

# Comparisons of UK General Practice and US Family Practice

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Both the United States<sup>1-3</sup> and the United Kingdom<sup>4,5</sup> are in the midst of major restructurings of their health care systems to expand and create more central roles for primary care. These new approaches create valuable financial efficiencies and improve quality of care.<sup>6-13</sup>

In the United States extensive definition and planning for these changes has been ongoing for more than 2 decades, especially by family practice educators. To a lesser degree, such planning has occurred in pediatrics and internal medicine, specialties that share primary care responsibilities with family medicine. Only recently, in the past 5 years, as a result of the dramatic shift to managed care health insurance systems, have the prestige, income, and job opportunities led to a reversal of the decline in primary care training. The number of graduating US medical students choosing training in primary care was estimated to be as high as 27 percent in 1995<sup>14-16</sup> and 37 percent in 1997.<sup>17</sup>

In the United Kingdom the role of the general practitioner has been defined and redefined during the past 25 years.<sup>18,19</sup> Although the UK government has emphasized the key role of the general practitioner in the primary care-led National Health Service (NHS), in 1995 only 26 percent of doctors finishing their required preregistration (internship) year planned to enter general practice, a rate that represented a 20 percent decline within the past 10 years<sup>20,21</sup> despite strenuous recruitment campaigns by general practice educators. Thus, primary care in both countries appeared to be at roughly the same recruitment level in 1995, but on the rise in the United States while on the decline in the United Kingdom.

In this article we examine the similarities and

the substantial differences between the health care systems and family-general practice education in Britain and the United States. Educators in both countries can learn much from each other about training methods for common generalist professional skills. At the same time, however, they still must tailor their educational systems to produce graduates who have the skills to succeed in their own national systems. A glossary of terms that have different meanings in the United States and the United Kingdom is displayed in Table 1.

## Commonalities

The essence of primary care has the same components in both countries<sup>11</sup>: first-contact medical care provided continuously by the same doctor to individual patients; comprehensive, without body system or disease agent restriction; coordinated with social, nursing, and other paramedical services as well as with specialized, secondary and tertiary medical care; holistic, considering both scientific and psychosocial aspects of patients and their health status. In both countries primary care doctors are clinical generalists who apply the scientific disease model to illness, when appropriate, then deliver or advocate for the patient to obtain medical diagnostic and therapeutic care, and finally interpret the whole process to the patient. When the disease model is inappropriate, the doctor guards the patient against ineffective specialist referral, testing, treatment, and medicalization of nonmedical symptoms.<sup>22</sup>

This latter portion of the role is often described as "gatekeeper," a description that can falsely imply the primary care doctor's primary duty is to ration a medical "commons" rather than to advocate for the individual patient.<sup>9,23,24</sup> The tensions between guardian and gatekeeping roles have increased recently in both countries. Health care payers have created financial incentives for primary care doctors to ration medical services by capitating not only primary care but also secondary care services

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**Table 1. Glossary of Terms With Different Meanings in the United States and the United Kingdom.**

US Term	UK Term
Continuing medical education	Continuing professional development
Faculty physician	Trainer
Family practice	General practice
Internist	Physician
Junior resident, intern (R1)	Preregistration house officer
Junior resident (R2)	Senior house officer
Office	Surgery
Office visit	Consultation
Partner	Principal
Physician	Doctor
Preceptor	Trainer
Residency program	Training scheme
Residency director	Course organizer
Resident	Trainee
Senior resident (R3)	Registrar
Specialist	Consultant
Visiting or home health nurse	District nurse (community nursing sister)
(No similar term or training)	Higher professional education (additional training while in practice immediately or soon after residency training)

through managed care contracts in the United States and by fund holding<sup>25-27</sup> and, more recently, commissioning<sup>28</sup> in the United Kingdom. This conflict between the needs of the individual patient and distributive justice for the collective good is now a major ethical dilemma in both countries.

In both the United States and United Kingdom, primary care doctors are recognized as having an important role in promoting healthy life styles at individual patient encounters.<sup>29</sup> Overkill is possible, however, and many British general practitioners reasonably point out that when health promotion is required by payers at the potential expense of other, more appropriate types of care, elements of blaming the victims of inadequate public health protection can result. For example, in Britain until 1996 physician payments were effectively contingent upon documenting that smoking cessation be brought up at every encounter with a smoking patient. This policy has now been reversed to allow practices to determine individually their health education strategies.

