit I was told that the two thousand items of service, antibiotic was ordered in only eight cases, and these were for penicillin. Even allowing for the fact that the material here was mainly paediatric, and for the erudition of the centre, this was most surprising.

The common analgesics, placebo, vitamin, and iron preparations are available over the counter and need no prescription other than high pressure advertising. Very little pharmacological rubbish is prescribed. The small quantities were explained to me as being a way of keeping control of the patient (although this can be evaded by the habit of shopping from doctor to doctor), and preventing addiction. I was also told that if larger quantities were prescribed, the patient would find the cost prohibitive. The high cost of drugs is giving both doctor and patient good ground for complaint.

The average prescription cost was just over $3, three times that in this country, but when allowance is made for the socio-economic differences between the countries, it could be said to be relatively the same.

My most disturbing thought here was that, although my own costs (to which I pay relatively little attention) are below average, if my prescriptions were placed amongst the samples I saw, they could stand out as being excessive both in quantity and cost. One of the reasons for this might be the fact that in treating more serious illness at home, without such strict clinical control as one would have in hospital, we err on the safe side and prescribe potent drugs often unnecessarily. Another reason for this is that the American practitioner with his extensive clinical investigations to offer in his office, does not feel driven to give unnecessary medication. In this country we have nothing so spectacular to offer, and so bolster our position in our own and in the patient's eyes, by handing out drugs often of doubtful value.

Undergraduate Education, Family Care and Psychiatry

In common with his counterpart in Britain, the medical undergraduate in America had very little training in psychiatry prior to the war. A short course of lectures, covering psychoses and organic syndromes, and a few visits to a mental hospital completed the subject. It was not until after the war years that the subject of mental illness became acceptable to either public or profession, and then public demand forced a rapid expansion. Psychiatry left the confines of the mental hospital to extend into the general ward, and
into all other specialties. It was however for a long time taught in the form of "diseases" or "cases", and the person as a whole was of little interest. Only in recent years has there been an advance from this, to teach psychiatry as a study of people under stress, and further, no longer people in isolation, but within the family group, which itself required study and sometimes treatment.

It was in the field of undergraduate education that I found some of the brightest spots in transatlantic medicine. In several schools, both in Canada and U.S.A., the concept of family care with its emotional stresses and disguised psychiatric problems, has been accepted into the curriculum. The psychodynamics of the doctor-patient relationship, with interview-techniques and other psychotherapeutic tools, is presented to the student throughout many programmes of internal medicine, paediatrics, family care, and psychiatry.

Paradoxically, it is due to the fact that the family doctor of the generalist type has not on the whole been accepted on the staffs of the medical schools, that family care has appeared in the curriculum at all. This is because of the trespass of the internist and the paediatrician into the field. Both are on the academic staff and undertake the teaching of family care. I do not think that either is ideal as a family physician, but the introduction of the subject is welcome as a step in the right direction, and the average internist has a much better psychiatric perspective than has his equivalent in Britain. A healthy aspect of this situation also, is the fact that although the teaching of family care involves much that could come under the domain of the psychiatrist, the latter has not monopolized the subject. I spoke to several departmental heads on this point, and they agreed that as family care involves so much which is within emotional normality, they should be content with the role of supervision and a few lectures in the programme. All this is not to say that the generalist in North America is not qualified to teach. In Canada he certainly is, and the College of General Practice of Canada is working continuously to promote the teaching of family care by the general practitioner.

Similarly in U.S.A. the Academy of General Practice is striving in the same direction, but is having a harder task with a small proportion of generalists. This has not however discouraged exceptional practitioners such as Dr Thos E. Rardin, whom I had the great pleasure of meeting in Columbus, Ohio, and who, as the Chairman of the Section of General Practice of the American Medical
Association, has worked tirelessly in this field. He writes (Rardin, 1961):

It is time that those family doctors capable of dedicated teaching, as well as educators who profess to know the value of family doctors in family practice, get together at the medical school faculty level.

