Questioning Thoughts From Across the Atlantic

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As a long-time member of the Editorial Advisory Board and enthusiastic, regular reader of *The Journal of Family Practice* and as a British general practitioner in the National Health Service for over 40 years and a student of comparative systems of health care,[1,2] I have been intrigued by the similarities and differences of primary care practice in the United States and the United Kingdom. The issue of August 1989 provided me with very special opportunities to comment and make some suggestions.

All issues of the Journal have had material of considerable relevance to those of us working in the United Kingdom, but the August 1989 issue in particular has some important contributions on general conceptual issues and also on some specific clinical dilemmas.

Should there be a single primary care specialty in the United States for the 21st century?[1,2] Gerald T. Perkoff and Joseph E. Scherger argue for and against. In the United Kingdom[3,4] we have always worked "horizontally" as generalists, and since the introduction of the National Health Service in 1948, we have had the privilege of and opportunity for providing total personal and family clinical and preventive care to a specified population who are registered with a practice; the average now is some 10,000 persons per group practice.

This system has worked well and is acceptable to patients and physicians, but it could be better in applying the principles of preventive social as well as medical care. In the United States, I noted[4] over 20 years ago that primary care was provided by a disparate collection of "specialoids"—family physicians, internists, pediatricians and others from among whom patients could choose freely and to whom patients had direct access. The system works, but is it the best, and for whom? It seems to this outsider that what is required, and urgently, is a serious study in the United States comparing single-specialty primary care with the present arrangements and comparing quality of care as well as its quantity and costs.

The article by Raymond C. Bredfeldt and his colleagues[5] on use of transdermal clonidine for headache prophylaxis and reduction of narcotic use in migraine patients was interesting, and the commentary by my old friend and compatriot Robert Smith[5] raises questions to which I would add. Headache in primary care is one of the most frequent of symptoms, yet we know little of its nature and even less of its likely course. My own experience[6,7] is that most headaches in my practice have been mild to moderate, are easily controlled with safe analgesics, and invariably cease naturally and spontaneously in time.

Two reports from Gordon T. Schmittling on an American Academy of Family Physicians (AAFP) survey in 1988 highlight the use of computers and the prevalence of hospital privilege in obstetric care. The report on computer use[8] revealed that although almost one half of the subjects surveyed used a computer in the office, it was almost exclusively for billing. What a waste of opportunities. In a small way I have carried out clinical studies in my practice for over 40 years, including long-term follow-up.[6] How I wish that I had had access to computerization. It is sad that the opportunities for fundamental research in primary care are being missed through nonuse of modern data technologies. Surely leadership and stimulation are required from within the profession. Gordon T. Schmittling's other paper, co-authored by Carole Tsou,[9] raises the corner of a curtain on obstetrics in family practice. Only one in four (28.7%) of active AAFP members perform routine obstetric care in their hospital practice, "although most have privileges"; Only about 1 in 10 (11.2%) carry out "complicated obstetric delivery," and these consult their peers only in 1 in 10 (12.8%) of these cases. Surely these figures once again must call into question the future of obstetric care in family practice except in rural and other special situations. Again, what is best and for whom?

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Finally, Paul S. Frame[10] in his guest editorial carries the flag for more "clinical prevention," but Steven M. Ornstein and colleagues[11] show that even in a superbly staffed academic practice, fewer than 20% of patients accept the recommended preventive care apart from Papanicolaou smears (41%). It would be wise to pause and rethink the matter and again put the question on prevention,[11] How beneficial and for whom?"

Family practice, general practice, primary care, or whatever label we give it, has very similar roles and functions[3,4] in all systems. All of us who are involved in such care are faced with major crises, dilemmas, and questions about our future. In the United Kingdom we are involved in revolutionary changes proposed by a government keen to achieve better value for the money, although our expenditure on health care at 6% of the gross national product is only one half of that in the United States, and includes greater accountability and more data to apply controls and to provide a service concerned more with patients' wants and needs.

From this mini-review of papers in one issue of *The Journal of Family Practice*, it is evident that physicians in the United States are likely to face similar problems. It is time for a group of us to come together to share experiences and plan common studies to tackle common problems.

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