UK primary care doctors and US primary care physicians experience enmeshed social, mental,

and medical service needs that are met through separate and minimally congruent delivery systems. Having generalist, one-stop social service systems integrated with primary care medical practices could decrease the frustration of delivering primary care, especially to poor and mentally ill patients.<sup>30,31</sup> In both countries fragmented, rapidly changing, categorically organized social service and mental health systems remote from medical practices prevent maximal coordination of social and primary medical care services. Even so, British home health nursing services are more closely linked with general practices than in the United States by virtue of shared and defined geographic territories, regular meetings, and often shared office space. In its most recent White Paper on the National Health Service,<sup>28</sup> the UK government requires general practitioners to lead multiprofessional primary care groups to manage community-oriented primary care locally. These groups will include nurses, managers, social workers, and public health physicians as well as local general practitioners.

In both countries women represent an increasing percentage (nearly 50 percent) of medical students, postgraduate trainees, and practitioners in all fields, especially primary care.<sup>20,32,33</sup> As a result, educational and practice systems are searching for ways to accommodate part-time training and work both for women who have traditional family responsibilities and men who wish to assume greater responsibilities for child care. In both countries the social values and work expectations of more recent generations of doctors are changing considerably.<sup>34</sup> They seek increased medical career structure flexibility<sup>35</sup> and are more reluctant to commit to the traditional 60-hour or more work weeks and substantial personal financial investment in long-term practice commitments. Furthermore, because a crucial and most professionally gratifying element of primary care is continuity of patient care, finding ways to balance requests for increased personal time without sacrificing the essence of the professional experience is difficult but necessary in both educational systems.

In professional self-regulation, the United Kingdom adopted a uniform summative assessment method of certifying graduates of general practice training programs in 1996, similar to board certification in the United States. Rather

than periodic recertification testing as in the United States, however, general practitioners and directors of postgraduate education are piloting practice-based recertification. Thus, the British approach is to follow Berwick's admonition<sup>36</sup> that "the profession should polish all the apples rather than select out rotten ones." Regular rigorous training program oversight and accreditation occur in both countries by the regional directors of general practice and the Joint Committee on Postgraduate Training for General Practice in the United Kingdom and by the Accreditation Council on Graduate Medical Education in the United States. Such systems of accountability enhance primary care doctors' arguments for retaining professional autonomy, a goal commonly held in both countries.

Finally, primary care doctors on both sides of the Atlantic are experiencing patients who are becoming more demanding consumers.<sup>37,38</sup> Such feedback is, appropriately, also being incorporated into parts of quality assurance processes on both sides of the Atlantic.

### Political Differences

Arguably the greatest difference between the two countries is the percentage of the gross national product devoted to health care: 7 percent in the United Kingdom and 15 percent in the United States. These rates represent the extremes of the Western world.<sup>4</sup> The options for British medical educators planning change in general practice education or practice are greatly restricted unless the total British allocation for medical care or the relative proportion spent on primary care can be further increased. In the United Kingdom approximately 20 percent of these limited total health care funds are spent on general medical (primary care) services,<sup>33</sup> whereas even within US primary care-oriented health maintenance organizations, the comparable figure is usually 12 to 15 percent. Thus, reallocation to primary care practice and education is much more possible within the more generous total US health care budget.

Another dramatic difference is that costs of medical care for the UK population are universally covered by a National Health Service, whereas the American population is only partially covered by a patchwork of employer-based, personal, and federal categorical health insurance schemes. Thus 100 percent of the British public

has uniform, comprehensive health coverage free at the point of delivery and paid by national taxation, with a small proportion of the population (12 percent) having additional, sometimes partial supplemental private insurance, often a perquisite for top business executives. A large but decreasing proportion of the US population has some form of health insurance coverage, 85 percent in 1992,<sup>39</sup> which in many cases is less than comprehensive.<sup>40</sup> These differences are the result of the two, very different roles played by the respective national governments in the provision of health care.