Undergraduate contact with the family, owing to the absence of domiciliary care is difficult, and in only a few instances did I find that the family doctor was used. It is made sometimes at the patient's attendances at an outpatient clinic, sometimes at a birth, or a child's illness may be used as an introduction. The student is encouraged to make at least one home call, but information on the home is usually obtained at second hand through a social worker or nurse.

In Canada my first contact with this enlightened teaching was at the University of Alberta in Edmonton. Here Professor Stanley Greenhill in the Department of Social and Preventive Medicine has initiated a programme of Family Care, some of the aims of which are:

1. To acquaint senior medical students with the importance of interpersonal relationships within the family, as a factor, not only in medical care, but also in symptom production, and
2. To acquaint medical students with the concept of using the family as a unit of study, rather than just the individual patient.

While some carefully chosen family practitioners are co-operating in the scheme, the key personnel are listed as the internist, the paediatrician, and the psychiatrist. It is to be remembered that the first two undertake a proportion of the family care in North America.

Again in Vancouver the Faculty of Medicine of the University of British Columbia has introduced a form of family care teaching, where each student is assigned a family which he follows in health and sickness, for a period of at least twelve months. Tutors in this course represent the departments of psychiatry, paediatrics, obstetrics, preventive medicine, internal medicine, surgery—and two are from general practice. It was here too that I found the junior student being introduced at a very early stage, to the psychodynamics of the doctor-patient relationship and other psychotherapeutic principles.

After entering the United States I did not encounter this kind of teaching again until I reached Ohio, where at Western Reserve University Medical School the fourth year student is introduced to the comprehensive care of the patient in an "Ambulatory Clerkship". Here all aspects of personal and family care are taught under the
supervision of a team of internist, surgeon, psychiatrist, gynecologist, and dermatologist. The junior students are introduced to the family at the birth of a baby and follow its progress thereafter in a most general way. It was here also that my enthusiasm received a set back, when I found that while family and home influences were being demonstrated, the object was not to produce a family doctor, but a better orientated specialist. Family doctors were excluded from the tutors.

I came across a similar situation in Boston, in the Family Health Care Programme of Harvard Medical School, where comprehensive family care was again taught, involving departments of medicine, obstetrics, paediatrics, and public health. Introduction to the family here occurred at the point of a child’s illness, and attention spread from there to the whole family. While here again, alas, the emphasis is on a better qualified specialist, better because of his family knowledge, it is of interest to quote from the original proposal of this scheme:

> Although medical science rather than medical practice has been the principal subject of research, we believe the latter deserves serious attention. Our present patterns of practice and specialization have evolved in answer to the needs of a previous period. *Even though a physician may practise a specialty, it is our experience that the best care results when the family focus of medical care is maintained.*

There is then, recognition in medical schools of the importance of family care, but owing to the pattern of specialization in recent years, in America they are finding it difficult to supply the necessary teachers of the subject. The work is being done by a team of experts who, though they undertake some family care, are only intruders in the field.

In Britain, we do not now have these internist-paediatric-family practitioners, with broad enough background to teach comprehensive family care, but we do have still a large body of genuine family doctors who could be encouraged by contact with hospital, and postgraduate instruction to enter the academic field, and teach their successors for the future.

The internist in American then, has withdrawn from surgery, obstetrics, and paediatrics, but has found that he has had to advance into psychiatry and family care. The paediatrician has had to make similar changes in his perspective. The psychiatrist also is in a quandary. He has two roles to play, either as the traditional specialist in mental disease, or as the psychiatrist-internist who works as a sub-physician in all other departments of medicine. His is the only
specialty which is common to all others, and so most apt to the interest of the general-practitioner family physician.

Extreme specialization, at least in the case of the internist, paediatrician, and psychiatrist, has been forced to a halt by the realities of the community's needs. Even the occasional surgeon has found his way into psychiatric seminars. All are turning back to a more comprehensive medicine—back towards the general practice from which they came.

