Clinical Medicine 2010, Vol 10, No 1: 6–7

The interface between general and specialty medicine

Solomon Almond

This editorial explores the interface between general and specialty medicine from the patients' perspective. The objective is to have the collective expertise to configure services so that patients see clinicians with the correct training and ability and that interfaces between services are seamless and safe. Territorialism and professional sensitivities should be set aside to provide value for the taxpayer and care tailored to patients' illnesses and suited to medical manpower and training constraints. From the perspective of acute medicine it is tempting to view this as a new area but the specialties of general practice, geriatric medicine and emergency medicine have all had to establish their niche as generalists and interdigitate effectively with specialists.

The fact that we spend less per head of capita on healthcare than most of our counterparts is in part due to the effectiveness of primary care as a gatekeeping function referring patients appropriately. This has been lauded as cost effective by US healthcare funding bodies where twice as many people are referred to a secondary care physician compared to in the UK.[1]

Writing 12 years ago, John Grimley Evans highlighted tensions between specialists and the emerging specialty of geraitric medicine in the 1950s and 1960s and foresaw the need for front line staffing of acute hospitals with geriatricians.[2] More recently British Geriatrics Society guidelines have focused on the role of the geriatrician for non-specific symptoms of acute illness manifest as failed function (confusion, falls or immobility), and the very elderly.[3] The elderly with single organ pathology and subspecialty cases can be managed by general physicians and subspecialists respectively.[3]

Rational design of services involves a pyramidal structure with most illnesses amenable to community-based care while tertiary services are reserved for the most complex patients. One role of the generalist at any stage of the pyramid is to know when to refer upwards so that the care provided is appropriate to the complexity and rarity of the presentation. From a systems perspective, it is as the baton for responsibility of care is passed that danger occurs in communication and continuity. An analysis of closed malpractice claims involving junior doctors in the USA showed that supervision and handover problems featured in 70% of claims.[4]

While breakdown in continuity is in most part predicated on working time limitations, configuration of UK hospital services has produced stays with several episodes of care. The UK is somewhat new to the concept of 'hand over of care' and must learn to do it well. Seeking lessons from non-clinical arenas, Emily Patterson and colleagues scrutinised shift handovers in four settings with parallels to healthcare, being complex, event-driven, time-pressured, resource-constrained and interconnected systems, having potentially serious consequences for system failure. Observation revealed 20 different strategies for handovers and the authors concluded that best practice in clinical settings included the chance for incoming workers to interrogate the outgoing staff, the need for some record of any problems (paper or electronic) and the isolation of handover from interruption.[5]

Dunn and Murphy termed the handovers at specialty interfaces as 'nodes of interface' and suggested that lessons should be learnt from the Formula One pitstop teams who perform miraculously accurate and complex team-based procedures in just seconds.[6] Dunn and Murphy were commenting on a study from Israel which had sought to improve nursing handover after a fatal sentinal event stepping down a patient from intensive care unit to the ward. Structured observation of handovers generated a protocol to ensure that no detail was missed and this was backed with simulation training before results of the handovers were compared with data gathered before and after the intervention. Looking at 12 factors based on demographics and past history, current status and orders, after the intervention every single measure significantly improved.[7]

An interface can be a sharp divide or a blurred margin; this can be applied to both real estate and professional activity in the context of this topic. Where to have clear divisions and where to have overlap between general and specialist hospital services is partly down to local resources. It is probably best to have a blend of each.

Specialty knowledge is always useful to a generalist and when acquired from a specialist can improve patient outcomes.[8] The totality of patients will benefit from this slight spreading of a specialist's time as only those with the most requisite needs have to be fully cared for by them. This has to be balanced against clarity of direction of management and line of responsibility, both of which are benefited by watertight clinical care from a single team. Ultimately, flexibility and a willingness to provide specialist advice when called for are the best assets of a specialist from the generalist's perspective and this holds true for patients.

Providing specialist care suited to patients' needs has been shown to improve outcomes for individual disease[9] and NHS trusts.[10] Ensuring that patients receive care from the most appropriate clinician requires expertise and judgement in knowing where to direct a patient and how to get them there. Ease of referral and transfer of specialty care has to underpin this crucial interface requirement and it all has to be responsive, expeditious and (preferably) continuous. The justification for specialist care becomes undermined if it is inaccessible, though this is sensitive to the limitations of resource constraint.

As acute medicine enters early adulthood as a specialty in its own right, another raft of bedding in has had to occur with the

Solomon Almond, consultant physician, Royal Liverpool Hospital

wider body of physicians. Other new specialties have emerged during the lifespan of the NHS and similar challenges have been tackled and largely overcome. Acute medicine arrives at the table amid unprecedented threats to continuity of care. Integration has presented difficulties as well as opportunities for building links between departments and mutual professional development. It is to be hoped that as services mature, the interface between general and specialty medicine becomes a site for improving clinical outcomes by configuration of services and manpower.

References

1 Forrest CB. Primary care in the United States: primary care gatekeeping and referrals: effective filter or failed experiment? *BMJ* 2003;326:692–5.
2 Grimley Evans J. Geriatric medicine: a brief history. *BMJ* 1997;315:1075–7.
3 British Geriatrics Society. *Acute medical care of elderly people*. London: BGS, 1995.
4 Singh H, Thomas EJ, Petersen LA, Studdert DM. Medical errors involving trainees a study of closed malpractice claims from 5 insurers. *Arch Intern Med* 2007;167:2030–6.
5 Patterson ES, Roth EM, Woods DD, Chow R, Gomes JO. Handoff strategies in settings with high consequences for failure: lessons for health care operations *Int J Qual Health Care* 2004;16:125–32.
6 Dunn W, Murphy JG. The patient handoff, medicine's formula one moment. *Chest* 2008;134:9–12.
7 Berkenstadt H, Haviv Y, Tuval A *et al.* Improving handoff communications in critical care. *Chest* 2008;134:58–62.
8 Lazano P, Finklestein JA, Carey VJ *et a*l. A multisite randomized trial of the effects of physician education and organizational change in chronic-asthma care: health outcomes of the Pediatric Asthma Care Patient Outcomes Research Team II Study. *Arch Pediatr Adolesc Med* 2004;158:875–3.
9 Pearson MG, Ryland I, Harrison BD. Comparison of the process of care of acute severe asthma in adults admitted to hospital before and 1 yr after the publication of national guidelines. *Respir Med* 1996; 90:539–45.
10 Moore S, Gemmell I, Almond S *et al.* Impact of specialist care on clinical outcomes for medical emergencies. *Clin Med* 2006;6:286–93.

Address for correspondence: Dr S Almond, Link 52, Royal Liverpool Hospital, Prescott Road, Liverpool L7 8XP.
Email: Solomon.Almond@rlbuht.nhs.uk