The general physician—dinosaur or superman?

The design of national health care systems and their financing are not matters readily influenced by practising doctors, individually or collectively. (Witness the White Paper of 1989—*Health of the Nation*—published as a fait accompli, with no visible medical input). Nevertheless, doctors' co-operation is necessary to allow such systems to work, and their influence can be crucial in defining the details of health-care delivery, and in designing and operating it. These microsystems need to work by medical consensus which can come about because it is such obvious common sense, or as a result of guidance. The RCP report *Future patterns of care by general and specialist physicians* is a continuous guidance document. It simultaneously advocates adaptation to the many recent changes in the NHS structure, working hours and training patterns, while accommodating the accelerating shift towards ultra-specialisation. In the first paragraph the report hints that not all recent trends have been desirable, and approaches its subject from the perspective of the 'needs of patients ...'. ('Need' being 'the ability of the recipient to benefit from diagnosis and treatment').

For physicians, patients' needs fall into four main categories: system-based specialty disorders, non-specific symptoms, multi-system disorders (especially in the elderly), and medical emergencies. This is an old admixture. What is new are the near limitless opportunities presented by technological advances in the specialties, the growth of emergency work combined with decreased availability of trainee doctors, the whole matter compounded by patients' rising expectations .

One medical reaction to these pressures, defensive but portrayed as offering 'best care', is to retreat into single-system specialties (SSS), accepting only patients with appropriate complaints, and rejecting those shown by investigation to have no discernible disease in the defined area. This North American pattern is demonstrably expensive and often gives an unsatisfactory outcome. In the British system, however, its worst excesses should be controllable by GPs—always gatekeepers, increasingly signposts, and now often paymasters.

Nevertheless, patients are increasingly asserting their right to choose 'the best doctor', not simply the one selected by their GP. To some extent the SSS pattern can also cope with emergencies, provided the specialty departments are large enough to offer a continuous service, and the triage, at home or at the hospital's front door, works well enough.

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But even if the SSS referral and emergency service worked perfectly (and it plainly cannot, except in dense conurbations with large hospitals) the problems of non-specific symptoms and multisystem disease remain. The traditional British response to these needs has been to have some generalist physicians (sometimes age-related in the form of paediatricians and geriatricians), and others who are system specialists but from time to time broaden their scope and become generalists. Being a part-time *anything* always risks being out of touch; to be a part-time generalist is especially hazardous, and stressful. Little wonder that consultant physicians (and surgeons) have sought to limit or abandon their generalist component, usually on the grounds of being too busy with their SSS. Neurologists and dermatologists did it decades ago; cardiologists are going fast, closely followed by rheumatologists and nephrologists ('will the last one out please turn off the lights in the emergency admissions ward').

In various utterances, some post-dating the report, government encourages general practitioners to shoulder more of the burden, allowing them at times to be simultaneously purchaser and provider, and providing community hospitals to help them. Specialists doubt whether they will make any perceptible impact on the rising numbers of emergency admissions or on management of chronic multisystem disease.

The RCP report examines three models of acute emergency care—all specialist, generalist with some specialty training, and a mixture of the two—without firmly advocating any. Neither does the report deal with the paradox, thrown up by the new specialist registrar training programmes, that while it takes 4 – 6 years to train in a given SSS, another year is required if a generalist (general internal medicine (GIM)) Certificate of Completed Specialist Training (CCST) is to be gained. This means that the specialist—who may be considered 'superior' by patients and general practitioners, and who will be relatively protected from the hurly-burly—achieves specialist registration sooner than a physician who will be doing the take. Moreover, those with only a specialist registration are automatically protected from dealing with the ill-defined and non-specific emergency because they are 'not trained'. Specialist departments, if pressed to recruit someone to their department who will also do general medicine reply, often correctly, that the mixed job will attract less talented applicants. So, ultra-specialisation becomes self-perpetuating and the disincentive to adding GIM to an SSS CCST is substantial. A recent College survey of SHOs (unpublished at present) showed that many want a career including GIM, which is a hopeful sign, but it may reflect an idealism which

needs fostering if it is to survive the subsequent years of specialist training.

These are serious issues needing early solutions. The report has already been overtaken by events, and the College is in discussion with government, health authorities and trust managers, the Joint Committee on Higher Medical Training and the Royal College of General Practitioners to delineate the future of service delivery and of appropriate training patterns more clearly. The pace must quicken, lest matters drift beyond recall. The report believes that 'innovative ways of providing care to cover the spectrum of needs are likely to evolve...'. Evolution is a slow process, and the results of natural selection are not always desirable. Without active measures, proficient generalists, already endangered, may become extinct.

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