There is a lesson in this for us in Britain, not to follow too closely the American pattern of over-specialization, and to bring the drift in that direction to a halt, before it is too late. One also gets from the American scene a clear picture of what the basic training of a family physician should be. There should be a sound grounding in internal medicine—including paediatrics and geriatrics, as age grouping is pointless; a very broad knowledge of psychiatry is essential, and much more emphasis must be put on normal emotional reactions, interpersonality relationships within the family, and between doctor and patient; interview technique and superficial psychotherapy are essential tools for the family doctor. All these "fringe" subjects must be taught with orientation towards the home and family circle rather than towards hospitalization.

Before leaving the subject of undergraduate teaching something might be said of the teaching of "pure" psychiatry. In nearly all medical schools the subject is presented throughout the whole four years of clinical curriculum, and there is continuous correlation with all the other subjects.

A majority of the teachers have an analytic approach, and many have had a personal analysis. There is no dogmatism however, and the teaching on the whole is eclectic. While it is accepted that a personal analysis is beneficial to one's handling of a psychiatric illness, even the most ardent Freudian I met would admit that it was not a sine qua non for good general psychiatry. Most teachers admitted that there had been a swing away from the extreme psychoanalytic standpoint. I visited one or two schools where the emphasis was more on the physical and biochemical treatments, and couldn't say that their dogmatism was in any way less than that attributed to their opponents.

There was everywhere friendly liaison between psychiatry and the other departments of medicine, and in several schools, residents in psychiatry were seconded to each of the other departments, as part
of their training. Classes were small; a common practice was to teach in groups of 6-8 students, with one student presenting a case which was then open to criticism by the group. This method, if carried on in a frank enough atmosphere, encouraged insight into the students own personal problems, and the handling of these is no small responsibility of the tutor.

One way screens are used extensively in teaching the art of interviewing and in some schools television issued. While patients are usually of the lowest income groups, this is not universal, and in one school all teaching was done on private patients. In every instance I was conscious of continuous experimentation and evaluation of teaching method. The student is often asked to report on his benefit from, and reaction to, the instruction. The present and future graduate will never again be able to excuse his practice by lack of training.

**Postgraduate Education in Psychiatry**

Both family physician and psychiatrist know that the complex skills required to manage emotions, related to medical and surgical illness cannot be learned from a text-book, journal or incidental lecture alone, nor are they born full blown from the good intentions of a loving doctor (Sheeley, 1960).

A recent joint commission survey estimates that some 17½ million persons in the United States suffer from nervous or mental illness of such significance as to warrant treatment. Most medical undergraduate curricula are now providing a basis of training which should greatly improve the general physician’s handling of this problem. However, as this dates only from the past ten years there is a tremendous back-log of neglected training to be made up.

The American Psychiatric Association and the American Academy of General Practice have recognized this, and in collaboration with other bodies have been working together to provide programmes of postgraduate education in psychiatry. These take the form of lectures, seminars, supervised group studies, and clinical meetings. The goal of these efforts is to give the non-psychiatric physician some practical indoctrination so that he will be better able to recognize and handle the ever present psychiatry in his general work.

The federal government in the United States has expanded its activities in the field of psychiatry by offering financial assistance in many of these projects. In its efforts to overcome the shortage of trained psychiatrists a scheme was introduced of subsidizing suitable general practitioners, over a period of psychiatric training, with the view to specialization. This I think is an error, as a well-trained
general practitioner treating his own cases properly is of more value to the community than an inadequately trained specialist. "The need today is not so much for more psychiatrists as for more comprehensive doctoring" (Watters, 1961).

One of the most striking things in my journey throughout the whole of North America, was the amount of general postgraduate education undertaken by the average physician. All hospitals, whether staffed by generalist or specialist, provide regular seminars, clinical meetings and lectures, at which everyone is duty bound to attend. The motive for attendance varies from sheer enthusiasm—I met practitioners who thought nothing of driving 120 miles to an evening meeting—to mild coercion, reflected in the fact that both the Academy of General Practice in America, and the College of General Practice of Canada, keep a very strict record of work, done by members. I heard of courses taking place between 8 and 9 a.m. so as not to interfere with the day’s work.