In contrast to the United States, the British government runs a nationalized secondary and tertiary medical care system. Primary care services are contractually purchased by the government from individual general practitioners. Within this system the government pays age-specific fixed capitation fees for acute and most chronic medical care, as well as fee-for-service payments for much preventive care and some specific chronic disease monitoring. Thus the responsibility and accountability for health care and its costs are centralized and public in the United Kingdom, despite some extremely modest, recent, and soon-to-be-abandoned attempts at decentralization and quasi-privatization. These attempts included the creation of so-called "NHS internal markets" (modest hospital competition by US standards) and of fund holding (modest, by US standards, financial risk sharing with general practices for secondary medical care costs, such as orthopedic referrals and physical therapy). The new Labor government has announced its intention to abandon these schemes in favor of community-wide variant commissioning.<sup>4,37,41</sup> By April 1999 general practices, along with other primary care and social services, will be formed into primary care groups, each serving populations of around 100,000, to commission and plan local health care and community services and to govern clinical standards.<sup>28</sup>

This huge difference in the governmental approach to health care in the two countries reflects an underlying substantial difference in public tolerance of inequities in access to health care. In contrast to the United States, in the recent UK national election, prominent public debate occurred between the Conservative and Labor parties about whether to extend or retract the modest risk contracting with general practitioners (fund holding) and internal hospital market health care experi-

ments of the past 5 years. Certainly the concern about the potential development of a two-tiered system, with some subsets of the population having better access to care than others, has been hotly debated within the UK medical community as well as the general public and is the basis for the current government's actions to abolish fund holding for selected practices in favor of area-based commissioning for all general practitioners.<sup>28</sup>

A further major difference between the two countries is in the approach to workforce planning. The United States relies principally on market forces, which, given the 10-year pipeline for practicing physicians, has a boom-or-bust effect on primary care as well as specialty recruitment. UK general practice planning has been impaired by a lack of national statistics on numbers entering, in, and finishing general practice training, unlike the United States, where primary care numbers are available annually despite the more complex job of counting subsets of internal medicine and pediatric trainees destined for primary care compared with other specialty training. The United Kingdom is now investing in national workforce planning not only for physicians but also for all health care professionals because of commitments by the UK Department of Health to collect better statistics and require regional NHS executive offices to devise coherent workforce plans for all health professionals.<sup>42</sup>

Finally, there are major differences between the popularity of primary care careers in the United States and the United Kingdom. The percentage of physicians both already in and planning to enter primary care (100 percent of family physicians and a smaller percentage of pediatricians and internists) declined constantly in the United States from 50 percent in the late 1950s to 35 percent in practice and only 14 percent of graduating medical students entering primary care training in 1992.<sup>14-16</sup> In the last 5 years, the number intending to enter primary care has doubled as a result of both limited job opportunities for specialists and markedly enhanced job opportunities, salaries, and prestige for primary care physicians. In contrast, general practice in the United Kingdom has historically been dominant with nearly one half the practicing doctors engaged in general practice, but fewer than 26 percent of young doctors are now entering general practice.<sup>20,43-45</sup>

There might well be multiple causes for this

decline. First, despite the national vision of a "primary care-led NHS," the morale of general practitioners in the United Kingdom has declined rapidly.<sup>46-48</sup> Since 1990 general practice contract revisions have been viewed as imposed and onerous by most general practitioners, and early retirements have increased dramatically.<sup>46</sup> As in the United States, discouragement of medical students as well as interns from general practice by specialty teachers is thought to play some role. Ironically, attempts to humanize specialty training in the United Kingdom have had the unintended consequence of further contributing to this decline in interest in entering general practice, as described below.

### **Training Program Differences**

Formal training in general and family practice is 3 years' duration in both countries, but there are substantial differences nevertheless. Unlike American medical students, upon completion of secondary school, British students enter 5 years of medical study. After completing medical school, they must do a 12-month preregistration or internship year of training in medicine and surgery and occasionally general practice before being allowed to enter training in a specialty or general practice. Even at that point, commitment to a particular field is often tentative; in general practice in recent years more than 50 percent construct their own training program, usually in 6-month blocks of various hospital specialty training posts, until committing later to a final year of general practice training.

