done as part of locally developed guidelines which are actively disseminated, reflect local circumstances, such as the additional barriers to immediate treatment in rural settings,[10] and involve all relevant professionals in both primary and secondary care.[18] In the absence of district-wide guidelines, general practitioners should agree general practice based policies or guidelines. These should reflect the correct interpretation of the research evidence, and should be used to ensure that all patients with a potential to benefit from thrombolysis and aspirin therapy are given the opportunity to do so. A recent publication, *Effectiveness Matters,*[19] has been distributed to all general practitioners in the United Kingdom and summarizes the relevant research; this could be used as the basis of such guidelines.

In the absence of any district or practice guidelines all health professionals coming into contact with a patient within the first 24 hours after the patient has had a suspected myocardial infarction should make it their responsibility to check whether at least 150 mg aspirin has been given, and commence treatment if it has not. Given the weight of the evidence, all eligible patients should receive aspirin and thrombolytics during the acute phase. Although hospital doctors are responsible for providing aspirin therapy during the inpatient stay, the responsibility for ensuring that aspirin therapy is continued both beyond the acute period and the first month lies with the general practitioner. If these policies are widely implemented, the large benefits anticipated in rigorous research may be achieved in practice.

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Family practice in the United States of America — a new dawn?

IN recent years family medicine in the United States of America has become the poor relation of a technology-driven medical establishment. Graduates from medical school, hampered by large loans and attracted by the high earnings and prestige of specialist medicine, have rejected family medicine as a career. In 1994 federal health care reform temporarily threatened to overcome the reign of the specialist physician and restore the self-esteem of primary care physicians in the health care system. However, despite the failure of congress to pass health reform legislation, the American health system is steadily undergoing market-based evolution. This evolution is having a profound effect on the work and careers of family physicians, and results from the fact that an increasing number of consumers in the USA are leaving traditional fee for service medicine for a new form of health service delivery, managed care.

Managed care is the provision of complete primary and secondary care for a fixed fee each year. Patients use the primary care physician as their point of contact; there is therefore a care co-ordinator or gatekeeper, unlike fee for service insurance schemes where patients can refer themselves to the specialist of their choice. The managed care organizations, or health maintenance organizations, are paid by capitation for the delivery of services

which are provided by a panel of primary and secondary care physicians. These physicians are employed by or are in contract with the health maintenance organization. The financial arrangements vary from one organization to another but in many cases the primary care physicians are paid by capitation for all primary and secondary care, and are therefore at risk financially. Managed care is usually less expensive for the patient as the premiums and the charges payable at the time of receiving care are lower then fee for service insurance. Managed care is also cheaper overall than fee for service medicine as the capitation system goes some way to reducing the inappropriate care that fee for service medicine has encouraged. The Congressional Budget Office estimates that health maintenance organizations reduce the use of health services by a mean of 8%.[1] Critics of managed care maintain that appropriate care is often reduced and a poor quality service results.

Managed care is not new; in some areas of the country health maintenance organizations have been in existence for over 20 years. For example in Minnesota, 30% of the population were enrolled in health maintenance organizations in 1993.[2] In other areas penetration is zero. Congress is now debating the transition of Medicare (care for those aged 65 years and over) and Medicaid (care for the poor) to managed care, in an attempt to reduce the financial burden of these programmes on the country. Some states, such as Tennessee, have already transferred Medicaid patients to managed care and used the savings to increase the number of low-income people covered by insurance.

Private sector purchasers are active supporters of managed care. Many large employers have made the transition to purchasing managed care for their employees and employees' dependants, primarily because it is less expensive than fee for service medicine. Managed care provides major non-financial benefits that traditional health insurance does not. Preventive services are encouraged by health maintenance organizations which have an obvious incentive to keep people healthy, unlike fee for service medicine. A paper has illustrated the beneficial effect of cancer screening and preventive services by showing that Medicare patients enrolled in health maintenance organizations were diagnosed at earlier stages for the detectable carcinomas of the breast, cervix, skin and colon than Medicare fee for service patients.[3] Managed care also changes the focus of care from isolated encounters with individual patients to an ongoing responsibility for a population, something the USA health care system needs desperately.

