LETTERS
TO THE EDITOR

Please submit letters for the Editor’s consideration within three weeks of receipt of the Journal. Letters should ideally be limited to 350 words, and can be submitted on disk or sent by e-mail to: Bettina.Klar@rcplondon.ac.uk.

The future of general medicine

Editor – It is said that general medicine is the last refuge of geriatricians, and certainly a lot of trainees in geriatric medicine also seek accreditation in general medicine. I was, therefore, disappointed that the paper by Hampton and Gray (January/February 1998, pp 39–43) did not describe in more detail the possible role of their consultant geriatrician colleagues in managing acute admissions. They simply write that a consultant in the health care of the elderly (HCE) is on call at the same time as a consultant general physician. I would imagine in the Queen's Medical Centre, Nottingham, as in other district general hospitals, most of the emergencies in elderly patients will present with more than one medical problem. Should these elderly patients go to a consultant general physician or a consultant geriatrician with accreditation in general medicine? Are there agreed criteria – such as the needs of the patient, or an arbitrary age limit – that determine which patients are admitted directly into an elderly care ward? If a consultant opinion is needed, do the junior staff in Nottingham call the general physician or the consultant geriatrician?

In some hospitals, like Southmead, consultant geriatricians in the rota for general medicine are responsible for all adult medical admissions and continue to care for both young and old patients, who do not need a ‘specialist’. When the geriatrician is on call, there is no need for a general physician to be on at the same time. Perhaps some general physicians – and geriatricians – are appalled that geriatricians should wish to ‘keep’ young medical admissions. If so, why encourage trainees in geriatrics to spend so much of their training in unselected general medical takes?

Trainees in geriatrics are also encouraged to develop expertise in certain areas – such as therapeutics, diabetes, Parkinson’s disease – and, in this way, increasingly encroach upon the ground of other medical specialists. This may be a cause of friction in some hospitals, but the special interest groups in the British Geriatricians Society are flourishing. I believe that the future of general medicine is intimately tied to the fate of geriatric medicine in this country: these discussions in the JRCPL are timely and relevant.

CHRISTOPHER CHAN
Consultant Physician/Geriatrician
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Editor – As we approach the twenty-first century we might expect changing roles for physicians but Hampton and Gray recently concluded that ‘...if we...follow the single-system specialist model, most physicians...would have to be cardiovascular specialists... [and so] most physicians will have to remain generalists’ (January/February 1998, 39–43); such an analysis leans too heavily on current stereotypes. Later they state that ‘It would be inappropriate for the physician running an admissions ward...simply to sort the patients into the care of the apparently relevant specialist...’ Agreeing entirely, I propose that emergency medicine should become a specialty in its own right. In an emergency the ability to act appropriately at speed can be more important than the organ system(s) involved. This skill differs importantly from that required for non-emergency medical work. The role of an emergency medicine specialist need not be simply to pass patients onwards as soon as possible, but a matter of performing all their appropriate early management. (Those patients in need of intensive care after initial emergency management could be passed on to another kind of physician already emerging: the ITU physician.) The presence of such an admitting physician in an A&E department would make available expertise which should benefit patients’ immediate management and care. Furthermore, it would improve the teaching of emergency medicine to juniors.

Another new role for physicians could be the medical management of surgical cases. As increasingly complex surgery is performed on an ageing population, it becomes unreasonable to expect of surgeons, in addition to high surgical competence, the same ability in medicine. A role can be envisaged which encompasses medical aspects of care from pre-operative assessment through to rehabilitation. The presence of such physicians on surgical wards would mitigate any tendency to a surgical culture in which medical problems are ignored and rehabilitation is neglected and would broaden trainees’ perception of the implications of surgery for patients.

The need for general physicians continues but their role will not remain untrammeled by change. Though the appropriateness of new roles may not be universal, a need exists and posts will arise, with or without central planning.

DOMINIC DE TAKATS
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Editor – Further to your leader ‘The future of general medicine’ (March/April 1998 pp 97), I would make the following points:

- There is a danger that the British medical system will be producing a generation of physicians who will become somewhat blinkered specialists, unable to deal with the breadth of medical problems with which a properly trained physician in general (internal) medicine can deal. The ability of a physician to deal with unselected emergency admissions and to work as a generalist requires specialist training and experience. This is now recognised, rather belatedly, by the Royal College of Physicians and the Calman Training Scheme. It must be remembered that patients’ illnesses do not confine themselves to the special interest of the doctor seeing them.
With reference to Professor Wardener's comment, I would not like a spouse with asthma, diabetes and coronary artery disease to be treated by a specialist in respiratory medicine who, through lack of experience, had to refer to a cardiologist and a diabetologist for what would be considered baseline knowledge by a general physician.

