documents to the home, together with x-ray films, if available, is essential in domiciliary visiting.

Finally, what is the specialist's role in the management of routine backache? It is first to try and make a definite diagnosis or check on the diagnosis already made. In most cases the diagnosis is highly provisional, and further investigations are often necessary, for the backache may be a manifestation of a whole host of disorders ranging from an anxiety state with mild degenerative spinal changes to multiple myelomatosis. Admission to hospital or outpatient visits will be arranged and the future therapeutic programme organised in the light of the findings and clinical progress. In this case, if the condition settled down entirely satisfactorily no more would be needed; if mild or moderate symptoms persisted an outpatient consultation and appropriate investigation would seem to be indicated; but if the condition of the patient and the familial tension persisted unabated then a domiciliary consultation would seem the correct procedure but, speaking as a physician, with a

physician initially rather than an orthopaedic surgeon, though his services and opinion might well be required later.

Postscript to the problem

A domiciliary consultation was arranged with an orthopaedic surgeon. He wondered if tuberculosis of the spine might be present and arranged an x-ray examination at his outpatient clinic. This provided a nasty shock; metastatic tumour was seen, the source being an ulcerated tumour of breast, not mentioned by the patient and not diagnosed clinically by either general practitioner or specialist. The patient died two months later with brain and lung metastases. Fortunately, the profession redeemed itself in providing sympathetic and relevant care during the terminal period, and, as so often happens, the family were profuse in their thanks for the attention we had provided.

Medicine in the 'Seventies

Medical contrasts: Britain and the USA

An interview with Dr J M Forsythe

[FROM A SPECIAL CORRESPONDENT]

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When we think of differences between British and North American medicine, one aspect which may not be immediately obvious is the greater flexibility of the American system. Dr J M Forsythe, an NHS community physician recently returned from three months in the USA and this was, he thought, the most striking contrast. "What really hit me" said Dr Forsythe "was

Dr Malcolm Forsythe, MSc, FFCM, area medical officer, Kent Area Health Authority. Dr Forsythe served on the RAWP working party and has recently visited the USA as a result of the award of a Jack Masur Fellowship by the American Hospitals Association (as the nomination of the Nuffield Provincial Hospitals Trust).

outside monitoring of the way the service was being delivered, and perhaps outside financing of innovations. Central government would always have difficulty in innovating because of its

that we have now moved to a state where the NHS is financed almost 100% by central government funds. When the reorganisation took place in 1974 we lost an important source of finance from local government. In the past, progressive authorities could innovate, if necessary, entirely with their own funds through the rates. We now have to rely on central finance—and work within a document on priorities which lists specific yardsticks for most of the services. Health authorities are going to be pressed to try and conform with these yardsticks. The room for innovation and flexibility in the service has diminished quite dramatically." He would like to see some development of

need to consult with the professions and the unions. Something like 35 times more money was being put into health care by charitable funds in the United States than in Britain. In terms of individual giving the British contributed roughly £2 per caput to health and welfare from charitable organisations and in the United States it was about £20 per caput.

Approach to audit

Another contrast between the USA and Britain was to be seen in their approach to the concept of audit of process and of outcome. Dr Forsythe had no doubt that it had been developing in this country in a much healthier way than in the United States, where audit was being imposed. There the real motives were not quality of care: the Americans, and Congress in particular, were seeking to contain costs; and in their audit system imposed by legislation they were concentrating on length of stay and whether or not procedures were necessary. "To my mind that is totally missing the real issues, and in fact they are collecting the wrong sort of data for the measurement of *quality* of care." In part the difference of approach reflected the different problems: for example, they had an appalling problem of physicians "ripping off" the Medicare and Medicaid systems. But, Dr Forsythe continued, "that's the way their health service is run. It's not an organised health service, it's pluralistic. The government's role has been to create a whole series of programmes for specific purposes for which they have then developed a whole lot of regulations, which they have then had to monitor to see if they are being abused." He saw audit of quality of care as really being concerned with outcome. "In Britain at the moment we have no good measures of outcome. We can get case fatality rates of people treated in hospital; but the follow up of conditions other than cancer is very difficult. More important, we have no data on the satisfaction of people with the medical care they've been given; no data on iatrogenic

diseases; and no data on disability or time off work or time off before they go back to work. On the other hand we do have built-in mechanisms which help to ensure good care, such as postgraduate education, our advisory procedure for consultant appointments, and the tradition of GP-consultant referrals."

