Family practice in the USA: a better tomorrow?

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DURING the 1950s and early 1960s general practitioners in the USA found their numbers were dwindling and their future was in question. Scientific and clinical advances had brought about the belief that no physician could train himself adequately in all aspects of medicine, and only one of every 10 medical students planned to enter general practice. Medical education made little attempt to support general practice and one eminent physician, while lamenting this situation, wrote: "In the minds of many academicians the word 'general practitioner' evoked thalamic responses that precluded thought" (White, 1968).

Unlike the UK, general practitioners in the USA have never had a monopoly in primary care, the latter being defined as internal medicine, paediatrics, and family practice. Obstetrics/gynaecology does not have the official stamp of primary care, but for all intents and purposes functions as a front-line specialty. For some time it appeared that internal medicine and paediatrics were ready to assign a sizeable proportion of primary care to physician assistants and nurse practitioners, and it is interesting to note that primary care was finally embraced by internists after direct legislative funding of family practice training programmes.

It was against this background that general practitioners of yesteryear struggled to retain respect. Reports in the mid-1960s from the American Medical Association (1966a and b) and the National Commission on Community Health Services (1966) stimulated debate about the future, and general practice was finally designated as American medicine's twentieth specialty in 1969. The lingering disquiet about the implied association between inadequate care and 'general practice' subsequently led to a change in name, and in 1972 the American Academy of General Practice became the American Academy of Family Physicians.

Since then the growth in undergraduate and residency training (vocational training) in family practice has been phenomenal: by 1977 family practice courses and clerkships had been included in the undergraduate curricula of 85 per cent of medical schools, and approved family practice training programmes had been created in over 300 centres. With yesterday's struggle for acceptance over, family practice may now be entering an era when it will have a major impact on tomorrow's health care services in America.

Content of family practice

It would be impossible to generalize about the content of family practice in a huge continent of contrasting cultures still dominated by medicine of the marketplace. The spirit of free enterprise prevails, and fee for service is still considered by the majority of physicians as an essential component of the doctor/patient relationship. In a country where competition thrives and symbols are a necessary adjunct to any movement searching for identity, the family practice movement frequently emphasizes the family component of the family doctor's clinical territory (Rakel, 1977; Medalie, 1978; Geyman, 1978). The mother/father/children motif (Figure 1) of the American Academy of Family Physicians, which reinforces this family concept of care, has a certain irony at a time when the extended family has all but disappeared, divorce rates continue to increase, and the mobility of American life threatens the structure of the nuclear family. If one were to assume that the family doctor provided direct service to several or all members of a given family unit, then many of the family physicians in the United States would be excluded.

A large-scale workload study (Marsland *et al.*, 1976) provided information about the clinical content of family practice, showing that five conditions accounted for one quarter of all problems encountered, with a further 561 clinical entities being responsible for the remaining three quarters, thus highlighting the wide range of conditions dealt with by family doctors. In contrast with the United Kingdom, the most frequent doctor/patient consultation was for medical examination for preventive purposes; such consultations accounted for almost 10 per cent of all patient visits to family physicians. The most common illnesses encountered were pharyngitis, acute bronchitis, benign hypertension, and lacerations and abrasions. Apart from rural areas, obstetrics, including antenatal care, is often conducted by specialist obstetricians and there is much less home visiting than in the past.

Marsh and colleagues (1976) have described contrasts

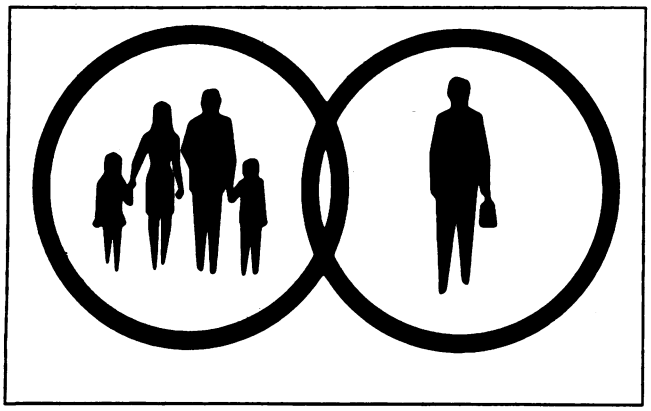


Figure 1. *Logogram of the American Academy of Family Physicians.*

in Iowa and North-East England and confirmed the findings of Mechanic (1972) that the American primary care physician is more orientated towards physical examination, laboratory investigations, and hospital support. The American family doctor still jealously guards his hospital privileges, which are regarded as a means of maintaining clinical skills and an essential part of continuity of care. In a fee-for-service system the American family doctor is encouraged to extend the horizons of his care and is keen to retain technical skill.

