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Inpatient care: should the general physician now take charge?

Editor – Kirthi *et al* have described the difficulties for a specialist whose contract involves the general take in caring acutely for patients with several problems, and discuss the role of the acute physician and the hospitalist (*Clin Med* August 2012 pp316–19).

I think an alternative or additional way of improving this service is to rethink the role of general practitioners (GPs) and increase the role of physician assistants. (I had a physician assistant in America; as I am a cardiologist and he was trained in gynaecology this wasn't a great help, but the principle still stands.)

GPs are burdened with a great number of minimal problems, so have to take less time with the more serious issues. Their great expertise can be in deciding who is ill and who isn't, and using time as a means of clarifying diagnosis. This is harder to do since the partial loss of the personal GP. They are trained for several years and learn, as junior hospital doctors, to deal with severe conditions appropriately. After a few years in general practice they tend to lose confidence in their ability to deal with conditions which they very rarely see acutely, ie in this area they become 'deskilled'. However, their training need not be lost.

In hospitals it is hard to find a truly general physician who has a wide range of expertise because virtually all specialists now spend so much time learning how to perform procedures of various sorts, and doing so. The new acute medicine specialists pass their patients on or out, leaving only the paediatricians and geriatricians as specialists with a range of knowledge across an age group. This leaves quite a lot of the population out!

One solution to this situation would include the following elements:

(a) A physician assistant as the first port of call in general practice. These could be nurses with additional training to cover diagnostic skills, but someone trained specifically for the job would perhaps be better.
(b) GPs being available in the practice for referrals from the assistant. The reduction in their surgery numbers would allow them to take more time with more difficult problems. The GP would also see their patients or the practice's patients in hospital, acting as the patient's primary physician (they would only have a few patients at a time), helped by the appropriate specialist. This would produce continuity of care for the patient through admission and after admission, and allow the GP to maintain their skills at a higher level.
(c) The specialist, therefore, would spend less time on daily management of the patient and would have more time available for interventional procedures. Many specialists long for this situation.

I have seen this plan work well in America and I think it would work well for everybody.

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US-style hospitalists are unlikely to improve delivery of patient care in the NHS

Editor – Over the last 15 years, I have watched the increasing impact of physician specialists, known as hospitalists, on the delivery of patient care at the institution where I have my principal appointment. More recently, I have had the opportunity to interact with hospitalists at two other medical centres (one a university hospital, the other a community hospital). Accordingly, I read with great interest Kirthi *et al's* recent paper advocating a clinical leadership role for hospitalists in the National Health Service (NHS) (*Clin Med* August 2012 pp316–9) as well as your accompanying editorial (*Clin Med* August 2012 pp 307–8).

Few hospitalists in the US have trained specifically for hospital medicine. Indeed, in a recent survey, it was found that only 1 in 50 hospitalists had either completed or were currently involved in a hospital medicine fellowship.[3] The typical hospitalist's postgraduate training is limited to three years (most often in general internal medicine). In addition, 55% of the current pool of US hospitalists have only been practising as hospitalists for five years or less.[1] Accordingly, Kirthi *et al's* attempt to equate US hospitalists with NHS general physicians is somewhat misleading, at least with regards to depth of training and experience.

There have emerged national hospitalist management companies that individually employ often hundreds of hospitalists in facilities throughout the US. One particular company employs physicians in 900 facilities (including the three medical centres at which I work) in 27 states.[2] Such private companies provide intense instructional programs, teaching billing and coding,