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# Acute medicine – an alternative take

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**ABSTRACT – This article explores the role of a GP with a special interest in acute medicine working with secondary care. The reasons why such a role may be helpful are outlined. Philosophies within primary and secondary care are explored and system changes explained. It is argued that while the primary/secondary care interface is widening, objectives on both sides are the same. It is suggested that future training programmes should allow enough flexibility for this role to evolve.**

**KEY WORDS: acute medicine, decision making, GP, interface, uncertainty**

Recently there have been increasing numbers of acutely and subacutely ill patients attending hospitals. Providing appropriate care is a challenge.[1] Strategies are outlined in a report from the Royal College of Physicians and state that 'patients with an acute medical illness should have access as soon as possible to a competent clinical decision maker at the front line of acute medical services'.[2]

In Coventry we advocate an extended role for GPs to act in a general medical capacity. In developing this role we intend that admissions should be more appropriate and that the interface between primary and secondary care should be bridged. The setting is an acute medical clinic which accepts referrals from GP colleagues and from the emergency department. It is staffed by several consultants and has a general practice arm. The aim is to see patients either on the same day or within a few days where the need is less urgent.

Most doctors will recognise that the interface between primary and secondary care has changed. Those who are younger may wonder about life in the 'other' sector especially if their early training predated foundation posts. For the minority who have moved to the other side it is apparent that there is misunderstanding about the respective roles.

There are many reasons for this. They include the advent of evidence-based medicine over the last 20 years and the development of super specialisation. Few would deny the importance of this. The downside is, however, the demise of the general physician who, for many of us, was perceived as a kindly, rather cerebral sort of chap who would put his finger on the diagnosis which had eluded others. There are of course other factors – not least the reduction in junior doctors' hours and the breakdown of 24-hour personalised care in general practice. Conversely many GP colleagues assume that hospital medicine is the same as when they were senior house officers.

What can a GP with a medical interest offer secondary care? Qualifications may flatter since we do not profess to have the expertise of consultant physicians. An important role can nonetheless be argued in the management of sub-acute problems. I am less convinced that we should be dealing with the acutely ill patient.

Evidence on the cost effectiveness of GPs working in an emergency setting in secondary care is sparse.[3] In bygone years, clinical assistants and hospital practitioners would do sessions in accident and emergency but payment for such sessions was low and they were performed more for interest than any financial gain. The current GP out-of-hours arrangements have encouraged innovative providers to propose alternative models. These usually involve GPs performing general practice (but not an extended role) within emergency departments. Such models are therefore related to, but distinct from, the role I advocate.

Since general practice contractual changes in 2004, GPs with a special interest (GPwSI) have evolved. To perform this role requires accreditation but not necessarily a higher qualification. Many such doctors are in a specific field (for instance endoscopy). Acute medicine is an example in which a GP is effectively performing a hybrid role with the objectives of not only reducing admissions but fostering communication between primary and secondary care.

One compelling argument for the involvement of a GPwSI as opposed to a doctor in training lies in the fact that there is no substitute for experience. Experience allows the development of a sixth sense. License is given to reassure certain people without resource to tests or overtly defensive investigations as long as there is an appropriate safety net. Important in achieving this is an awareness of one's own limitations as well as the confidence (sometimes determination) to approach colleagues for help.

In making any clinical decision, best evidence and the current guidelines are crucial determinants. Any experienced GP or hospital doctor will recognise, however, that other factors can play an equally important role. These include knowledge of medical ethics, an understanding of patient values and (crucially) the ability to communicate issues in a way that is understood.[4,5] GPs have a unique knowledge of what is (and what is not) available outside the hospital walls thus potentially increasing the range of options.

The differences in philosophy between general practice and hospital medicine are worth exploring. In general practice we set great store on the concept of 'uncertainty' – a skill that sits far less comfortably within the hospital setting. In general practice

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we form hypotheses more often than making diagnoses (at least initially) since we see many conditions early in their evolution. To deal with uncertainty we may use 'time' – and while this is also a feature of secondary care the temptation to do a test or two is greater in the hospital setting.

The challenge is to how to not only share that uncertainty with colleagues in primary care but also to communicate it effectively. A system needs creating that allows patients to be managed in the appropriate sector while at the same time retaining accessibility to a team in the other which has the necessary clinical and social information. Thus interested GPs should not only have clinical expertise but the ability to liase with colleagues on both sides of the fence.

Any idea of utilising a GPwSI in this capacity is fraught with challenges. Locums in general practice cost upwards of £450 per day and it is unlikely that a partner (maybe with a higher qualification) can work for less. Furthermore commissioners require robust evidence. To provide this, sufficient patient numbers, as well as reliable outcome measures, are required. We have encouraging data from our own unit suggesting that admissions are reduced without adverse effect but numbers are small.

There is also an agenda mismatch. Hospital colleagues and managers see ever increasing numbers of admissions passing through emergency departments. While some of this is undoubtedly due to a reduction in the number of GPs available out of hours it is also due to the pressures that four-hour targets put on the system. While I take the view that an experienced pair of eyes can sometimes speed the process and avoid tests (sometimes admissions) my hospital colleagues are just as concerned about the number of inappropriate referrals sent up from primary care and the poor quality of the communication received.

The short-term solution perhaps lies in offering sessions (both in and out of hours) to certain GPs in emergency departments. They should be part of an integrated team (instead of an offshoot down the corridor) and be given access to investigations. In this way a two-way dialogue with hospital teams would be established. Feedback could be given to GP colleagues regarding referrals and hospital staff should be advised on what information is useful in a community setting.

I am often asked by junior doctors how to become a GPwSI in acute medicine. This demonstrates that the interest is there. In order for this idea to come to fruition, however, more flexibility is required in training and recognition is required by clinicians and managers that the interface between primary and secondary care is a chasm which should be bridged.

## About the author

Mike Houghton left London in the early 1980s to join a general practice training scheme in Manchester. He was a senior house officer at St Thomas' Hospital and the Hammersmith Hospital and was briefly a partner in a general practice in Lancashire before becoming a single-handed GP in Warwickshire for eight years. His practice has become an established training partnership and he has been an MRCGP examiner for 12 years. In 2003, he sat the MRCP and in 2004 commenced work as a GP with special interest in acute medicine. He was elected FRCGP in 2003 and FRCP in 2009.

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