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CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

General medicine in the 'eighties

SIR,—Drs C Davidson and R C King (30 August, p 547) demonstrate again[1] the need to clarify the definitions applied to general physicians, medical specialists, and the work done by them. This is not just of academic interest as it affects the figures which influence planning of consultant expansion and career structures.

Currently, DHSS census returns classify physicians according to the specialty to which they devote most of their time. The first Körner report on health services information stated, "The hallmark of a general physician or general surgeon is the continued care of unselected emergency referrals. Any consultants who have such a generalist component to their work should normally be designated general physicians. . . ." This is the approach favoured by the Royal College of Physicians. The third Körner report is less specific, recommending that the current specialty or main specialty be recorded. The DHSS intends to adopt a Körner designation of specialties from 1987, which implies a change from the current census classification. However, the DHSS also expressed the hope that from 1987 it would be possible to record the second specialty of consultants.[2]

A working party on coordination of medical training and manpower was set up by the West Midlands Regional Health Authority in 1984, and as part of its study in 1985 we asked the 95 physicians, classified by the RHA as general physicians, for estimates, by sessions, of the distribution of their work between general medicine and specialties. There was a 96% response, the details of the remaining 4% being obtained subsequently.

We found that: 46 (48%) spent more than half their time in general medicine (five with no special interest, five with two, one with three, and the remainder with one); 15 (16%) spent half of their time in general medicine (one with two special interests and the remainder with one); and 34 (36%) spent less than half their time in general medicine (two with two special interests and the remainder with one).

Thus 52% did not fulfil the current DHSS definition of a general physician. In contrast, 41 consultants listed as being specialists by the region said that they practised general medicine, most taking part in acute takes of unselected medical hospital admissions.

To avoid confusion, we recommend that any physician who takes part in the continued care of unselected medical emergency referrals be considered a general physician. If he has a specialty interest which takes half or more of his time he should be considered a general physician with a *major* interest in the specialty. If the specialty interest takes less than half his time he should be considered a general physician with an *interest* in the specialty (or specialties). When whole sessions are assigned to general or specialist work the position is clear, but when a variety of patients are referred to an outpatient clinic the situation is more complex: a physician with an interest in gastroenterology will probably regard thyrotoxicosis as general medicine, while one with an interest in endocrinology will regard it as part of his specialty.

It was clear from our study that the peripheral non-teaching hospitals require general physicians with interests and not specialists. The specialties most needed in peripheral hospitals are gastroenterology, cardiology, endocrinology (mainly diabetes), chest medicine, and rheumatology. It would appear to be preferable to have a general physician with an interest in these subjects working entirely in each district rather than a specialist without any general medical work visiting several districts.

The work of a general physician with a major interest in a peripheral hospital can be very different from that of a physician with the same major interest in a teaching hospital. For example, the former with an interest in cardiology may provide only echocardiography and exercise testing, and there will always be need for referral to central hospitals for further expertise.

At senior registrar level the advantages of appointments leading to dual accreditation in general (internal) medicine and a specialty are obvious. In planning the numbers of specialty options in such programmes, and in counselling trainees, it is important to take account of the likely demand for consultants in general medicine with various specialist interests or major interests. The balance between specialties during senior registrar training can easily be distorted by popularity and academic and supernumerary posts. For example, Joint Committee for Higher Medical Training data for 1985 suggest that in England and Wales there were 62 senior registrar posts in haematology, with a further 21 under consideration and four part rotations, 28 lectureships and other academic posts at senior registrar level, with a further nine under consideration, and 14 ad hominem appointments, making a possible 138 trainees. Actual NHS returns for 30 September 1985 show 120 senior registrars in haematology—one third of the number of consultants. The development of a control mechanism such as the joint planning advisory committee should be valuable in coordinating training and career posts if good data are available about both.

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1 Houghton J, Richings J. The second specialty of general physicians. *J R Coll Physicians Lond* 1981;15:28-31.
2 DHSS Medical Manpower Division. Medical and dental staffing prospects in the NHS in England and Wales, 1984. *Health Trends* 1985;17:45-52.