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GENERAL PRACTICE IN AMERICA AND GREAT BRITAIN

SOME OBSERVATIONS AND COMPARISONS

BY

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In the spring of 1952, through the generosity of the Rockefeller Foundation, I was enabled to make a three-months visit to the United States, the main object of which was to study conditions in general medical practice. The time seemed most opportune to see what range of work was actually undertaken there by the general practitioner, and to find out how the patient fared—the ultimate test—under the conditions of American practice. It was no part of my purpose to try to assess the general standard of American practice. Not only would that have been impossible of achievement in the time, but it was unnecessary. My object was simply to see what opportunities are available to the American doctor and how they are actually utilized.

First-hand knowledge of what happens to the American patient when he consults his doctor seemed to me essential. I had expected difficulty in at least some practices in being present during actual consultations. In the event, my fears were groundless; no doctor or patient showed even hesitancy about my presence, and I was made most welcome. A second requirement was to see what advantages accrued to patients of group practices and other medical-care schemes. From my point of view, only the scope and quality of medical care in these schemes was of special interest, since in Britain we are no longer concerned with questions of contributions, entitlement to medical care, and the many organizational aspects of such schemes. I confined my attention, therefore, mainly to what happened to the patient when he presented himself for treatment. Finally, I was anxious to visit medical schools and other bodies interested in medical education in order to learn about undergraduate and postgraduate training for general practitioners.

The task was a formidable one, and I cannot pretend to have done much more than make a rapid and limited survey. I should like to say at once that I do not claim an exhaustive or a meticulously accurate knowledge either of medical education or of practice conditions in the United States. I am satisfied about the value of what I saw and heard for the purpose I had in view, and of its correctness in principle if not in detail; but I appreciate that there must be many features of practice in the United States about which I am still ignorant. Nothing spectacular or dramatic was expected or discovered. I was able to cover only a very small part of that vast country—though my journey took me long distances by our standards—but I saw both urban and rural practice under widely varying conditions.

At all stages of my tour I was given the greatest possible help, and was enabled to see and hear far more in the time available than I should have thought possible. The simplicity and efficiency of the arrangements made for me by the Rockefeller Foundation contributed very largely to this result. Wherever I went appointments were made in advance with key people in my particular sphere of interest. But ample time was left free for other meetings and visits suggested in the course of discussions. In this way I was able to study, as my journey progressed, what I felt was likely to be of greatest value to me. The broad plan was sketched for me, but I was left completely free to fill in the details.

Places Visited

My tour began in New York, and I returned there at the end. The Health Insurance Plan of Greater New York, a very large and highly organized system of group practice, took up a good deal of my time there and proved of great interest as regards both its headquarters organization and its various group centres. I also saw the work of individual general practitioners. The three medical schools I visited—Columbia, Cornell, and New York Universities—provided a wide range of information of the greatest value, and helped me to get a working knowledge of the general set-up of American health services. During my last days in New York discussions with officials of the American Public Health Association, the Commonwealth Fund, and other bodies enabled me to put into perspective many things I had learned in the course of my visit.

Baltimore, my next stopping-place, afforded a great wealth of experience. The Johns Hopkins School of Hygiene was my temporary spiritual home, and I cannot put too high a value on the privilege of the casual daily contacts there, quite apart from attendance at more formal interviews, seminars, etc. I was able also to see something of the Johns Hopkins University Medical School, the famous Johns Hopkins Hospital, and its diagnostic clinic. In particular, I spent a considerable time studying the work of the Baltimore Medical Care Scheme clinics at Johns Hopkins Hospital, the University of Maryland Hospital, and the Sinai Hospital. This gave me a very close insight into one form of group practice and enabled me to see many general practitioners actually at work. I also attended office consultations and did house calls with private practitioners both in Baltimore and in several rural areas of Maryland. I had numerous discussions with officials of the City Health Department, and also of the State Health Department, including county health officers.

I paid a short but very profitable visit to Washington, where most of my time was spent with officials of the U.S. Public Health Service. From them I received a great deal of background information which was invaluable in assessing much of what I saw and heard during my whole visit. I also saw something there of group practice, and learned from an authoritative source about the work of the American Academy of General Practice.

The next stage of my journey took me to Cleveland, Ohio, where I was privileged to attend the annual meeting of the American College of Physicians. In itself this was a fascinating and instructive experience, but it also proved an enormous saving of time by enabling me to meet teachers from several widely separated American medical schools.

From Cleveland I went to the South, where I spent a week in New Orleans and a week in Jackson, Mississippi, and paid a flying visit to Chattanooga, Tennessee. The officials of the two medical schools whom I met in New Orleans took the greatest pains to help me in every possible way, and my visit there was one of the most useful of the whole tour. I was able to see general practitioners at work in urban and suburban practices. Jackson proved a valuable base for visits to rural doctors, and the State Health Department took endless trouble to provide information and assistance.

Returning to New York, I made short visits to Toronto and Boston. On my way to Canada I saw a very interesting development in group practice, at the Rip Van Winkle Clinic and Foundation in Hudson, N.Y. My stay at Toronto was a brief but intensive introduction to Canadian medicine, made with the help of officials of the School of Public Health, the Medical School, and the Canadian Medical Association. Here also I was able to see general practice at close quarters.

Boston was well up to expectation and I had a short concentrated visit which included the Harvard Medical School and School of Public Health, Boston University, and the New England Medical Center.

In this report I have not attempted to record my experiences in detail. That was done in diary form each day during my trip. While I have found my diary a most valuable personal *aide-mémoire*, it is by no means a complete account of all the many interviews and discussions in which I took part. In common with all visitors to the United States, I experienced boundless hospitality, and on these social and semi-social occasions I obtained a great deal of information of high professional interest and value. Indeed, I am tempted to believe that many of the most useful lessons of all were learned in this way. Impressions of American medical practice acquired by either of these methods are insensibly and inevitably modified by all the other experiences packed into such crowded days. What I have written here is based on my experience as a medical officer concerned in the administration of general practice in the National Health Service, modified by my experiences in the United States. I have tried to describe briefly the training and working conditions of the American general practitioner and to make some comparisons with what obtains in Britain. I have then attempted to define the scope of general practice. Finally, I have put forward some suggestions on what might be done for the future development of general practice in Great Britain.

I. THE AMERICAN GENERAL PRACTITIONER

School, College, and Undergraduate Medical Training

In the United States most children go to school at the age of 6, and they are in the primary school for approximately eight years. They then proceed to their secondary education at a high school for about four years.

A prospective medical student, on leaving school, usually takes an arts or science course at college. At least three years, and often four, are spent in this way, and most students graduate with an A.B. or B.S. degree. Certain subjects, such as physics, chemistry, botany, and zoology, are obligatory. English and mathematics are usually taken, and many schools also require a foreign language. Not more than the minimum is required in science, and stress is placed on sociology and philosophy. The intention clearly is to encourage the student in every way to get a good general education.

Undergraduate education at a medical school lasts four years and leads to the M.D. degree. Speaking broadly, the course consists of the subjects which in this country follow the first M.B. examination.

In the United States, as here, it is being appreciated in many quarters that the student who sees only people in hospital beds or who attends out-patient departments is missing a most important section of illness in the community. Moreover, two present-day trends—the smaller number of house visits made by American doctors, with the consequent tendency for the patient to become the sole judge of when he should see his doctor, and the shortened average stay in hospital—result in the medical student seeing even less than formerly of the beginnings and consequences of illness. Some medical schools have therefore made provision for students to gain experience in domiciliary medical practice. Patients are assigned to students, who look after them both in hospital and at home. Guidance is given by a senior, every care being taken to avoid interfering with the rapport established between the student and the patient. The student stands in something of the relationship to the senior that the general practitioner does to the consultant. The value of team-work is emphasized by showing the use that can be made of social workers, health visitors, and the full range of community resources. The importance of such teaching in clinical and social medicine is obvious. The student is given an early opportunity of appreciating the practical value of the concepts of preventive medicine as applied to the individual patient and his family.

