OBSERVATIONS ON GENERAL PRACTICE IN THE UNITED STATES

H. W. MARTIN, M.D.
Ilford

My visit to the United States was a short one, just thirty-one days, and like some Americans " doing Europe " in about the same period of time, I tried to see as much as I could. Also I wanted to learn as much of general practice over there as opportunity provided.

In England we live in a society that has absorbed American influences for a long time. The cinema and television, books and periodicals published in the United States and widely read here, and of course the successive waves of American servicemen with their families and American tourists, all contribute to the first impression on arriving in New York that one visits a country where everything is just what one expects it to be: the skyscrapers, the bustle, the immense materialism.

One is constantly tempted to compare the American way of life with life here and to use European standards when judging the things one sees but this can be most misleading. Here in England, American cars appear big and ostentacious, they are difficult to handle on our roads and expensive to run. When therefore I had decided to hire a car in the United States I thought that one of their " compact " cars would be the right type to get, as it would correspond to a medium sized British saloon. On enquiring about terms of car hire for my contemplated journey from New York to San Francisco I was strongly advised to hire a large sedan instead and succeeded only with some difficulty in hiring a compact model. Now after a journey of about 5,000 miles on fast freeways and on roads badly in need of resurfacing, after travelling through deserts and mountains and endless plains, confined to the car for days at a time, I realize that the advice given to me was most sensible and of course in America their cars don't look big because they are all big.

My journey took me from Connecticut to New York, then through Maryland to Washington. From Richmond, Virginia through the Carolinas to Atlanta, Georgia. From there through Alabama and Arkansas to Oklahoma City. Straight west from there through Texas, Arizona to Redlands, California. Finally north to San Francisco. A jet aircraft took us from there back to New York.

The journey which had taken us a month was now completed in just over 4 hours flying time.

When I arrived in the United States I had many prejudices. I granted the Americans great natural resources and technical skills but considered them outright materialists lacking in tradition and culture. I very much wanted to visit their country but knew that I did not want to live there. I have now returned home and find that I cannot confirm these common prejudices. But this is taking me far away from my subject which is an account of general practice in the United States.

Through some personal contacts and the help given by the officers and members of the American Academy of General Practice, I saw general practices and hospitals (voluntary, state, and federal) in various parts of the country, each presenting very individual and regional features. I collected much information and found amongst the doctors great willingness to discuss anything from surgery equipment to medical fees, from hospital facilities to medical records. I was shown in hospitals and offices literally everything there was to see and received great kindness and overwhelming hospitality in many places.

My purpose here is not to give an academic review of general practice in the United States. This would be presumptuous after such a short stay, especially as the most comprehensive studies of general practice were published in the United States since the war and also two articles recently in the medical press of this country. However, an honest, personal account of what I found may add detail and substance to the picture given there.

Even a short visit to the United States conveys the impression of great prosperity. An index of it is the price of human labour and to achieve efficient use of it great ingenuity and technical competence are exercised.

It is in this environment that the general practitioner takes his privileged place. After qualification, a rotating internship (equal periods in surgery, medicine, obstetrics, and often paediatrics) is the usual preparation for general practice.

The premises

The practitioner can select his practice location without difficulty and becomes established quickly. The time honoured custom of occupying low rent premises near a drug store is now little in evidence. Instead one sees carefully planned premises in central locations, providing off street parking for the patients. Architect designed " medical arts buildings " provide professional premises for doctors, dentists, and optometrists. These offices are rented,

sometimes shared on 'a split-time' basis, and often groups of doctors own their own building. The doctor's office is usually air-conditioned and divided into consulting room, two—three examination rooms, a small waiting room, reception office and small store room also equipped with a laboratory bench. Often a lead shielded x ray room and a room for ECG. and BMR. are added.

Equipment

The doctor's equipment includes the instrumentarium for minor surgery, gynaecology and obstetrics, proctology, a steriliser, refrigerator, microscope and centrifuge, electrocardiograph and x ray machine, the latter usually just for fluoroscopy, enabling the practitioner to view chests, suspected fractures, sinuses. Ba meals, I.V.P.'s, and gallbladder x rays are not undertaken. All these aids to diagnosis widen the scope of general practice. To consider them just " money makers " would be unfair and ignore the fact that many of these expensive items are not used enough to pay for their keep. Expendable equipment is widely used from waxed paper cups to paper tissue sheets for the examination couch. It can cause quite a sensation if one tries to use an old fashioned linen handkerchief in America today.

Staff

A nurse and a receptionist are considered essential non-medical staff. The receptionist works an appointment system, leaving room for urgent consultations and attends to the payment of fees. (For monthly billing photostats of ledger entries are often used). The nurse in addition to conducting patients to the examination rooms in rotation and assisting the doctor there often carries out simple laboratory routines like urine analysis, Hb's, E.S.R's. Complete blood counts, stool examinations, Rh typing and blood serology, blood sugars, etc., are done in a medical buildings laboratory by a shared technician.

