High hopes . . . for general (internal) medicine

Sir—like R P H Thompson and D R Parker (May/June 1994, pages 192–3), I too have high hopes for general medicine. In the larger hospitals, demand to see a specialist will lead to numerous and often needless internal referrals and a frequent stream of assessments for the disease-challenged elderly. In the smaller hospitals, review by a specialist is unrealistic. In the new NHS, we will utilise our specialist resources most efficiently when restricting specialist referral to common conditions which become complicated or require long-term follow-up.

Recognition and treatment of common conditions must be the goal of current general medical training, and keeping up with general medical knowledge could readily be incorporated into programmes of continuing medical education.

The late Professor Tony Mitchell was fond of quoting one of his patients—'the specialists look after my special bits but its the bits that hold my special bits together that are causing problems'. The generalist is not dead, merely resting. In the new NHS, managers may recognise the benefits of 'generalists with an interest' before specialists.

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What ever happened to the 'general physician'?

Sir—As a medical undergraduate and junior hospital doctor I can recall quite clearly that although special interests were expressed by hospital physicians they all considered themselves to be generalists first and foremost. It was the one important factor of UK medicine which distinguished us from many other countries where the absence of a strong network of community practice and the presence of a major emphasis (principally commercial) on medical specialisation obliges patients to self refer for a 'specialist' opinion. With the proliferation of specialists within the UK Health Service, the need for a general physician, perceived as an important part of UK medical practice, appears to be less evident now and is potentially under threat.

General practitioners have always been the 'gate keepers' for referrals to hospital outpatient clinics. This role has become more apparent with the advent of GP fund holding and the perceived need to reduce hospital outpatient attendances, often on the basis of cost rather than clinical necessity. Thus in some respects the general practitioner has tended to take on the mantle of 'general physician'. The result in many hospitals has been a significant reduction in attendances of new patients at general medical clinics coupled with a significant increase in referrals to specialist clinics. There is little or no evidence however to show whether this is better or worse for patients. But one consequence of this change has been that waiting times for a first outpatient visit at a specialist clinic have become longer. In addition, many of the patients on these waiting lists would previously have been readily dealt with by a general physician and do not necessarily require the immediate attention of the specialist. I hope this will in future lead to an assessment of the real clinical needs of the patients and not, as the national norm now seems to be simply to throw 'waiting list' initiative funds at the problem.

The renaissance of the 'integrated physician': is there a future for general medicine as a discipline and for the general physician with an interest as a worthwhile career option? In my view the answer is definitely 'yes' for three reasons: first, despite the problems of postgraduate medical training in the post Calman era and the constraints imposed by the European Union initiatives, we remain committed in the UK to the need to provide physicians in training with an all round experience of general internal medicine. This is principally because we believe that this produces doctors who still think of patients as individuals and not diseases and are prepared to share their patients with other carers. The precept of individualisation of care is embodied in the 'patients' charter' and for some of us represents the single most relevant aspect of recent NHS reforms. In order to achieve this we must therefore retain the generalist approach in undergraduate medical education as well as postgraduate training and career development.

Second, the needs of the acute medical emergency intake still remain an important part of everyday activity in all district general hospitals. The market economy in the NHS has tended to downgrade this aspect of hospital care and it is in danger of becoming yet another 'Cinderella' service despite the fact that in resource terms (human and consumable) it represents a major financial drain on the institution. I see no likelihood of any future downturn in the quantity or type of acute medical admissions and a number of hospital trusts have also recognised that this situation requires a radical change in their attitude. Thus the acute services should no longer be considered as an annoying core function and a 'yoke' around the neck of the trusts, reducing the possibilities for more lucrative contracts. They are in fact a marketable service for which a more enlightened and flexible approach to contracting with purchasers is needed. The assessment, triage and management of acute medical admissions cannot be left entirely in the hands of medical staff in training. It is essential that consultant general physicians contribute directly to both quality control and supervision of the juniors' experience and training.

Finally, I believe we are witnessing a renaissance of the generalist with the introduction of integrated medical teams in many hospitals. The association of geriatricians with general physicians as a single team