

The Changing Pattern of General Practice and Its Educational Implications*

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One of the many aspects of society which has changed during this century is the pattern of medical care. Home visits by physicians have decreased from 40% of their total visits in 1931 (personal communication with Dr. Odin W. Anderson, Center for Health Administration Studies, University of Chicago, using data from Falk, et al., 1933) to 5.4% in 1964 (U. S. Public Health Service, 1965). The changed pattern of home visits has, of course, been mirrored by a rise in office visits which constituted 50% of all visits in 1931 (personal communication with Dr. O. W. Anderson) and 69.8% in 1964 (U. S. Public Health Service, 1965). A similar trend is seen in hospital clinic and emergency room visits which contributed 11.9% of the total visits in 1964, an increase of 3.1% since 1959. These figures undeniably point to the fact that the ambulant patient today receives care in two main locations, i.e. the office and the hospital clinic-emergency room complex. Consultations in these locations comprised 81.7% of the total patient visits to physicians in 1964 (U. S. Public Health Service, 1965).

This change in the location of patient consultation has been accompanied by the rise of specialism in medicine. In 1931, 14% of physicians in private practice were

full time specialists; in 1962 this figure had changed to 38.4%. During the same time, the classification of part time specialists and general practitioners dropped from 70.8% to 27.2% (Peterson and Pennell, 1962). This decrease was made greater by the increase in number of physicians entering other full time practice, e.g., teaching, government service, administration, and research, and also by the influx of doctors into internship and residency programs. These changes have resulted in the patient being cared for by a multitude of specialists in office and hospital instead of a family physician in office and home.

The general practitioner at the turn of the century was the only doctor available to most persons and was therefore required to practice all branches of medicine. He was able to do this because of the limited diagnostic and therapeutic measures available which, with the lack of hospitals, necessitated the bulk of his practice being conducted in the office and home. Today, however, the specialist and the hospital have assumed pride of place in medicine and consequently the general practitioner has seen his practice change from domiciliary general medicine to a type suited to the demands of his more medically sophisticated patients. Conversely, many specialists indulge in general medicine, at least until their practice is established. The assumption is, therefore, that the general prac-

itioner is being forced to limit his practice in the specialties to some extent, particularly in the urban centers which now house 70% of the United States population and two thirds of the physicians in full time specialty practice.

SURVEY METHOD

The survey described below was made preliminary to a meeting on general practice which was convened by the Dean of the School of Medicine, Medical College of Virginia in October 1964. The aim of the survey was to define the content of general practice in urban and rural areas in the State of Virginia. A questionnaire was sent to all members of the Virginia Academy of General Practice with an accompanying letter signed by the Dean of the School of Medicine and the special consultant in general practice to the College, himself a general practitioner. The information requested was confined to two items:

1. The population of the town or city in which the practitioner was located.
2. The percentage of time spent in each of the specialties of internal medicine, pediatrics, surgery, obstetrics, and gynecology.

Three hundred and ninety-two (82%) of the 478 questionnaires sent out were returned. Of the 392, 20 could not be used because of incomplete information. A total of 372 (78%) questionnaires were

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TABLE 1 Respondents by Population Size	
Population Size	Number and Percentage of Respondents
Under 5,000	115 (30.9)
5,000 to 9,999	41 (11.0)
10,000 to 49,999	62 (16.7)
50,000 to 99,999	31 (8.3)
Over 100,000	123 (33.1)
Total	372 (100.0)

TABLE 2 Percentage Time Spent in Specialties in Areas of Under 5,000 and Over 100,000 Population								
Specialty	Population	Percentage Time						
		0	1-19	20-39	40-59	60-79	80-99	100
Internal Medicine	< 5,000	4.3	0.9	25.2	43.5	18.3	7.9	0
	>100,000	0	2.4	18.7	28.4	37.4	10.4	2.4
Obstetrics	< 5,000	27.8	54.7	14.8	2.6			
	>100,000	52.8	33.3	13.8				
Pediatrics	< 5,000	6.1	22.5	60.8	10.4			
	>100,000	8.9	26.0	57.7	7.2			
Surgery	< 5,000	28.7	63.4	7.9				
	>100,000	31.7	61.0	6.5	0.8			
Gynecology	< 5,000	23.5	65.1	11.3				
	>100,000	18.7	66.6	14.6				

TABLE 3 Respondents in Populations Above and Below 10,000 Reporting "No Time Spent in Specialty"										
Population	Internal Medicine		Obstetrics		Pediatrics		Surgery		Gynecology	
	Total	%	Total	%	Total	%	Total	%	Total	%
<10,000	6	3.8	43	27.6	9	5.8	49	31.4	36	23.1
>10,000	1	0.46	104	48.1	19	8.8	62	28.7	39	18.1

therefore used for the evaluation. Respondents were classified according to population divisions (table 1).

RESULTS

There were marked differences in the percentages of time spent in two of the five specialties when towns of under 5,000 and over 100,000 were compared. A greater percentage of time was spent in internal medicine in the large cities, whereas in obstetrics the opposite was true (table 2). Half the practitioners in areas with a population of 100,000 or more were spending at least 60% of their time in internal medicine, almost double the percentage in the same category in the small towns. In the large cities, half the practitioners completely excluded obstetrics from their practice while this was true of only one fourth of the doctors reporting from rural practice. Differences in the other three specialties within this population distribution were not remarkable.