We are in danger of producing a generation of specialist doctors whose knowledge is limited to their specialty and this will increase the referrals between specialties.

Physicians who are multi-skilled and can treat the majority of medical illnesses in the acute phase and refer on to specialists as necessary are surely more efficient and better for the patient.

It is essential that physicians of the future who deal with medical emergencies should be skilled and trained in treating those medical emergencies and should not be delegating these to their junior medical staff. Emergency medicine should be led by the consultant physician who is responsible for those patients. This doctor should have the same high quality of training that is afforded to those in the various medical specialties.

Dual training in general (internal) medicine and specialty medicine is essential for the future, has proved its value in the past, and is in danger of being undermined by over-specialisation in medical training.

Increased illness experience preceding chronic fatigue syndrome

Editor - The excellent paper by Drs Hall, Hamilton and Round is timely (January/February 1998, pp 44–8). When making a diagnosis it is essential to consider not merely the presenting or most prominent symptoms but all the symptoms and all the previous symptoms. The presenting symptom of fatigue is often accompanied by other somatic symptoms of anxiety such as tension headache or frequency of micturition, as well as sometimes by features of anxiety itself. There is usually a long history of previous episodes of similar symptoms, including lethargy, as this paper shows so well. If it can also be shown that the symptoms arose at a time of emotional conflict, the diagnosis of an emotionally-based disorder is supported, but more importantly the establishment of the aetiology indicates the line of treatment.

Concentration on the presenting symptom has led to the wide use of the terms 'effort syndrome' and 'chronic fatigue syndrome', encouraging the physician to focus on the presenting symptom. We need to use a term that indicates that the fatigue is only one amongst many somatic symptoms of anxiety. This paper serves to remind us that there is no substitute for a comprehensive history if we are to arrive at a correct diagnosis.

Reference

S Cohen. Emeritus Professor of Psychiatry, the London Hospital Medical College

Editor - In their paper on the above topic, Drs Hall, Hamilton and Round conclude that their findings ‘do not support a specific viral or immunological basis for CFS, and that ‘abnormal illness behaviour is of greater importance than previously recognised’ (January/February 1998, pp 44–8). I wish to challenge both of these conclusions. Regarding the first, it is difficult to see anything in their findings to justify any conclusion as to whether CFS could or could not be caused by virus infection. The paper simply studies previous medical records of CFS sufferers retrospectively. None of the patients appear to have been seen or had a history taken by the authors, and to attempt to draw any conclusions regarding aetiology on such superficial evidence is unjustified.

The second conclusion, referring to abnormal illness behaviour, is based on the excess of prior consultations for CFS sufferers over controls prior to diagnosis of CFS. The authors fail to discuss the possibility that many of these excess consultations were due to the patients already having CFS unbeknown to themselves or their GPs. With the exception of pneumonia, the top five excess symptoms were: lethargy, ‘glandular fever’, abdominal pain and headache. The authors fail to acknowledge that these are all common ways in which CFS/ME may present, and that this condition can have a gradual onset and be subject to delays in diagnosis.

If abnormal illness behaviour was an important component of the clinical situation in some CFS patients: a) this may have been secondary to having an unpleasant, undiagnosed condition (CFS/ME) for a number of years and therefore of no relevance to the question of primary aetiology; and b) in a significant number of CFS patients there was no excess consultation rate. Therefore, in these cases there was no evidence of abnormal illness behaviour.

I would submit that the evidence of this paper is compatible with the hypothesis that CFS/ME is primarily an organic illness in which the importance of psychological factors as a primary cause is zero, and in which the role of psychological factors in the prolongation of the condition has been greatly exaggerated.

Local research ethics committees

Editor - The experiences of Busby and Dolk (March/April 1998, pp 142–5) are of no surprise to me. Working in an R&D Directorate of a regional office of the NHS Executive, I have been involved in collecting information from researchers about their work. This has variously included data collection for our own funding schemes, the NHS National Research Register and the NHS R&D Levy declaration amongst others.