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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,

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medical record documentation, risk management and health care economics for every new hospital recruit. Several years ago I met a former resident who had just completed one of these courses. 'I've become a billing machine!' he told me proudly. In the US fee-for-service environment these skills are vital. The hospitalist is often under the gun from his or her employer (whether a hospital, a national chain or a local group) to consistently bill to the highest level that can be supported by their notes (electronic health records have been an enormous help) and to see as many patients as possible. For most hospitalists, a part, if not all, of their salary is determined by the number of fee-for-service relative value performance units (RVUs) they clock up.[3]

Like emergency room physicians, hospitalists are shift workers who generally do not have the opportunity to form significant personalised bonds with patients. They manage only hospitalised patients and have absolutely no outpatient responsibilities. They work in a very focused and efficient manner, recording medical history, carrying out physical examinations, writing discharge summaries and progress notes, checking results of investigation and carrying out the suggestions of the various consultants on the case. However, there is, quite frankly, no expectation of the hospitalist consistently providing significant clinical insight into individual patients. Moreover, when a patient needs to be transferred from the regular medical ward to an intensive care unit, hospitalists are generally out of their depth, and provision of comprehensive clinical care is transferred to the intensive care specialist.

In the past, hospitals looked to hospitalists to shorten length of stay. Now, as the Affordable Care Act starts to roll out, the key missions for the hospitalists will be to keep readmission rates as low as possible and to achieve, in every patient, compliance with 'core measures' (such as making sure that every heart failure patient is on a beta blocker and ACE inhibitor at the time of discharge). Hospitalists are very good at achieving the latter goal; their effectiveness in reducing readmission rates is less certain.

Accordingly, and in full agreement with the opinions expressed in your editorial, I feel that US-style hospitalists are unlikely to improve delivery of patient care in the NHS.

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In order to encourage general internal medicine (GIM) as a specialty we must learn from our peers outside the UK

Editor – It was heartening to read Kirthi *et al's* article (*Clin Med* August 2012 pp316–19) concerning the debate surrounding the role of the general physician in the UK.

Amongst others, the UK is facing two main challenges in healthcare provision: an ageing population and an obesity epidemic. Both old age and obesity are associated with increasing comorbidities such as diabetes and hypertension. However, it is not only within the confines of the inpatient setting that this demographic will be seen. Outpatient and primary care services will likely be dealing with the majority of people with complex multiple comorbidities. Moreover, it is not only physicians who will be affected, but allied healthcare and social services professionals as well.

As Kirthi *et al's* article rightly reflects, shared care and pooling of resources – as has occurred on orthopaedic wards with involvement of geriatricians – is an important step forward. However, roll-out of 'shared care' requires a body of generalists and support for the general physician as a specialist that appears to be thriving in countries such as the US and others within Europe, but is absent in the UK.

Having recently attended a European Society of Internal Medicine conference (ESIM 2011), it was encouraging to see the pride that certain EU countries (eg France and Spain) take in becoming a generalist in its purest sense, ie *not* a geriatrician, *not* an acute medical physician, but a 'general internal physician'. This distinction will be essential in shaping an evolving healthcare provision for those with multiple comorbidities, as will a potential redefining of what constitutes 'geriatric medicine' – an excellent specialty in its own right – in the modern day of longevity of life span. Where would be the arbitrary cut-off for review by a generalist as opposed to a geriatrician? Aged 75 years? Or would a generalist see patients of all ages?

In order to encourage general internal medicine (GIM) as a specialty we must learn from our peers outside the UK. Essential conditions for promoting GIM would include:

- viewing it as an 'ology' – a specialism in its own right – and according it the prestige it deserves
- educating medical students about the role of the generalist in hospital medicine
- involving role models for medical students and junior doctors to look up to in order to consider pursuing a career as a generalist
- ensuring reasonable working conditions to avoid the job dissatisfaction, noted in Kirthi *et al's* article, in medical registrars who are essentially on-call, albeit acute, generalists
- promoting and fully utilising such GIM bodies as the Royal College of Physicians and ESIM.

Future provision of care for an ageing population will require not only the above but also a bridge between hospital and community services that incorporates cohesive multi-disciplinary team input. We must put behind us the days in which a patient with multi-system complaints and health needs may be passed between multiple specialties prior to any formal diagnoses due to their condition 'not being my specialty'.

Humans are complex organisms that, as they age, require a generalist approach. This is currently missing in UK medicine.

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