Time studies (Parrish *et al.*, 1967; Brody and Stokes, 1970; National Ambulatory Care Survey, 1974; Buchan and Richardson, 1973) have shown that American family physicians spend about twice as long with office (surgery) patients as their British counterparts, and this may be a further reflection of the more detailed process of patient management in America. There are other variables to be considered when comparing physicians' use of time in different settings. In the absence of home visiting in the United States, all stages of illness are handled in the office or consulting room and continuity of care for chronic conditions such as hypertension and diabetes is often undertaken by the family doctor with no concurrent outpatient involvement. In a fee-for-service system the American physician is under pressure to resolve all presenting problems at one consultation and is less likely to adopt a 'wait-and-see' policy. Differences in the social class distribution of the respective patient population seen by American and British physicians may be a factor which requires closer scrutiny, as there is no doubt that the family doctor in the USA has greater freedom to choose the patients he wishes to treat, and many still refuse to take responsibility for low income groups. Despite differences in time spent with patients, the prescribing habits of American and British general practitioners show striking similarities, with antibiotics and psychotherapeutic agents accounting for 30 per cent of all prescriptions (Stolley *et al.*, 1972; Bain and Haines, 1975).

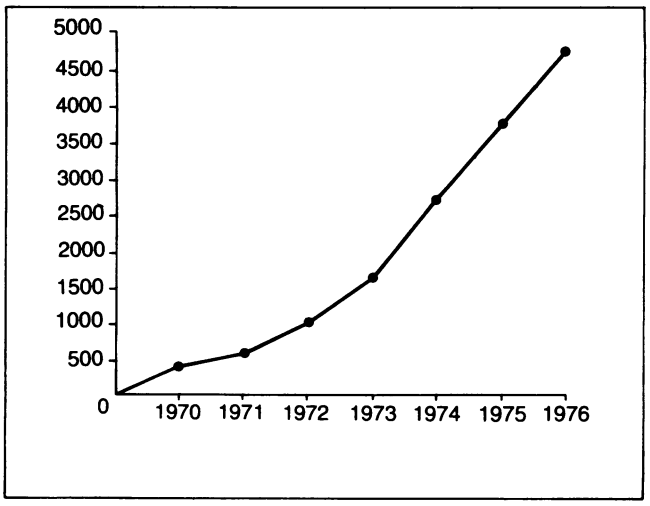
Morbidity statistics and prescribing rates can outline the content of practice, but give little indication of the style of American private practice. To British eyes, physicians' offices instil feelings of awe and disbelief, with consulting rooms littered with sophisticated equipment and the walls adorned with diplomas, certificates, and citations of excellence. The patient is left in little doubt about the physician's self-image, an image that is somewhat tarnished by the current wave of malpractice suits. Defensive medicine is now a sad feature of current medical practice in the United States, and the family doctor is not immune from litigation.

Training for family practice

The majority of medical schools have a four-year undergraduate course, and 85 per cent of centres have allocated teaching time for family practice throughout the years of medical training. The extent of training varies from four to eight weeks, and by the use of electives a number of students have even more undergraduate experience in family practice. With no mandatory intern year, students have to choose their residency training specialty in their final year at medical school. There is no shortage of applicants for family practice training programmes and Figure 2 shows the rapid expansion in the number of family practice residents since 1969.

Residency training (vocational training) lasts three years, and the focal point of training is a model family practice unit which serves a similar function to a large health centre in Britain. These model training centres are staffed by physicians in training who are supervised by full-time members of departments of family practice. The first year of training takes the form of a rotating hospital internship, with one half day per week in the family practice centre. The second and third years consist of further experience in specialty units and electives, with a proportionate increase in time spent in the ambulatory care centre. By the third year of training, each resident will have built up his own patient population of 300 to 400 patients who will receive their medical care in the model family practice unit.

Figure 2. *Number of residents in family practice programmes, July 1976.*



Training programmes are funded by a combination of patients' fees plus federal and state grants, and have to compete for patients with local physicians. Model family practice centres vary considerably throughout America but share two common problems. First, training centres are usually in urban areas with an abundance of private physicians for patients to choose from, and difficulties are encountered in attracting a satisfactory cross-section of patients. On the other hand, some family practice training centres provide a service for poorer patients who would previously have had to queue for care at the emergency room of the local hospital. Unfortunately these centres often become replications of outpatient clinics with little of the flavour of the private physician's office and "Teaching primary care in the underserved ghettos is like teaching botany in the midst of a raging forest fire" (Cowart, 1977). The second major problem is finding family physicians to act as full-time medical staff and to supervise medical students and residents. With relatively few family physicians in many communities and no long-standing tradition of academic departments of family practice, there is a paucity of suitable family doctors available to fill full-time academic positions.

Most American residents expect and request critical assessment from their teachers. An integral part of the resident's educational experience is continuing evaluation of his or her progress. This evaluation is performed in many ways but focuses largely on two topics: observation of clinical management by members of the teaching staff and frequent assessments of technical skills. Chart audit has many ardent supporters, and in many hospital centres this is becoming part and parcel of the day-to-day activities of physicians. At the completion of training the resident is eligible to sit the Board Examination of the American Board of Family Practice, and to remain Board Certified he must be re-examined every six years.

