Letter from . . . Missouri

Deep and unfished waters

A J M CAVENAGH

It serves me right for dishing out snide remarks about vocational training. I now find myself so immersed in this topic that, like Macbeth, "to wade o'er were easier than return." When I visited the United States nine years ago, a real eclipse of general practice had occurred. The ratio of specialists to general practitioners was three to one, and an embattled developing American Academy of General Practice had just changed its name to that of American Academy of Family Physicians in an effort to stake out territory for a specialty that could hold its own with the rest. Here in Columbia, Missouri, the department of family practice had established a bridgehead, consisting of two doctors using a spare laboratory on the fifth floor at the back of the medical centre—the 400-bed teaching hospital. But a major training programme appeared little more than a pipe dream.

Since then a happy connection has existed between Columbia and Brecon, whereby visiting medical students from Missouri have spent a month's "preceptorship" with us at the rate of one or two students annually. This is similar to the student attachments now becoming frequent in Britain, but here it is mandatory for all, whatever their ultimate career preference. Most preceptorships are arranged in Missouri—comparatively near to Columbia—but outlying attachments throughout the USA also occur.

Campaign for more family doctors

I was invited back to spend a year as "attending physician" in Columbia, and returned to a very different scene. The resuscitation of family practice has been approached with that unique blend of Anglo-Saxon stubbornness, Teutonic thoroughness, and Gallic impatience which characterises problem-solving this side of the Atlantic. The chosen solution is a 3-year residency training programme as the nationwide method of producing more family physicians. The programme in Columbia may be taken as typical of the 350 now in existence.

Ten newly-qualified doctors join the programme yearly, and are subjected to an extensive series of rotating appointments through all major specialties for the next three years. At the same time they provide primary care in the family practice clinics in the university town of Columbia, and in Fulton, a town of 12 000 population, 20 miles distant (where the British connection is tangibly preserved in the exquisitely restored Wren church, transferred thither from the City of London as a memorial to Winston Churchill's "iron curtain" speech made there, appropriately at Westminster College, in 1945). Each resident thus provides three years' continuity of care for a list

of patients, remaining responsible for them if they need to go into hospital, unless complete referral to another specialty is arranged.

Identify is the first aim. The opening month of the programme is devoted to orientation, to introducing residents to patients inherited from their predecessors, and to making sure that they know, as they rotate through all the major departments of a teaching hospital, that the department of family practice is their true home. At the same time, several afternoons are devoted to "team building"—under the benign auspices of the Behavioural Sciences Faculty these constitute mind-bending of a high order. Everyone seems to agree on their value, and this is perhaps not surprising in a group of young people from widely disparate backgrounds thrown together by the whims of chance and cybernetics. Medical students in their fourth year who have chosen family practice as a career may attend interviews for anything from five to 20 residency programmes—which means several weeks and thousands of miles of travel—before deciding their order of choices. These are fed into a computer of UCCA proportions which matches the requirements of programmes and applications on a nationwide basis. Results, essentially those of a competition, are generally deemed satisfactory by all concerned. Popular programmes, those which are well established with traditions of excellence, or the well situated for climate and amenities, may be dealing with a ratio of applicants to places approaching 100:1. At the opposite extreme may be programmes which have difficulty filling their vacancies. Competition for students is matched by that for recruitment of teaching staff. Competition for dollars from State and Federal funds is the most important of all, and the writing of federal grant applications has become an art form which no department of family practice (or anything else) can afford to ignore. Individual States vary in their support of family practice teaching programmes. Though all and sundry pay considerable lip service to their importance, regrettably Missouri remains near the bottom of the league in this respect. With a well-established reputation for cynical disbelief, the "show me" State remains to be convinced of the value of such newfangled ideas.

The residency training programmes do not develop in isolation. Annual meetings of directors under the auspices of the American Academy of Family Physicians and the Society of Teachers of Family Medicine both ensure considerable intercommunication and cross-pollination of ideas. A recent meeting in Kansas City, attended by more than 300 directors, gave three days of intensive discussion, in workshop form, to such topics as selection of applicants, their orientation, and how to persuade them to remain in the State at the end of training. Recruitment of private doctors to the teaching faculty was also discussed, as were the techniques of teaching, use of videotapes, and observation of consultations, inclusion of residents in research projects, and a great deal besides. There seems no risk of the developing faculty standing still.

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Some good results

What does it all achieve? It is accepted as an expensive means of training doctors, but competition is a great way of pushing standards higher. At the end of three years in the hot-house atmosphere of an environment devoted above all to teaching and learning, but with a considerable service commitment, the results are impressive. The average third-year resident has a seemingly casual across-the-board base of knowledge which bodes well for future family practice in almost any circumstances. From detailed management of cardiac emergencies to drug interactions, the knowledge of medicine is frequently sub-encyclopaedic. The habit of working as a team with colleagues, nurse practitioners, and social workers has been established, and the influence of behavioural scientists on interviewing and counselling techniques has left its mark. The use of hands for managing simple fractures, minor surgery, and inserting intrauterine contraceptive devices is routine, as is simple office pathology from microscopy of urine and Gram-staining to making and reading throat cultures. The place of obstetrics in the curriculum is even more critical than in the UK. A considerable, well-informed, and eloquent wing of the provisional feminist movement is in more or less open revolt against high-technology midwifery. As a result, the number of home deliveries is rising; and, in the absence of a recognised corps of midwives in most States (including Missouri), the long-term results are awaited with trepidation. Nevertheless, the family practitioner represents a real bridge between the aspirations of patients and obstetricians. His role in intrapartum obstetric care seems assured—even to the extent that a joint working party of AAFP and American College of Obstetricians and Gynecologists has pronounced that training in performance of caesarean section should be available to those residents who require it.

