MEDICAL AND ASSOCIATED SERVICES IN THE UNITED STATES

BY

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The purpose of this paper is to describe what medical practice is like in the United States and how the people are affected by it.

It is important to realize that there are 48 separate states, each with its own laws. While the basic outline remains the same throughout the country, there are, nevertheless, important differences from state to state.

Education

After leaving high school, which is usually finished at the age of 17 or 18, the intending medical student takes a "premedical" college course for four years, leading to the degree of bachelor of science. It should be appreciated that the commencing age of school is 6 years, and also that children in both primary and high schools do not work as hard as in England. A student beginning his medical course is therefore in the same situation as an English student after finishing "pre-med," except that he will be several years older.

The medical school course extends over four university years. The first two years are spent on basic sciences—atomy, physiology, biochemistry, pharmacology, pathology. The last two years are spent on clinical work. The graduating degree is M.D., which corresponds to the English M.B., B.S.

The standard of the schools is maintained by inspection by the Council on Medical Education of the American Medical Association, and all American schools are now considered grade A. All Canadian schools are accepted as on a par with American schools. The A.M.A. recognizes all English and Scottish degrees as being on a par with the American M.D., but the Conjoint diplomas are not considered so (Council on Medical Education and Hospitals, 1950).

Licence to Practise.—Each state is a law unto itself and regulates professional licensure through its state education department. Each state has different requirements regarding foreign graduates, citizenship, whether an internship is required, and if so whether straight or rotating—for example, New York State admits graduates of grade A equivalent foreign schools and does not require internship; non-citizens are admitted to its licensing examinations. One-third of the states will not license foreign graduates. All states hold licensing examinations and grant varying degrees of reciprocity to licentiates of other states. Most of the states recognize the National Boards examination, the most notable exception being Florida. Full information about licensing requirements is given in the annual State Board Number of the *Journal of the American Medical Association* (Turner and Tipner, 1955).

Internship and Residency.—Hospitals are approved for internship and residency by the Council on Medical Education and Hospitals of the American Medical Association. Each year the *Journal of the A.M.A.* publishes a special Internship and Residency Number giving the latest information about which hospitals are approved (Leveroos *et al.*, 1955). There are three types of internship—straight, mixed, and rotating. The appointments run for one year. A straight internship covers only one service—for example, surgery—while a mixed internship covers two services, and a rotating internship includes medicine, surgery, obstetrics, and sometimes

other services. Residency is the American equivalent of registrarship, and (except for the newly introduced residencies in general practice) is regarded as training for a specialty. Residency in internal medicine is at least three years, in surgery five years. Generally speaking, as in England before the National Health Service came into being, the better the internship or residency the less is paid. A good internship will usually not pay more than \$75 a month plus uniform, board, and laundry. Incidentally, there is a great difference in the attitude of the general public to interns as compared with housemen in England. In the States it is not unusual for the intern to be asked, "Are you a doctor or are you an intern?" He works much harder than his English counterpart, and, certainly in the private hospitals, vies with the Navy midshipman as "the lowest form of animal life."

Specialization.—While it is still possible for a doctor to start in general practice and gradually work towards a specialty it is becoming more and more difficult to do so without the training outlined above. Specialist boards have been set up by the specialist sections of the A.M.A. and act as examining bodies. They usually require formal training plus the taking of an examination. The American College of Physicians and the American College of Surgeons correspond to the Royal Colleges in England. However, the passing of specialist boards is considered more important than membership or fellowship of the colleges.

Associated Professions

Dentistry.—The course for D.D.S. (doctor of dental surgery, corresponding to the English L.D.S.) is four years premedical, four years dental school. The dental schools are inspected by the American Dental Association, and dentists are licensed by state boards in the same way as physicians.

Nursing.—The course for R.N. (registered nurse) is three years, and licensing is conducted by the individual states. Owing to the shortage of trained nurses, "practical" nurses have been utilized to fill the gap. These are people who have worked for at least a year as an aide in a hospital and have taken an examination in elementary nursing. Nurse anaesthetists are extensively used in many hospitals.

Osteopaths and Chiropractors.—Osteopaths and chiropractors are licensed in certain states, and in those states they have the same legal recognition as doctors. In New York State osteopaths are licensed, but they have to take the same state board examinations as regular physicians.

Medical Practice

As stated previously, to practise medicine a state licence is necessary. To prescribe narcotics a licence must be obtained from the Federal Department of Internal Revenue, which controls their manufacture and sale. All prescriptions must bear the number of this licence, which must be renewed each year.