The American Medical Association opposed many of the changes offered during the health reform efforts in 1994. There is a fear that as many as 165 000 doctors, mainly specialists, will become unemployed if managed care becomes the norm.[4] A recent article in the *Journal of the American Medical Association* summarized some of the other concerns that physicians have about managed care.[5] On the positive side, the article suggests that a shift to managed care may: increase the options for patients, especially in areas of the country that currently lack managed care; increase preventive services; make quality of care assessments more routine; and improve communication between doctors and patients, and between health professionals, by making greater use of primary care physicians and non-physician providers. On the negative side, it cites a potential threat to quality from the shift of care from specialists to primary care physicians, and a conflict of interest for physicians who have to take cost into consideration: 'the expansion of managed care and the imposition of significant cost control have the potential to undermine all aspects of the ideal physician–patient relationship.'[5] There is more general criticism that managed care brings with it reduced choice and access because patients must choose a provider who belongs to their health maintenance organization or pay more to see a physician from outside the system. However, the issue of access is not clear cut. A study of patients with ruptured appendices showed that more fee for service patients had appendiceal ruptures than managed care patients because they presented later. The authors suggest that this may be due to the fee for service patients' reluctance to seek help because of the need to pay fees each time they receive care.[6]

What are the implications of managed care for family physicians? They traditionally share the role of primary care physician with general internists and paediatricians (who are first contact providers in the USA).[7] Vocational training in family medicine is not as well developed as it is in the United Kingdom. Family physicians have to undertake a two-year residency programme, post-internship, in order to qualify for certification by the American Board of Family Practice. This residency period does not usually involve a full-time practice commitment in the community. Moreover, it is possible to be licensed by a state to practise without certification, particularly in those areas that have difficulty attracting primary care physicians. Health maintenance organizations are raising standards by only employing family physicians certified by the American Board of Family Practice.

It is a reflection of the status of family medicine as a specialty that one of the most prestigious medical schools in the USA, Harvard Medical School, has a department of ambulatory care and prevention but no department of family medicine. However, the status of family physicians is increasing, partly as a result of the increase in managed care. Like fundholding general practitioners in the UK, they are in a position of power in relation to their specialist colleagues. There is a national demand for more primary care physicians. In 1993 there were 457 000 physicians involved in patient care (not including residents or research fellows), of whom 14% were family physicians (62 000) and 25% were internists and paediatricians (112 000).[8] However, recommendations for an increase in the number of primary care physicians to achieve a 50: 50 split of specialists and generalists must be implemented with caution; the problem is more complex than just one of distribution.[9] There are already 71 primary care physicians per 100 000 population, which compares with 59 in the UK.[9] Perhaps the total number of medical school places should be reduced, in addition to encouraging a larger proportion of graduates to become primary care physicians. In the meantime, family physicians are in demand, and specialists who are completing training are having difficulty finding jobs. Some specialists are wishing to be considered as primary care physicians, either within their field of expertise, for example, endocrinology, or after retraining in the rudiments of primary care.

American medicine has not always been a high technology, specialist-based industry. In the past, general practitioners, as family physicians were once called, provided 'cradle to grave' care to widely dispersed communities and urban areas alike. The pendulum is swinging back from high technology, specialist care to the traditional family physician who knows his or her patients and continues to care for them through the spectrum of health and disease. One sign of this revolution is the patient record, traditionally consisting of scattered sets of notes in the offices of various physicians whom the patient has seen. There is no sense of history or continuity available from these records, hence patients often have investigations repeated. In some health maintenance organizations there is now a single patient record, which is held in the primary care practice and accompanies the patient on any visits to other health care providers, thus enhancing continuity of care and reducing the costs of duplication.

The future for American family physicians is bright but there are still issues to be resolved. The burden of administrative work is rising, as it is for their UK peers. Contracting can place physicians at personal financial risk and there is a growing problem of

how to manage the extended role of physician assistants and nurse practitioners.[10] However, it is an exciting time for family practitioners to seize the opportunity and, once again, be the backbone of the American health care system.

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