The grand design is to provide better primary care, particularly to rural America, where the supply has dwindled most severely. The briefest cross-country journey here is enough to convince one how totally the nation's wealth is founded on farming, and how the omnipresent enemy is distance. Some people have voiced doubts about the comparatively sophisticated residency training programmes' ability to produce doctors who will be happy to live and work in the simple atmosphere of small-town America. Yet, of last year's Columbia residents, most are in practice in small towns, from Alaska to Carolina, so conditions of work and facilities may prove more alluring than the bright lights. I have yet to meet a resident in any programme who would consider entering practice *without* having hospital privileges.

A hot and humid summer is thankfully drawing to a close—

everyone tells us it has been a comparatively cool one. We understand now the American insistence on iced water for all occasions. The chiggers (mites), poison ivy, and ticks which constitute the most obviously hazardous of the local flora and fauna will shortly retire from the scene, and only reclusive spiders will remain to trouble us. Their apparently mild bite may lead to considerable necrosis and ulceration. These apart, patterns of morbidity are not so different from those in rural Wales. Routine physical examinations and "health maintenance" figure highly in the reasons for patient attendance. Were it worth anybody's while, a similar pattern of work might infiltrate the National Health Service, but evidence that the onslaughts of disease are being appreciably delayed by all this screening is lacking.

Erratic weather

With two States to the north and south, and five on either side, Missouri is at the geographic point of balance of the USA. Even the weather manages to steer an erratic course between the competing demands of cool air from the Arctic and the hot breath of permanent summer in the Gulf of Mexico. Rainfall is sporadic and seldom less than an inch at a time, but the overall climate is so dry that farmers can happily abandon bales of hay in the fields for later consumption as necessary. Locally, the next 10 years will produce little change in the countryside, save the addition of a nuclear power station and the removal of some (largely invisible) Minuteman missile sites. Contrast will be in the figures rather than the landscape, and the good old "Doc" may change more than most of these.

And teaching as a job? A type-A coronary-prone personality has to make a considerable (and unsuccessful) effort of will to keep his hands off, to efface himself from consultations, and to view the whole transaction of medicine from a different standpoint. Kind advice on teaching methods and educational theory is always available, but I have a persistent feeling of wading in deep and unfished waters. The balance between theory and practice is precarious, and the difficulty of preserving it largely that of crossing the frontiers from Academe to Gadarene and back again. Unfortunately, we all seem hell-bent on demanding more in the way of passports for these journeys on which the joint futures of family and general practice must to some extent depend. I suspect that in both UK and USA nothing but good can result from an increasing exchange of ideas and personnel. It would be unrealistic hyperbole to suggest that as far as family practice is concerned the New World is once more about to come to the rescue of the Old; yet, for this newest of specialties, the Westward view is unquestionably bright.

A DHSS communication by the Joint Committee on Vaccination and Immunisation in March 1977 included the following paragraph on contraindications to whooping-cough immunisation: "History of seizures, convulsions, or cerebral irritation in the neonatal period. History or family history of epilepsy or other diseases of the central nervous system. Children with developmental neurological defects. Any febrile illness, particularly respiratory, until the patient has recovered." What diseases of the central nervous system occurring in the family and which developmental neurological defects in the infant should prohibit giving whooping-cough vaccine?

The question is an important one because the DHSS statement about contraindications to whooping-cough immunisation is open to widely differing interpretations, with regard not only to the neurological terminology but also the meaning of "family history." The ambiguity of the statement stems from the weakness of the evidence on which it is based. The evidence is weak in three ways. Firstly, it relates to vaccines that have since been modified and refined. Secondly, it is based on retrospective and selective studies. Thirdly, the main argument presented by those who believe that a causal relationship exists between whooping-cough vaccine and neurological disorders rests on

the occasional temporal relationship between administering the vaccine and the manifestation of neurological symptoms. One would expect such a temporal relationship to occur sometimes by chance, especially in babies already at risk of showing neurological symptoms. More recent evidence relating to whooping-cough vaccine (in particular, the preliminary findings of the National Encephalopathy Study) points increasingly to the safety of the vaccine and to its value in protecting babies against an infection with severe morbidity and significant mortality.

All this puts the immunising or advising doctor or nurse in a difficult position. I believe the over-riding principle should be to put the evidence about the vaccine, and the illness against which it protects, as clearly as possible to parents so that they can make an informed choice. In personal practice I guide parents away from whooping-cough immunisation *only* if: (a) the baby has already had a convulsion or displayed evidence of severe brain damage; or (b) a parent or sibling has established epilepsy or severe neurological disorder; or (c) the baby is in the acute phase of a febrile illness—that is, *not* an ordinary cold or the convalescent phase of a febrile illness. Even then I would be happy to give the vaccine if the parents, after discussion, asked me to.