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

of one or more specialist physicians with the technical expertise described above. Clearly one physician must be in overall charge, but the involvement of the others when necessary is not only ideal, it is essential.

Professor Ward states that there are inherent dangers in patients being seen only by specialists who may fail to see the total picture, both medical and social, from the narrower perspective of their specialism. This underestimates the common sense and wisdom of experienced physicians, and it is certainly arguable that it is more likely that the generalist will fail to manage a patient's asthma or pneumonia or diabetes in a sufficiently expert way because the generalist is simply unaware of the latest developments for potential recovery and rehabilitation. Even in medicine for the elderly, subspecialisation is occurring and, where it is not occurring, patients over a certain age, if age is used as a cut-off for admission practice, may be receiving a different quality of care from that given to their younger brothers or sisters.

Last, but certainly not least, patients themselves when surveyed, eg by the National Asthma Campaign and during the implementation of Cancer Calman proposals, hardly surprisingly always state that they expect to be looked after in hospital, by doctors and teams expert in their condition. We must also remember in our increasingly litigious times that inexpert care may be very expensive and not only in financial terms.

Teaching and training and education. As the medical curriculum becomes increasingly congested and the intensity of the work undertaken by trainee doctors increases following the entirely appropriate reduction in their working hours, it becomes evermore important that those responsible for teaching and training ensure that each teaching session and training experience counts. Again, using asthma as an example, it is surely better that the students and trainees should rotate through respiratory teams and see a lot of asthma managed well, rather than being exposed to a smattering of asthmatics managed in a variety of suboptimal ways from a range of general medical teams. Respiratory medicine and cardiac medicine together account for over half of all acute medical admissions. It should be possible for all house officer and SHO rotations and for all medical students to spend some time in these specialties. Other specialties must also be included in the rotations, perhaps in proportion to the frequency of their conditions in inpatient and outpatient practice. Using asthma as an example does not imply an attack on general physician colleagues, since the reverse logic of these arguments for non-respiratory conditions obviously applies equally strongly.

It will be very interesting when CME diaries are analysed, to learn what proportion of CME consultants spend in their specialty and what proportion in aspects of general medicine completely unrelated to that specialty.

Clinical research. Clinical research and operational research on the delivery of care for the commonest medical emergencies only seems to take place in units where those emergencies are concentrated under the care of the appropriate specialist physicians. This is not surprising since advances in management will be impaired if patients are scattered amongst all the general physicians and around all the medical wards.

In conclusion, using the example of what has happened in the USA to justify the role of the generalist is particularly inappropriate. In Britain, one of the pillars on which the NHS was built and which continues to sustain it, is general practice. There will, undoubtedly, be situations where a GP genuinely does not know the right specialist to whom to refer a patient, but for most patients it is perfectly obvious where the problem lies and which specialist the patient needs to see when secondary care is indicated.

None of this is to deny that many specialist physicians, particularly in district general hospitals, but also in many teaching hospitals, will retain some general medical responsibilities including for emergency take. This may be particularly true in the early years of a consultant's career, and it may change as careers evolve, with individuals becoming more committed and expert in their narrower specialist field, or in management or other organisation roles.

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The junior doctor handover: current practices and expectations

Roughton and Severs' study of the existing pattern of junior doctors' handing over practices in two district general hospitals [1] highlights the shortcomings of handing over of patient care between outgoing and incoming sets of junior