small homes with people with other handicaps and that elderly epileptics whose condition does not warrant hospital care should be placed in local authority homes for the elderly.

A geriatric patient with severe epilepsy would not be best served in a geriatric ward or a district general hospital, where it is doubtful that his special needs would be met. I am quite certain that epileptics requiring long-term care are not likely to be well looked after with a group of other patients suffering from other handicaps.

Wind of change

Sadly it now seems inevitable that the recommendations of the regional health authority that St Faith's Hospital should be closed will be accepted by the Department of Health and Social Security. But this is only part of the wind of change that is blowing through our mini-field of epilepsy. For some time the epileptic colonies have suffered through the failure of the appropriate local authorities to fund the admission of suitable patients. Similarly, St Faith's has had its catchment area progressively reduced and the hospital is no longer viable because it has been directed to accept no more long-stay patients. It is now administered at district level, and clearly it is considered a financial embarrassment. I am quite certain that the hospital should be seen in a supraregional context and should be developed to become an important unit in south-east England.

Some years ago, with the blessing of the then Ministry of Health, a Joint Consultative Committee (JCC), consisting of the staff of the epileptic colonies and, more recently, St Faith's Hospital was established. Its function was to serve as a channel of communication between the Ministry of Health, the colonies, and the special hospitals. All members of the JCC have naturally been concerned about recent changes, and at their last meeting representatives from the department of health, regional health authority, area health authority, and the district management team for the Brentwood area were invited to attend. In the event, no representative from any level of the Health Service hierarchy attended.

I am wholeheartedly behind the Reid Report's recommendation that great efforts should be made to assess and rehabilitate patients with epilepsy before the often final admission to a long-stay institution has taken place. But it is irresponsible to run these hospitals down and close them before the perhaps Utopian alternatives devised by Reid and his colleagues have even begun to be implemented. The diffusion of responsibility through the various levels of Health Service authority is such that often the wrong advice is taken from the wrong people and wrong decisions are made.

The future and even the present gives cause for much concern. What help can I give to a district social worker, general practitioner, or hospital urgently seeking a place for one of our underprivileged misfits, who collectively cannot speak for themselves? Somebody must speak on their behalf. My qualifications are that I have worked with them and attempted to serve them for 25 years.

Reference

[1] Joint Subcommittee of Standing Medical Advisory Committee and Advisory Committee on Health and Welfare of Handicapped Persons, *People with Epilepsy*. London, HMSO, 1969. (Reid Report.)

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Letter from . . . Chicago

Primary health-care crises

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As the great debate over the American health-care crisis continues to unfold, it becomes apparent that one person's crisis is not another's, and that different ailments need different remedies. Thus, the crisis of sizable rural areas deprived of doctors might well be corrected by appropriate incentives; the crisis of the urban poor may need suitable financial arrangements or some kind of national health insurance; and the crisis of the suburban lady with conflicting doctor's and hairdresser's appointments suggests the need for more hairdressers rather than the wholesale production of primary-care physicians. Yet it is about primary care that the debate is most intense, sharpened in recent months by the provisions of the new medical manpower legislation.

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Two approaches

The issues, in this debate, may well be narrowed down to two points of view, the pastoral and the pleuralistic. Of these, the pastoral approach is vigorously espoused by the adherents of the family practice movement, from the wide-eyed blonde resident who enthusiastically declares that she takes care of families, to her mentors who emphasise that most human illnesses are simple. Family practitioners, they point out, can adequately deal with 85% of all patients' complaints, and yet medical schools spend 85% of their time and money teaching future doctors about the other 15% of illnesses. For this and for the resulting maldistribution of doctors they tend to blame the Flexner report; and, having become organised within an Academy of Family Practice, they are trying to determine what skills should be taught to family practice residents during their three years of postdoctoral training. Meanwhile, they loudly proclaim the advantages offered by the family practitioner: he is available night and day; he is part of the community and may have known the family for generations; and he can often embellish or modify his history by interviewing relatives or neighbours. Moreover, in remote areas, he provides total care

by practising obstetrics and minor surgery as well as by prescribing medicaments and reassuring the worried well.

The proponents of the pleuralistic approach, on the other hand, prefer to view primary care and general medicine as functions, not as professions. This generalist function they envisage taking place within the context of primary office, secondary hospital, or highly specialised tertiary medicine, but not within any particular medical discipline. In an ideal system, they concede, one might as well have started off with an echelon of primary contact family doctors; but since family practitioners will be in short supply for years to come, one should face the reality that many other categories of doctors presently fulfil that function. By definition, then, a primary care doctor is someone whom the patient can call his own doctor, who maintains an ongoing concern for his patient's wellbeing, who will see him through all his tests and treatments and admissions to hospital, and who remains the central commanding figure even though many other doctors or agencies may care for him. To fulfil this role, the primary care doctor must be accessible, have a great deal of common sense, recognise his limitations, and be prepared to seek appropriate consultation. Primary care, then, becomes an attitude, not a profession.