Every physician who applies may get a state workmen's compensation board rating, permitting him to treat patients under the state industrial injuries laws. According to his ability he receives a rating permitting him to treat injuries of certain types and severity. The average general practitioner's rating permits him to treat minor injuries.

Membership of the County Medical Society, and through it the State Medical Society, is essential, as membership is usually required before obtaining hospital privileges.

Malpractice insurance is even more necessary in the United States than in England, as the general public is extremely litigious. This state of affairs is encouraged by the fact that lawyers generally take civil suits on a "contingency" basis, charging 30% to 50% of any damages won but charging nothing if the case is lost. The state medical societies arrange for coverage, holding group policies with the insurance companies. The rates vary from

county to county, and are probably higher in New York City than anywhere else in the country.

Most physicians start practice either by opening an office or by joining a group already in existence. The value of the goodwill of a practice for sale is very variable.

Annual Rates for Malpractice Insurance in New York City

Limit 1*	Limit 2†	Major Surgery‡	Minor Surgery§	Non-surgery
\$5,000	\$15,000	\$226	\$126	\$76
\$50,000	\$150,000	\$418	\$229	\$134
\$200,000	\$600,000	\$483	\$264	\$154

* Limit 1 means the maximum for any suit growing out of one act.

† Limit 2 is the total for all suits in any one policy term.

‡ This does not include x-ray therapy, cosmetic plastic surgery, or electroshock.

§ Minor surgery coverage is required to conduct normal obstetrical cases.

When starting in practice the surgical equipment houses will furnish a doctor's office completely on very liberal terms. The cost of furnishings for waiting-room, consultation and examination rooms, including examination table with stirrups for gynaecological examinations, instruments, sterilizer, instrument cabinet, and complete doctor's bag for house calls is about \$2,000. It is possible, however, to furnish an office much more cheaply. The general standard of furnishing and equipment is very much superior to that of the average English general practitioner.

The average single-handed practitioner has an office of at least three rooms—waiting-room, and consulting and examination rooms. After his practice becomes established he will very often have a suite of four or five rooms. Electrocardiographs and diathermy machines are probably standard equipment in at least half of all general practitioners' offices, while many have x-ray machines.

Every established physician has help, both secretarial and nursing. A most important aid present in practically every American town, both large and small, is the telephone secretarial bureau. For an average charge of about \$15 a month the bureau, which works on a 24-hour around-the-clock basis, will answer all calls which are not answered when the doctor's phone rings. The service is also used extensively by business people.

The general practitioner will investigate all cases so far as he is able, ordering laboratory work, x-ray examinations, etc. Much of the work done by the medical specialist in England is done by the general practitioner in the United States.

Most physicians are on the staff of the local hospital and follow their cases in, assuming full responsibility for them as in-patients. The type of work for which a physician may assume responsibility is determined by the medical board of the hospital. The general practitioner usually has full charge of his medical cases, and, as mentioned above, tends to usurp the position of the medical specialist as seen in English hospitals. An internist (medical specialist) may be called in case of difficulty. He is usually allowed, after preliminary supervision, to do minor surgery and normal obstetrics, but he is bound to call in a surgeon or gynaecologist for difficult cases. The exact types of surgical and obstetrical cases for which he must seek further aid are usually specifically defined—for example, in obstetrics any cases in hospital over 24 hours undelivered, severe toxæmias, breeches, any forceps except outlet, third-degree tears, caesarean section. As a result of hospital privileges for the general practitioner home deliveries are practically unknown in many parts. Throughout the country 85% of all deliveries are conducted in hospital. Also, the general practitioner does not feel as professionally isolated as in England.

The general practitioner starting in practice for himself will usually contact other doctors in the district and arrange to cover their night and emergency calls. In this way he may make enough to cover his expenses until his own practice builds up. If he has joined a group he will begin

by covering other group members. After a doctor becomes established he may begin to restrict his practice. This is one way of starting specialization.

Many county medical societies maintain lists of doctors who are willing to take emergency calls. A patient requiring a doctor and unable to contact his own may call the local medical society at any hour of the day or night, when he will be given the names and telephone numbers of three doctors whom he may contact. If he calls the police he will be referred to the local medical society unless it is an ambulance call. This system works very well in New York City.

In rural districts the local physicians usually have a duty roster posted in the local police station for availability for emergency calls.

It is considered that the average general practitioner works 60 hours a week, the average specialist 56 hours.

