General Internal Medicine

Opinion in the 1970s gave little support to Mayo's old claim that one well-trained physician would do better work for a thousand people than 10 specialists. It was considered that the mantle of the general physician had fallen on general practitioners, A & E consultants, geriatricians and even professors of clinical medicine. The growth of relative specialties, fuelled by new technology, had made serious inroads into the traditional province of general medicine and there was a large question-mark over its future. As a result of anxieties expressed from various quarters, the College set up, in 1979, a working party to assess the position and future prospects of the general physician, with particular reference to patient care, medical education and the economic use of resources. After five meetings it was resolved, in 1982, that a College committee devoted to the specialty should be established, and one of its first tasks was to undertake a fact-finding exercise, with the help of Regional Advisers, to determine the current role of the general physician. The results of this enquiry have just been published.

Involvement in the acute emergency take was accepted as the hallmark of the general physician and replies were received from 1,031 individuals in 185 districts. In both teaching and non-teaching hospitals the majority regarded themselves as general physicians with an interest, although 17 per cent claimed to be pure general physicians. Of those general physicians with an interest, four-fifths spent more than 40 per cent of their time in general medicine and this figure was remarkably constant over the whole range of special interests. All 20 specialties recognised by the College were represented, with the majority involved in gastroenterology, respiratory disease, cardiology and diabetes; 20 per cent had more than one specialty interest and no less than 36 per cent had interests not included in their original contracts. The majority of physicians worked in more than one hospital, with an acute on-call commitment averaging, in non-teaching hospitals, one in 4.7 days and in teaching hospitals one in 6.8 days. Average admissions per take per day varied from 8.9 in the non-teaching to 4.8 in the teaching hospitals. In a climate of increasing specialisation the routine transfer of patients to other units was expected to be high but, in fact, only 17 per cent of consultants routinely transferred specific patients to other departments or other hospitals. Details of firm structure predictably showed a greater number of senior registrars in teaching hospitals, with more registrars and senior house officers in the non-teaching hospitals.

In the intensive care facilities of 178 districts unit administration fell to anaesthetists in 66 per cent but continuing patient care remained with the physician or was shared between the physician and the anaesthetist in 88 per cent, suggesting a satisfactory compromise rather than competition between anaesthesia and medicine.

These figures suggest that the general physician, usually with an interest, remains directly responsible for both immediate and continuing care for the major part of acute medicine. Of particular interest is the large number of consultants who developed either interests not included in their contracts or more than one interest. This underlines the frequently expressed view that flexibility should be maintained in both training and career structures to enable changes in direction, and also for new specialties, to be developed in association with general medicine rather than in isolation. The difference in consultant acute workload between the teaching and the non-teaching hospitals must have implications for training in the undergraduate, pre-registration and post-registration periods and reinforces the view that all District General Hospitals should, in fact, develop a greater teaching commitment.

The general physician with an interest will continue to provide the basis for acute medical services and the average District General Hospital will require at least five such consultants. If the physician is to remain generally based, his acute experience will be diluted if his on-take commitment falls significantly below one in five. Special interests covering most of the major specialties will be required. This may call for the development of new interests, involvement with more than one and the sharing of specialty expertise across adjacent districts or with geriatrician colleagues. Involvement of geriatricians in specialty provision could encourage the College's desire for integration. The development of technology-based new specialties should be viewed with caution and possibly assisted by sub-consultant labour substitution. Training for general medicine should be broad-based and flexible, with greater exposure to the acute take, especially at District General Hospitals: we would argue that two years rather than one should be the requirement for accreditation. Serious thought needs also to be given to those areas to which other specialties now lay claim, such as intensive care, haematology and oncology. In each case the clinical component must be identified and quantified and the role and lines of communication specified to aid the development of interdisciplinary training programmes.

There is no doubt that the general physician has responded to the need for change and will remain an essential component of hospital staffing.

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