Working day

The doctor's working day starts with a visit to his hospital at about 8 a.m. By 9 a.m. he begins work in his office and sees patients until midday. A further visit to the hospital for the daily ward-round completes the morning's work. Office appointments and house calls take up most of the afternoon and after 6 p.m. a final visit has often to be made to the hospital, where the patients in greatest need of his care are to be found. The great shortage of residents also leads to the general practitioners undertaking many additional part-time duties at the hospital. Off duty periods are covered by a telephone answering service which carries out tactful

preliminary screening of calls and usually begins at 7 p.m. and ends at 8 a.m. Night calls are quite frequent.

Appointment systems are widely but not uniformly used. Many doctors work long hours and maintain office hours throughout the week including Saturday. But the working week seems to shorten and average weekly workloads given in a survey published in 1956 as about 60 hours may not be accurate any more.

Most doctors now will keep to a weekly halfday and in many practices appointments are booked for Monday, Tuesday, Thursday and Friday, giving attention to urgent cases only on the remaining days.

When holidays are taken they are usually covered by reciprocal arrangements, but as there is no undertaking to provide continuous medical care, even the closing of the doctor's office is feasible. As doctors have as much work as they wish to undertake, relations amongst doctors are friendly and stand-in arrangements work in spite of occasional loss of patients to the deputy and no effort is made to bind a doctor to an undertaking not to accept patients he has met during a deputizing period.

Comparison of Working Methods

Morbidity studies published both in this country and the U.S.A. show similar results. It is therefore not surprising to find the work of the general practitioner similar to ours. Health supervision, that is prenatal and postnatal care, well baby care and immunisations take up a lot of time, next in order of frequency come respiratory disorders, sore throats, accidents, benign hypertension, menopausal conditions. A total of up to 200 patients are seen in a week.

As the general practitioner sees large numbers of unsorted new patients every day, he has to be a diagnostician in the first place. Here his " physical plant " gives scope to his initiative and permits him to carry out a more complete examination. Easy access to hospital departments and their specialist staff will also encourage treatment based on competent diagnosis.

But there is of course a difference between theory and practice in this. I have not seen evidence of unnecessary routine investigations being forced on the patients or surgical measures being too readily advocated but safeguards exist. Medical care in the hospitals is carefully scrutinized. So called " tissue committees " can comment on the justification of an operation and " medical records committees " on the general handling of a case. All the same, the sins we commit are well in evidence over there too. Antibiotics are given without limitation, even when treating a common cold, on the

assumption that they are harmless and also prevent complications. Patients with high blood-pressure are given proprietary drugs containing mild sedatives, and when treating a low haemoglobin proprietary iron and vitamin preparations are supposed to cure everything except acute blood loss.

Income and Fees

It is of course not possible to give average income figures for general practitioners as the type or scope of practice and its location will be decisive. Since all the data I received are intimate and the figures given from memory, I can only say that they appear considerably higher than the figures given in some surveys. This may be due to the fact that incomes have generally increased substantially in the past few years, also the figures given to me were obviously unrelated to actually paid bills, depreciation, and full assessment of practice expenses, so for what it is worth I would put the gross annual income in an established urban practice at about $40,000 from which practice expenses at the rate of 35 to 45 per cent have to be deducted. In such a practice office calls would be $5—6, house calls $9—10. Full physical examination including blood count, ECG, urine analysis about $36, confinement and after care $150. Fees are often scaled down for patients who are less able to pay. Collection agencies are not used.

It is interesting that the threat of litigation makes " malpractice " insurance at a premium of $300—400 annually necessary.

Medical Insurance Plans

1960-61 figures given by the Health Insurance Institute put total medical costs per family at between $100—400 per annum and amounting to about five per cent of income. Cost of stay and doctors fees while in hospital are covered by a number of voluntary insurances to which nearly two-thirds of the population belong. The Blue Cross and Blue Shield plans have a high level-higher cost and low level-lower cost plan, the latter providing almost free maintenance and treatment at public ward level. But in the words of a well known labour leader " medical care that begins only when the patient is flat on his back in hospital is a program of poor quality ". Though the number of people covered by insurance is large, the coverage is far less so. It is claimed that less than half of the expenditure on medical care is covered by insurance.

The influence of organized labour on future health services is something that has to be reckoned with. The unions have over 18 million members and their dependants number over 30 millions. Politically the unions favour a compulsory health insurance. In

the practical field they have initiated a number of interesting developments. There is the " clinic movement " securing for their members prepaid limited services including diagnostic facilities, physiotherapy and others but usually supplementary to a voluntary insurance cover.

