Scenes from Postgraduate Life

Britain leads continuing medical education – whither America?

Desmond Abernethy

North Devon Medical Centre, Barnstaple, North Devon EX31 4JB, UK

I was honoured to be chosen as the American Travelling Fellow for 1992, honoured not just personally but also by the fact that it was the first time that the Fellowship had been awarded to a clinical tutor from general practice.

'Britain leads continuing medical education – whither America?' The title is somewhat provocative and this is because, although there is a large continuing medical education (CME) programme being offered to family physicians, the programmes are being produced by academic and hospital doctors with little or no involvement by family physicians themselves. What I did see and learn a tremendous amount about were the efforts of the Family Practices Residency Programmes to maintain strong family practice in North Carolina, and the struggle of American general practice to survive, particularly in the rural areas.

Every possible courtesy was extended to me by the School of Medicine at the University of North Carolina at Chapel Hill; by the Dean, Associate Dean, Professors, Directors and Managers; by the Area and District Hospital Chairmen and doctors; and by all the urban and rural primary physicians with whom we spent much of our time. This was in sharp contrast to our own Department of Health, which despite strong support from my post-graduate dean, turned down my application for extended study leave for 3 weeks. The reason the Department of Health gave was that 'it was *too short* a period!'

I was accompanied on my visit by my wife Elizabeth, who is a partner in my general practice, and a fascinating medical programme was also arranged for her.

Our visit started at the University of North Carolina at Chapel Hill where we spent 4 days. Then we flew to Asheville, the Mountain Area Health Education Centre (AHEC), then to Charlotte, then to Wilmington, the Coastal AHEC. After that it was to Greensboro AHEC and then

finally back to the University at Chapel Hill. We were flown everywhere in the University's private planes and spent about 4 or 5 days at each centre.

North Carolina has nine AHECs. Each AHEC is administered by a county hospital, a non-profit foundation or a university, which agrees to provide undergraduate, graduate and continuing education and training for health professionals throughout its region.

Everywhere I went, there was a tremendous amount of interest in what was going on in North Devon and, in particular, the scheme that North Devon has pioneered with the Link Man concept.¹

I realize that I am off my American path, but it was to learn and improve that I set off on my travels, and the background in North Devon is essential. When the doctors in North Carolina heard that not only had we a link man in each practice, but also had placed one of our link men from general practice in each and every hospital department to liaise on all points of contact between hospital and general practice, they were most impressed. At most AHECs that I visited, I was asked to hold a seminar regarding my work in the United Kingdom and at every district hospital, the lunchtime, usually about one hour, was given over to a working lunch question and answer session. I was really an ambassador for CME in North Devon, such was the interest generated, and there was nothing quite like it in North Carolina.

It became obvious in my first 4 days at the University of Chapel Hill that I was seeing medical care and research of a very high order. However, as far as I could see, there was little or no family practice-orientated CME going out to the family physicians, and absolutely no use being made of the knowledge and skills of local family physicians in the area in getting them involved in the production of their CME programme.

There was a most magnificent new Department of Family Medicine within the university precincts, marble floored and aesthetically pleasing, but this was very far removed from, and very little involved with, the local family physicians whom I visited later in my trip.

CME in America is a statutory requirement and

Correspondence: D. Abernethy, D.Obst., R.C.O.G.
Report on NACT Wyeth-Ayerst Fellowship, September 1992.

Accepted: 15 April 1994

consists of attending 50 hours of lectures – very much ‘bums on seats’. The programmes are arranged by hospital consultants without any input from family physicians, and in many cases are for a mixed audience of high-powered specialists and rural family physicians. This is in sharp contrast to the situation in the United Kingdom, where after years of battles with hospital clinical tutors and consultants, it is now the accepted norm that it is inappropriate for hospital consultants to decide on the content of, and teaching methods for, the CME of general practitioners.²

I began to realize that my planned schedules were bringing me into contact with university and hospital staff who were providing the CME, but I was not meeting the family physicians who were meant to be receiving the CME. Gene Mayer, the Associate Dean, immediately and drastically changed the programme so that I was able to spend a lot of time with family physicians. The quality of family medicine is very good but every time I asked about their involvement in CME – ‘Was account taken of their views?’ ‘Did they take part in planning the programmes?’ – the answer was always ‘no’.