Combining high standards of teaching by accredited, paid trainers in general practice, large numbers of applicants, formal educational assessment strategies, and direction by general practice educational specialists, general practice training in the United Kingdom was for many years a model of good educational practice and regarded as a reference standard by many other countries. Now, however, the directors of general practice education and the NHS chief medical officer perceive serious flaws in the training structure.<sup>49</sup>

In contrast to US family practice residency training, a typical UK medical school graduate destined to train as a general practitioner will first spend a preregistration (internship) year and then 2 more years on in-hospital rotations run exclusively by various specialists before experiencing



primary care in an office setting. During their first year, they must do two 6-month rotations, one in medicine and one in surgery. During their second postgraduate year, they must do two 6-month rotations from among those in general medicine, geriatrics, pediatrics, psychiatry, obstetrics-gynecology, accident and emergency, and general surgery. And in their third year, they must do two 6-month rotations from a longer list of specialty service rotations approved by the respective specialty and general practice royal colleges and the regional general practice postgraduate committee. Despite these arrangements and despite guidelines published by the government's Standing Committee on Postgraduate Medical and Dental Education, service pressures and the specialists' overall lack of primary care teaching skills have resulted in considerably lower standards of primary care teaching in UK hospitals than in the general practice training practices.

During their second and third postgraduate years, those already committed to general practice and in a formal program supervised by general practice course organizers (currently about 50 percent of those who will eventually commit to general practice) attend a half-day per week "general practice release day" seminar series along with those in their fourth, office-based year of training. On specialty rotations UK general practice residents (trainees) are exposed to strong hospital specialist role modeling and sometimes, as are American family practice residents, to anti-primary-care prejudice. Trainee work hours, 65 to 85 hours a week, are similar in both countries.

In the fourth year of their training, British trainees apply to work with an approved, practicing general practice preceptor (trainer) in his or her practice. There the resident, now called a general practice registrar, constructs an educational plan with the preceptor and is supervised and summatively assessed in both clinical and administrative aspects of general practice. The registrar sees patients at a slightly slower rate than the senior physician but in all other ways is integrated into the small, 3- to 6-physician group practice structure. Much one-on-one precepting in office and on home visits occurs. Communication skills teaching, especially using videotaping, is well developed, perhaps more so than in the United States.

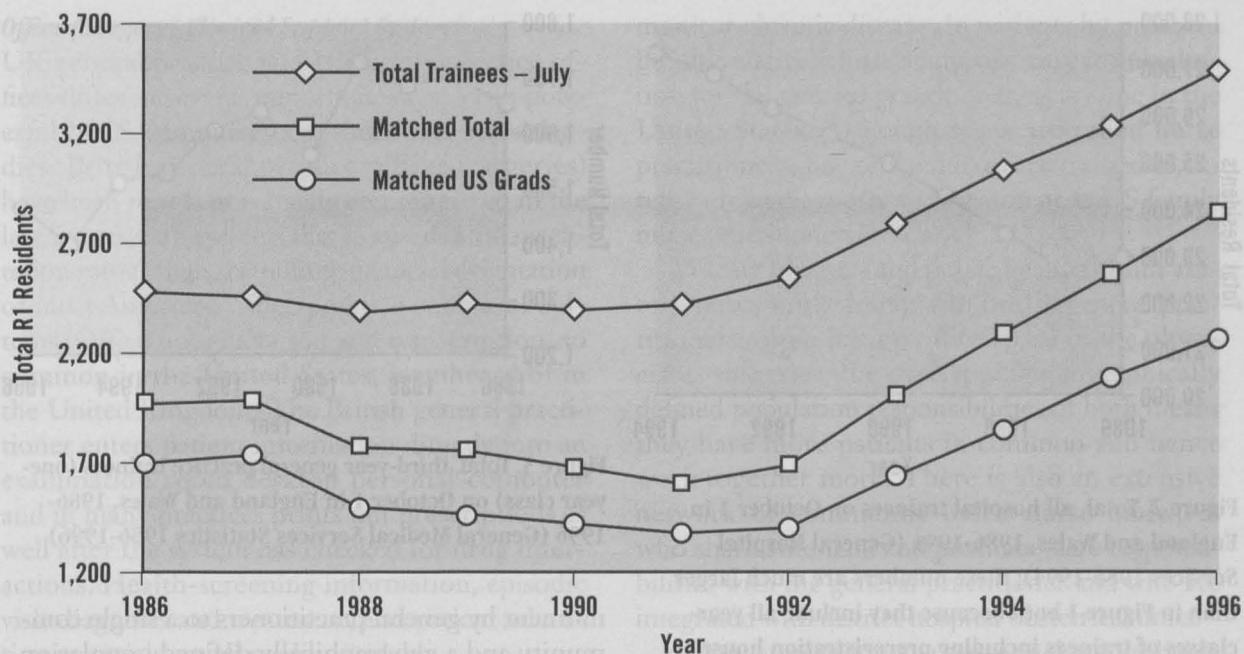
Although feedback about these experiences

