Mandatory National Health Service

To the Editor.—I had to write a response to the article concerning mandatory national health service by Dr Johns.1

Ideas concerning future medical delivery systems have been expressed well by authors of various articles in JAMA over the last few years. I am beginning to tire of articles emphatically pushing the “right” to medical care, the fact that “universal access” will solve all our medical problems, and the “fact” that specialists are always high-priced, do inappropriate procedures, and are now concerned about their financial bottom line. Now, to paraphrase Johns, “public service physicians would insure society’s goal of competent, compassionate, and dedicated physicians.”

I have spent time in Haiti, Romania, and Mexico donating medical time, equipment, and service. In all situations I’ve found that I have most enjoyed giving medical care when my efforts have been received with gratitude, even when all I had to offer was compassion. Often my “payment” has been only a smile or a handshake, sometimes a Haitian dollar, or a small item presented as a gift.

This type of care is not “free”—it is an interaction involving gratitude on behalf of the patient and humility on the part of the provider.

In this life, we all learn that you don’t get something for nothing, and this unfortunately is implied when we accept health care as a right. Nationalizing our health care system will generate negative and demanding attitudes in physicians and patients. My friends in third world countries, as well as I, have had a very difficult time finding competence, compassion, and dedication as common attributes in public “servants.”

Gary L. Brown, MD
Mount Vernon, Wash


To the Editor.—While it is gratifying to read that someone from Johns Hopkins acknowledges family medicine and general internal medicine in one sentence, the recommendations made by Dr Johns for health care reform exhibit a naiveté about primary care that seems to characterize overspecialized institutions such as Johns Hopkins.

Johns recommends a dual track in which “the path of the young physician would divide into those pursuing generalist training and those pursuing specialist training. For the first group, the internship year would be followed immediately by 2 years of advanced generalist residency training...” My medical school graduates pursuing specialist training... would go directly into 2 years of national health service...”

Johns here establishes a false Cartesian duality that maintains that primary care medicine is not a specialty and suggests that primary care can be adequately provided by internship-level “warm bodies” awaiting “specialty” training.

From my own experience as a National Health Corps physician in New Mexico (two cases of plague, several cases of pertussis, one clostridial sepsis, complicated diabetes and congestive heart failure, heroin addiction, medical problems complicated by chronic psychiatric disorders, eclampsia, histiocytosis, myxedema, thyroid storm, and more), I do not believe that a physician with 12 months of internship can provide adequate primary care.

The success of any health reform plan depends not on the placement of “warm bodies” in certain locales, but on the training of primary care specialists who can provide quality and cost-effective care. Comparisons of family medicine specialists and general internists have found that family physicians order fewer blood and x-ray examinations, charge less, hospitalize for fewer days, and consult less, without compromising the quality of care.

Consequently, any national health service program that relies on internists to provide sophisticated primary care in today’s complex medical-social environment is likely to shortchange the public in quality while further inflating the cost of medical care.

While some form of national health service will do much to address inequalities in access to medical care, a true plan for health care reform would recognize primary care as a sophisticated and demanding specialty.

I would like to see only primary care residency lasting 3 years. After 3 years of primary care training (focusing on cost-effective outpatient medical care), family physicians would complete an additional year in obstetrics and neonatology; pediatrics, an additional year in pediatrics; and medical subspecialists would go on to complete their fellowships. Such a program would best serve the health of the public.

Neal Devitt, MD
Santa Fe, NM


To the Editor.—The Editorial by Dr Johns1 is an important reminder to the health care task force that the success of any reform depends ultimately on the people who will implement it. Currently there are too few general practitioners in areas

Requirements for Letters

Letters will be published at the discretion of the editors as space permits and are subject to editing and abridgment. Letters will be considered if they are typewritten double-spaced and do not exceed 500 words of text and five references. Please include a word count. Letters discussing a recent JAMA article should be received within four weeks of the article’s publication. Letters must not duplicate other material published or submitted for publication. A signed statement for copyright, authorship responsibility, and financial disclosure is essential for publication. Letters not meeting these specifications are generally not considered. Letters will not be returned unless specifically requested. Also see Instructions for Authors (July 7, 1985).