The Internship

The next stage consists of one year's training as an intern (H.P. or H.S.). According to Pullen (1952a) about half the States require a doctor to have served an internship before they will grant him a licence to practise. The licensing examinations are, incidentally, quite separate from the degree examinations. An American Medical Association report states that for over 20 years practically every graduate of an American medical school had voluntarily acquired a year of hospital experience and that by the mid-thirties more than 75% were completing two years and more of hospital training before entering on the practice of their profession (Diehl *et al.*, 1950a). The rotating internship, consisting of three months each of internal medicine, surgery, paediatrics, and obstetrics and gynaecology, is the most common type. Great importance is attached to this form of training, and it is an absolute prerequisite to many later appointments and advancement. There are also "straight" internships in these subjects. In a straight internship in surgery, eight months would be spent at general surgery and the remaining four months at surgical specialties. Similarly, the last four months of an internship in internal medicine would be spent in paediatrics, psychiatry, neurology, etc. The American Medical Association controls this training, in so far as it certifies hospitals at which credit may be given for an internship. At present there are many more internships than young graduates of American medical schools. In 1951 there were only 6,135 medical graduates to fill 10,044 internships (Pullen, 1952b). This leads to competition, with the result that some hospitals pay much more attractive salaries than others. It is said that some of these hospitals do not make any great effort to teach.

Graduate Training

Graduate or residency training is intended for the trainee specialist, and may be said to correspond to the period of a registrarship in Britain. It may last from two to five years, according to the specialty. There are over 20 specialty boards in the United States; each lays down what the training for its own specialty should comprise and conducts the examinations. The American Medical Association has begun to certify hospitals which should be approved for specialty training. As with approved internships, there are more residency vacancies than there are trainees, and this has again given rise to unfortunate results. The percentage of failures at the examinations of the specialty boards is considered by many to be unduly high. Actually, it is probably not very different from what obtains in this country in the higher examinations in medicine and surgery. Darley (1952a) put the proportion of failures in 1949 at an even third. In his presidential address to the American College of Physicians in 1952, Pincoffs (1952) attributed the high percentage of failures partly to the inadequate training given by some hospitals.

Some American schools have in recent years provided, in addition to the year of internship, a three-years general practice residency—consisting of one year of internal medicine, one year of surgery, and one year of obstetrics and gynaecology. This is a particularly interesting development in that it places general practice on the same level with regard to length of training as most of the major specialties. Unfortunately, and for various reasons, according to some of those intimately concerned in the promotion of these residencies, they have not been an unqualified success. It is suggested, for example, that the general-practitioner resident takes second place in training to the specialist resident. An alternative—attractive in more than one way—has been put forward whereby, after a period as an ordinary resident, the trainee general practitioner would go to a special hospital where the staff would not be members of a university faculty or medical school, but would, of course, be thoroughly imbued with the spirit of teaching.

Postgraduate Training

At least two agencies in the United States are actively engaged in stimulating postgraduate education with an enthusiasm and energy not equalled in this country. The American Academy of General Practice requires of its members certain minimum amounts of formal and informal instruction, and its local branches arrange to have the necessary courses and other forms of instruction made available. A number of medical schools are concentrating on providing general-practitioner postgraduate training, even to the comparative neglect of specialist training. There are, of course, variations in the courses provided at different medical schools, but the following are the main types:

(1) Short intensive courses of from one to three days are held perhaps every two to four weeks. Lectures, clinical pathological conferences (C.P.C.s), and panel discussions are given. The short length of some of these courses makes it easier for the general practitioner to attend without leaving his practice, a point of great importance in the United States. This type of instruction is very popular and the demand is steadily increasing. One medical school had 1,000 registrations in one year—a most impressive achievement, as the total number of general practitioners in the State is 1,600. The greatest care is taken to appeal to the general practitioners by framing the courses to meet their calculated needs and by employing a number of carefully designed methods of holding their interest.

(2) Through the generosity of the Kellogg Foundation, about 20 medical schools are now providing a most attractive scheme of postgraduate instruction. The essence of it is to bring the instruction to the doctor in his practice. A teaching team of two or more members of a medical faculty is sent to a small peripheral hospital of perhaps 50 to 80 beds. A morning ward round is made and the doctors see their own patients examined and demonstrated. In the afternoon more of the doctors' patients are seen as out-patients. The evening may be employed for a lecture or talk. Variations of this programme are, of course, used by different teaching schools.

(3) Evening courses once a week for 12 weeks are held by some schools. Each week a different team, usually of two, attends. Patients may or may not be used. These courses are normally built around the local medical society.

Perhaps the most striking feature to the British visitor of all these courses is the care devoted to making them attractive and useful to the general practitioner.

General Practice

Entry into Practice.—The American general practitioner enters practice as a rule straight from an internship and learns his new job by experience. Some doctors, before beginning practice on their own, serve a period as an assistant to an experienced practitioner, though this arrangement seems to be less common than in Britain. Naturally, a certain number of entrants to general practice have had residency training for varying periods. Some of the latter aim at becoming specialists in, for example, internal medicine. To do so, they may seek the Certificate of the Board of Internal Medicine or of one of the other specialty boards; but such doctors can acquire consulting practices solely by gaining the confidence of their fellows.

The "Family Specialist."—It is necessary to consider in relation to American general practice a type of practitioner unknown in Britain—the "family specialist," he might be called. These doctors may be orthodox specialists with the certificate of the appropriate board, or they may merely have taken a long period of hospital training. They do, however, limit their practice to their specialty, which is usually internal medicine or paediatrics; but they are prepared to accept patients direct in the same way as a general practitioner. In addition they may do some consultant work. Such practitioners are still relatively uncommon; but the total number of doctors specializing in internal medicine is growing rapidly in America. The President of the American College of Physicians stated that in 1940 there were roughly 6,400 and in 1950 about 11,600. He predicted that the number would have risen by 1960 to 20,000 or 25,000, and that there would be a growing demand by the public adequate to absorb at least all those who engaged in this form of family practice (Pincoffs, 1952).

Types of Practice.—In urban areas, individual practice is still the usual form seen; but group practice is now quite common and is widely accepted. The object of such groups is to provide practically complete medical care on a prepayment basis, and the staffs comprise both general practitioners and specialists. Individual practices in these areas may be run by general practitioners or by the family type of specialist. In semi-urban areas one or more doctors may endeavour to limit their practice to internal medicine and may combine such a family practice with a limited amount of consulting work. No doubt examples of group practice in these areas are also to be found, though I did not encounter them. I did see, however, in a rural area, an interesting example of group practice, though as a rule in such places the individual general practitioner still reigns supreme. Indeed, the rural practitioner in America commonly goes beyond the usual scope of general practice as we know it; he may do a considerable amount of specialist work—in particular, major surgery.

Accommodation, Equipment, and Staffing

The American practitioner often has professional accommodation and equipment on a scale seldom seen in this country. It is perhaps dangerous to generalize on the basis of such a limited number of doctors' offices as I had the opportunity of seeing, but I can say that I never met any doctor who had less than three rooms and whose equipment was not well above the British average. The three-roomed suite—waiting-room, consulting-room, and examination or treatment room—is gradually appearing here, and is advocated in all reports and articles on health centres or group practice. In the United States it was, in my experience, the basic minimum. More elaborate accommodation, often in *ad hoc* buildings, was quite common. Developments of this

sort were by no means limited to urban areas, and indeed perhaps two of the best *ad hoc* buildings I saw were in small rural practices in Mississippi. While I did see examples in country practices of old-fashioned waiting- and consulting-rooms with well-worn furnishings—to me, not at all unpleasant features—these were uncommon. Even so, they differed from many similar premises in Britain in that they contained all the essential modern diagnostic equipment of general practice.

Equipment was usually elaborate by our standards. Examination couches were of particularly good quality and design and, more important, were not merely for ornamental purposes. It was quite common to find a short-wave diathermy machine, ultra-violet ray lamp, electrocardiograph, and a well-equipped x-ray and dark room. B.M.R. apparatus, surprising to the British visitor, was by no means a rare piece of equipment to encounter. Oxygen and anaesthetic apparatus were sometimes in evidence. Refrigerators for the storage of biologicals, dressings trolleys, and weighing machines with height measures might be said to be standard equipment in most doctors' offices.