from the trainee, usually verbal, is solicited during both the hospital and office phases of training, this effort is undertaken only two or three times a year. Our observation is that program evaluation is usually less open and frank than in the United States, where monthly written evaluations encourage more constructive criticisms. But 1 year's time to undo specialist attitudes and teach all trainees need to know about office practice is too little. Recent, but so far unfunded, legislation might in the future allow one half of the last 3 years of general practice training to occur in primary care practices.

More extensive integration of postgraduate training with undergraduate medical student training in primary care occurs in the United States. Unlike Britain, US medical school departments of family practice usually oversee undergraduate training as well as some residency training in family practice; this system allows substantially more vertical integration of family practice education from medical student through residency training. In the United Kingdom undergraduate and postgraduate education are distinctly separate and rarely integrated, with the medical schools responsible for the former and the postgraduate deans with the regional directors of general practice responsible for the latter.

There are also major differences between the two countries in medical school debt load carried by trainees upon entry into postgraduate training. British general practice residents rarely owe more than £3000 to £5000 (\$4500 to \$7500) unlike the frequent debts in excess of \$60,000 incurred by many US medical students. As a result, newly trained British general practitioners are generally freer than American family practice graduates to take time off before entering practice and lose less personally if they change fields completely.

The number of training slots in family practice in the United States has been climbing steadily from 2600 in 1989 to more than 3600 per year<sup>17</sup> as family practice training programs have proliferated, expanded their enrollment, and responded to increasing demand for training by medical students and family physician recruiters (Figure 1). Financially and legally there is no central control of program numbers or size, so medical education is also a marketplace wherein programs compete with each other for the medical school graduates. Until the recently passed 1997 budget reconciliation act, federal funding of residency training in any spe-



**Figure 1.** First-year residents in family practice residencies, 1986-1996. Total and US graduates matched in annual March National Residency Match Program (NRMP) and total first-year family practice residents in July, 1986-1996; July numbers reflect recruitment of both US and international graduates to slots unfilled in the March NRMP match each year.

Data from Kahn et al.<sup>17</sup>

cialty has been open-ended and unrestricted despite urgings by the Council on Graduate Medical Education for the past 5 years.<sup>50</sup> Increasing US medical student interest in entering primary care since the low of 15 percent in 1993 has led to fill rates of family practice training programs, with US graduates rising from 56 to 72 percent in the last 5 years.<sup>17</sup> This increase is all the more impressive given the extensive expansion of family practice training programs during the same period.

A huge pool of foreign-trained immigrant physicians of widely variable backgrounds and English language skills is available to US programs unable to fill with highly qualified American medical school graduates. More than 400 applications from this immigrant pool are received each year by most family medicine residency programs. In the early 1990s many US family practice programs accepted many such physicians, but with the growing popularity of primary care training with US graduates, acceptance is more selective and less frequent now. About 17,000 physicians graduate from US medical schools annually, and up until 1998, an increasing number of immigrant physicians were permitted to enter the

country—2000 in 1990, 7000 in 1995.<sup>16</sup>

In Britain the distribution of practicing general practitioners is controlled by the British Medical Association Medical Practices Committee. Although more coordinated workforce planning is anticipated, as in the United States, there currently is no national manpower planning for general practice. Paradoxically, with the implementation of the 1993 Calman report on revising specialist training,<sup>51</sup> national manpower planning for all other specialties became required. The Calman revisions also for the first time guaranteed trainees in hospital-based specialties full training and employment after a predictable (usually 5 years) training period and thus greatly enhanced the attractiveness of specialty training.