Concentration on audit of process on both sides of the Atlantic might, he thought, have been simply due to its being much easier to measure than outcome. In the United States it was virtually impossible to produce the sort of data available in Britain. For example, it had taken some special studies to identify the colossal variations in their tonsillectomy and hysterectomy rates. Here there were some encouraging trends: disease registries and record linkage, for example. If we could get those schemes and the measurement of outcome right, then he thought the profession would co-operate with audit. In his opinion it was best done by the medical profession; although the long-stay specialties audit should not be solely the doctor's responsibility, since the care of such patients involved a whole range of disciplines.

Distribution of doctors

There were big differences between Britain and other countries, too, in the distribution of doctors between hospital and primary care. In fact the ratio was almost reversed between the USA and Britain; here there were twice as many general practitioners as hospital specialists, whereas in the USA there were twice as many specialists as there were doctors in primary care. Even within specialties the proportion of physicians varied. In Britain 14% of specialists were in anaesthetics—far more than in other countries where nurse anaesthetists or anaesthetic technicians were used. Clearly there was scope for relieving the doctor of some of this work by putting in technicians—in fact almost every element of general medical care could be broken down into component parts each one of which need not be done by a doctor. Furthermore, British consultants were different from the specialists in most other countries. In contrast to much of Europe the British did not have specialists providing direct care to the patient without much in the way of help from juniors. "Our consultants expect to have registrars, housemen, and the like. Having been through the mill themselves," he went on "consultants expect to have the same infrastructure under them that they have suffered on the way up."

There was, however, a tremendous untapped potential of consultant effort available to the service if consultants' pay could be put right. That issue would blow up very soon, he thought, because the number of junior doctors was probably going to drop quite rapidly in the next few years as the number of overseas doctors tailed off. Someone would still have to do the work; either consultants or general practitioners. "I don't think you could look to GPs doing much more hospital work," said Dr Forsythe "but I think the consultants will, provided there is an incentive for them to do it." A third great untapped resource was the better use of women doctors. There was still a substantial proportion of women not working who would like to or who were working fewer hours than they would like. We had failed to take enough account of the changing age and sex pattern of the medical profession in this country. At a time when around 40% of our medical school entrants were women we were still operating the same old system that expected them either to work full-time or to abandon any hopes of a consultant career. There were too few occasions when doctors were encouraged to apply for a limited number of sessions—and often it was local opposition by the medical staff to blame. They seemed to believe that anyone who was going to give only five or six sessions was unlikely to carry their fair share of the cover and out-of-hours work. "This may change within the next few years—if only because area health authorities may not be able to fund a whole-time post and instead may advertise the number of sessions they can afford. That might perhaps get women into more career posts than it has done."

Financial squeeze

The financial crunch was coming—more and more of the academic staff at centres of excellence were taking one day off a week to do private work to get themselves the financial rewards they thought they deserved and that they were not getting in the present system. People who, five years ago, would never have contemplated doing any form of private medicine were now doing it in order to get school fees paid. "Within my own region," said Dr Forsythe "specialists have been doing locums overseas during their annual leave because of their incredibly high commitments—mortgages and school fees—in their early years as consultants. Most of them have great loyalty and want to stay in this very good system. The NHS is good; most people who have seen other systems come back and say ours would be superb if only it was adequately funded and if there were much more local control in decision-making and greater incentive to work."

