A British view of American family practice

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SUMMARY. I report my impressions, as a British doctor, of American family practice and describe training schemes for family practice and the American approach to assessment and continuing education.

Introduction

FAMILY practice is the American term for general practice. During a recent visit to the USA, I observed family practice and family-practice training programmes and discussed my impressions with some of the people involved.

Marsh (1976) considered that American family physicians (or practitioners) and British general practitioners are doing broadly similar jobs. I agree, but, in discussing my impressions, I emphasize those aspects of American practice which differ most markedly from British practice, such as the facilities and income available to a family practitioner, the design of training programmes, and the approach to assessment, continuing education, and audit.

American family practice

Almost all family physicians are in private practice and compete for patients with other primary care physicians such as paediatricians, obstetricians, 'internists' (general physicians), as well as with other family physicians. Most work in groups, usually with other family physicians but sometimes with primary care or other specialists.

American patients may attend any family physician or specialist who offers his services. This open access to specialists has led to an organ system approach and dissatisfaction with this by patients has probably contributed to the resurgence of American family practice. The use of the term family physician signifies an ability to treat the individual members of a family rather than a specific approach to family dynamics. Many patients still prefer to choose specialists directly.

The family physician practises from his own modern suite of rooms, his 'office'. A single doctor will have several office staff and nurses to assist him. He may be equipped with problem orientated medical records. He will have an ECG machine, peak-flow meter, tonometer, microscope, and centrifuge, with direct access for further investigations. Patients are seen by appointment, except in an emergency. Usually when a patient attends the office he may be seen initially by a nurse who questions him and undertakes some investigations, such as taking the blood pressure and temperature. In some practices the patient may be seen by a nurse practitioner who investigates, makes a diagnosis, and starts simple treatment under the supervision of a physician.

After initial screening the patient is seen by the physician. The 'work-up' of the patient is similar to that in Britain, although the physical examination and laboratory investigations may be more comprehensive. Each investigation ordered by the doctor (and some are ordered purely for medico-legal reasons) is charged to the patient. The doctor charges for his services according to the amount of time and skill involved. The cost is paid from the patient's own pocket or by one of a number of insurance schemes. The federally funded schemes are unpopular with many doctors, some of whom refuse to see patients under the Medicare or Medicaid schemes, because they involve much paperwork and are open to abuse by patients and doctors. There is no doubt that the impoverished patient with no Medicare, Medicaid, or private medical insurance is at a disadvantage. (Medicare is a social security insurance for all people over 65 years of age; Medicaid is a tax-supported programme for poor people.)

The same illnesses send patients to their doctor in Britain and America (Marsh, 1976). The American doctor sees less of the elderly and the chronically ill, but more of the well patient. The well baby is seen by the doctor at birth, two, four, six, nine, and 12 months. The healthy adult often has a complete physical examination and the middle-aged American executive is well known for his annual check-up. There is a small but growing tendency to abandon regular screening examinations for the healthy adult. Screening programmes for the elderly are rare.

Hospital 'privileges', which most family physicians obtain if they wish, allow the doctor to admit his patients to the hospital under his care and he can continue to look after patients with acute medical problems beyond the point at which most British general practitioners would relinquish the care of their patients if they were admitted to hospital.

A request for a specialist opinion produces just that: an assessment is offered and advice given. The family physician does not have to 'hand over' the care of his patient in order to obtain the specialist opinion.

The same range of maternity services as is offered in Britain is available in America. The doctor who chooses to provide complete maternity services performs his own deliveries since midwives generally perform a more subsidiary role than they do in Britain.

Home visits are rare. Patients calling out of hours are seen in the emergency room (casualty department) of the local hospital in which the doctor has privileges.

Educating patients and patient 'compliance' are seen as important and interrelated subjects. Many doctors provide an abundance of informative leaflets for their patients on a variety of illnesses. Some have lending libraries designed for lay people. Nurses are trained to 'educate' people with certain conditions, such as urinary tract infections. They ensure that the patient understands his illness and treatment and is aware of the adverse effects of drugs, prophylactic measures, and how to recognize exacerbations. All this is usually done according to a protocol so that the information is provided in a comprehensive, systematic way. This education of patients, it is hoped, leads to greater patient compliance, leading in turn to an improved cure rate and a reduction in the frequency of recurrence of the conditions. Unfortunately, the growth of such patient education has not been accompanied by rigorous evaluation, although it is mostly practised in university departments.

Training for family practice

I feel that British and American students reach approximately similar standards by the time they graduate. Generally, the 'internship'—the equivalent of the British pre-registration year—has been abolished and replaced by the first year of a residency programme; therefore, the American doctor starts his general-practice training immediately after graduation.

There are now more than 280 family-practice residences in the USA with over 4,700 residents. These residencies, or programmes, are based on family-practice departments which are often also university departments situated near general hospitals. Many university departments are paid for by states which lack family physicians. In addition to the usual range of equipment, they may have computerized information retrieval systems and laboratories capable of carrying out simple haematological and bacteriological investigations. All have problem orientated medical records.

All departments are well staffed with ancillary workers. Larger, usually university, departments may include on the staff educational and clinical psychologists, social workers, ministers of religion, and sometimes a number of full-time or part-time physicians from specialties such as psychiatry or paediatrics. Residents are supervised by experienced general practitioners. One supervisor to three or four residents may be an average figure but other factors, such as undergraduate teaching, may affect this.