The four AHECs which I visited operate family practice residency programmes, and it is their primary mission to improve the distribution and retention of primary care physicians in the state, but they are fighting a losing battle. In North Carolina the number of family physicians is declining and the estimates are that approximately 500 more doctors are needed to meet the 3,000:1 patient:doctor ratio recommended. In the United Kingdom the ratio is approximately 1,800:1. This situation is not peculiar to North Carolina and nationally it is estimated that approximately 18,000 further family physicians are required. In rural areas the situation is quite acute, with basic requirements barely being met. It is really a worrying scenario for primary health care in North Carolina and indeed for the whole of America.

All the time that I was there the thought that kept coming to me continuously was ‘Thank God for the National Health Service’, particularly when I heard of impoverished women both Black and White arriving at the hospital in full labour at 39 weeks, never having had a single antenatal examination; or when I heard of children enrolling to start school and never having had a single immunization for diphtheria, tetanus and polio, let alone pertussis, mumps, measles and rubella vaccine and (MMR).

However, the other side of the coin shows a system where the individual very much looks after his or her own health, a fiercely burning pride in the provision of local community services and, providing one can afford to pay, a desire to have good medical care as quickly as possible. Surely in two of

the most democratic nations in the world, it should be possible to devise a system somewhere between the deficiencies of the British National Health Service and American private medical care.

Talking to the directors of the AHECS and family physicians whom I visited, it became obvious that there were many factors contributing to the decline in the number of family physicians, particularly in rural areas, in North Carolina. The changing attitudes of medical students over the years has been put forward as a major factor in the decreasing interest in family medicine. Twenty-five years ago the majority of medical students were more interested in medicine as a vocational way of life; today many more students are much more interested in earning a high income. When they have finished medical school they will probably be in debt sometimes by as much as \$50,000, and when it comes down to choosing family practice at \$95,000 a year compared to a radiologist or orthopaedic surgeon’s salary of \$200,000, then it is not hard to see why the numbers entering family practice are declining. Thirty years ago there were roughly equal numbers of family physicians and specialists, but by 1990 the ratio had dropped to as low as 30:70 and in some quarters it is being predicted that unless the trend was reversed it would fall to as low as 25:75 in favour of specialization.

The AHECs are doing an excellent job with the family practice residency training programmes but at the end of the programmes young family physicians have a difficult choice to make as to whether they should enter rural practice with a much lower income or go into a town practice with increasing competition from the specialists and sub-specialists.

The policies of insurance societies make it very difficult for family practices to succeed financially. Family practices, by and large, receive less money than the specialists for providing the same service. It is much worse in the rural areas where the patients are very often earning low wages and where there is a high proportion of elderly patients. In these rural areas family physicians find it very difficult to make ends meet.

Even in North Carolina, which has a very active family practitioner training programme, there is a great shortage of family doctors in the rural areas. Between 1983 and 1988, a total of 37 counties within the state had a net loss of 71 family doctors and during the same period had a worsening in the patient:doctor ratio.

How does one reverse this deteriorating state of affairs? Towards the end of my visit I had lunch with the president of a large hospital who had just finished interviewing surgeons for his second heart transplant post. He was the epitome of the American businessman who had turned around

this provincial hospital into a centre of excellence that was vying with the Mayo Clinic for the provision of medical services. The hospital had to write off bad debts of \$70,000,000 for 1991 but at the end of the day it could point to profits of \$45,000,000. This hospital had a large thriving family practice residency programme but in the surrounding rural areas there was a need for 75–100 family physicians. His revolutionary plan was to fill these vacancies by paying well above the average \$95,000 per year – paying \$125,000 and for a guaranteed period of 5 years. Some would stay and some would leave, but overall the rural communities would be well served and, of course, these family doctors would refer to the specialists in his hospital, raising the hospital income. He promised me in 3 years he would be interviewing for his third heart transplant surgeon!

My fellowship was meant to enable me to study

CME in America and in North Carolina particularly, and to learn from it. Instead, I was able to see at first hand the threats to primary medical care in one of the richest nations of the world. It was an education in itself and I was able to talk to doctors and managers in open and frank discussion, and everyone was agreed that something had to be done to stop the breakdown in medical care.

President Clinton, or rather Hillary Clinton, must look very carefully at the ever increasing costs of health care, if America is to truly reform its health care system, and family practice is to survive.

To sum up, in North Carolina, the family practice residency programmes for the young doctors are excellent, but for the family physician, particularly in rural areas where it is most needed, participating CME has still a long way to go.

References

1. Abernethy, R.D. Continuing medical education for general practitioners in North Devon. *Postgrad Med J* 1990, **66**: 847–848.
2. Lewis, A.P. & Bolden, K.J. General practitioners and their learning styles. *J R Coll Gen Pract* 1989, **39**: 187–189.