In the field of psychiatry unfortunately, attendance at postgraduate courses is relatively poor. In Ontario, of over a hundred practitioners invited, only 11 accepted; in the Detroit region, I was told that out of a medical population of 2,500, only 30-40 practitioners attended courses in psychiatry, and, when repeated, the result was only half this number.

In Seattle I had the opportunity of visiting the University of Washington, and was told something of the postgraduate educational opportunities of the local practitioners. Here I was given a most interesting survey on “The General Practitioner and the Emotionally Disturbed Patient”, by Dr J. B. Taylor, of the Washington Public Opinion Laboratory. Some of the findings of this survey were:

Physicians felt that 30-40 per cent of their patients suffered some significant emotional disturbance. . . . Less than half of the physicians desired any further training in psychiatry, and only 13 per cent felt a strong need for it. . . . A majority of general practitioners have major reservations about the adequacy of psychiatry as a medical discipline. . . . That modern medical practice is based on a smooth flow of patients through a complex clinical setting. Emotionally disturbed patients with their unreasonable demands on time, disrupt this flow, and produce a financial loss.

This reflection of medical opinion was commonly encountered throughout the whole of the U.S.A. It is based I think on a poor relationship between the practitioner and the psychiatrist. Both are full of good intention, but they lack a common language. The psychiatrist does not know what the practitioner wants, and the practitioner is not too sure himself. It derives from postgraduate
instruction in the form of pontifical lecture, with little relation to the family doctor's every-day work.

For all this, there were many very bright spots in the picture which promise much for the future. In Saskatchewan University Medical School, Professor D. G. McKerracher, who has always upheld the importance of the family doctor in the psychiatric field, has given facilities to a family doctor to admit and treat his own cases in the psychiatric ward, as a full member of the staff. This experiment has shown that the general practitioner is perfectly capable of holding his own in psychiatry, with only occasional support from the specialist.

At first sight I reacted unfavourably towards this arrangement, as I believe that the practitioner's role in hospital inpatient care is limited, but viewed against a perspective of a system whereby every doctor admits and treats his bed cases in hospital, I could see no reason why psychiatry should be excluded. Professor McKerracher has been doing everything he can to persuade the government authorities, who are at present enquiring by Royal Commission into future health services, to recognize the fact that the family doctor, if given training time and incentive, could carry out treatment of mental illness in 80 per cent of cases, and leave the rest to the proper care of the specialist.

In Edmonton I encountered a most enthusiastic group of family doctors, who, in addition to offering services in undergraduate teaching, were themselves producing a comprehensive seminar in psychosomatic medicine. Not the least impressive feature of this effort, was that the initiative appeared to come from within the ranks of the practitioners themselves, and the speakers were, for the great part, family doctors. Subjects included "The heart and the emotions", "Starting and stopping the patient talking", "The patient with insomnia", "Patient manipulation of the doctor", etc. These are the subjects of real general-practice psychiatry. I was very envious of the enthusiasm and energy here, and it was present over a large part of the west of Canada, leaving me with the conviction that here I was seeing the best family care of my tour.

In the United States, I did not encounter anything of this type of self education, but I had my first experience of group indoctrination after the form taught by Dr Michael Balint of the Tavistock Clinic. This has "caught on" in many parts of the country, and to me seemed the most promising form of education—far exceeding the didactic lecture type of programme in value. Indeed as mentioned
above, the traditional form of teaching appeared to me to be the main cause of the general resistance to psychiatry.

I was first to meet group instruction in the University of California Medical School, at the Langley Porter Institute of San Francisco. Here a twelve weekly course of five hours a day, is held every three months.

The course, attended by a limit of twelve practitioners consists of weekly interviews with patients, supported by individual hours of supervision and consultation with a faculty member, with joint reviews of all patients. Course participants may attend the weekly staff conferences at the Institute. It is designed to give physicians a grasp of psychodynamic principles and psychotherapeutic skills applicable to both physical and mental illness. I attended one of these meetings and came away very impressed, the more so as I found normally heretic surgeons attending.

