Generalists and specialists

THE relationship between generalist and specialist doctors is a topic of continuing interest. Whilst it has long been discussed within the medical profession, it has more recently been subjected to historical and sociological analysis (Stevens, 1966; Mechanic, 1968; Honigsbaum, 1979).

To an individual doctor, whether generalist or specialist, the relationship may appear static, but the evidence suggests that it is under constant, although gradual, change. The change is taking place in two ways.

First of all, the numbers are changing substantially. The number of hospital doctors, for example, has been growing ever since the introduction of the National Health Service far faster than the number of general practitioners. Apart from the large number of junior hospital staff, which now exceeds the number of general practitioners, the number of consultants in Great Britain rose between 1970 and 1977 by more than the number of general practitioner principals in Great Britain in the same years, and indeed the Royal Commission on the National Health Service (1979) reported that general practitioner principals were increasing at a rate of only about one per cent a year.

Secondly, a fundamental realignment of roles is now taking place. The medical profession is constantly defining and redefining its criteria for referral, and it is only when they look back over the years that doctors become aware of how dramatic some of the changes can be. It was only a few years ago when patients with pernicious anaemia were invariably admitted to hospital and patients often went in for routine investigations, such as glucose tolerance tests, which are now often carried out by practice nurses in treatment rooms. Nor is severity or threat to life an inevitable criterion for hospital admission: ever since the study by Mather and colleagues (1976), the home treatment of coronary thrombosis has been gaining ground. Thus we find that some conditions which used to be treated at home are now treated in hospital, and some for which hospital treatment was indicated may now be treated at home.

Continuing dialogue

This dialogue between the two main branches of the profession will continue, but at present the broad trend seems to be a shift from institutional towards community care; there can be no doubt that the continuing responsibilities of the community clinicians, the general practitioners, are continuing to rise. It is a triumph for medicine as a whole and psychiatry in particular that so many patients have been discharged from hospital during the last decade, and the impact on the primary medical team has been substantial in terms of complexity of decisions and continuing care.

These changes flow from pure and applied medical research aided by improved technology and the increasing ease with which modern medical machinery can be miniaturized (for example, portable ECG machines, mini peak flow meters, and desk-top machines giving blood sugar levels). General practice is becoming both more interesting and more intellectually challenging.

The scope for reviewing the criteria for referral and particularly for continued follow-up is questioned today by Lester (p. 230) and there can be little doubt as Forsyth and Logan (1968) found many years ago that clinical care in outpatient departments is particularly worthy of critical audit and review. Grüneberg and Richards (p. 224) in a different kind of article, report for the first time assessment of domiciliary visits by pathologists and try to evaluate their benefit to patients, colleagues, and the community. Detailed examples are given of how shared home care between general practitioner and consultant proved clinically superior for some patients to hospital admission. This too can be seen as keeping in step with the growing trend for home care of patients, even with complex conditions.

A study from an accident and emergency department (Inwald, p. 220) looks at the number of patients who refer themselves to hospital, which pinpoints another of the interesting boundaries between generalist and specialist care.

Whitfield's survey (p. 228) shows that the gap in attitudes between newly appointed consultants and general practitioners underlines why proposals are arising (*Journal of the Royal College of General Practitioners,* 1980) that all future consultants should have more experience of general practice.

The degree of specialization which is appropriate for general practitioners is the theme of Tudor Hart's article (p. 216) today, while Pereira Gray (p. 231) in the 1979 Gale Memorial Lecture analyses some of the problems of the generalist/specialist relationship and offers some solutions.

How efficient, how competent, general practitioners are especially in relation to quality of care remains the ultimate test, and two of the other articles provide a

contrast in this respect. Bull (p. 208), reporting on ten years' experience in a general practitioner obstetric unit, shows as others before him (Marsh, 1977) that general practitioner care can produce not just good but excellent results, comparable with the best available reports.

Wilkes and Lawton, however (p. 199), in a different kind of survey, look at the consequences for patients of their discharge from a hospital diabetic unit. This article is more disturbing, suggesting that serious deficiencies of care have been found, and leads one to question the clinical competence of at least some of the practitioners involved. Studies like these are ammunition to those who see general practice as an inferior clinical discipline and they raise major questions about the quality of general practice training and continuing education.

All these articles refer in one way or another to the generalist/specialist relationship. This has changed greatly, is still changing and, we suggest, will continue to change in the future.

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Sociology of Health & Illness

THIS *Journal* has commented before (1977) on the close and growing links between general practice and medical sociology. Now a new journal has appeared with the title *Sociology of Health & Illness—a Journal of Medical Sociology,* which has arisen through the inspiration of members of the Medical Sociology Section of the British Sociology Association. It has a British editorial board and aims to be international in outlook. Contributions are now welcome.

The first issue promises well with articles by Peter Conrad on types of social control, Tim Dartington on fragmentation and integration in health care, and a revealing article by David Hunter on coping with uncertainty, which looks at the ways in which decisions are made and resources allocated within health authorities.

Gail Eaton and Barbara Webb examine boundary encroachment, relating to pharmacists in the clinical setting, and conclude that the medical hegemony remains unaltered. Roger Jeffrey's "Normal rubbish: deviant patients in casualty departments" is a classic of its kind and one of particular value to vocational trainees, especially those whose programmes include casualty appointments. Peter Heller, Maria Riyera-Worley, and Paul Chalfant examine socio-economic class, abnormal behaviour, and mental health. The journal also includes a number of book reviews.

Sociology of Health & Illness is published quarterly by Routledge & Kegan Paul, 39 Store Street, London WC1; the subscription rate for 1979 was £8·50, single issues £3·00.

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Prescribing for the elderly in general practice

PRESCRIBING in general practice has emerged as a topic of recurring interest and has been the theme of several issues of this *Journal* in recent years.

Usually the topic has been considered generally but a recent development has been to consider prescribing in relation to age groups. Historically it was prescribing for children which attracted most attention, but now, as the proportion of the elderly in the population rises and about 80 per cent of the very old take some form of medication, attention is turning to older age groups.

Today this *Journal* publishes as a *Supplement* a review of the current literature by Professor J. D. E. Knox, Director of the Scottish General Practitioner Research Support Unit at the University of Dundee. This gives much detail about the literature on prescribing for the elderly in general practice with comments, principles, and studies. An important point made by Professor Knox is that hospital-based studies should not be too readily extrapolated into the community.

Prescribing for the Elderly in General Practice, Supplement No. 1, 1980, is being sent to every reader of the *Journal,* whether members of the College or subscribers. Additional copies can be obtained from 14 Princes Gate, Hyde Park, London SW7 1PU, price £2·25.