This increased attractiveness of specialty training has worked to the detriment of general practice training recruitment. These changes, the post-1990 contract morale decline,<sup>46-48</sup> and an expansion of the total number of hospital resident (senior house officer) positions (Figure 2) to diminish house staff workloads, all contributed to further decreases in general practice residents (trainees) (Figure 3). Many general practice train-



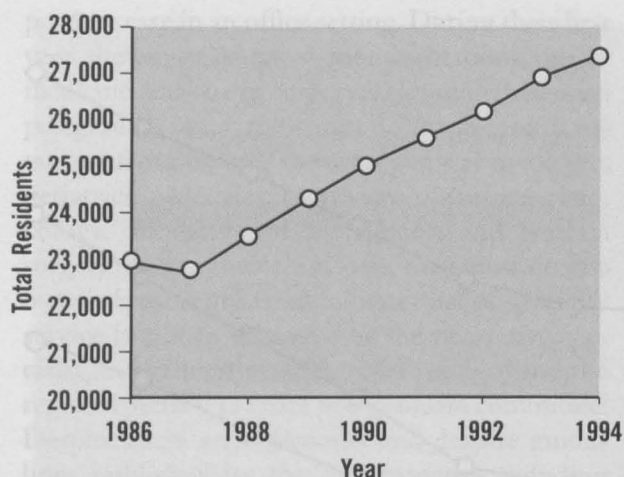


Figure 2. Total, all hospital trainees on October 1 in England and Wales, 1986-1994 (General Hospital Services 1986-1994); these numbers are much larger than in Figure 1 both because they include all year-classes of trainees including preregistration house officers (interns) as well as registrars and senior registrars (residents and fellows) and because many specialties required or allowed 5-15 years of training.

ing programs now have substantial numbers of trainees from other European Union countries filling positions no longer attractive to UK graduates, much like the immigrant family physician phenomenon in the United States a decade ago.

In Britain changing aspirations, perhaps associated with the increasing proportion of women entering the field (more than 50 percent in 1994<sup>20</sup>), have led to an increasingly common disinclination by recently trained general practitioners to commit to the predominant single practice mode for general practice, that of permanently buying into a small-group practice and thereby providing the retirement fund for retiring partners.

## Practice Differences

### *Continuity of Care for Patients and Communities*

Patient care continuity, a central element of primary care, is on average probably better in the United Kingdom. Self-referral and referral by other health care providers are not possible, although this situation is becoming more common in the United States as managed care systems are implemented. In the United Kingdom the use of accident and emergency departments does not require general practitioner referral, but triaging of nonurgent problems to longer waits discourages overuse for minor illness. Also, the lifetime com-

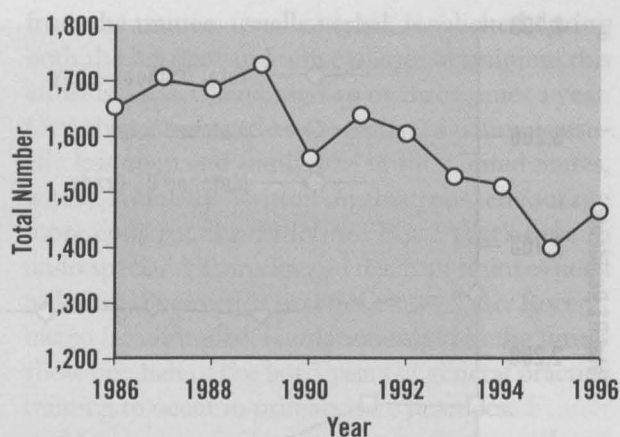


Figure 3. Total, third-year general practice trainees (one-year class) on October 1 in England and Wales, 1986-1996 (General Medical Services Statistics 1986-1996)

mitment by general practitioners to a single community and a geographically defined population greatly enhances continuity of care, whereas in the United States greater physician and patient transience limit it. Similarly, the UK geographical practice definition allows for potentially much easier, clearer identification of a doctor's community in which to practice community-oriented primary care.

