ABSTRACT

Objectives: To determine the opinions of general practitioners (GPs) on requirements for a general medical service, and whether doctors themselves, when ill, prefer admission under a generalist or a specialist.

Methods and subjects: One questionnaire was distributed to 100 GPs and a second questionnaire to 144 doctors in both general and hospital practice.

Conclusions: Among physicians debate about the role of generalists has focussed on their emergency workload, but general practitioners also see an important need for generalists in the outpatient clinic. General practitioners recognise the necessity of increasing specialisation, but are concerned that it is leading some physicians to practise as ‘partialists’. Both of these findings have implications for the training of junior physicians and the continuing education of consultants. The survey also revealed that if they themselves were taken ill, consultants were slightly more likely to prefer admission under the care of a specialist, whilst most GPs would prefer admission under a generalist.

The debate over the future of general medicine, which has recently re-surfaced in the JRCPL, has been dominated by the opinions of hospital physicians with only one contribution from a general practitioner (GP). My study was prompted by the concerns expressed about the general medical service by six GPs in the Herefordshire district. Informal discussions with these GPs indicated that they were generally satisfied with the inpatient component of general medicine but considered that there was insufficient provision for outpatient services. They also detected some unwillingness on the part of consultants to see referrals outside their own specialty and considered that this resulted in an unnecessary amount of cross-referral between consultants. A questionnaire was therefore designed to obtain a more comprehensive view of the GPs’ perspective.

Two of the contributors to the recent debate have repeated the oft-quoted assertion that a doctor who was acutely ill would want to be admitted under a specialist rather than a generalist. To test whether this assumption is true, a second questionnaire was sent to both general practitioners and hospital consultants.

Methods

I The GPs questionnaire

This questionnaire focussed on four issues that had been identified in the preliminary discussions: the percentage of GPs’ referrals to a department of medicine that they would prefer to direct to general rather than specialist clinics; the current level of cross-referral between hospital physicians; the ability of physicians on acute takes to deal with the GPs’ acute referrals; and, if responsible for appointing a new physician, whether the GPs would prefer a generalist or a specialist. Additional information was requested to determine whether the answers to the first four questions were influenced by the age of the respondent, possession of the MRCP, or by post-registration experience in general medical posts.

The questionnaire was sent to all 100 of the principals in general practice in Herefordshire, including three whose practice is partly based in Herefordshire and partly in Powys.

II The GPs and hospital consultants questionnaire

The second questionnaire, asking about admission preferences for three common acute medical conditions (myocardial infarct, gastrointestinal haemorrhage and asthma), was sent to 97 principals in general practice in Herefordshire and to all 47 consultants whose contracts are held in Hereford (but excluding those who are based in hospitals outside Herefordshire, and only visit Hereford on a sessional basis).

In both surveys, differences between groups were assessed by the Chi² test.

Results

I The GPs questionnaire

Replies were received from 94 (94%) GPs; the full results are shown in Tables 1–4. Of patients who are referred to medical clinics, the GPs would wish to send approximately 20% to a general rather than to a specialist clinic and, if responsible for appointing a new physician, 90% of general practitioners would choose someone who would welcome a wide range of general medical referrals. Fewer than one-fifth of respondents thought that cross-referrals between outpatient clinics were excessive.

Respondents were not asked to identify themselves, but eight chose to do so. Twenty-five (27%) had qualified between 1960–72, 36 (38%) between 1973–82 and 33 (35%) between 1983–92. Forty-two percent had some post-registration experience in general medical posts, 20% of all respondents having worked for more than a year in such posts. The MRCP was held by 12% of respondents, whilst a further 23% were working with a partner who held the MRCP, to whom they either referred patients with general medical problems or from whom they regularly sought...
Table 1. Percentage of total referrals to a department of medicine that GPs would wish to direct to a general rather than specialist clinic.

| Percentage of referrals to a general physician* | No. of GPs (n=89) |
|-----------------------------------------------|-------------------|
| <10                                          | 9                 |
| 10–19                                        | 29                |
| 20–29                                        | 22                |
| 30–39                                        | 15                |
| 40–49                                        | 4                 |
| 50–59                                        | 9                 |
| >60                                          | 1                 |

*Median 20%, range 1–80%.

advice about such patients. One respondent referred patients to a colleague who had an interest in general medical problems but who did not hold the MRCP. Twenty-eight percent of respondents worked in practices where the partners commonly cross-referred to colleagues with other special interests, eg gynaecology, dermatology, psychosexual counselling. None of the responses to questions 1–4 was related to the decade in which respondents qualified, post-registration experience in general medicine, possession of the MRCP or access to a colleague with the MRCP.