Unfortunately it was becoming generally recognised that the NHS was underfinanced, especially on the capital side. On the revenue side there were some examples all over the country of fat that could be mobilised if only we knew how to do it. But buildings were antiquated and this was becoming more and more of a problem as the Government puts through its policy of "people before buildings." Furthermore, when dealing with problems such as overbedding in London and the population drift away from it, capital was essential to rationalise the services and get rid of inefficient plant. On the resource allocation working party (RAWP) one of the problems had been that the members had known that if a health authority was trying to function with poor housing and inadequate social services it needed more resources than an equivalent health authority with the same population structure with good services. "How do you compensate?" asked Dr Forsythe, who was a member of the RAWP working party. "By giving extra money for supporting outside services? The argument which eventually won was that two wrongs don't make a right. In fact if the social services people should be building more training centres, or having more home helps or meals on wheels or the district councils should be building more group homes, if in these circumstances the Health Service gave more money to compensate for those deficiencies, then the local authorities concerned would never pull their socks up." Could one not argue then, that what RAWP was doing by removing money from inner London to the North was to leave the unfortunate patients caught between two negatives? Their hospital services, which had to some extent been compensating them for their inadequate social services, would now have less money while the inadequate social services remained. Dr Forsythe did not accept that the social services in London were inadequate; by and large he thought they were pretty good. Furthermore, the population in London was changing from year to year, and in fact going down by about 90 000 a year. "If we did nothing," he continued "Londoners would become better off year by year. Are the London advocates really saying that the health service in London should be given more and more money each year per head of population, while the rest of the country gets less?" That was the implication if the money was not taken away when there was no overall growth.

Priorities and sharing

According to the DHSS, RAWP was to be interpreted in the context of the priorities document, and there was a great deal of political pressure to make more resources available for the mentally handicapped, for the old and chronic sick; and yet as things stood at present this could be done only at the expense of the acute sector. Many people working in acute hospitals believed they had already been pared down to the bone. Was that in fact the case?

Dr Forsythe thought that was fair comment. The fallacy in the political argument had been the Health Service could not

be considered in isolation. With the chronically sick the buck stopped with the Health Service, so that in fact if social services housing and all the welfare services were inadequate the individual concerned would end up as a patient. "We should not only be looking at the way the money is spent between the acute and chronic sides within the health service," he said, "but also at the ways the money is spent between health and the social services and other services."

"Now, I am all in favour of prevention, but I can't think that there are many preventive techniques which have not been implemented through lack of money." There had usually been other reasons. Fluoridation, for example, had not basically been held up because of shortage of money.

Why, then, were not all children in big cities fully immunised? Partly because of parental inertia and partly, more recently, because of the outburst of propaganda about pertussis vaccine; but could not the inertia have been overcome by a vigorous and better financed programme? Again, Dr Forsythe had doubts. While a full computer system would increase the uptake of immunisations somewhat, he thought that adverse publicity had been the most important factor in the drop. In any case the West Sussex scheme had shown that the costs of the computer system was less per person immunised than a manual system, so that again finance should not be a problem. Prevention was held up by lack of motivation, not lack of money. In contrast, however, health education was one big field in which Britain was not spending very much money compared with the North American continent. Even so, he thought that health education had yet to prove itself as being an area where it would be worth spending large sums of money. In terms of facilities which might effect perinatal and infant mortality and neonatal morbidity, such as genetic counselling and the intensive care of newborn babies, he accepted that in much of the country they were totally inadequate.

Acute services were indeed having to be rationed in many conditions. Classic examples such as hip replacement surgery and renal dialysis were nevertheless very real for the patients affected, though with dialysis delays the problem was, he thought, often a shortage of donor kidneys. There would probably be enough dialysis places if more kidneys were made available; in fact the nephrologists did not think they needed more dialysis machines. He was not sure whether, with an adequate flow of transplants, the service would need much more money. Joint replacement surgery, however, raised the whole question of defining objectives in the Health Service. In Britain, with 14% of the population over the age of 65, the problems were more apparent than in most other countries. "I don't know at what age an orthopaedic surgeon should say he would not replace a joint; but if society was not going to establish any limits then someone would have to decide how much could be spent." In the affluent sectors of society hip replacement had become very common; people were prepared to pay for it, in both this country and North America, and were happy with the results. Possibly 10% of the population over the age of 65 might benefit. At present, like many other operations such as removal of cataracts and some gynaecological disorders, because of differences of expectations, the operation was class-linked, but this would change. "We don't ever ask the population in this country what they regard as their need for health care; it's basically determined by professional people who work within the service."