Within this definition, the internists clearly provide most services. There are now 50 000 of them, their numbers are increasing, their training has been lengthened to a three-year-programme, their curriculum and examinations have been redesigned to emphasise primary care problems, and their spokesmanship has been unified and strengthened. They have also embarked on comprehensive self-study programmes. One such study shows that 75% of graduates from internal medicine residencies spend at least half their time in primary care, in solo practice, or within multispecialty groups. And another study recently showed that most internists spend about six hours a day in direct patient contact and a further three in other patient-related activities. They see in their offices a daily average of 12 patients, with whom they spend about 18 minutes each (12 minutes for a cold; 28 minutes for a physical examination); and they treat various illnesses, with hypertension (7%), ischaemic heart disease (5%), and diabetes (4%) being the commonest. In the hospital they have an average of eight patients under their care at any one time; and they spend a considerable amount of their hospital time providing consultations to surgeons, obstetricians, and other specialists.

Practising subspecialties

While many internists are generalists, others also practise a subspecialty—and indeed regard this combination as a good mixture, with the various ingredients complementing one another so that they retain common touch as well as scientific ability. Internists provide primary care in such specialised settings as renal-dialysis centres[1]; prepaid systems such as Kaiser-Permanente, in which much preliminary screening and counselling is left to nurses and paramedics[2]; and teaching hospitals and universities, where they bear the brunt of teaching medicine to all future doctors and remain the major bulwark for preserving general medicine as a non-fragmented, integrated, scientific, and patient orientated discipline.

Yet, as I first reported some two years ago, the general internist is not alone in primary care. A survey of 100 doctors in various disciplines indicates that about 60% of all specialists give some primary care, with the highest numbers being in the medical subspecialties of rheumatology (81%), cardiology (80%), and gastroenterology (78%).[3] Even dermatologists now claim to be primary doctors, seeing as they do myriads of patients with acne and rashes without the prior interposition of a general practitioner; and a similar claim is made by the modern psychiatrist,[4] who has usurped the functions of the family confessor, who alone among doctors still has the time to talk to his patients, and who attends to thousands of women and men who would be at a loss if asked to name their family doctor. Most mothers still take their sniffling children directly to the paediatrician; and almost 75% of surgeons not only cut but also treat general medical complaints. In addition, some 80% of obstetrician-gynaecologists exceed the immediate boundaries of their specialty; many claim to be the patient's chief source of care; and they apparently fulfil a real need in counselling girls who have outgrown their paediatricians and who have menstrual, sexual, or urinary problems.

So much for the pleuralistic approach to primary care. Whether a highly trained (or overtrained) specialist is the person best suited to unravel the tangled web of the careworn polysymptomatic patient has long been debated. But the story has been told about a northern American city where the climate predisposes to sinusitis, and where the ENT specialists had traditionally become identified as first contact doctors. With headaches, indigestion, bronchitis, and tiredness being universally attributed to sinus trouble, it was the ENT man who first listened, decongested, washed out, or drained, referring only the unresponsive cases to the internist.

Another approach, popular in some countries and often considered in America, is to draft young medical graduates into providing primary care in medically deprived areas, perhaps in return for paying their medical school tuition. This view, however, has now come under criticism from Spiro and Mandell.[5] In what their critics have called a tongue-in-cheek or even colonoscopic view (at least one of the two gentlemen being a gastroenterologist) the authors suggest that recent graduates—being blessed with unlimited stamina and recent knowledge about modern drugs and equipment—should provide the care in acute hospitals, and that the over-50s should be put to pasture in medically deprived areas or in the benign atmosphere of office practice to listen and sign prescriptions for the chronic repeater. Needless to say this proposed motion had no seconders—at least not in the correspondence pages of the *New England Journal of Medicine*, except for the idea that perhaps a similar principle might be applied to politicians, statesmen, and university deans.

Primary death care

Be that as it may, clearly for the foreseeable future various disciplines will continue to meet the primary care needs of the living American people. As for the others, I wish to refer in closing to a pamphlet published in the subterranean literature and ostensibly emanating from the American Association of Family Pathologists. The pamphlet emphasises that primary death care is a live issue; that death care is a right for those who repose and decompose; and that the modern death care delivery system requires a death care team consisting of the physician, the pastor, the family pathologist, the undertaker, as well as possibly the psychologists, florists, insurance agents, and potential heirs to the estate.

The association also feels the need for more courses and direct instruction on casketside counselling, interment medicine, burial behaviour modification, diagnosis and treatment of rigor mortis, and the fundamentals of decomposition. Although no special board or examination is as yet recommended, the potential for further fragmentation (of medicine) is obvious, so I offer this information without comment.

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