As we went south through the country districts of California and New Mexico, I found the general practitioners too busy and over-supplied with physical illness to have much time for the neurotic. Treatment was limited to sedative or tranquilizer, and if this failed the patient was referred to the psychiatrist where available. In this region I found little in the way of organized postgraduate instruction for the family doctor in psychiatry, although I was given to understand that in Texas undergraduate teaching compared at least favourably with other parts, and a large proportion of graduates turned to psychiatry. In this state too, figures suggested that since 1950 at any rate, there had been a swing back from specialization to general practice.

I was again to find group instruction of non-psychiatric physicians organized in New Orleans under the guidance of Dr T. A. Watters of the State University of Louisiana. This was again on the lines of that described at the Langley Porter Institute at San Francisco, but in this instance there was no limit set on the exercise, and one group had been in existence for more than five years and had resisted attempts to break it up. Again I was impressed by the enthusiasm of the group, which was made up of generalists, internists, paediatrician and a surgeon, but I was left in some doubt as to the value of prolonging the activity to such an extent. It seemed that in this instance a great deal of effort was being spent in preaching to the converted, and the majority of practitioners who needed instruction was left untouched.

From New Orleans calls at several smaller community centres
brought us to Kansas City, headquarters of the American Academy of General Practice. Here I took the opportunity of visiting the renowned Menninger Psychiatric Clinic at Topeka. This region was disappointing to me in so far as I could find little evidence of liaison between the psychiatrist and the family doctor. This was one of the few places in which I was unable to contact a family physician who was interested in psychiatry, and it seemed that everyone, including teachers, lawyers, business executives, were indoctrinated in psychiatry, but not the family physician.

Two more active groups were encountered later in New York, one at Mount Sinai Hospital with Dr Mr. R. Kaufman, and one sponsored by the Medical Society of the County of Kings, the Brooklyn Psychiatric Society, and the Brooklyn Chapter of the American Academy of General Practice. In each case the supervisor was an analytically orientated psychiatrist, and the group a mixed class of general physicians. A member of the group presented one of his own cases which served as a basis for discussion and illustration of the psychodynamics of the patient’s illness and also of the physician’s treatment.

An interesting feature of these postgraduate courses was that very few of those attending graduated after 1947. Two reasons might be offered for this; in the first place the older groups were ready to admit that their training was deficient. The other reason is that it might well take 15-20 years for a practitioner to admit that a large part of his work is concerned with emotional and neurotic illness. Perhaps also, the younger graduate has benefited from his modern teaching and does not wish to return so early to continued education.

I visited several private mental institutions, each caring for less than 100 patients, and some of these, for instance the Carrier Clinic of New Jersey, are playing an active part in the postgraduate field by offering seminars and clinical demonstrations in psychiatry for general practitioners.

To summarize, it appears that there are only two methods of postgraduate instruction open to the family doctor—that of didactic lectures, and that of group indoctrination under the direction of a trained psychiatrist. The former is easy for both teacher and pupil, but both lack common ground on which to work, and the result is often increasing resistance to the subject. The latter method gives excellent results, but is time consuming, and can appeal to only a small proportion of established practitioners. The only answer in my opinion, is in undergraduate education—to turn out a properly
trained doctor from the start, and to modify his conditions of work so that he can apply his knowledge throughout the whole of his professional life in the way he was taught.

**Summary and Conclusion**

A journey of almost 15,000 miles makes it difficult to do other than generalize. One cannot compare in detail, as owing to the heterogeneous nature of the country, findings in one part will almost certainly be contradicted in another. One must remember that medical practice is to some extent decided or modified by social custom and national "way of life". What suits a compact homogeneous community like ours, will not necessarily work in a country like North America. Of the two American communities, Canada, having something of both our cultures, has the opportunity of evolving the best system of community health, if she can extract the good parts of both.

I could not but be impressed by the energy and industry which obviously stemmed from a system in which some return was immediately apparent from hard and good work. I envied the constant contact with the hospital, and, although I realized that more treatment could be carried out in the home, the constant stimulus of meeting and collaborating with hospital colleagues made for a higher standard of clinical acumen. This increased by constant healthy self-criticism which is absent in the British system.