Domestic staffing was in keeping with the amount of accommodation. Practitioners made great use of ancillary staff, such as nurses, technicians, and secretaries. I saw only two doctors who did not have a nurse (not necessarily fully trained) to assist them; the wife of one of them, however, did a certain amount of less skilled nursing work. Commonly, the nurse undertook simple laboratory tests and secretarial work, but a separate secretary-receptionist was often employed, and sometimes also a technician. In group practices, furnishing and equipment are on at least as good a scale as in the best type of individual practice. Sometimes a standard is reached which has to be seen to be believed by the visitor from this country. The first experience I had of a waiting-room belonging to a New York group made me feel I was in the lounge of a luxury hotel. Laboratory work in such group practices is sometimes quite complete, and no work has to be sent elsewhere.

Laboratory Facilities

Clearly, many American practitioners are equipped to carry out a considerable number of diagnostic investigations in their own premises. In addition, they seem to have no difficulty in getting more elaborate work done at hospital laboratories or at other laboratories run on a purely commercial basis. Indeed, some city doctors rely almost completely on commercial laboratory investigation, rather than employ a technician or do their own laboratory work. It is a common criticism of American medicine—heard more often, I should say, in America than in Britain—that too many laboratory tests are performed. Hawkins (1952), describing his impressions of postgraduate education in America, remarks that “in Britain the clinical approach and good bedside teaching are characteristic, whereas in America the laboratory aspect is highly developed.” He at once adds that such a generalization does “an injustice to the many outstanding medical men of the U.S.A. whose clinical acumen is beyond reproach.” Arnott (1952) was greatly impressed in America by the emphasis placed on the simple clinical methods of history-taking and physical examination, and saw no tendency whatsoever to rely on esoteric laboratory tests. These British writers refer to hospital practice.

The opposite view, this time in relation to practice outside hospitals, is expressed by McCombs (1950), of Boston, who speaks of certain doctors employing as a means of profit diagnostic tests that they are not qualified to use. My own experience was that the good general practitioners, like the hospital clinicians quoted above, did not abuse laboratory tests. It is a foolish attitude, that is sometimes assumed by critics of American practice, that few of the laboratory tests used are really required. General practitioners in Britain would do well to avail themselves of all useful corroborative diagnostic evidence according to the best standards of modern hospital practice.

Hospital Appointments for General Practitioners

Attitude to the Problem

A large proportion of American general practitioners have some form of hospital appointment. This seems to apply in both town and country practice; almost every doctor whom I met had some form of association with a hospital. A statistical investigation made in Baltimore in the early 'forties showed, I was informed, that approximately 45% of practitioners had really satisfactory attachments to hospitals, that 35% had no attachment, and that the rest had rather slender attachments. A statement that in one large city only 56% of the general practitioners had a recognized hospital affiliation appears in the recent Report by the President's Commission on the Health Needs of the Nation (1952a). The figures for these two cities are quoted as disappointingly low from the American point of view. In Britain such proportions of general practitioners with hospital attachments would be regarded as startlingly high. I am unable to say accurately to what extent hospital appointments for practitioners are available throughout the whole country; but there is ample evidence to show how vastly different is the American attitude to our own in this important question.

For example, the Report of the Hospital Survey for New York (1937), after stressing that the public must be concerned with the relationship of the hospital and the practitioner, goes on to state: “To keep up with the ever-changing methods of diagnosis and treatment, the medical practitioner needs the stimulus provided by association with the organized medical staff of a well-equipped modern hospital.” Similarly, the Hospital Council of Greater New York (1951a) states that not only should a practitioner have the privilege of caring for his own private patients in hospital, but that he must have the opportunity to work under supervision in the wards and out-patient department and to participate in the teaching and training of medical students, members of the house staff, and other physicians. The Subcommittee on Medical Care of the American Public Health Association (1949a) reported: “General elevation of medical standards requires the closest possible contact of all practitioners in the community with the hospital facilities that are available. Good care is impossible to provide in isolation from the consultants, laboratories, equipment, and other facilities of the modern hospital.”

Types of Appointment

In the United States a regular staff appointment gives the opportunity of looking after patients in the wards and out-patient department. The holder is given specific duties and responsibilities towards public patients, and he takes part in all the educational activities of the hospital. Where a practitioner merely has the right to attend his private patients in hospital he is said to have private-patient privileges. Private patients and semi-private patients may be in single rooms or occasionally private wards. In general, patients in wards are those who cannot pay for private care, and they are looked after without charge by a doctor on the staff. The doctor with only “privileges” may, in a well-organized hospital, be subject to certain limitations in the procedures he may carry out; his work is to some extent supervised. But he has no responsibilities in the wards or out-patient department, and he is not required to attend staff conferences or participate either as a learner or teacher in the educational side of the work of the hospital. Where a doctor has both a regular appointment and private-patient privileges he is said to have a combined appointment.

New York City Appointments

In New York City on January 1, 1948, there were 17,703 licensed medical practitioners, of whom 14,850 were doctors in active practice. Doctors in related fields (administration, public health, research, teaching, etc.) and doctors in training (residents, interns, etc.) were excluded in calculating the number in active practice. Over 80% of these doctors,

including specialists and general practitioners, had hospital appointments, as the following figures show :

No. of doctors with hospital appointments:			
Combined or regular appointments	10,602	..	71%
Private-patient privileges only	1,770	..	12%
	12,372		83%
No. of doctors with no hospital appointment	2,478		17%
Total No. of doctors in active practice ..	14,850		100%

As there are estimated to be 7,000 specialists in the city, most of whom have hospital appointments, then more than 5,000 general practitioners must have hospital appointments. It is also estimated that most of those 2,478 doctors with no hospital appointments are general practitioners. In other words, two-thirds of the general practitioners have hospital appointments (Hospital Council of Greater New York, 1951b).

A Comparison with Scotland

The Hospital Council makes the claim, which at first sight is quite astonishing to the British reader, that to provide combined appointments for all doctors in active practice in New York City would require no appreciable increase in the existing 32,652 general-care hospital beds. (This number of beds is little short of the 33,600 recommended for 1950 by the Master Plan for Hospitals and Related Facilities. It is said, however, that a redistribution is required in view of the relative shortage of semi-private facilities : there were 12,724 private and semi-private beds.) (Hospital Council of Greater New York, 1951c.)

In Scotland in 1952 there were 2,400 principals and 306 assistants in general practice under the National Health Service, making a total of 2,706 ; and specialists numbered 826, including those working both part-time and whole-time (registrars, interns, and specialists not engaged in general care excluded). The number of general practitioners not working under the National Health Service is probably less than 50, so that the total number of doctors in active practice seems to be about 3,500. General-care beds are about 27,583 for a population of 5,000,000 (Report of Department of Health for Scotland, 1952).

In New York City there are then, in proportion to the population of 7,888,000, more than two and a half times as many doctors (general practitioners and specialists) in active practice and more than five times as many specialists as in Scotland. Relatively, general practitioners are almost twice as numerous in New York. On the other hand, Scotland has proportionately about four beds for every three in New York. The highly urbanized needs of New York cannot truly be compared with the needs in Scotland either of doctors or of hospital beds, but the ratios are so different that they may well not be completely accounted for by differences in the type of population. Indeed, it could be argued that any difference in needs would serve only to accentuate the differences in the ratios shown above.

At least two points stand out. First, it would be simple, if our Scottish hospitals were run on the American principle, to find hospital appointments for all doctors in practice. Such a revolutionary change, even if desirable, could clearly not quickly be effected. But, at the very least, it is reasonable to argue that no vast modification is required to find useful employment in hospital for a considerable number of general practitioners. Secondly, the question at once poses itself : does the American method of practice not seem to be much more economical in the use of hospital beds ?

Conditions for American General Practitioners in Hospitals

Among the recommendations of the Hospital Council of Greater New York (1951d) it is urged: (1) that all hospitals appoint general practitioners to their staffs and, under the jurisdiction of the chiefs of the various services, give them the opportunity of working in different departments, and the educational advantages afforded by the institution ; and (2) that general hospitals establish appropriate professional units to guide the activities of general practitioners on their staffs, and work out a programme for each individual practitioner with the various clinical departments. It is under-

stood that the extent of hospital privileges given to a doctor should depend on his training, experience, and competence, and that his work should be supervised.