### *Practice Arrangements and Clinical Components*

A striking difference exists between the plethora of practice options in the United States and the single predominant UK model. In the United States multiple and complex practice organization possibilities range from solo independent practice to a salaried position in a multispecialty group. Clinical components of family practice range from practices with broad responsibilities, including obstetrics, surgery, and intensive care and coronary care units, as well as extensive office procedures, to variations of a skill set such as that of the typical British general practitioner of strictly ambulatory, home, and nursing home consultations, few procedures, and almost no hospital practice. Nevertheless, US primary care physicians are increasingly preferring to be employees of corporate health care systems, both because of the lesser personal financial investment required and the buffering from the external regulatory climate such arrangements afford.<sup>52,53</sup> In Britain, very few general practitioners hold salaried contracts, but older schemes for salaried employment are being restructured and new ones piloted.

### ***Office (Surgery) Clinical Support Systems***

UK general practice and US family practice offices differ in several important ways. With powerful NHS reimbursement incentives and subsidies, British general practice offices (surgeries) have been nearly universally computerized in the last 5 years with systems that have a clinical orientation rather than the billing-financial orientation of most American office practice computer systems. Office note dictation and transcription, so common in the United States, is unheard of in the United Kingdom. The British general practitioner enters patient information directly into an examination room desktop personal computer and in many practices prints out prescriptions as well after the system has checked for drug interactions. Health-screening information, episodic visit diagnosis and treatment, and patient education materials are all readily available.

This type of system also allows for easy, practice-wide audits and patient recalls. On-line reference searches and evidence-based practice protocols are now being implemented into these extant systems. Several competing software programs vie for the general practice business and support. Although several American systems can duplicate parts of these services, none achieve the wide use and easy accessibility found in British surgeries, although some worry about the effect of a computer screen between physician and patient.

Laboratory testing in the United Kingdom is rarely available in offices, unlike their US counterparts, and it is used much more sparingly. US stipulations that model practice units for resident training in family practice must have laboratory testing capability on site would not make sense in Britain.

Examination room use is also dramatically different. US family physicians insist on and use two to three examination rooms per physician when seeing patients, whereas British general practitioners rarely use more than one room. Even so, both groups of physicians see roughly the same number of office (surgery) patients each day, 25 to 30.

Physician assistants are relatively unheard of in the United Kingdom, but they, along with nurse practitioners, provide a considerable amount of acute and chronic care to ambulatory patients in more than one half the family practice offices in the United States. Office nurses in the United Kingdom provide health promotion advice and

monitor chronic diseases in patients by protocol but do relatively little acute visit care in substitution for the general practitioner, as is done in the United States. Although some are called nurse practitioners, few office nurses are trained as extensively in diagnosis and treatment as US family nurse practitioners.

Visiting (district) and public health (health visitor) nurses work closely with British general practitioners, often having office space in the physicians' surgeries; the overlapping geographically defined population responsibilities of both means they have more patients in common and hence work together more. There is also an extensive network of community-based nurse midwives who share antenatal and postnatal care responsibilities with the general practitioner and who are integrated with district hospital obstetrical units.

Other surgery support personnel are probably comparable, since US offices employ on average 3 employees for every physician<sup>54</sup> and the British, with less complicated multiple payer insurance systems, have 2 per doctor.<sup>33</sup>

### ***Relationships With Other Medical Practitioners***

Relationships with other medical practitioners are more competitive in the United States because chiropractors, nurse practitioners, specialists, and surgeons can all practice without the referral of patients from family physicians, at least until the recent proliferation of managed care systems. Even with managed care the tradition of more open access remains while the transition from fee for service, with completely open referral systems, occurs.

### ***Responsibilities***

Clinically, the US family physician usually has both inpatient as well as office (surgery) responsibilities each day. Obstetrics, including deliveries, is an important practice component for about one third of family physicians, who typically deliver 25 to 50 babies annually. The US family physician usually will do several procedures both in the office and the hospital, see 25 to 30 office patients each workday, manage most common chronic and acute diseases, and take call every 4 to 5 nights in a call pool with other family physicians. On nights and weekends patients who need to be seen are seen either in the office or more commonly by the family physician in the emergency depart-



ment, not or only rarely at home. Medication dispensing is rarely part of US family practice.