There was another possible approach to the definition of need. How much did somebody immobilised through hip disease cost society from the time they became immobilised until their death—not only in terms of the Health Service but also in terms of the social services and other agencies? Set that against what it cost to operate on them, and whatever disease they would then develop afterwards, and a cost-benefit analysis was possible. But was such an analysis valid? Particularly after the age of 65, one could point to the ways in which a number of diseases could be circumvented, prevented, or cured, but everytime that

merely exposed the patient so treated to the risk of developing further expensive diseases—indeed it had been argued that everyone should be encouraged to smoke like chimneys, so that we all die at 65 of lung cancer, which is cheap. "*Cancer cures smoking.*"

Government responsibilities

Again, there were contrasts with North America. In Canada, for example, they seemed to see the duties and responsibilities of Government more clearly than we did. The Federal Department of Health had a responsibility to ensure, where legislation by other departments would benefit the health of the nation, that legislation would go ahead. "It may not be the responsibility of the British Department of Health to pass legislation about seat belts, but it is the Department's responsibility to make sure that all other government departments and the politicians are aware of the ways in which legislation could improve the health of the country." On alcohol, for example, the Government seemed to be taking a very neutral position on extending licensing hours, whereas the substantial body of medical evidence was that there was a link between the availability of alcohol and the amount consumed.

A more general criticism of the DHSS was that it spent far too much time meddling around with the details of the Service which it should leave to the area health authorities and spent far too little time getting its strategic role clear. In its priorities document, for instance, it had talked about bed "norms"—instead of giving minimum levels or a range in, for example, geriatrics it repeated the specific figure of 10 beds per 1000 over 65, as if that were the only proper figure. "But," Dr Forsythe said, "we all know that with the inpatient services for the elderly a lot depends on the social and cultural makeup of the community, what the housing services are like, and what the social agencies are like. It might well be that for two identical populations situated in adjacent health districts twice as many geriatric beds might be needed in one than the other; but where there were good extended family relationships twice as many home nurses or twice as many health visitors might be needed to enable the maximum number of the elderly to remain in the community. In any case the bed norm should be related to 5-year age and sex groupings because of the increasing morbidity with age."

Fortunately, primary care was perhaps the stronger feature of the NHS at the moment. It was the focal point of the Health Service, and health authorities were putting more effort into the building up of community primary health teams. Sadly, however, in the last few months general practitioners had lost their trust in the Government. One recent example in Kent had been the cancellation of a health centre at a very advanced stage of development. It was going to be a health centre on a cottage hospital site—an absolutely perfect situation, everybody had been happy about it; but the GPs had pulled out at the last moment because they had felt that they might be committing themselves to a set up where Government could move in and control their activities. They'd lose the autonomy they'd got at the moment in their group practice. "They're disappointed, and I'm bitterly disappointed," said Dr Forsythe. "But one can understand why they've acted that way. But apart from that it seems to me that the general practitioners have become well organised both operationally and in the way they are paid. They have much greater job satisfaction now than they've had over the last few years, and in fact the pendulum has swung completely round. Whereas in the 1960s job satisfaction was to be found with the consultants in hospitals—with their increased specialisation and increased technology—and general practitioners were frustrated, it is now the other way round. Consultants are under pressure to discharge patients from hospital and they see very little of the patient as a whole. They are short of equipment that they used to be able to obtain reasonably easily, and the general facilities in which they are trying to work are deteriorating. And it's still going on, isn't it?"