Group Practice.—A considerable proportion of doctors work in group practices. These are either entirely specialist or specialist-general-practitioner. They usually work in specially designed offices and share facilities which would be uneconomical for single-handed practitioners. A group with which I was associated consisted of five general practitioners, each with his own patients, and a surgeon. Two of the G.P.s each conducted over 200 deliveries a year and intended eventually to limit their practices entirely to this field. A third G.P. did no obstetrics, was specially interested in cardiology, and took all the electrocardiograms. The surgeon maintained a second office at his home, where he saw patients referred by doctors outside the group. An allergist came two days a week, and a dermatologist, who had an x-ray-therapy machine on the premises, came once weekly. The building occupied by the group had a common waiting-room and reception desk. All visits were by appointment, and the telephone switchboard was in operation 24 hours a day. Each doctor had a suite consisting of an office, examination room, and toilet, and each had a qualified nurse. There was a room for minor surgery, an x-ray room with a full-time radiographer (the local radiologist came in each day to read films and do screening for barium meals and enemas), and a laboratory with a full-time technician to do urinalyses, blood counts, and simple blood chemistry examinations. The business office handled all the accounts. The group ran a sterile syringe and rubber gloves service for the doctors' bags.

New Drugs.—As soon as new drugs come out they become available to the general practitioner. For example, both chlortetracycline and cortisone have been available on prescription for the last five years. Considerable enterprise is used by the drug manufacturers in bringing their products to the notice of the physician. The average doctor receives 2,500 pieces of advertising and samples each year (certain states forbid sending samples of barbiturates through the mail). The larger drug companies send detail men, usually qualified pharmacists, to visit doctors' offices and encourage their prescribing. One firm has gone so far as sponsoring nation-wide close-circuit television programmes (in this case a national conference is shown simultaneously on screens all over the country at selected halls and hotels, and all members of the profession are invited to attend).

There is considerable pressure on doctors to use new, but not necessarily better, drugs as a result of articles in lay newspapers and magazines. Another difficulty is that newspapers receive advance notice of articles to be published in the medical journals, and patients are likely to read of new forms of treatment in the lay press before the doctor is informed about them.

Military Service.—All doctors and dentists under the age of 45 years are liable to be called up for two years' military service if they have not already served in the armed Forces. Service in any of the armed services of American allies is accepted in lieu of this service.

Paying the Doctor

The annual sum spent on health in the United States is 5% of the total national income. Cognizance of this fact is taken by the Federal income-tax authorities, who allow anything over 3% (until 1954 it was 5%) of an individual's income spent on illness (doctors, dentists, hospitals, drugs) as a deductible allowance from his income tax.

The annual net income of the average physician varies from \$17,900 in the far west states (California, Oregon) to \$13,000 in the middle Atlantic states (New York, New Jersey) and \$12,000 in New England (Massachusetts, Maine) (Seventh Medical Economics Survey, 1954). The average income in group practice is slightly lower, but is compensated by the greatly increased leisure. Generally speaking, the doctor in the United States occupies a position in the community equivalent to that of his colleague in the United Kingdom.

The usual charge for a general practitioner's office visit is from \$3 to \$5, and for a house call from \$5 to \$10. There is usually an extra charge for injections—a dollar for penicillin.

63% of the population are covered by some form of hospital insurance, while 54% also have some surgical expense protection, and 34% carry protection against the cost of non-surgical medical care by their doctors. The above coverage is divided roughly equally between private insurance companies and non-profit health plans, the most important of the latter being Blue Cross and Blue Shield. Less than 14% of the population carry insurance against catastrophic illness. Out of a total population of over 160,000,000 people, 39,000,000 workers have loss-of-income protection through insurance companies and plans for paid sick leave (*The Extent of Voluntary Health Insurance Coverage in the United States, 1955*).

Blue Cross and Blue Shield account for nine-tenths of the voluntary non-profit-making health insurance plans. Blue Cross covers the hospital costs for semi-private accommodation for two periods of 21 days each in any year. There is a 50% discount for the next six months. Transfusions, health check-ups and admissions for diagnosis rather than treatment, and communicable and mental diseases in the main are not covered, nor is radium or x-ray therapy. There is an allowance of \$80 towards the cost of obstetrical delivery in hospital. The cost of private nurses and doctors' bills is not covered. The cost per family is about \$55 a year. Blue Cross, like Blue Shield, is organized on a state basis, but a subscriber may be admitted to any recognized hospital in the United States. There is no pre-insurance physical examination for Blue Cross or Blue Shield.

