LETTERS TO THE EDITOR

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.

DAVID GRAY
Senior Lecturer/Honorary Consultant,
University Hospital, Nottingham

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 (particularly 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
Letters to the Editor

for care across the adult age groups represents an important step forward in providing better quality of care for medical inpatients. In some hospitals this association has simply been a realignment of previous groupings with only limited interactions between the consultants; in others, true integrated function is achieved with equal sharing of wards, junior medical staff and on take responsibilities. As a junior doctor I recall that the general physician was responsible for the acute care of adult patients of all ages and the geriatricians were left to supervise slow stream rehabilitation and long stay patients. Then came the ‘care of the elderly’ physician with more responsibility for the acute assessment of elderly patients, arbitrarily defined as those over the age of 65. With the advent of the ‘integrated physician’ we have perhaps come full circle, the way forward being clearly defined as the need for a fully trained generalist able to deal with patients’ needs across a wide age range. This should be an acceptable and worthwhile career path for a young doctor and does not preclude the additional development of individual special interests.

I do have high hopes for general internal medicine. In my view it is not a relic of a bygone age but is a vibrant and important part of the future of clinical practice in the UK; underpinning the high quality of patient focused health care for which we are justifiably respected worldwide.

DAVID B BARNETT
Professor of Clinical Pharmacology, University of Leicester

The complementary roles of local and national ethics committees

Sir—The paper by Harries et al (March/April 1994, 150–4) and the accompanying editorial comment by Meade (March/April 1994, 102–4) raise a number of important issues relevant to the organisation and function of local research ethics committees (LREC). Meade urges a move to centralisation and suggests that the time has come to turn the spotlight on LRECs and audit their performance. We recognise some of the problems Meade raises but suggest that LRECs continue to have an essential role and should be supported by and work closely with central bodies.

LRECs are constituted and mandated to encourage and support good research and protect volunteers (patients or healthy subjects), others who might be affected by the research (eg those on waiting lists) and investigators. Members are drawn from and have a duty to the local community. In many instances the LREC will have knowledge of local factors relevant to the research including the presence of ‘over-researched populations’, ethnic or cultural factors, problems with particular hospital services. Furthermore, national committees are no more foolproof than are local committees and we know from the experience of our committee that the current system that involves ‘double-checking’ has detected problems that would not have come to light if the LREC had not received a full application. Nevertheless it is important to keep delays in considering studies to a minimum.

What is the way forward? For local studies the LREC will continue to be the committee that grants approval. For multicentre studies the current dual system offers advantages and safeguards but we believe that simple measures could lead to considerable improvement.

1. A clear definition of multicentre research requiring central and local committee approval should be given in the Department of Health guidelines. The central committee responsible for different types of research should be stated and these committees should only grant approval subject to endorsement by the relevant LREC.

2. There is an urgent need for a national application form acceptable to all committees. Each LREC could append a customised sheet to take into account particular local factors.

3. LRECs should meet sufficiently frequently to ensure no more than two months delay between submission of an application and a decision being reached. High quality administrative support is essential.

4. Local investigators should expect to produce an information sheet for their patient population and the trial organisers and central committee should accept this without trying to produce a compromise information sheet acceptable to all committees.

5. National committees and LRECs should ensure consistency of decision making and audit this regularly. A standardised computer database would help.

Constructive debate is required and we believe that the Colleges should take the lead in close cooperation with LRECs.

KAY SONNEBORN
Chair
PATRICK VALLANCE
Vice Chair, Wandsworth District Ethics Committee, St George’s Hospital, London

‘Prion’ diseases

Sir—Professor Prusiner is not the first to moot the heretical idea that the unique organism(s) which transmits these sinister spongiform encephalopathies might replicate without the benefit of nucleic acid: Iain Pattison and his colleagues, put forward this hypothesis in 1967 [1]. This notion is by no means universally accepted, however, and to label these afflictions ‘prion’ (a cryptogram of ‘infectious protein’) diseases, implying that the agent is a self-replicating protein [2], is therefore to obstruct research. There is good evidence that the infectious agent does contain