Direct medical care arrangements have also spread. The subscribers receive complete medical care on a kind of panel basis at home and in hospital. But the patient has to choose his doctor from one of the salaried physicians employed by the group. One of the best known is the Kaiser Foundation Health Plan providing comprehensive medical care for over half a million people in California. Fourteen hospitals, over 40 clinics and, not unimportant for their success, a television network are owned by the group. The United Mine Workers Program grew out of the need to provide direct medical care in areas where inadequate medical facilities existed but now the UMW run ten hospitals and their medical plans dominate whole communities especially in Kentucky and Colorado. Other direct medical care arrangements exist in New York City, (H.I.P.) in Detroit (C.H.A.) in Chicago (U.H.S.)

There is in fact a growing conviction that direct medical services are preferable to insurance cash payments and prepaid arrangements with group practices are increasingly used to broaden existing cover.

It is interesting in this connection to mention a " comprehensive health insurance " plan sponsored by the California Medical Association which when available promises a 90 per cent cover of all health expenditure including check ups, laboratory investigations, even a moderate amount of psychiatric care at $24 per family per month. I should add that the sponsors hope to develop it within the next two years.

Postgraduate Work

Even a good medical training cannot be complete but it will induce the habit of self education in the student and so make him later add to his experience and keep him abreast of current knowledge.

Postgraduate training of the general practitioner can take many forms. In the United States the principal objects of the American Academy of General Practice are: " To assist the general practitioner in his postgraduate training " and thus promote and maintain high standards of medical practice, but also, significantly, " To preserve the right of the general practitioner to engage in medical and surgical procedures for which he is qualified in training and experience." It is firmly believed that it is important for the con-

tinuous medical education of the general practitioner and in fact essential for the quality of medical care as a whole that he should have access to hospital facilities for his patients. I found, therefore, that practitioners without hospital appointments are few. Less than one in ten of the doctors I met were without hospital facilities. These were accounted for on the grounds of remoteness from hospitals making attendance too time consuming, doctors doing nearly full time industrial work also. But nowhere are general practitioners excluded from hospital. A credentials committee examines each applicant before hospital facilities are granted and these can range from a courtesy membership to active staff appointment, from a restriction from doing surgery without supervision to granting minor or major surgical facilities. As there is a shortage of doctors in junior hospital grades it will depend mostly on the general practitioner concerned whether he will restrict his hospital attendance solely to the care of his patients or take on other duties. Department heads will expect attendance of all members of the staff at ' grand rounds ' and clinico-pathological conferences, and they may hold regular reviews of case histories when comments and progress reports are invited.

Planned postgraduate education is considered necessary to confront the rapidly changing field of medicine, and most doctors I met had attended one or more postgraduate courses in the past three years. Over a thousand are held all over the country in the course of a year, and subjects that are favoured include: cardiology and electrocardiography, practical obstetrics, geriatrics, and paediatrics. Most of the postgraduate work is done locally, but the doctors portion of expenses incurred in attending a course away from home is recognized for income tax purposes. Postgraduate study requirements for the continued membership of the Academy of General Practice consist of 150 hours of postgraduate study credits every 3 years. A distinction between category I credits (of which there have to be 50) and category II credits (of which there have to be an additional 100) is made. Examples of category I credits are: Attendance at postgraduate courses given by an approved medical school, publication of a scientific paper by the member in a national medical journal, presentation of an original scientific paper to a medical audience, teaching of medical students, and attendance at the annual scientific assembly of the Academy of General Practice. The latter is an annual meeting lasting for several days during which carefully selected lectures on medical research and clinical study pertinent to general practice alternate with social functions, and scientific exhibitions. The maximum hours of credits are based here on actual hours of attendance of the scientific program. Category II credits can be earned by attending the meetings of the American Medical

Association, postgraduate seminars of the local hospitals, hospital staff journal conferences and so on. The careful classification of planned medical events is the responsibility of a " commission for education " elected by delegates of the American Academy of General Practice. The rules laid down insist on submission of an advance copy of the scientific program to the Commission to enable its members to decide whether the AAGP should sponsor it and authorize category I or category II credits. Active participation of members of the education committee in the actual planning of programs is also encouraged to produce courses of interest to the general practitioners and assistance is therefore often requested by medical schools when planning postgraduate courses.

This careful scrutiny of medical events both for high educational and ethical quality of production and interest to general practitioners results in a wealth of available activities to stimulate his postgraduate studies. Examples of lectures and discussions sponsored by the AAGP during April and May of this year included: A consideration of common ear problems including catarrhal otitis and vertigo, an examination of procedures suitable for minimal care of dermatologic patients in the surgery, a lecture on drug addiction, a discussion on the psycho-dynamics of adolescence.

