EDITORIALS

General practitioners and general physicians

For most patients the "ever increasing complexity of modern medicine" has no relevance. For only a microscopic proportion of all the people who see their general practitioners, and a very small proportion of those referred to medical outpatient departments, is advanced technology appropriate.

J. W. Todd (1978).

THE unity of medicine is threatened today as never before. Almost every year brings a new specialty, a new branch of medicine, and a further tendency to fragmentation of patient care. At times during the last 20 years the concept of re-integrating branches of medicine and pulling the services together for the benefit of the patient has seemed more and more like a remote dream and less and less of a practical reality.

In recent years the day of the general consultant physician has been increasingly threatened and few consultants are now appointed in medicine without at least a special interest and often this forms a substantial proportion of their work. Meanwhile the Royal College of Physicians has done what it can to maintain the importance of a general training of all future consultant physicians.

A recent article by Todd (1978), a retired general physician, reports a series of 450 patients referred to him by general practitioners to a medical outpatient department at hospital. He has analysed the broad categories of symptoms and diagnoses and found a remarkable similarity with 500 soldiers referred consecutively to him in 1944 by their regimental medical officers (Todd, 1944).

Times do not change. Perhaps patients do not change either. The remarkable similarity between these two big groups, the first referred in 1944, the second during 1976 and 1977, suggests that there are still some interesting constants in medicine, as all older general practitioners will know.

Equally striking is his disclosure that he "did no investigations (beyond an electrocardiogram in some cases) in no fewer than 70 per cent of patients" and his quotation from Korvin and colleagues (1975) who analysed the records of 1,000 patients who had each had 20 chemical and haematological tests. Their conclusion that "possible benefit to one person from 20,000 tests" is, in the author's words, "not impressive".

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In an article full of useful generalizations there is emphasis that diagnosis is not an end in itself but merely a means towards helping the patient and that some obscurely ill patients contrive to recover without ever being diagnosed. Of special value to general practitioners, and especially vocational trainees, is his conclusion that "the longer the history and the greater the number of symptoms the less relevant is the single diagnostic label, and patients with long histories and multiple symptoms are the typical attenders at medical outpatient departments." Chronically complaining patients, therefore, should be diagnosed not by a word but by a sentence, such as, "Habitually worrying man with a boring job and a nagging wife who has myocardial ischaemia not interfering with his ordinary activities, but about which he is very worried".

He tried never to change treatment recommended by his general practitioners, "For if a change in treatment is advocated this usually implies that the general practitioner has been mistaken in his previous handling of the situation, and the consultant should be sure of his ground before recommending such a change".

It is encouraging to read of doctors in medical outpatients striving to leave their patients with some positive encouragement and recognition from within organic internal medicine of the value of simple psychotherapy.

Dr Todd's view and his previous article on specialization (Todd, 1951) leads him inevitably to defend the value of the generalist, whether physician or practitioner. He emphasizes that specialists are genuinely needed when their work "includes the mastery of techniques. We therefore need surgeons who deal with specific areas, since no surgeon can be expert in operations affecting all parts of the body". He remains convinced that physicians should remain basically generalists.

As far back as 1931 Barclay, then a lecturer in radiology at the University of Cambridge, delivered the thirteenth Silvanus Thompson Memorial Lecture on the "Dangers of Specialization in Medicine". Todd's conclusions are similar: "If in future we can have a more equitable distribution of general practitioners of high quality with good back-up facilities, and possibly an increase in their total number, we shall be able to do with fewer consultant physicians, and many fewer geriatricians and psychiatrists".

This article in the *British Medical Journal* can be recommended to vocational trainees throughout the

UK, for it underlines many of the educational objectives of modern vocational training courses for general practice and may help trainees, particularly as it comes from a consultant physician, to value their role as generalists.

After years of increasing fragmentation the essential unity of medicine is emerging again.

References

Barclay, A. E. (1931). Thirteenth Silvanus Thompson Lecture. *British Journal of Radiology*, **4**, 60-82.

Korvin, C. C., Pearce, R. H. & Stanley, J. (1975). *Annals of Internal Medicine*, **83**, 197-203.

Todd, J. W. (1944). *British Medical Journal*, **1**, 19-20.

Todd, J. W. (1951). *Lancet*, **i**, 462-467.

Todd, J. W. (1978). *British Medical Journal*, **1**, 417-420.

Anaphylaxis and the community nurse

ANAPHYLACTIC shock may develop within minutes of the parenteral injection of drugs or foreign protein. The patient may develop severe dyspnoea, acute urticaria, and a marked fall in blood pressure, producing severe and sometimes fatal shock. Fortunately it is rare although the exact incidence is difficult to determine. In a recent edition of the *Adverse Drug Reaction Bulletin* (1977) it is stated that 140 cases of anaphylaxis, with 41 fatalities, were reported to the Committee on Safety of Medicines between 1966 and 1975. It is likely that an unknown but probably fairly large number of adverse reactions are not reported to the Committee.

Nevertheless, many general practitioners and nurses will never encounter the condition during their professional career. However, because of its dramatic nature, its high mortality rate, and the possibility of its prevention, anaphylaxis is a condition with which all those who administer drugs should be completely familiar.

The same paper reports the results of a survey into the use of drugs by community nurses in the treatment of anaphylaxis and includes the instructions given to the nurses on its diagnosis and management. This survey has revealed that practice varies considerably throughout the country and in almost a third of the health districts from which information was obtained nurses are not permitted to administer drugs for the treatment of anaphylactic shock on their own initiative. Even in those districts where nurses are allowed to carry drugs for treating anaphylactic shock, a quarter of them receive no special instruction in the diagnosis or management. The Department of Health and Social Security have recently issued a circular on the involvement of nursing staff in vaccination and immunization procedures (DHSS, 1976). A further circular discusses the legal implications and training requirements for extending the clinical role of nurses (DHSS, 1977). Both circulars emphasize that nurses should undertake only work for which they have been adequately trained and that doctors should not delegate work for which nurses have no special qualification.

Health authorities and general practitioners who employ their own nursing staff should ensure that those nurses who work in the community and administer injections are adequately instructed in the diagnosis and management of anaphylaxis. These instructions should include the necessity of questioning a patient about sensitivity to drugs before administering an injection, and should give information about the groups of drugs most likely to cause anaphylaxis. In domiciliary practice these are the penicillins and cephalosporins, streptomycin, vaccines, toxoids and antisera, corticotrophin, and tetracosactrin (*Adverse Drug Reaction Bulletin*, 1977).

Doctors and nurses should remember periodically (perhaps annually) to renew the ampoules of adrenaline which must always be available when injections are being given. It is also essential that supplies of adrenaline are clearly dated.

The suggestion has been made that the range of injections given in a patient's home should be reduced (*Adverse Drug Reaction Bulletin*, 1977) but this could well give rise to difficulties. It seems better to ensure that all doctors and nurses are fully conversant with the prevention, diagnosis, and management of anaphylactic shock. Once adequate instruction has been received, the community nurse should be allowed to give immediate treatment to the rare case of anaphylaxis which she may encounter in the course of her work.

References

Adverse Drug Reaction Bulletin (1977). **65**, 228-231.

Department of Health and Social Security (1976). HC (76) 26. *Vaccination and Immunization—Involvement of Nursing Staff*. London: DHSS.

Department of Health and Social Security (1977). HC (77) 22. *The Extending Role of the Clinical Nurse–Legal Implications and Training Requirements*. London: DHSS.