The percentage of practitioners reporting "no time spent in specialty" in towns with populations above and below 10,000 again showed that in the large cities about one half the practitioners practiced no obstetrics compared to 28% in the smaller towns (fig. 1). The opposite was true in internal medicine; practically all large town practitioners practiced some internal medicine, while some 4% of small town physicians said they had no internal medicine practice. This statement must, however, be viewed with suspicion because of the small sizes of the samples (table 3). In addition, small town practitioners saw a lower percentage of surgical and gynecological patients, while their urban colleagues practiced less pediatrics. The differences in these three specialties, however, did not have the magnitude of those in internal medicine and obstetrics. These data confirm the proposition already suggested, i.e. that there is more obstetrics practiced in small

town, and more internal medicine in large town, general practice.

CONCLUSION

The survey confirms an assumption based on changes in population distribution, and in the medical profession, i.e. that the traditional pattern of family practice is more common in small towns and rural areas than in the conurbations which now contain almost three fourths of the United States population. The urban practitioner is becoming less of a general practitioner in the old sense of the term and spending more time in the practice of internal medicine. No attempt was made in this survey to find the percentage of time spent in psychiatry. It is probable, however, that a considerable amount of time spent with patients may be categorized as office psychiatry in all types of practice. There is, of course, no indication of the number of specialists who are practicing family medicine from this survey.

The implications of these interpretations have a considerable bearing upon the content of training for general practice. The inclusion of the traditional specialties, i.e. internal medicine, pediatrics, surgery, obstetrics, and gynecology is no longer valid for all general practice residencies. Where possible, a resident intending to enter a rural practice should still have the opportunity to work in these specialties. All general practice training should, of course, contain the fundamentals of psychiatry and social medicine. The latter term is used as a synonym for the more usual "preventive medicine" and applies to the understanding of the patient as a member of society and of the role of society in medicine. It may well be difficult for a general practitioner trainee to decide upon his future practice location before he begins his residency, but this would be most desirable if he is to derive the maximum benefit from his training program. Another

way around the dilemma of residency content may be that of having certain requirements, e.g. psychiatry and social medicine, met during the first half of the residency and electives permitted before completion.

SUMMARY

The results of a mail questionnaire sent to members of the Virginia Academy of General Practice demonstrate the changes occurring in the content of family practice. Practitioners in small towns practice more obstetrics and less internal medicine than those in large cities, and conversely. The implications for training in general practice are discussed.

Acknowledgement

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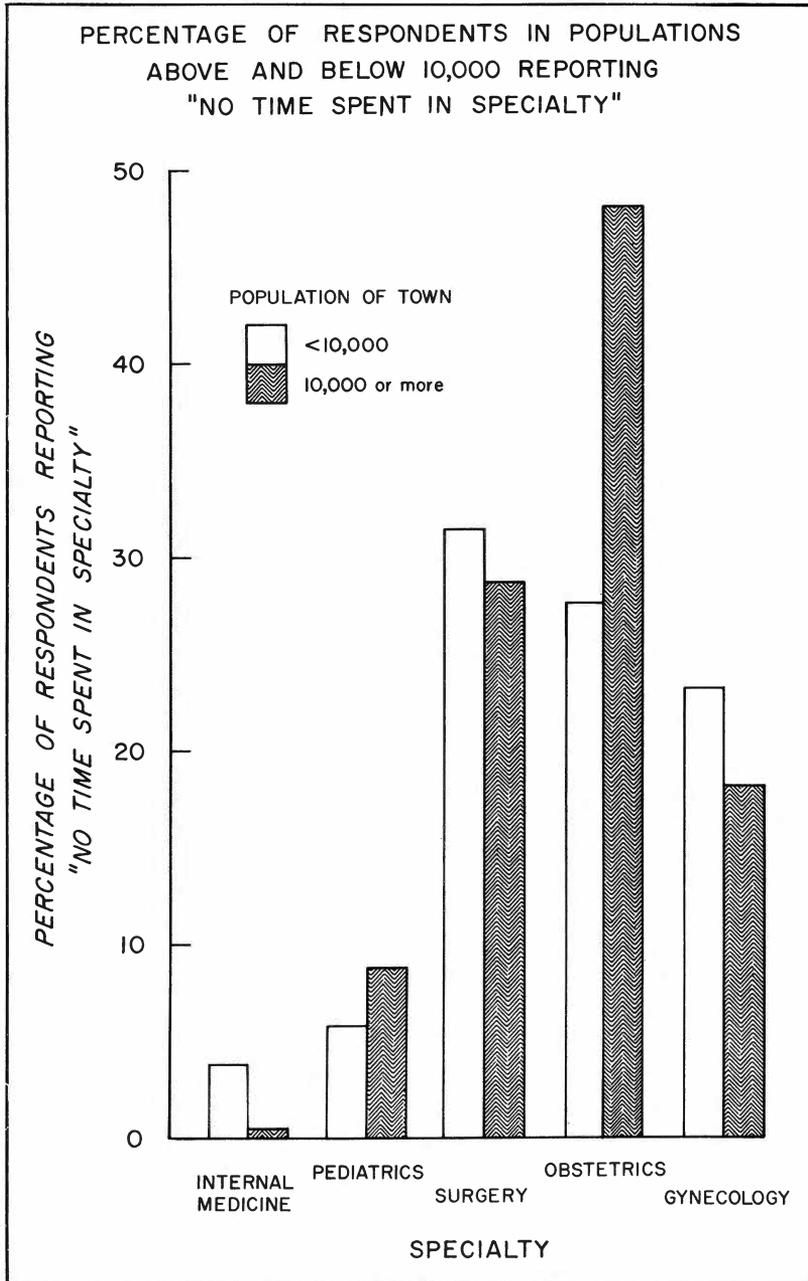


Fig. 1