The future

With the cost of health care in the United States approaching 200 billion dollars, the federal government is committed to cutting unnecessary costs and is providing considerable support for the training of family physicians, who probably generate less expensive care than other specialists. At a time of trenchant criticism of over-specialization (Illich, 1975), the notion of family practice is appealing both to the public and to politicians, and the leaders of the family practice movement utilize this social support to the full.

Attempts by academic family physicians to define their specialty have focused on the importance of 'family' care, yet the claims made by advocates of 'family medicine' of having overwhelming knowledge of family interactions in matters of health, require more supporting evidence. Marinker (1976) has questioned the idea of treating the family as a unit of medical care, and his views warrant serious consideration by the more zealous leaders of family practice in America. However, the symbolism of family medicine has had an important function in bringing to the forefront the need for more balance in American medical education. Recent federal government legislation has threatened to withdraw support to medical schools if they have less than 50 per cent of their postgraduate training channelled towards primary care. The growth of model family practice centres has not gone unnoticed by internal medicine and paediatrics, where the traditional approach has been to educate doctors in tertiary care hospitals, and then have the majority of these aspiring consultants practise as primary care physicians.

With no strong links with social support services and the reluctance to provide home-based care, the family physician continues to function in close contact with hospital-based services (Robinson, 1977). Many doctors express private concern that any reduction in hospital privileges would mean both the loss of a patient constituency and of job satisfaction, not to mention prestige. If the desire for hospital privileges does not subside, decisions remain to be taken about the length of residency training required for the future family doctor seeking to participate in the hospital management of medical, obstetric, and paediatric patients.

To date there have been adequate federal and state funds for setting up training schemes, but even America does not have a bottomless pit of long-term resources. Where minimum standards prove difficult to achieve, fears have been expressed that numbers alone are not what counts, and that hastily devised schemes will tarnish the image of family practice (Keith, 1977). There is considerable emphasis on evaluation of quality of family practice residency programmes; for example, the Residency Assistance Programme is a national programme of consultation and external review of residency programmes. The anticipated increase in model ambulatory care training centres for budding internists and paediatricians will pose a considerable challenge to family practice programmes, as there are few signs of an integrated approach to the training of primary care physicians. One solution to the staffing problems in training centres might be a more positive attempt to make use of private physicians in the training of residents. The majority of family physicians are more comfortable teaching in their own practices, as opposed to transplanting their skills to a training centre where they are often divorced from day-to-day management of their own patients.

It is disappointing that family practice training programmes have made few attempts to encourage home visiting to the disabled, chronically sick, and the elderly. If family practice is to be true to its philosophy, it would be reasonable to suggest that lack of exposure to the patient's home environment is a gap that has yet to be bridged in the training of most American family doctors.

Lessons for the UK

Can training schemes for general practice in Britain learn anything from American family practice? University departments of family practice in America have greater input to teaching at the postgraduate level than in Britain, where departments of general practice are mainly concerned with undergraduates. As a result, the American system allows for more continuing supervision and evaluation of trainees throughout the three years of postgraduate training. It seems paradoxical that many British trainees often spend more time, both at the undergraduate and postgraduate level, in hospital than their American counterparts, when their future careers in British general practice will largely be divorced from hospital work. The American idea of continuing involvement with primary care throughout the years of postgraduate training may be worth consideration on an experimental basis in some centres in Britain. At the same time, it would be only fair to recognize that the Royal College of General Practitioners has been in the vanguard in the development of training objectives (RCGP, 1972), and there is certainly a more substantial body of original research from general practice in the UK than in the USA.

Conclusions

It has been fashionable to dwell on the faults inherent in the super-specialization which characterizes American health care, but it would be wrong to assume that America is not a caring country. On the surface it may appear aggressive and over-competitive but the citizens are prone to severe self-questioning, and many express strong disapproval of the flagrant discrepancies between the rich and poor in their society. It is against this background that the spirit of family practice has been rekindled, and there is evidence that the production of more family doctors is leading to a more equitable distribution of medical services (Geyman, 1978). Although yesterday's battles for acceptance are almost over, the territories for tomorrow's activities in family practice are not without a few stormclouds on the horizon. The young physician entering family practice today can look forward to a lucrative career, but he is certainly not choosing a soft option at a time when the competitive forces of private practice still predominate.

It was my pleasure to spend two years in a University Department of Family Medicine in America. Following one's profession in a country not one's own has many problems but also great advantages. It calls for adaptability and tolerance, the need to rid oneself of prejudices, and to approach new routines with an alert and open mind. I learned much which I hope will be of lasting value to me. General practice in America is undergoing change, too gradual some physicians think, but it was my privilege to witness a broad range of physicians' activities, and to participate in a small way in the work of those searching for a better tomorrow for American family practice.

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Addendum

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