Departments of General Practice in Hospitals

The American Academy of General Practice has prepared "A Manual on the Establishment and Operation of a Department of General Practice in Hospitals." In the preparation of the Manual the Academy obtained advice from the American Medical Association, the American College of Surgeons, and the American Hospital Association (Editorial, 1950).

The Manual advocates that the general practitioner as well as the specialist should be able to use the modern hospital to the degree that his training and experience warrant. It is recommended that the medical staff should be organized into at least three departments, consisting of medicine, surgery, and general practice, and that within the last-mentioned section the general practitioner should be given hospital privileges in the practice of internal medicine, paediatrics, obstetrics, and surgery as determined for each applicant by the credentials committee of the staff. It is laid down how the evaluation should be made of the qualifications and ability of those members of the general practice staff who feel that they have had the necessary training and experience to engage in more advanced work within a specialty field.

Scope of General Practice in America

The scope of the general practitioner's work in America is a good deal wider than here. This, at least in part, explains his more elaborate diagnostic and therapeutic equipment, much of which he must find really necessary for his work. It is not entirely a matter of his own choice that he practises a wider range of medical work ; his patients expect it of him. This may explain the occasional major surgery by general practitioners which is still done in places like New York and Baltimore, where expert surgical skill abounds. This situation has both its good and its bad features. There is great interest and stimulation for the general practitioner to investigate and treat his patients with a full range of diagnostic and therapeutic facilities, such as is available here only to the hospital specialist. This seems to be accepted practice, for the Subcommittee on Medical Care of the American Public Health Association (1949b) stated : "With the receipt of complete consultation reports, the general practitioner can usually continue with the management of all but the most specialized therapeutic procedures." Moreover, American general practitioners seem to have a familiarity with the appropriate methods for such work almost unknown among their British colleagues. It is idle to discuss, on my slender experience of American practice, whether the work done is on the whole more efficient than in British practice. What I endeavoured to learn was what the general practitioner could do, given the necessary facilities. I am satisfied that he can and does do a better job in many, but not all, ways than is done by the general practitioner here.

Group Practice in America

Definition of Group Practice.—The term "group practice" has a different meaning in the United States from what is usually implied when it is used in this country. The Medical Group Practice Council (1946a) has laid it down that "in order to be considered a medical group practice unit, an association of physicians of different skills, using medical equipment and nursing, technical, and administrative personnel in common, must have a formal pattern of professional collaboration, a definite relationship as a group with a hospital or hospitals in the community, and a unified administrative and financial organization." A formal pattern of professional collaboration means that the consultation and co-operation between the different types of doctors in the group are definitely planned so that they are

readily available for the patient's benefit. A unified administrative and financial organization requires the pooling of incomes and that financial relations with patients are handled in the name of the group. It is accepted that three or four doctors sharing accommodation and auxiliary personnel are not engaged in group practice, although they may enjoy some of its advantages.

Types of Group Practice.—This form of organization is, of course, merely an extension to outside practice of what has long obtained in teaching hospitals. As Clark and Clark (1941) put it: "Having been trained in the group method, the medical graduate of to-day is well-fitted to continue his career as a member of a professional group where he can practise the type of medicine he has been taught. It is often difficult, on the other hand, for him to adjust himself to the professional and financial limitations of individual practice." We are not concerned here with reference groups such as the Mayo Clinic, or diagnostic groups like those at Johns Hopkins Hospital and elsewhere. The principal other type is that which provides general family care and specialist services.

Advantages of Group Practice

The doctor is able to do his best work, having readily to hand access to the necessary specialist advice and diagnostic and therapeutic facilities. At the same time economy is effected through sharing of accommodation, equipment, and ancillary personnel. The saving has been estimated at from 15 to 30% (Medical Group Practice Council, 1946b). There is also an economical use of medical manpower in that the young doctor is at once fully employed and has no long period of waiting for patients in a newly established practice. Indeed, the view has been advanced that the United States "cannot afford the wastage entailed in the partial idleness of the solo practitioner while he is building up a practice" (Report by the President's Commission on the Health Needs of the Nation, 1952b). Moreover, the doctor has opportunities for private study and attendance at postgraduate courses, and is enabled more easily to work at any specialty in which he may wish to develop his knowledge. All doctors in group practice have, of course, the benefits of sharing night duty, emergency calls, and so on.

For the patient the advantages are not limited to having the advice of the appropriate specialist: that could be obtained under almost any form of practice. The fundamental justification for group practice is the opportunity it offers for greater efficiency in the key member of the team—the family doctor. He is enabled to continue the best features of his training period throughout his professional life—"the stimulation to keep up with medical progress through constant appraisal by informed colleagues and ready access to consultations and technical assistance" (Report by the President's Commission on the Health Needs of the Nation, 1952c).

Examples of Group Practice

The Health Insurance Plan of Greater New York (HIP) has as its aim to provide comprehensive medical care—preventive, early diagnostic, and curative. The entire cost is covered by combined HIP and some form of hospital insurance such as Blue Cross. It began in March, 1947, and was responsible for the care of almost 400,000 persons by 1953. Medical services are available in the homes of patients, in doctors' offices, in medical group centres, and in hospitals. There are 30 medical groups scattered throughout the city. Each group has a sufficient number of family physicians for its size, the appropriate number of specialists representing the 12 basic specialties, and it has the requisite laboratory, x-ray, and other diagnostic and therapeutic services. Almost a half of the 950 doctors employed in the scheme are diplomates of the American specialty boards.

The medical groups are autonomous and each is a professional partnership. They are required to meet definite professional standards and to provide specified facilities.

The scheme is, of course, a prepayment one, and subscribers may choose any medical group and any one family physician. After deduction of administrative expenses the income is distributed to the groups on a capitation basis.

The family physicians see most of their patients at their own private offices, which are usually nearer the patients' homes; but generally they also have certain office hours at the group centre. The specialists see most of their patients at the centre.

The medical director claims that the maximum amount of diagnostic and therapeutic procedures is carried out on an ambulatory basis and that in consequence many hospital beds are saved. He also claims that in hospitals where members of the staff practise group medicine the family physicians in the scheme become essential members of the hospital group and enjoy all the educational advantages of an intimate hospital relationship. Moreover, the hospital has the advantage of being more intimately related to the medical and socio-medical problems of the community (Baehr, 1953).

Many other schemes in the United States provide in one way or another useful and continuing postgraduate associations with medicine as practised in hospitals. In addition to HIP, I have referred above to the medical care scheme in Baltimore. I was also able to see the Bingham Associates Plan in Boston. It is impossible here to give a detailed description of these schemes. Many of their features are, of course, concerned with means of providing medical care, but they afforded me excellent opportunities of studying certain aspects of general practice in the United States, and particularly the association of the family doctor with the hospital and teaching centre.

Is the Pattern of American General Practice Wholly Satisfactory?

I certainly saw much in the United States that showed me how our own standards could be improved. I realize there may be, as I have been told, general practitioners of poor standard. But I was concerned only with the achievements possible under American conditions, the potentialities of that type of practice. Obviously the American doctor has more time to see his patient: he requires it to practise his wider range of skills. Again, he must give a patient who is paying a high fee a consultation of some length. These things are in his favour and, apart from cost, in favour of the patient. But sufficient time for every patient will probably long remain, even in America, a counsel of perfection. There will always be a need to do what must be done and to leave at least some of the other less necessary things undone. The art of practice—and it is still an art despite modern scientific resources—will consist then in doing for each patient what he or she most requires.

I should hesitate to criticize American general practice on the basis of the small sample of it I saw. It did seem to me, however, that more time might sometimes have been given to consideration of the patient as a person. It may be this is due in some measure to preoccupation with instrumental investigation, laboratory tests, x-ray examinations, etc.—and time, as always, is the enemy. At any rate, the "history" sometimes seemed rather a stereotyped interrogation. It is but fair to say that one of the doctors who best appreciated the importance of establishing rapport with his patient, of considering emotional factors, and of viewing the patient as a person, was the possessor of quite the most elaborate accommodation and equipment I saw anywhere.

