33 years of changes, and lack of changes, in US general practice

Six years ago I was one of a group of doctors who visited Vietnam. We gave presentations to Vietnamese colleagues on our favourite topics. I made the mistake of asking what they would be interested in and ended up lecturing on the American Medical Insurance System. This is hard enough to explain to an American. Whatever part of my talk was not lost in translation evaporated as the Vietnamese GPs, who earned between $100–200 per month, tried to get their heads around the details I presented.

'You mean that it costs $12 000 annual premium for a family of four, and you still have a co-pay of $25 for each visit?'

Sometimes I can't get my head around it. And those were figures from 6 years ago. A more recent estimate is that a family of four could expect to pay $20 000 on health care annually.

I moved to the US 33 years ago. I had just turned 31, was married, and still childless. It was a big adventure and an adventurous alternative to settling down in UK general practice. Besides, I was only going to try it for 5 years.

Somewhere along the way I forgot to go back, and somewhere in those 33 years the cost of living in the UK exceeded that in the US. So, when my MRCGP membership renewal notice (retired, overseas) arrived recently I realised I was at a crossroads. I hesitated, but decided to not pay the $400 and severed my last professional tie to the UK.

Looking back over those years there have been striking advances in patient care. I recall a paper published in the mid 1970s in the UK which showed that an uncomplicated myocardial infarction (MI) patient was just as well off at home as in a hospital, and it was common practice to manage MIs at home.

In the US it was the rule to admit the same patient to hospital; not necessarily because outcomes were better, but because that is where they showed up and still do. There was no home care. If your doctor was not in you went to the emergency room for all medical attention, and in many communities this is still the norm.

In my first years in practice I tried home visits. Patients loved them, and so did I. Driving through the southern Indiana countryside in late summer was relaxing, peaceful, and rewarding, but not financially. Any income I could generate from home visits never matched the expenses I incurred. Eventually, like most US GPs I retreated to my exam rooms with only an occasional foray across a patient's threshold.

An outsider looking at the US can get misleadingly skewed impressions of life here. In that southern Indiana county, population 40 000, every one of its 40 churches was filled on a Sunday morning. Every one of its 40 bars was filled on a Saturday night. Health care is the same. Parts of it are incredibly efficient and provide timely, appropriate medicine. Parts of it are so inefficient, or totally absent, that the mean does not represent the extremes. There is no such thing as a US medical system: it is a hotchpotch of systems.

Personally, I consider this a national disgrace, which could have been fixed several times during my practice here. Medical bills are still the largest cause of personal bankruptcy. Health care here consumes 17% of GDP, higher than any other Western country, and yet is consistently low in multiple measures of outcomes. It is a drain on employers, who provide most of the non-governmental health insurance, and reduces their competitiveness.

Yet it doesn't change. The free market does not work well for health care. Competition means more MRIs and more people getting them for no good reason. It rarely means competing healthcare systems vie for your attention because they offer better quality and outcomes. Reimbursement for items of service means the more you do, the more you get paid, and so insurance companies and the government develop systems to make sure you performed what you get paid for. They do not question if what you did was necessary in the first place.

This nation of innovators is matched by a land of conservatives. We hang on to the dollar bill, pounds, ounces, the US gallon, 'gas-guzzling' cars, and in medicine measure temperatures in Fahrenheit and blood chemistry in grams and milligrams. SI units are something other countries use, but not the US.

We also don't change because someone's job, someone's company, someone's college career, depends on maintaining the status quo. Americans, like most people, don't like change, but unlike most people, they still have the resources to resist it.

I have not hung up my stethoscope completely. I volunteer at a 'free' clinic in Tacoma near where I now live in Washington State. I also volunteered for a mass clinic in the Tacoma Dome last year. One thousand volunteers served 1500 patients over 2 days.

There was the man dying with amyotrophic lateral sclerosis, unable to walk for the last week, who was crying during the interview. There was the woman with diabetes and hypertension who could not afford her medications. Both had no insurance, little money, but most importantly, no political clout. When you are poor and struggling to get by, you have other priorities than political involvement.

Thirty-three years ago I wrote my notes by hand. After 10 years I dictated them to a rising population of medical transcriptionists. Ten years ago along came the electronic medical record and the resurrection of my typing skills. Now we can dictate again to software which understands us (if you speak with an American accent) and transcriptionists have been replaced by highly paid IT personnel. Coding experts tell us what to write so we get maximum reimbursement. Everyone, but Americans, benefits from the status quo.

By the time this is published the US Supreme Court may have decided if the government can compel us to purchase insurance. The bill in question is an imperfect solution to the US healthcare problem, but it does begin to address universal coverage and efficiency. If I were a gambling man I would bet the Court throws out the bill. I hope I am wrong.

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