Whilst no specific questions were asked about GPs’ satisfaction with the outcome of general medical referrals, spontaneous comments made in the replies to the questionnaire and during informal discussion indicated some areas of dissatisfaction. For example, some respondents commented that they are often tempted to make a patient’s symptoms fit with some preconceived notion of what they think might be acceptable to the specialist whose specialty seems most nearly appropriate to the patient’s problem, and to couch the referral letter in these terms. Some commented that referral to a specialist, as opposed to a non-specialist, is more likely to result in inappropriate investigation. Although it is important to be reassured that a significant condition is not being overlooked, it is counter-productive if the patient is rebuffed in the outpatient clinic with the response that ‘this is not a cardiovascular/endocrine/gastroenterological problem’. General practitioners comment that such a response, whether explicit or implied, can and does have an adverse effect on their relationship with the patient, encouraging some patients to doubt their doctors’ competence because they have been referred to the ‘wrong’ specialist, and prompting yet further inappropriate referrals in an attempt to pinpoint the ‘right’ one.

Some GPs expressed the opinion that the extent of specialisation in the 1990s was producing consultants who focus their attention too narrowly on just one system or even just one organ when the solution to the patient’s problem often requires a wider view of the patient as a whole person; indeed, one respondent encapsulated this view by saying that some ‘specialists’ were better described as ‘partialists’.

Table 2. GPs’ opinions of the current level of outpatient cross-referral between hospital physicians.

| No. of GPs (n=93) |
|-----------------------------------------------|
| About right 50 (72% of those expressing an opinion) |
| Excessive 13 (19% of those expressing an opinion) |
| Insufficient 6 (9% of those expressing an opinion) |
| Don’t know 24 |

Table 3. GPs’ opinions on whether the physicians on acute takes are adequately trained to deal with their acute referrals.

| No. of GPs (n=92) |
|-----------------------------------------------|
| Adequately trained 66 (89% of those expressing an opinion) |
| Inadequately trained 8 (11% of those expressing an opinion) |
| Don’t know 18 |

Table 4. GPs’ preference if appointing a new physician.

| No. (%) of GPs (n=93) |
|-----------------------------------------------|
| a) Someone who would provide a predominantly specialist service | 3 (3) |
| b) Someone with a specialist interest but who would welcome a wide range of general medical referrals | 90 (96) |
| c) No preference – either a) or b) | 1 (1) |

Two respondents remarked that although many GPs have some post-registration experience in general medicine, few hospital physicians have any first-hand experience of general practice. Such experience, they suggest, would help to counteract a tendency to tunnel vision, and would also make physicians more sensitive to the difficulties faced by GPs in deciding which patients to refer, and to whom.

II The GPs and hospital consultants questionnaire

Replies to the second questionnaire (Table 5) were received from 73 GPs (75%) and 35 consultants (74%). The response rate may have been lower than that for the first questionnaire, because it was distributed in August and no reminder was sent. The median age of both GPs and consultants was 45–46 years. Overall, a small majority of consultants (57 out of 105 choices) opted for admission under a specialist physician, whilst GPs preferred admission under a specialist in only 49 out of 219 choices (Chi²=16.4, p<0.001). More GPs chose admission under a cardiologist for an acute myocardial infarct than chose admission under a gastroenterologist for an acute gastrointestinal haemorrhage or under a respiratory physician for acute asthma, but the
difference only just reaches statistical significance (Chi^2=4.55, p<0.05>0.02). The choices of both GPs and consultants were unrelated to their ages.

Discussion

General physicians are sometimes defined, in terms of their acute workload, as those physicians who take responsibility for acute, unselected, emergency admissions, but it is evident that GPs also require them to provide a substantial contribution in the outpatient clinic. If 20% of the out-patient referrals to a department of medicine are to be directed towards general medical clinics, then general medicine must be regarded as one of the larger outpatient specialties.

The Royal College of Physicians (RCP) has recognised two categories of outpatients which may be regarded as the particular province of the general physician:

1. Patients with unexplained, non-specific symptoms such as fever, weight loss, lethargy.
2. Patients with problems that do not fit readily into the province of a single specialty, eg multi-system disorders.

This survey of GPs, however, indicates that several other categories could be added:

3. Patients whose multiple and apparently unrelated symptoms are probably non-organic but in whom the GP feels the need for a second opinion.
4. Patients for whose problem there is no specialist in the local district general hospital, eg the patient with a serum creatinine of 300μmol/L in a district that has no nephrologist.
5. The patient who has a specific problem, but whom the GP wishes to refer to a non-specialist because, with his knowledge of the patient, he judges that the non-specialist is the consultant most likely to establish a good professional relationship with that particular patient.
6. The patient who, in the judgement of the GP, is likely to be best served by a conservative line of management or even 'masterly inactivity', and where the GP expects that such a course is more likely to be pursued by the non-specialist than by the specialist.