Equipment was everywhere lavish and staffing efficient, especially in the cities where one or two of the general practitioners' establishments outdid some of our hospital amenities. But lest this add to the criticism of our outdated hospitals, I must say that in one or two mental hospitals in the United States I found conditions just as delapidated as in our oldest, and the staffing problem in state mental hospitals leads in many cases to little more than custodial care.

After experiencing such wonderful hospitality and unstinted kindness, it seems churlish even to mention aspects of American medicine which made an unfavourable impression, but it would be unrealistic not to do so.

While very conscious of the failings of the capitation form of remuneration in our National Health Service, I did not see the answer to this problem in the fee-for-service method of payment. It certainly stimulates effort, and prevents much of the frustration and discontent felt by some British practitioners, but it is flagrantly open to abuse, and has a noticeable effect on the patient's treatment which
is not always beneficial to him.

In the field of medical education I was left in no doubt as to the superiority of the transatlantic curriculum. I was particularly impressed by the teaching of family care and comprehensive psychiatry which pervaded the whole field of medicine. This teaching contributes to a graduate who is better equipped for practice than his British counterpart. If however one has to decide on whether the community gets better overall medical care in North America or in the United Kingdom, I think there is no doubt whatever that the British system gives the better service. The excellent product of the American medical school is spoilt in the delivery of his services to the community. The individual American can purchase a very high standard of medical attention, but community care is another matter. Perhaps this is a reflection of our greater national social consciousness, with less emphasis on financial incentive and the rights of free enterprise. Both systems have their good and bad points and if we work to develop the former and reduce the latter, there seems little doubt that both communities will, in the near future, arrive at much the same point in the road to comprehensive medical care.

As to the question of psychiatric care by the family doctor, I found that the quotations mentioned in my introductory remarks were largely true. As in Britain, there is still a common attitude of rejection towards the psychoneurotic patient, with the excuse that his treatment is too time consuming and frustrating. Even where training is now not lacking, conditions of practice tend to prevent the best treatment. Physicians are only human, and if the community pays them well for engaging in organic medicine and surgery, and nothing for treating mental and emotional illness, they cannot be blamed for engaging in the former. The blame rests, as it does in this country, in the conditions of work, which are not the sole responsibility of the medical profession. I felt strongly that the insurance bodies could do much to correct this situation if, as surgical privilege is withdrawn from the general practitioner, some recognition and incentive were given to his proper role in the field of psychotherapy, both prophylactic and curative.

In postgraduate education, while much energy and time is spent in teaching psychiatry, only a small proportion of established physicians are able to profit from it. Perhaps it is over ambitious to try to convert the mass of organically indoctrinated family
practitioners, and the main hope is in undergraduate training, so that they have adequate psychiatric training from the start.

As to future trends, I have no fear about the future of the family physician. The generalist in Britain is dead, and in North America is dying, to be replaced by the concept of the family physician. This concept is partly developed in Britain already, from the old general practitioner, and in America from both generalist and specialist of whom the latter is retracing his steps towards more general knowledge. Family care is becoming a recognized subject of academic interest, and if the medical schools play their part in training, with the community providing conditions of work in which this can be efficiently translated into service, the family doctor will continue to be, as he was in the past, the corner-stone of community medical care.

Acknowledgment

I will not attempt to list all to whom I am indebted for the immense amount of help and hospitality received by us in our journey. I hope I was able, though I am sure quite inadequately, to thank most of them personally. We hope that all our newly made friendships will be permanent—and will not be affected by any disagreement with opinions expressed in this report.

One cannot close however without mention of some; of all the members of the College of General Practice of Canada who did so much for us, especially of their indefatigable director Dr W. V. Johnston; of Professor D. G. McKerracher and his colleagues in Saskatchewan; of Dr Pat. Rose and Professor Stanley Greenhill in Edmonton, and of Dr Tim McCoy in Vancouver.

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