It is also difficult on my limited experience properly to assess the value of the American family internist. For some Americans, possibly an increasing number, he takes the place of the general practitioner, within the limits of his restricted form of practice. Possessed of over-average experience in internal medicine, he may surpass the general practitioner in the technicalities of medicine. If the general practitioner neglects what he is best qualified to do—act as

family guide, philosopher, and friend—and enters into competition in another's chosen field, he is destined to defeat. However able the family internist may be, he is bound to be at a disadvantage in the role of family doctor as compared with the general practitioner adequately grounded in internal medicine, who is present when the children are born, who advises the mother about the bringing up of her family, and who is the first to be called in time of illness. The family internist is not, of course, a specialist in the ordinary sense. He seems usually to do at least some very minor surgery, dermatology, eye work, etc. Clearly, it must be well-nigh impossible for him to limit himself rigidly to his specialty, though he will certainly not engage in obstetrics or paediatrics.

The family paediatrician also has no British equivalent. Much of his work is child welfare; and in that he probably has more experience than the paediatric specialist in Britain, who is mainly concerned in the care of sick children. I have discussed the question of the family paediatrician with doctors in that form of practice and with paediatric teachers in medical schools. They agree that a general practitioner who is adequately trained in internal medicine and has a reasonable knowledge of other branches of his work, including paediatrics, can give entirely adequate care to children, well or ill, provided he has access to specialist help when necessary.

If, then, these family specialists have a technical lead in their own sphere over the good general practitioner, it must be reduced by a relative lack of the real basis of general practice—knowledge of the patient, his family, his work, and his background. There are undoubtedly some who consider that the internist is the one who should be concerned chiefly with the very personal type of care which most people require, that he should take over such duties from the general practitioner. Darley's (1949) wise answer is: "If this is to be so, the training of the internist will have to be much different from what it is to-day."

At the beginning of my visit a knowledgeable adviser told me that someone of considerable standing in the profession had recently said to him that the general practitioner in America was a disappearing entity. He added that he did not himself believe the statement but would be interested to hear what conclusions I came to after my survey of general practice. I can answer emphatically that I saw no reason to fear for the future of general practice in America.

Darley (1952b) states that between 1938 and 1949 there was a 19% increase in the total number of doctors, and that specialists increased 98%. Pullen (1951), after quoting similar figures, says "the pendulum is swinging and the general practitioner is coming into his own." He quotes student polls by the Council on Medical Education and Hospitals of the American Medical Association which indicate that the percentage of students planning to enter practice has increased from 36 to 47%, and that the number planning to specialize has decreased from 36 to 31%. Whatever may be said of these figures, general practitioners still constitute 47.5% of doctors registered in the United States, while specialists form only 27.3%; the remaining 25.2% are interns, residents, Government servants, etc.

I was most impressed, not by figures, but by the standard of work I saw done by certain general practitioners, the reactions of patients, and the refreshing confidence of all in the future of general practice. This confidence was undoubtedly contributed to by the success of the American Academy of General Practice. With its membership of 17,000 it has already done a great deal to enhance the status of the general practitioner.

II. THE BRITISH GENERAL PRACTITIONER

School and Undergraduate Medical Education

In Britain, school education begins and ends, generally speaking, at the same ages as in the United States. I have no information on the relative standards of attain-

ment; but, presumably, any balance in favour of one or other country must be a small one. The American medical student has then a rather longer preparation for the study of medical subjects, while his British counterpart devotes a little more time to the medical course proper. Everyone who has written about the place of general cultural studies in the training of doctors agrees about their importance. If the preliminary cultural requirements in the United States are greater than here, we must acknowledge their value and criticize, if at all, only on the grounds of cost and practicability. Whether as much ground is covered in their shorter medical course I cannot say, but most people who have intimate knowledge of American medical schools speak of the great industry of the students. No doubt there will be difference of emphasis in the teaching as between the two countries, but it is enough here to say that in Britain and America the medical student receives a very high standard of training.

As in the United States, some medical schools in this country have made provision for introducing the student to the problems of general practice. Similar developments in association with health centre practice are now being introduced.

Graduate Training and Entry to Practice

In Britain to-day there is so much competition for practice vacancies that the doctor without adequate postgraduate experience in hospital and as an assistant has little chance of becoming a principal. Most informed people agree that entry into practice is at present too difficult, and a good deal of harm has resulted from this state of affairs. On the other hand, one beneficial consequence is that adequate preliminary training is now practically ensured. Other developments are leading in the same direction. From January 1, 1953, a doctor must serve a year as an intern before registration.

A committee under the chairmanship of Sir Henry Cohen produced a report on "General Practice and the Training of the General Practitioner" (British Medical Association, 1950a). The report recommends for general practitioners a three-year period of training after registration—that is, four years after graduation. The first of these three years will be spent under the supervision of a general practitioner, the second year in specially designed hospital appointments, the third year will include a choice of opportunities in hospitals and as an assistant or locum in general practice. The Report of the Working Party on the Distribution of Remuneration among General Practitioners (1952) laid down as a qualification for an Initial Practice Allowance (a grant to assist doctors to set up in practice) that the applicant must have been in general practice for not less than two years or have been registered as a medical practitioner for not less than four years. The trainee assistant scheme under the National Health Service has enabled many specially suitable doctors, not otherwise available as trainers, to have assistants; it has thus provided young doctors with an opportunity of an assistantship under favourable conditions for real instruction in the problems of general practice.

The Registrar Problem

A somewhat special situation, presumably temporary, has arisen as a result of more registrars (trainee specialists) being employed in the hospital service than seem likely to be absorbed by promotion to the rank of full specialist. Some of these doctors have decided to give up their attempt to become specialists and have tried to enter general practice. It is natural that, having been qualified for perhaps three and often more years, they should attempt to obtain a practice without a period of assistantship, but such attempts have not as a rule been successful. These doctors should eventually prove to be valuable recruits to general practice if they have the requisite qualities of personality. Even where their postgraduate training has been of a very special nature it should be by no means wasted. The

potential worth of all these doctors with their long hospital training is very high indeed, and could be realized if they were enabled to find part-time hospital appointments in their specialty in addition to working in general practice.

Postgraduate Training

Whatever the defects, then, that may have existed in graduate training for entrance to general practice, they are being steadily reduced. The Cohen Report points out that there has in the past been a tendency "to regard the postgraduate education of the general practitioner mainly as a matter of occasional refresher courses and lectures." The report wisely advances the view that this is far too narrow a conception and that "professional education should be a continuous process extending throughout the practitioner's active life and forming part of the very fabric of practice" (British Medical Association, 1950b). As has been shown, this view is not only shared in the United States, but steps have been taken by some medical schools to cater appropriately for the continuing educational needs of general practitioners. The American Academy of General Practice, by requiring of its members a minimum of 150 hours of informal instruction and 50 hours of formal instruction over three years, has done a great deal to ensure regular, rather than merely occasional, postgraduate instruction. The deans of the American medical schools which are successfully offering regular and well-planned general-practitioner postgraduate courses are no less deserving of credit. In Britain a College of General Practitioners has lately been founded. Certain postgraduate educational requirements are already demanded by it of some of its members, and later these may well be extended.

Health Centres

The present policy of both the Government and the British Medical Association is that health centres should meantime be regarded as experimental only. Quite recently a few centres have actually been completed. It is only reasonable to wait for the results of running these centres before coming to final conclusions. The large type of centre has, however, proved expensive to build, and more interest is now focused on the possibilities of the smaller type. Some hope that in the health centre will be found a solution to the problem of co-ordinating the three parts of the Service and of raising the standard of general practice by providing good accommodation, equipment, and ancillary help. The practitioner in the centre, it is argued, will be in an unrivalled position to use the full resources of the community.

The main argument used in favour of health centres and group practice, so far as general practitioners are concerned, is that the doctor, if he is to be able to use efficiently the resources of present-day medicine, must have working conditions which, in this country, are scarcely possible in independent practice. The standard of accommodation, equipment, and staffing in the United States is strikingly good; but no general practitioner can make sufficient use of the more expensive articles of equipment mentioned earlier, of which x-ray plant is the most obvious, to make them justifiable, except on a group basis, in a publicly organized service. The same argument applies, in a less degree, to accommodation and staffing. It is possible, however, to have on an economic basis for a single-handed practitioner adequate accommodation and ancillary help. One of the best general practitioners I saw in America—so far as I was able to judge with my limited opportunities—had good but certainly not lavish accommodation, and was assisted by a lady secretary-receptionist who assisted with minor nursing and laboratory work. This doctor, with a good-class practice, came as near to the ideal as anyone could, humanly speaking, expect. In addition to ordinary consultations, he did a considerable amount of maternity and child welfare work and routine overhauls of patients who wanted that form of advice. On the whole, however, it is as a rule

easier to provide an efficient standard of accommodation and staffing when doctors are working in a group.