The last two categories are, perhaps, contentious reasons for referral to a general physician but there is no doubt that many GPs regard them as legitimate reasons and that they constitute a significant minority of general medical referrals. What is evident from the GPs' comments is that physicians must not rebuff patients whose illness is not explicable in terms of that physician's own specialist interest. Some GPs who want a second opinion on an uncertain medical matter now prefer to approach another GP. 'I don't ask a hospital physician – the reason being that if I don't choose a specialist in the correct field I receive a letter reading, for instance, “Chest pain, not cardiac”, but not a letter informing me of what is actually wrong with the patient'. As Richard Asher wrote 50 years ago: 'It is right that a doctor should have special interest and knowledge about one subject. It is wrong for him to show special indifference and ignorance about all other subjects'.

The physicians in Hereford were already aware that a minority of GPs regard the numbers of cross-referrals as excessive because this opinion had been forcefully expressed by one or two of them at purchaser-provider meetings. We were, however, unaware of the slightly smaller but silent minority that considers the extent of cross-referral too low (Table 2). A different response might have been found if the question had been asked of GPs who refer into teaching hospitals, where doctors are more likely to cross-refer than they are in a district general hospital.

Among hospital physicians the debate about the need for specialist care has focussed largely on patients admitted on the acute take. Logistics dictate that, for the foreseeable future, the immediate care of most emergency admissions in average-sized district general hospitals (which the RCP sees as having a major continuing role in the provision of acute services) will have to be provided by physicians whose specialist interests are relevant to only a minority of those admissions.

In Hereford the great majority of local GPs regard the current cohort of general physicians as adequately trained.

Table 5. Admission preferences of GPs and consultants for three acute medical conditions*.

| Condition                              | No. of GPs (n=73) | No. of consultants (n=35) |
|----------------------------------------|-------------------|---------------------------|
| For acute myocardial infarct:          |                   |                           |
| a) Cardiologist                        | 23                | 20                        |
| b) Physician who is not a cardiologist but who regularly admits patients with acute myocardial infarct | 11 | 6 |
| c) No preference – a) or b)            | 39                | 9                         |
| d) Don't know                          | 0                 | 0                         |
| For acute gastrointestinal haemorrhage:|                   |                           |
| a) Gastroenterologist                  | 14                | 18                        |
| b) Physician who is not a gastroenterologist but who regularly admits patients with acute gastrointestinal haemorrhage | 14 | 7 |
| c) No preference – a) or b)            | 45                | 10                        |
| d) Don't know                          | 0                 | 0                         |
| For acute asthma:                      |                   |                           |
| a) Respiratory physician               | 12                | 19                        |
| b) Physician who is not a respiratory physician but who regularly admits patients with acute asthma | 11 | 5 |
| c) No preference – a) or b)            | 50                | 11                        |
| d) Don't know                          | 0                 | 0                         |

*Doctors were asked to reply as if they were ill and had to make this choice for themselves.
to manage their acute referrals (Table 3). Of the minority who did not, some commented that their reservations related to the capabilities of junior doctors (one-third of our senior residents are first-year senior house officers) rather than to those of the consultants. Their confidence is reflected in their responses to the second questionnaire where the difference in preferences between GPs and consultants is striking (Table 5). General practitioners are probably better placed than most consultants to be aware of the outcome of admissions under different physicians, and it may be that they are not conscious of any marked differences in outcome between admission under a specialist and a non-specialist. An alternative, and perhaps more probable, explanation is that GPs are themselves generalists and are therefore more sympathetic to the idea of admission under a non-specialist than are consultants, who are either fully committed specialists or have a specialty interest.

The views expressed by the GPs in this study have implications for the training of hospital physicians and it is debatable whether these have been adequately addressed in current training programmes or in the present arrangements for continuing medical education. When doctors in medical specialties at St Mary's Hospital in London were asked whether 'increasing specialisation is a good thing for patients' only one-third of both junior doctors and consultants answered 'yes'. However, when asked whether 'increasing specialisation is a good thing for doctors' two-thirds of consultants but only one-fifth of juniors answered 'yes'. Perhaps consultants should be encouraged to take a greater interest in what is good for their patients rather than for themselves – this needs to be reflected in the requirements for the continuing medical education of consultants.

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