Programmes developed with the financial assistance of pharmaceutical firms have to conform strictly to a ' code of practice ', which insists that the invitations to the guest speaker, honoraria and publicity have to be handled only by the chapter of the AAGP conducting the programme.

Credits assessed on an individual basis would apply to the use of teaching aids like films, colour slides, tape recordings, radio conferences and television, all of which are valuable in the more remote districts. Credits for study in a foreign country are also given. No credits are granted though for military training of the reserve officer as in the educational commission's opinion no advanced education in medicine is given but only instruction in military organization and administration.

Medical Journals

The doctors reading and study habits are of course not easy to judge but I was impressed seeing current editions of medical textbooks in most doctor's offices and the hospital libraries are constantly in use for reference purposes. Several journals are kept in most cases. The *Journal of the American Medical Association* is provided with the membership of the society, as is ' *G.P.*' the journal of the AAGP, but the *American Practitioner*, *The Journal of General Practice*, and *The Medical Clinics of North America* are also widely read.

Many doctors are aware that their medication is materially influenced by the information provided lavishly by the drug houses and are weary of the thousands of brochures in their mail. It is generally understood too that a lot of the money publicised as going into expensive research is really spent in the quest for new variants of existing drugs that sell well. Therefore a publication with wide circulation is the *Medical Letter on Drugs and Therapeutics* providing simple and unbiased information on new drugs. It is also interesting that it is the editorial policy of '*G.P.*' the first class monthly journal of the AAGP, not to accept articles dealing with the evaluation of new drugs.

Future Trends

It is not possible to speak to doctors in the United States without sooner or later being made to discuss ' socialized medicine ' the term used when speaking of the National Health Service. The uncompromising attitude of the American Medical Association towards it is sufficiently well known but it is interesting to see the effort made to reach the public when reading the following advertisement that appeared in a well known magazine:

" The practice of medicine is a unique thing.

It makes more demands on the doctor than most of the rest of us ever experience in our jobs... And it places the ultimate burden of life and death on him if he fails to perform each of his roles properly... The practice of medicine is truly the ultimate in one human being's service to another... The sort of service you must be able to choose—and change—freely to fit your own needs. It is the kind of service relationship which requires respect and confidence and the kind of individualized attention which cannot possibly be reduced to legislated regimentation."

In spite of the efforts of the A.M.A. in the public relations field, the medical profession has a " bad press " just now. The United Steel workers completed a two years study of the medical care of their members in September 1960 which must be considered a grave indictment of existing services.

Medical care for the aged has become a pressing problem. About nine per cent of the population are over 65 years of age. Voluntary insurance can be bought only at very high cost at that age with the result that few are insured. Excellent state and federal hospitals undertake the care of the indigent but here we deal with a different group, the " medically indigent ". Legislation on medical care of the aged is now debated in congress and extension of social security has become an avowed aim of both the Democratic and Republican political platform. The pattern of medical services in the United States is slowly changing.

Conclusion

As I stated at the beginning,—my random observations cannot give

you a complete picture of general practice in the United States, but they may induce a critical appraisal of our own conditions of practice. The thought as to whether anything I saw over there might be usefully applied at home was never far from my mind. The most important conclusion I came to was that any observer of the American scene would have to concede to the general practitioner in his hospital work a most creditable performance.

So, should it not be possible in our hospitals to take advantage of the help the general practitioners could give? It would fill the void created by the chronic shortage of junior hospital staff and at the same time end the clinical isolation of the general practitioners in this country.

THIRD CONGRESS OF THE INTERNATIONAL COLLEGE OF MEDICAL PRACTICE

The congress took place, as in 1960, in Salzburg on 11—14 September 1961. The proceedings were opened by Dr Engelmeier (Oelde Westphalia), the vice-president and co-founder with Dr Braun of the College. This was followed by a prize distribution for essays on " Changing Concepts of Disease in Changing Times ".

The opening lecture was given by PROFESSOR SCHULTEN (Cologne) on " The Doctor and Ethics ". He maintained that there were no specific medical ethics, merely the application of universal ethical standards to the conditions of medical practice. To uphold his ethical standards it was essential that the doctor be independent. While it was customary to demand that the doctor should not lie, it was also important for him to consider what the patient made out of the ' truth ' imparted to him. At the conclusion of his address Professor Schulten was made an honorary member of the College.

DR BLUME (Göteborg, Sweden) spoke on the psychological basis of many common orthopaedic complaints showing parallels with other known psychosomatic conditions and pointing out the ineffectivity of purely physical treatment in such conditions as lumbago, brachalgia, and the cervical syndrome.

DR GEIGER (Ötz, Tirol) gave his address on the subject of unusual pain localizations in influenza and influenza-like illnesses as pointers to later disease.

DR KUSS (Göttingen) demonstrated his apparatus for hip traction