We must ask ourselves if our present conception of a health centre is adequate. The family doctor working in a centre may well have a closer link with the advisory services provided by the local authority and with the medico-social agencies in the community. But the association of general practitioners with specialists in health centre work is almost non-existent in many of the types of centre so far in being. The Report of the Nuffield Provincial Hospitals Trust (1951) records, however, how the Trust has supported a project to provide a diagnostic health centre for general practitioners; and, jointly with the Rockefeller Foundation, has assisted in a most promising scheme for a health centre, which when fully developed will provide facilities for teaching general practice to undergraduates, and where the family doctors will not only have appointments at hospital but will undertake local authority clinic work. These are excellent experiments, and have the merits, among others, not only of giving much needed diagnostic facilities to general practitioners, but of securing for them an association with hospitals.

Are General Practice Conditions in Britain Satisfactory?

Whatever criticism may be levelled at the training given in medical schools, no one would say it was unsound or grossly inadequate. No doubt it could be improved: of necessity, since conditions are always changing, that will always be so. It is by no means a complete training for practice, nor is it intended to be. As Welch (1910) wrote: "The student cannot go out a trained practitioner, a trained pathologist, a trained anatomist, or a surgeon. Looked at from the point of view of knowledge alone, he has only a smattering. The training of his powers and methods of study are the important things. He should be put in a position to continue his own education." But, even so, the young doctor entering practice, though his education is admittedly still incomplete, is reasonably well equipped to begin the practice of a wide range of medicine and to complete his education by practical experience and further study.

What is so striking is that, however limited are the skills that have been acquired, many are so often and so soon lost in practice. Other skills and experience may compensate, but the loss is still a real one. The problem is to provide not only continuous postgraduate education but the opportunity to use every talent to the fullest extent. If, in addition to the compulsory year of internship, entry to general practice develops on the lines of the Cohen Committee's recommendations, recruits to general practice of an even higher standard should come forward in the future. That would be a welcome development, but some of the benefit may be lost unless conditions of practice are altered. The American practitioner has more time to deal with his patients. Until many British general practitioners can arrange their affairs so as to have much more time than at present they cannot hope to undertake the full scope of practice so desirable for their own continuing interest and efficiency. In the same way, adequate access to diagnostic facilities and some useful association with hospital work are imperative. The recent arbitration award of extra money to general practitioners and the recommendations of the Working Party on remuneration have done something to ensure that doctors have more time and should be able to develop more efficiently organized forms of practice by which they may secure better working conditions generally. But, at best, only a few steps have been taken; that is, however, our traditional way, and we may well hope that before long there will be further progress in the same direction.

III. THE SCOPE OF GENERAL PRACTICE

In any consideration of the training and working conditions of general practitioners it is essential to define what should be the scope of general practice.

The general practitioner should be the family doctor in the fullest sense in which that expression can be used. In Britain he has been gradually displaced over the years from that position by a lack on his part of positive adaptation to the organizational needs of medical progress, and by passive acceptance of further and further encroachments on his province by the clinic system and the growth of specialism, the latter being recently intensified by the introduction of the National Health Service. Concurrently, his status in the view of the public, of his specialist colleagues, and even of himself is said to have diminished. Inversely has the status of the consultant increased. However justifiable this last-mentioned development may at one time have been, it is now not infrequently, Ogilvie (1952) suggests, a change in status without change in stature.

If there has been so serious a diminution in the status of the general practitioner then it is clear that what is required is a new faith in general practice by general practitioners. They must stake out their claim and hold it. They see the patient first—or should do—and patients must be directed from them to the specialist in hospital, or at the clinic; but only as and when the practitioner considers that necessary. This may seem to be leaving for the specialist the role of a mere technician. But by yielding up to the general practitioner territory they have taken from him specialists should lose nothing in technical skill; and from the consequent closer association with the family doctor they should very definitely gain in knowledge of the patient as a whole.

Almost always in this country the patient first consults the general practitioner. To define the scope of general practice it may be useful to consider what the general practitioner can and should do for the patient. He should always—unless in very trivial cases—take an adequate history. The importance of good history-taking for purposes of diagnosis and treatment is recognized, but in general practice it has, if possible, even more importance than in hospitals; the patient must feel he is being taken seriously from the start, and the doctor, who is to decide the relative importance in diagnosis and treatment of all causative factors, including emotional and social ones, must necessarily precede his examination by a full and wide appreciation of the "whole" patient. Physical examination must be supplemented by special diagnostic measures as indicated. A diagnosis and appropriate treatment should then be possible for the vast majority of patients. The treatment should, wherever possible and appropriate, include all prophylactic, curative, and rehabilitative measures.

When the general practitioner is unable to arrive at a diagnosis or to give appropriate treatment—that is, when specialist assistance is required—he should seek aid through the hospital and specialist service. Such aid should not necessarily involve the help of a clinical specialist. Often the general practitioner should be able, by the use of specialist laboratory facilities, x-ray examination, etc., to make the diagnosis. Similarly, he should be able in appropriate cases to use all specialist and community resources of treatment. When it is necessary to consult a clinical specialist—and this is a decision for the general practitioner—by reference to a hospital or by domiciliary consultation, the principle should, wherever possible, be observed of the patient's illness being interpreted to him by the general practitioner. Whatever treatment is necessary in such circumstances should be given by, or at least in association with, the general practitioner. The specialist should not "take over" a patient unless that cannot be helped, as, for example, when the practitioner lives too far away from hospital. This principle suggests free access for general practitioners to beds where their patients are under specialist care. These observations refer to the whole clinical field.

There are in this country a certain number of general practitioners who prefer not to practise obstetrics, but the more this tendency is limited the better. No better opportunity will afford itself to a family doctor to establish a relationship of confidence and understanding than when he

looks after a woman before and during the birth of her child, in the period before her return to normal duties, and when he guides her in the earliest care of her baby. The later care of the child in health and sickness should put the seal of trust on the relationship already developed. None of this work should be beyond the skill of the general practitioner making full use of the assistance available to him from all other sources. Indeed, the term "family doctor" becomes a ludicrous misnomer when these duties are relegated in the first instance to the specialist.

The position of surgery calls for special comment. Apart from the now few isolated districts in this country where surgical emergencies cannot await specialist assistance and must be done by the general practitioner, major surgery will rightly have little place in the work of the general practitioner. The practice of surgery is not incompatible with general practice; but, for efficiency, it involves certain prerequisites not likely in Britain to be at all common. Exceptions would be where a doctor has had specialist training and qualifications in surgery and holds a current part-time surgical appointment in hospital. In general, surgery by general practitioners should be limited to the more straightforward minor procedures.

Preventive Medicine

A vital role for the general practitioner, and one in which he has unique opportunities, is in the practice of preventive medicine and health education. A great many vague generalities are to-day being talked on this subject. We read that the great need of the general practitioner of the future is that his heart should be in preventive medicine, or other words to the same effect. Such an approach to the problem of preventive medicine in general practice is not likely to appeal to or convince the average general practitioner. Nor is it indeed sound. It would be unrealistic to think of the general practitioner as ever being mainly occupied in giving advice to well people. Since most of those who consult him are ill people who wish to be made well "quickly, safely, and cheaply," that must always be the practitioner's main interest and object. His heart should be—and fortunately usually is—in clinical medicine. And the good general practitioner has been practising preventive medicine every hour of his long day from time immemorial. Is it to be wondered at, then, that he is puzzled, and perhaps a little resentful, when he is told that he must in future accept responsibility for prevention of disease and for health education?