Blue Shield is a scheme similar to Blue Cross to cover the doctor's bill. There are a number of different policies available covering surgery only, surgery plus in-patient medical treatment, and comprehensive coverage of all medical bills. A schedule of fees is laid down and there is free choice of doctor.

There are a number of non-profit-making comprehensive health insurance schemes which do not allow free choice of doctor. The best known of these are H.I.P. (Health Insurance Plan of Greater New York) and the Kaiser Health Insurance plan in California.

Very commonly, members of trade unions have coverage, either through Blue Cross and Blue Shield or with a private insurance company, either as part of their membership subscription or paid for by their employer as a result of agreement with the union.

Under the state workmen's compensation laws every employee is protected against industrial accidents by his employer's legal liability. Insurance protection against such liability is usually purchased by employers. The cost of medical treatment and hospitalization, pay while unable to

work, and compensation for permanent disability is covered by law. Payment of the doctor is according to a fixed schedule.

The local welfare departments, which correspond to public assistance in England, pay for the care of welfare patients and for those totally unable to pay. The cost is shared by the county, state, and federal governments. The patients continue under the care of their own doctors.

Hospitals

Private Hospitals.—Most hospitals in the United States are private (corresponding to the English voluntary hospitals) and many have religious affiliations. The majority of patients pay for their accommodation and are treated by their own doctors. A certain number of beds are reserved for "service" patients. Service patients are given ward accommodation and are treated by the doctors on service at the time. They pay only for ward accommodation, no doctors' bills. If they are unable to pay, their bills may be taken care of by the local welfare department. Examples of private hospitals are Columbia Presbyterian Medical Centre and Mount Sinai Hospital in New York City, Michael Reese Hospital in Chicago, and the Cedars of Lebanon Hospital in Los Angeles.

City and County Hospitals.—These hospitals compare to the municipal hospitals in England and are usually larger than the private hospitals. All patients are admitted "on service" and are charged according to the amount they are able to pay. (In New York City the maximum charge is \$20 a day flat rate, irrespective of the type of treatment given). The attending physicians are usually unpaid. The best-known city hospitals are Bellevue and Kings County Hospitals in New York City, Cook County Hospital in Chicago, and Los Angeles County Hospital in Los Angeles. Each of these hospitals has about 3,000 beds. The care of the tuberculous is a county responsibility, and the counties run their own tuberculosis hospitals either singly or in groups.

Proprietary Hospitals.—These are run by their owners for financial gain. They are supervised by the local health authorities.

State Hospitals.—The care of the mentally ill is a state responsibility, and all states maintain hospitals for this purpose. The laws concerning voluntary and certified admissions vary from state to state, but the basic outline is similar to the procedures in force in England.

Veterans Administration.—This organization corresponds to the Ministry of Pensions. It provides medical care and pensions for veterans—that is, ex-Service men—with disabilities connected with their service. It has a number of hospitals scattered throughout the country, to which veterans with Service disabilities are admitted. If accommodation is available they admit veterans with disabilities and illnesses not connected with their service, provided that the patient signs the pauper's oath. This leads to considerable abuse, as little or no investigation is carried out to determine the patient's ability to pay. The Veterans Administration hospitals are staffed by residents and full- and part-time paid attending staff.

Marine Hospitals.—These are maintained by the Federal Government at the principal ports for the treatment of merchant seamen. Staffing is similar to that of the Veterans Administration hospitals.

Supplementary Health Services

Aid to the Disabled.—The States of New York, New Jersey, California, and Rhode Island, with a total population of about one-fifth of that of the United States, have compulsory disability insurance for employed persons. In New York State a disabled person receives half his pay, up to a maximum of \$33 weekly, for a period of up to 13

weeks in any calendar year. There is a waiting period of one week before eligibility. Certain states also run schemes for rehabilitating cardiac, blind, and orthopaedic cases.

Workmen's Compensation Laws.—As mentioned previously, all states have workmen's compensation laws, covering industrial injuries. All employers must carry insurance against these injuries, and provision is made for medical treatment by the physician of the patient's choice, hospitalization, compensation while sick, and pensions for permanent disability. In New York State under the Workmen's Compensation Law the patient away from work owing to industrial injury receives two-thirds of his pay up to a maximum of \$36 a week. He receives no pay for the first week unless he is disabled over 35 days.

Blood Tests.—In most states a serological test for syphilis is required before obtaining a marriage licence. A prenatal test for syphilis and determination of the Rh factor is also very often required. Many states insist on pre-employment physical and serological examinations for food-handlers and hairdressers.