The newly graduated doctor joins such a family-practice department as a first-year resident. In most states he is, as yet, unlicensed. To obtain a medical licence he must pass a national examination and complete the first year of his residency.

In the first year, about 80 per cent of the resident's time is consumed by junior hospital posts and he rotates in turn through such specialties as medicine, surgery, paediatrics, and obstetrics. The resident does on-call duties for these specialties and for family practice. The equivalent of one or two half-days per week is spent in the family-practice department caring for a small personal 'list' of perhaps 50 families. In this first year, the resident is carefully supervised, attention being paid to his skill at taking a history and examining the patient. Much assistance from supervising physicians is necessary at this stage, both for office visits and for out-of-hours calls.

During the second year, the resident divides his time more equally between family practice and other commitments. His personal list now comprises about 100 families. The possession of a medical licence and a year's experience allows some relaxation of supervision. Outside the family-practice centre, experience is gained by further rotation. This may be based on more hospital inpatient work or may be in the offices of private physicians. Like the first-year rotation it may be fixed, or it may be chosen by the resident. The choice in this and the third year will be influenced by the need to rectify omissions in training or by the desire to develop special skills or interests: for example, the would-be single-handed rural practitioner may wish to acquire competence at performing caesarean or emergency surgery.

In the third year, the resident spends about 60-80 per cent of his time in the family-practice department caring for about 250 families. By now, he is capable of working on his own, requesting advice only for special problems. During this year, he devotes the majority of his time to the department, but he may be expected to spend one month as a locum for a physician in private practice. Approximately one or two days a week are spent in specialists' offices.

Throughout the three-year residency, the resident has access to hospital beds and is encouraged to admit his patients and seek advice, if necessary, either from his supervisors or from specialists.

Also throughout the three years, the department runs a number of seminars each week. These may be given by

members of the department or by outside specialists who may be medical or non-medical. Talks may be individual or part of a systematic course of instruction. For example, psychiatry is often dealt with in this latter way with little practical experience in psychiatry outside the family-practice department. There are case conferences and journal clubs.

On completing the residency programme the new family physician will have little difficulty in obtaining a post and earning over £30,000 net a year. He may join his professional body, the American Academy of Family Physicians (AAFP) and present himself for assessment by a separate organization, the American Board of Family Practice.

The role of the Academy is broadly similar to that of the Royal College of General Practitioners: it is involved in the recruitment and training of family physicians, the maintenance of medical and economic standards, and the provision of continuing medical education and research. It is an avowedly political organization with its own Washington lobbyists.

Like the RCGP, the Academy must be satisfied with the training of applicants for membership. The candidate must have completed a three-year training programme or an approved equivalent. If the candidate can meet certain other requirements, then he is admitted to membership of the Academy for three years. A member must be re-elected every three years and, to be eligible for re-election, must have completed during that period at least 150 hours of study acceptable to the Academy. These hours can be obtained in various ways; for example, by attendance at approved courses, as in Britain, or by reading an article in an approved magazine and then submitting for marking a completed multiple choice question paper based on the relevant article. Several hours of credited study may be regularly accumulated in this way. It can be seen that the Academy is more explicit in its approach to continuing medical education than the RCGP.

Unlike the RCGP, the Academy is not an examining body. This is a function of the American Board of Family Practice. At present, there are various ways to establish eligibility to take the examination. From 1978, however, all candidates will be required to have completed an approved three-year residency in family practice. Success in the examination leads to certification as a specialist in family practice. Certification must be renewed every six years by an examination based on medical advances in the intervening period and by a medical audit of the candidate's practice. The Board serves primarily as an examining body but also concerns itself with education and training standards.

Some states now require evidence of continuing medical education as a condition of medical relicensure.

Membership of the AAFP and Board certification is voluntary but is becoming more common. With the growing interest in consumer affairs and the publication of consumers' guides to physicians, certification can be seen to be of practical value.

Discussion

Many of the ways in which the American approach to the practice of and training for family practice differ from the British approach are due to the pre-existing system of practice and training from which they have evolved rather than to any radically new appraisal, and this must be borne in mind when making comparisons.

I draw no conclusions, but I hope I have given the reader some cause for reflection.

Reference

Marsh, G. N., Wallace, R. B. & Whewell, J. (1976). *British Medical Journal*, **1**, 1321-1325.

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Royal Commission evidence

There is also urgent need for some reconciliation of the apparently opposing philosophies of the trade unions and the professional associations. The latter are firmly convinced that the maintenance of professional standards and the development of a spirit of service are inseparable from the achievement of acceptable standards of pay and conditions and that consequently the same organizations must be directly involved in both functions. The unions contend that the two functions should be pursued quite separately and by different organizations, the first by professional associations and the second exclusively by trade unions.

The arguments will lose some of their force as the professional associations adopt the legal status of trade unions but the welfare of the NHS demands a solution of this unnecessary and harmful conflict.

Reference

Joint Committee of Professional Nursing and Midwifery Associations (1977). Evidence to the Royal Commission on the NHS.

All prescribing should be in generic terms, for reasons both of economy and of patient safety. They suggest that prescribing by brand name removes the safeguard of knowing what therapeutic class of drug is being prescribed. They claim bioavailability variation between generic brands occurs in only a small number of drugs.

Reference

The Regional Pharmaceutical Officers (1977). *The Pharmaceutical Journal*, **218**, 311.