Would it not be more fruitful of results to tell him the truth—that the potentialities of what he has been doing in this field are only now being realized, and try to show him that by making full use of all community resources he could do even better? "The great physicians of all times have understood and have followed the principle that the practice of medicine is not simply an exercise in diagnostic acumen, nor a test of therapeutic skill, but requires a complete understanding of an individual as a person who is a member of a family, and who lives in an environment that has a profound influence, for better or for worse, upon his health. They have also understood and followed the principle that he is entitled to the benefits of preventive medicine as an essential part of his medical care" (Smillie, 1952a). There are welcome signs of this attitude being adopted, more so perhaps in the United States than here.

In a discussion on "The Future of Public Health" at the Johns Hopkins School of Hygiene, which I was privileged to attend, one of the principal speakers asserted that the future of public health lay in the development of medical care schemes which would ensure for the patients the services of a really good physician who was alive to the preventive aspects of medicine and who would strive hard to educate his patients in health matters. The control of communicable diseases, sewerage problems, and water supplies were all very necessary in their day and were still of paramount importance in certain more backward

countries. The future of public health in countries like the United States should be in making use of modern scientific advances for the benefit of individuals; and the only person who could really influence the public was the personal physician.

This new orientation is well expressed by Hilleboe (1952): "Clinical medicine is becoming increasingly aware of its role as a social instrument, and public health practice is perceiving more keenly the problems of the individual in his relation to the family and community in which he lives and works." The American Public Health Association's Subcommittee on Medical Care (1949c) states that "effective preventive service requires prompt, comprehensive, and continued personal care as well as community service of the kind traditionally associated with public health activity." I was interested to learn of two well-known medical schools where an internist had been appointed as professor of preventive medicine in the teaching of undergraduates. This seems to me another example of the same trend of thought. (Postgraduate teaching for those contemplating a career in administrative public health is an entirely different matter.) One of these professors told me that he felt much more able to interest his students in the social aspects of medicine through his ordinary ward teaching and by means of his home care scheme than by more formal instruction. The same view is well put by Smillie (1952b): "Preventive medicine must be thoroughly incorporated in clinical medicine and not be presented as a special block of knowledge which is to be added to the foundation. Preventive medicine is the mortar and cement that intermingles with the other foundation stones, binding the whole together, and giving it strength."

Personal preventive medicine, as opposed to community preventive medicine, may be considered under the following heads:

(1) The promotion of health. The general practitioner is uniquely well placed to advise on how individual good health may be maintained and on the general principles of healthy living. He can also do much in the course of his work in the special fields of antenatal and post-natal care, and infant and child welfare.

(2) The primary prevention of specific diseases by immunization and vaccination. No one has the same opportunities or influence as the general practitioner to persuade the public of the value of such measures.

(3) The control of asymptomatic disease, by multiphasic screening, including miniature radiography and other forms of mass investigation—assuming for the moment the desirability of multiphasic screening. With his knowledge of the patient's make-up and background, the general practitioner, more than any other doctor, is able to interpret to the patient the results of mass inquiry, without which such investigation can result in much harm.

(4) The secondary prevention of disease: by limiting progress; by preventing relapses, recurrences, sequelae, and disability; and by ensuring rehabilitation. This is an already well-worked field in general practice.

It will surely be obvious that the good general practitioner has been practising preventive medicine under all these heads. Admittedly it is only recently, and to a very limited extent, that he has done work in connexion with mass investigation, which in Britain is so far limited to radiography.

The general practitioner has a very special place also in mental hygiene. He is ideally situated to deal with many of the vast number of emotional problems in his patients. Indeed, it is clear that an adequate number of specialists to cope with these is outside the realm of reality. As a family doctor he comes to know many secrets from his patients about husbands, wives, and children; and he has to lend a sympathetic ear to the problems arising out of the strains and stresses of everyday life and work. Knowing intimately the family, home, and environment, and with a long experience of similar problems, the general practitioner is uniquely placed to advise such troubled patients.

IV. SOME PRESENT-DAY NEEDS IN BRITISH GENERAL PRACTICE

The main needs of the general practitioner to-day are: (1) adequate time to do his work efficiently; (2) facilities to practise medicine in the way in which he has been taught, including his own accommodation, equipment, and staff, and access to special diagnostic and therapeutic services at hospital or elsewhere; (3) some useful form of attachment to a hospital; and (4) regular and appropriate postgraduate training.

The Report of the President's Commission on the Health Needs of the Nation (1952d) laid down certain principles to be used as a guide in approaching their health problem in the United States. It is interesting that these included the statement that everyone should have a personal physician (family doctor), and that "the physician should have access to proper facilities and equipment, affiliation on some basis with a hospital, and the help of trained personnel." And one of their recommendations for general physicians was that "educational programs for the undergraduate, graduate, and postgraduate student be planned to provide the general physician with the best possible basic training and with continuous education throughout his professional life; and that hospitals and professional groups explore ways of extending appropriate hospital affiliation to all general physicians" (family doctors).

The Time Factor

This factor must depend on the number of patients a doctor has to attend and the way in which his work is organized, and, where appropriate, delegated to nursing, technical, or clerical assistants. The recommendations of the Report of the Working Party on the Distribution of Remuneration among General Practitioners (1952), which are now in operation, are designed to make entry into practice easier, to stimulate the formation of partnerships, and to reduce the permitted maximum number of patients a doctor can have on his list. These recommendations should go at least a considerable way towards achieving their object. Time may also be gained by a better distribution of patients among doctors.

In addition to administrative measures, general practitioners could try by individual or group effort to improve the distribution of patients. Those with smaller lists should be encouraged to see the very real possibilities of gaining new patients in a perfectly ethical way by offering a better and more attractive service.

There are evidences in Scotland of a few practices in which the patients are offered service manifestly above the average, and where growth has in consequence taken place to a very obvious extent without any lessening of ethical standards. It is very definitely not suggested that this result is the outcome of the doctors concerned putting "all their goods in the shop window." These practices are well organized, staffed, and equipped, and allow the doctors more time and adequate facilities for strictly professional work. The College of General Practitioners might well lay down standards for their members as to size of practices, equipment, etc. As an academic and educational body they would not be concerned with negotiations to secure the implementation of these recommendations: that could be done according to existing practice.

Diagnostic and Therapeutic Facilities

In American practice there may at times be overuse of such special facilities as a result of the doctor's own action or from demand by the patient. But there is no doubt whatever that the American general practitioner, perhaps mainly from force of circumstances, knows a great deal about the use of such facilities and can, in consequence, do many things for his patient which would not otherwise be possible or might at least be greatly delayed. I saw repeated examples of this as a result of studying case papers in the Johns Hopkins Medical Care Clinic. The American

general practitioner is naturally surprised that his British colleagues do not employ such measures in general practice. Three American observers in a recent report to the American Medical Association went so far as to write of the general practitioner in Britain: "He seems destined to a routine life which does not offer the necessary facilities to practise good medicine and which fails utterly to offer the professional incentives which lead to continued growth of the physician" (Diehl *et al.*, 1950b).

Hospital Appointments for General Practitioners

The excellent report on this subject by the Scottish Health Services Council (1952) points the way. If its recommendations are not fulfilled and are left to the fate of so many other valuable reports in the past, an opportunity for a reform of the first magnitude in our health services will have been lost. Unfortunately there are many concerned who are opposed to the idea of introducing general practitioners to hospitals. On the practitioners' own side there is far from whole-hearted support. To the American practitioner this would seem incomprehensible. He is convinced of his need of hospital privileges, and the American Academy of General Practice has had perhaps its greatest appeal to practitioners through its success in opening more hospital doors to them.

In the British general hospital, the "unit" system with its hierarchical arrangement of medical staff—specialists, trainee specialists, and interns—seems to hold little place for the general practitioner, and he has come to accept that position. It must be agreed that to have a useful function in one of these units a general practitioner would require to have had recent and very considerable specialist training and experience. This prerequisite is in fact possessed by the registrars, for whom consultant rank is not available. If they were enabled to enter general practice on a part-time basis there is no reason why they could not indefinitely hold their own in specialized knowledge and technique; and as their experience of general practice grew they would make a contribution to the hospital service which would be of inestimable value to their specialist colleagues and the patients. At the same time such doctors could become general practitioners of a very high order. To those who find difficulty in believing such a suggestion to be practicable the answers are simple. First, it has been done in this country in the recent past, even by doctors who rose to positions of pre-eminence in the hospital world and who in some cases achieved professorial status in the universities. Secondly, it is the experience of the morning spent in hospital work which enables the specialist in his outside practice to cope with private patients in the afternoon—not the other way round; so why should a doctor who devotes the rest of his day to general practice be incapable of performing his specialist duties in hospital in the morning?