In contrast the British general practitioner rarely has hospital responsibilities, sees a more uniform mix of outpatient illness in the surgery, and is interrupted at midday typically by three to five house calls. Patients with chronic diseases, such as asthma, diabetes, and hypertension, are now more frequently being cared for by general practitioners rather than in hospital-based clinics, as they commonly were 5 to 10 years ago. The percentage of general practitioners doing obstetrics has declined from 28 percent 20 years ago to 2.5 percent now.<sup>33</sup>

Night call is typically similar to that of the US family physician but without hospital responsibilities, and patients who need to be seen are usually seen in the patient's home. General practitioners believe this house call tradition is being increasingly abused, especially after health care reforms in the early 1990s enhanced the expectations for emergency house calls by the unilateral governmental promulgation of a patient charter that included all patient-requested house calls as one of the general practitioner's duties. Britain does not yet have a contingency fee-type malpractice litigation system, which further contributes to increased anxiety regarding patient expectations in the United States.

With national government financial support, traditional 4- to 5-physician coverage arrangements for night and weekend call are being rapidly replaced with so-called "general practice cooperatives," which are responsible for whole regions and require the individual general practitioner to take 6- to 12-hour call once every 3 to 4 weeks; these cooperatives operate from acute care clinics, some hospital-based. They have reduced the out-of-hours house calls, because usually one member of a team of doctors sees patients in the clinic while another is out doing house calls. The cooperatives lack any primary care doctor records on patients but fax a report back to the primary general practitioner the next working day. National patient education campaigns to encourage more appropriate use of primary care on-call services have had equivocal success.

Total patient panel (list) sizes are apparently fairly similar, 1500 to 2000 per practitioner in the United Kingdom and roughly the same in systems in the United States, where managed care systems

or geography make the number ascertainable.

British general practitioners are uniformly expected to co-manage a small 3- to 4-physician practice or to delegate those responsibilities to one of the other partners. Recent subsidy support for practice managers by the NHS has increased the presence of some additional trained managerial help, but the ultimate responsibility of the practices still rests with the partners (principals). The NHS contracts with each general practitioner individually, so with the exception of certain pilot programs,<sup>55</sup> practices cannot corporately assume patient care. This system differs from that in the United States, where family physicians can run their own practice, with variations all the way from an autonomous practice to being simply an employee of a corporation of other physicians, a hospital, an insurance company, or some other corporate entity running a primary care practice.

### *Fears for the Future*

General practitioners in the United Kingdom fear increased clinical responsibilities for what was previously specialty care without any commensurate increase in resources.<sup>56</sup> They hope for longer patient visit times and fear further loss of control in their work because of increased consumerism and management bureaucracy. They also fear the greater administrative burdens of more system changes, including universal general practice "commissioning" and primary care group planning in the NHS. They share US physicians' fears about competition from other medical practitioners but have more enthusiasm for collaborative primary care delivery. They share none of the US family physician's worries about exclusion from clinical areas, exclusion from caring for their current patients by managed care company contracts for primary care with other physicians, or unfairly applied managed care organization cost-based standards.<sup>57</sup>

### **Conclusions**

US family practice and UK general practice educators thus share a substantial number of common training goals and curricula objectives that are more extensively advanced on one side of the Atlantic than the other. By increasing dialogue between us, we believe each might be able to adopt or incorporate successful methodologies developed in the other country into our own training programs.

Such commonly useful areas include methods for teaching skills in clinical primary care; lifelong learning; the use of computerized medical records; community oriented primary care, public health, and community medicine; multiprofessional collaboration; medical leadership; quality-assurance techniques; and maintaining a patient advocate role in various insurance systems.

Some major differences in the content of general and family practice in the two countries will preclude completely common training programs. Those differences, which are unlikely to change, include extent of hospital practice, obstetrics, procedural medicine, and corporate versus public service roles of physicians.

This side-by-side examination of US family practice training and UK general practice training points out essential commonalities of primary care in the two countries but differences in primary care doctors' roles, responsibilities, and training. Differences in the political environment in the two countries will probably remain, but regular comparisons, academic exchanges, and borrowing from each other's training ideas and systems, as well as approaches to similar threats, seem to us to have considerable merit.

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