State and County Public Health Services.—The organization of state and county health services is similar to that of the Ministry of Health and local health authorities in England. Local county health commissioners correspond to medical officers of health. There are also public health nursing services as in England. Some states run serological laboratories where serological and bacteriological examinations are performed free of charge. A few states provide free histological services and Papanicolaou smear examinations for cancer.

Blood Banks.—Many communities run blood banks, often in conjunction with the Red Cross. Blood may be purchased for \$35 or more a pint. Alternatively, it may be replaced on a two-for-one basis. Many clubs and social organizations maintain a credit of blood with the local bank so that their members may draw on it in case of need.

Indian Health Service.—This is maintained by the Department of the Interior, which is responsible for most of the Indian reservations under treaties made many years ago. The service is very underpaid and is chronically short of money. Reservations often find their hospitals closed for several months at the end of the fiscal year, having spent all the moneys appropriated. An additional difficulty encountered out West, where the largest reservations are situated, is that many of the Indians do not speak English, and live in the direst poverty.

Summary

The working of medical practice in the United States is discussed from both the doctor's and the patient's point of view.

It is important to realize that, while the standard of living in the U.S. is higher than in England, the cost of living is also higher.

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The Clean Air Act, which went on the Statute Book on July 4, is a comprehensive measure of 37 sections and four schedules. The National Smoke Abatement Society has published a summary of it as a 12-page booklet, which describes and explains the Act in a handy form for general reference. The booklet is available from the Society at Palace Chambers, Bridge Street, London, S.W.1, at 6d. for single copies, or 4s. 6d. per dozen, postage included.

MENTAL HEALTH

CONFERENCES IN BERLIN

Last month two important congresses on mental health were held in Western Berlin. The World Federation for Mental Health, meeting from August 12 to 17 at the Free University, took as its theme "Mental Health in Home and School," while on the two previous days the European League for Mental Hygiene discussed modern forms of leisure activity, exemplified particularly by the radio, television, the cinema, and the pursuit of speed. Dr. DORIS ODLUM (Britain) presided at the European League's meeting.

Influence of Films, Radio, and Television

Dr. ANDRÉ REPOND (Switzerland) opened the scientific session of the European League for Mental Hygiene with a contribution on the biological repercussions of the new forms of leisure activity. At first sight, he said, it might appear that human beings adapted rapidly to the various changes which modern technical advances had brought about in their circumstances, but this was not so. All these changes had biological repercussions which tended to alter physical and psychological resistance. Dr. ELFRIEDE HOHN (Germany) said there was a tendency to brand listening to the radio as dangerous and damaging. The characteristic of radio was its appeal exclusively to auditory perception. Thus listening had come into its own again after having lost ground to the written word for several centuries. Auditory perception was nearer to our emotions than visual perception, which was related essentially to our intellectual faculties, and this was one of the underlying reasons for the great success of the wireless. Listeners felt personally addressed by the voice of a living fellow creature. Modern man had been largely cut off from human contacts in a deplorable way, and the fear of loneliness had become the most common pattern of insecurity in our age of anxiety. Housewives, city dwellers, and old people were the most consistent listeners, largely for this reason. But the radio offered only a poor substitute for real human relations. Dr. Hohn thought that the dissociation of attention with background listening could have unfavourable effects, and that the fear of loneliness might lead to people being unable to exist without the permanent dripping shower of sound. Commercial broadcasting offered a good example of what could happen. Very few people believed they focused their attention on the advertising slogans, yet they often found they knew them by heart. It seemed that radio exercised a subconscious influence with considerable suggestive power. It might be that this power had a greater force when the speaker was not seen.

Dr. A. D. LEIGH (Britain) introduced the subject of television. Most of the serious literature about it came from educationists, he said. There was practically none from psychiatrists. This suggested that psychiatrists had no reason to think television had startling effects on either individuals or the community. It appeared that school learning had not been affected, that parental control over children's viewing habits did not appreciably affect their school achievements, and, according to a B.B.C. study last year, there was very little change in the leisure habits of viewers as compared with non-viewers. The educational uses of television had, however, been quickly recognized as extremely valuable.

Dr. D. STAFFORD-CLARK (Britain) discussed some of the television programmes broadcast by the B.B.C. and I.T.A. on problems of health education. He thought they were having a valuable effect in helping people to understand the real meaning of mental health and to become more sympathetic to the role of psychiatry.

In the absence of a speaker from Unesco, Dr. THÉRÈSE LAMPÉRIÈRE (France) dealt with films, and discussed the report of a working party on mental hygiene and the cinema