Registrars at present going into general practice probably often become located where the chances of early reappointment to hospital on a part-time basis are far from promising. Hospitals should seek to retain such doctors on a part-time basis rather than part completely with their services; and an effort should then be made by some agency to find a local general practitioner who wants part-time help in his work from an assistant with a view to partnership. It would be surprising if such arrangements proved difficult to effect if the effort were made by some appropriate person engaged in promoting general-practitioner interests through local medical committees or otherwise.

Many general practitioners, perhaps through no fault of their own, are now of little potential use to the hospital service. Their unsuitability and unwillingness to undertake hospital work must not be allowed to prejudice the whole future of general practice. The absorption of general practitioners into the hospital service must necessarily be a slow process, and there will be more than enough willing candidates for the available places. The important point is that a start should be made now to find a reasonable

number of openings for those already in practice, and that arrangements should be made—and here lies the main hope of success—for as many as possible of the coming generation of general practitioners to have hospital attachments suited to their qualifications and experience.

Postgraduate Training

Regular and appropriate postgraduate education is essential. The best method of keeping up to date is, of course, by means of a hospital attachment. There are, however, certain needs which cannot be met even in that way, and there will always be practitioners who cannot be found a place in hospital. For such it is essential to have a satisfactory system of postgraduate training. This should be based on the medical schools, and should last throughout each doctor's professional life. This attitude already exists in many American schools. In the Bingham Associates Program of Postgraduate Medical Education it states: "It is our belief that a primary responsibility of a medical school is to help practising physicians fulfil their duty of giving patients the best possible medical care" (*Bull. Tufts Coll.*, 1951). It is too narrow a conception to think in terms merely of refresher courses. These must be available, and in such form as to provide a continuing appeal to the practitioner. But it is essential also to think in terms of the total needs of the doctor in general practice. The College of General Practitioners should interpret these needs to the medical schools. Such stimulation as can be provided by research must be utilized, apart from its obvious value in more direct ways. Library facilities, local medical societies, and indeed anything which has a bearing on the subject of postgraduate education, should have the active assistance of the medical schools.

There are, I believe, quite a number of general practitioners—many of whom are capable doctors—who regard the sort of reforms advocated in the Cohen Report as unnecessary. A reasonable postgraduate experience, such as a year's internship before entering practice, is, they feel, enough for a doctor who maintains his interest in medicine and in the welfare of his patients. Some of these critics have maintained their own efficiency by efforts beyond the capacity of most. They are justly proud of their attainments and jealous of the good name of general practice. The Cohen Report argues that "the fulfilment of its recommendations will ease the lot of the general practitioner by raising his status in the eyes of the profession and the public, by stimulating his interest in the progress of the art and science of Medicine, and by providing him with the means of maintaining and refreshing his knowledge and skill and so of pursuing his practice with the pleasure and satisfaction that result from efficiency" (British Medical Association, 1950c). It is certainly difficult to see how general practitioners can expect to be regarded as the most important section of the profession—as they should be—unless they are prepared to undergo at least as serious a preliminary preparation as their specialist colleagues.

The Future Entrant to General Practice

An effort must be made to recruit to general practice as many as possible of the best types of young doctors. The difficulties of getting established in general practice which appeared at the outset of the National Health Service must have deterred many doctors from this career. Concurrently, there were apparent attractions towards specialism which, perhaps fortunately, have proved deceptive. More should be done to show medical students the attractions of general practice. In the United States I came across one country general practitioner who lectures every year to students in the University of Maryland. He told me that at these lectures he just tells the students simply what he does in his country practice and gives illustrations of the sort of experience he has and the features of a doctor's life in the country that appeal to him. I learned from several sources that his lectures have proved very popular indeed. The College of General Practitioners could help through medical schools to provide authoritative information about earnings, conditions

of work, and the interest general practice provides to the right kind of doctor. Requisite standards of equipment, accommodation, and staffing should be taught to students by someone of undoubted authority in the field of general practice. If exact information on these topics were known to all young doctors the standard would rise as they entered practice and influenced their seniors.

Health Centres

Experimental health centres such as are now ready and those about to be constructed may well provide useful indications for future policy. It might be worth while at least to experiment with centres designed with the aim of providing practitioners not only with full diagnostic and therapeutic facilities but also with intimate association with specialist work. The diagnostic and therapeutic facilities at present available in health centres are generally speaking of the simplest type. Such a new type of centre might go further towards meeting the needs of the present-day practitioner. Moreover, buildings of the same size as those presently contemplated could serve a much larger number of doctors and thus be more economical. It would seem possible also in this way to bring the benefits of group practice to many rural areas, except where distances are very great. At the Rip Van Winkle Clinic at Hudson, N.Y., for example, two practices, 5 and 10 miles respectively from the centre, form an integral part of the group.

Centres of the type described could be planned somewhat on the lines of the medical group centres of the Health Insurance Plan of Greater New York. Doctors could continue to practise from their existing accommodation and be associated with their group centre. It is unlikely that any financial association between the doctors would at first be possible, but that should not be an insuperable difficulty. Diagnostic and therapeutic facilities would either be available at the centre itself or, where appropriate, they would be readily obtainable through an associated centre or elsewhere. The appropriate staff of specialists would work in the centre on a part-time basis; at least some of the remainder of their time would have to be devoted to hospital ward work. It might be possible to link a number of subsidiary centres of an even less expensive type with a major centre. In some cases major centres could well be established at existing out-patient departments of hospitals; in any case, a link with hospital would be necessary, directly or indirectly, for each centre or group of centres.

This may seem merely to be a plan for building out-patient departments, sometimes in physical isolation from the hospitals themselves. So far as buildings are concerned that is probably true. But the essence of the scheme has yet to be added: it is the presence at these centres of the family doctor. Not only would the family doctor have direct use of diagnostic and therapeutic facilities and specialist advice on request, but he would himself be a member of the staff. He might consult at the centre at certain times, but he would also have a much more intimate relationship with his specialist colleagues than he has at present with out-patient department staff. The specialists would be seeing patients for family doctors in a group—a relatively limited number, since certain specialists would be allocated to each group. Like the family doctors, the specialists would come, as members of a group, to know their patients as persons and to appreciate them against their home background, and would be enabled to take their share of preventive and social medical responsibilities. Such a scheme at least not only holds out promise of providing the family doctor with the opportunity of practising preventive medicine better than he can do at present and of employing to the full for the benefit of his patients the clinical skills he has acquired and could develop, but it would enable the specialist to limit his work to cases of real difficulty and at the same time to see important aspects of medicine not now open to him.

There can be little doubt that in groups of this type the family doctor could deal on an ambulatory basis with many patients who at present are admitted to hospital. And

a further number could be treated in their own homes by the family doctor, backed by specialist facilities and advice. Under present conditions both specialist and family doctor naturally expect the patient to be taken over by the hospital and specialist service if any diagnostic and therapeutic measures of the type now available only in hospital are required. Under the scheme suggested it would be incumbent on both specialist and doctor to use their group resources to the full before seeking to have the patient admitted to hospital. And the family doctor would himself be accustomed to and capable of carrying out a far wider range of work; so that he could do more on his own, apart from what further efforts he could make under specialist direction.

Not only would this method of group practice lessen hospital costs, but it might help to solve the medical manpower difficulties of hospital and family practice. There are to-day too many registrars in hospitals: they do not wish to leave hospital work, and, in any case, cannot easily enter general practice. Some of these doctors might be employed as specialists in such a scheme, while others might be attracted to general practice under group conditions. Lastly, they could have a part in both camps and practise a specialty and general practice. On the family doctor side there would be scope to develop skill in a specialty and eventually, if desired, to practise it partly or exclusively. It is not merely desirable, but essential, if the level of family doctor practice is to be raised, to secure hospital experience for the general practitioner. It will be difficult to achieve and may never be possible for all, but group practice offers a solution that could be a means of providing on a very large scale an association with the methods and practice of specialism outside the actual hospitals.

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