Letters to the Editor

The future of dermatology

Editor—Robin Russell-Jones' appeal for . . . 'a more sympathetic view of the fundamental issues which now confront our specialty' (see pages 413–14) should receive support. It should not only reach the ears of the RCP, but should also be seriously considered by the Department of Health and the GMC. In this age of 'evidence based medicine' it is important to note that there is no evidence to support the view that 'outreach clinics' supply a more effective or responsive service than current hospital based services. I am puzzled as to how anyone could believe that specialists can practice their professional skills adequately outside of any ancillary support resources. To expect dermatologists to function in this way suggests that their only useful diagnostic ability is via their eyeballs and puts us back at least two or three decades.

Apart from the general undesirability of having one's diagnostic and therapeutic hands tied because of the expedience of seeing fundholders' patients quickly in a peripheral 'surgery', there are some other quite important matters of principle. A subject (such as dermatology) moves forward and develops its clinical abilities because of its academic ethos and it is pertinent to remind ourselves that the basis of any academic institution is the aggregation of professionals and experts for the purpose of advancing the subject in question. Of course individuals can accomplish great feats in isolation, but it is the sharp clash of minds and the hot house atmosphere of a 'department' that generates and develops ideas and nurtures innovation. Fragmentation of a department by sending its specialists to peripheral clinics can only do irreparable harm to its teaching and research activities. The present fashion for 'outreach clinics' ought to be categorised as a fashionable but foolish mistake.

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The district general hospital as a resource for the provision of neurological services

We were interested to read the recent College report, *The district general hospital as a resource for the provision of neurological services* (summarised in the Journal, May/June 1996, pages 198–9). It is unfortunately a very one-sided report which leaves unanswered a large number of questions which have to be addressed if patients are to continue to receive a service. We would argue that the statement (Recommendation 1): 'Neurological consultants with appropriate junior support, should be appointed to every DGH' cannot be allowed to go unchallenged.

Where will all the additional neurologists come from? How will the neuroscience centres (which have historically been largely responsible for the research, the development of neurology and the teaching) be funded and staffed if appointments are to the district general hospital (DGH) with only minimal time spent in the centre? Can a neurologist visiting the centre once a week accept responsibility for inpatient care in the centre? Should inpatient care be provided by neurologically trained nursing staff, junior medical staff and therapists? If so, how can that be achieved? During annual and study leave, who will provide the service? Is cross cover for inpatient care from another DGH (10–30 miles away) satisfactory? How can relationships between neurology and other neuroscience disciplines be made most effective? Where will junior staff be able to get the range of experience necessary for Calman type training? Where will CME take place? How will research and development take place?

We agree that patients should be seen as close to their home as possible. We also agree that the DGH needs a committed neurological input; an infrequent visit from a distant 'ivory tower' is not acceptable. However, we do not agree that this means that neurologists should be based in the DGH. The model of care which we have developed (and continue to develop) in the former Mersey region is a serious attempt to provide a good DGH service while creating a centre to which it is worth travelling. In developing this service, we have tried to answer the questions listed above, making the best use of limited resources.

By employing all neurologists in the centre we have been able to provide as many DGH outpatient clinics each week as the district wishes to pay for: sessions can be increased gradually as demand changes. Using a minimum of two neurologists to provide the service to each DGH generally ensures that there is a neurologist present 52 weeks each year. Indeed for the cost of a full time neurologist we can provide at least as much outpatient and ward work in the DGH as a DGH-based neurologist, and offer a very much wider range of subspecialties in the centre. We are also able to deliver a good training programme for junior staff and to run CME, research and development. What we cannot do is provide inpatient care in the DGH: but without neurologically trained junior staff, nurses and therapists, it is at least arguable that neurologists should not try to do so. Nowadays, neurology is largely an outpatient specialty; the need for admission is mainly confined to the very ill patients, complex rehabilitation, difficult diagnostic

problems and expensive new treatments, all of which are better dealt with by a team of neurologists, nurses and therapists in a neuroscience centre.

We do not claim to have answered all the questions nor to have the only acceptable model of care. Provision of specialist services will always be difficult and necessitate compromise. At a time when some relatively larger specialties are being restricted to fewer DGHs and the future role of the DGH is being discussed, a serious examination of the issues involved in the provision of neurological services would have been valuable. Sadly, the College report fails to take this opportunity and can, at best, be seen as a stimulus to further thought.

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The hospital general physician in the 1990s

I am writing to express a rather different view to that described by Professor Ward, on behalf of the College Committee on General Internal Medicine (May/June 1996, pages 209–10) approaching the issue of the balance between the general physician and specialist physician within general medicine from the perspectives of patient care, teaching and training of medical students and trainee doctors, continuing medical education, and clinical research.

Patient care. Using asthma as an example there is now a significant body of evidence suggesting that patients with this condition have significantly better inpatient treatment and significantly better outpatient follow-up outcomes when they are admitted under a team that is run by, or associated with, a consultant respiratory physician [1–6]. Although evidence for other conditions such as myocardial infarction, gastrointestinal haemorrhage or diabetic ketoacidosis may be wanting, possibly because the studies have not been performed or published, what happens when doctors themselves or their families become patients with these conditions is instructive. The consultant contacted is invariably the consultant with the expertise in the condition for which the patient has been admitted, regardless of who is the duty physician; at the very least the duty physician will contact the relevant specialist physician. If we provide this quality of care for our colleagues and their families, surely we should be aiming to provide the same quality of care for all patients.

Clearly in smaller hospitals the four or five physicians cannot all be on call all the time, but physician numbers are increasing and whilst we cannot immediately achieve the 'ideal for patients always to be seen by a real expert in a particular disease' we can progress towards that ideal. Many hospitals now have two, three or even four chest physicians, cardiologists, gastroenterologists or endocrinologists and when this happens it is possible to provide subspecialty cover throughout the week, even if the majority of admissions come in under the duty physician of the day. The key here may be for patients with the commonest emergencies to be admitted and managed according to a protocol agreed by the specialists locally and then to be transferred to the care of the appropriate specialist the following day. As Professor Ward states, the long-term management of the majority of patients with specific diseases should be in the hands of specialist physicians and their teams, and it is important to emphasise the word 'teams'. For patients whose condition leads to their admission to hospital, the long-term management either begins during that admission or can be modified and enhanced during the course of the admission. Again, to use the example of asthma, patients discharged from the care of a general physician have greater morbidity in the weeks and months following their admission, a higher readmission rate and, when appointments are made for them to attend the local respiratory medical outpatients, a lower frequency of attending their follow-up appointment than when patients are discharged from the care of a chest physician.

Asthma is but one example in respiratory medicine, others include the inpatient and outpatient management of patients with chronic obstructive pulmonary disease, the management of patients with suspected or confirmed bronchial carcinoma, and the inpatient management of patients with pneumonia. Examples of the commoner conditions seen by the other major specialties include ischaemic heart disease, gastrointestinal haemorrhage, stroke and diabetes.

Current technology alone makes it very unlikely that in Britain one physician or one medical team will be able to perform bronchoscopy or initiate nasal intermittent positive pressure ventilation, cardiac pacing or expert manipulation of anti-dysrhythmic medication, upper GI endoscopy or injection of oesophageal varices, be able to commence patients on renal dialysis, and to be up to date in the current management of insulin-dependent diabetes. This makes the statement concerning an expanding commitment for the general physician in the care of the critically ill with increasing involvement in high dependency and intensive care units particularly surprising. It is especially in such units where the multidisciplinary team is required with involvement