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Those receiving disability benefits have suffered disproportionately from the austerity measures

Editor – There has been much debate about the causes, precipitating factors and management of the financial crisis. However, it is clear that a major factor has been the spending by governments and individuals of money that they do not have. Therefore the solution must include a return to financial probity. A major contributor to the fiscal deficit is social expenditure and this must be reduced to balance the budget. Many of those receiving benefit have suffered disproportionately from the austerity measures that many feel are necessary. So it is not only just, but also essential, that claimants, new and old, be treated both compassionately and realistically during reduction of the benefits budget.

Over the last few decades the disability expenditure has tripled at a time when the ability to treat disease has improved, so the increase cannot be due to failure of treatment. Change in the age profile of the working population might be partially responsible and the drift from physical to intellectual demands might work either way. Neither is likely to be a whole answer, but I believe the principle cause is deconditioning. In many chronic conditions the relationship between objective findings and performance is poor. To give an example from my own respiratory practice, I have seen patients with identical FEV1s whose sole complaint is an inability to carry guns across a heather moor or to run briskly playing tennis, while others are genuinely limited to 30 m walking on flat ground. The exercise limitation in the latter cannot be directly due to the respiratory impairment, but is due to a vicious circle of decreasing activity and increasing breathlessness – in other words deconditioning.

Deconditioned subjects are not malingerers, albeit often labelled as such, because by the time that they reach that stage they are actually disabled. The medical profession makes a major contribution by not recognising the need for aggressive rehabilitation at the earliest stages of chronic disease. Indeed habilitation is a better term, emphasising that attempts at rehabilitation during the late stages may be too late. The benefits system should recognise its contribution to the problem, which is a particular hazard during times of financial depression. It should facilitate and require attendance at (re)habilitation programmes, with frequent reassessment until the performance threshold is reached. It should also emphasise that Disability Living Allowance is not a long-term sickness pension, but, as its name implies, financial help for the disabled to reach full potential including employability. Similarly, benefits contribute to social deconditioning among the unemployed. In response to this the unemployed must be given the opportunity to experience work, but they in their turn should be under an obligation to accept it. One of the barriers to this is the perceived indignity of working for nothing. This would be mitigated if the benefit were presented as a state wage for the unemployed. Then like all wages it should be taxed or withdrawn fairly at no more than one pound for every three earned.

Both health and benefit sectors must recognise that deconditioning, and not impairment, is the determinant of limitation of performance in many subjects and they must act accordingly. If the immediate use of resources to reverse the latter for long-term benefit is to be acceptable to the tax-payer, the public must be educated to accept that the major toll on the disability budget is not fraud but deconditioning.

CK CONNOLLY
Retired physician, North Yorkshire

In patient care: should the general physician now take charge?

Editor – Kirthi *et al* (*Clin Med* August 2012 pp316–9) argue a case for the management of emergency-admitted medical patients by general physicians. There is, however, evidence that patients with a range of acute problems including coronary artery disease, stroke, asthma, acute upper gastrointestinal bleeding and ulcerative colitis all have better outcomes when looked after by relevant specialists.[1–4] Moreover it seems illogical that we might condone a system in which patients who are well enough to come to an outpatient clinic will be seen by a relevant specialist whereas those who are so ill that they require emergency admission will not. We have shown in Liverpool that changing the system for hospital medical admissions from care by general physicians (with a specialty interest) to one in which patients have their initial care on an acute medical unit followed by early transfer to the appropriate specialty team reduced mortality significantly for those aged under 65.[3] Kirthi points out that this did not improve mortality for those aged over 65, but nor did it worsen it. Older patients with multiple pathologies should surely be appropriately looked after by specialists in the care of the elderly medicine who are likely to be better able to deal effectively with the complexities of their medical and social care. We have more recently demonstrated, in a prospective assessment of medical admissions to our Acute Medical Unit (AMU) with a primary gastroenterology problem, that specialist gastroenterology consultant review within 24 hours of admission increased the proportion of patients who were discharged direct from the AMU from 3% to 23%.

A return to general internal medicine as a specialty to provide care for acutely admitted patients might be an appropriate solution for a small hospital serving an isolated rural community, but as a general model of care we think it would be a retrograde step. Seven-day cover by the acute medical specialties, which should include care of the elderly and acute medicine expanded appropriately, would, we feel, be a much better way forward. Moreover it will be very

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difficult to establish seven day consultant working for the acute medical specialties if they are going to be encouraged to participate at the same time in seven day rotas for general internal medicine.

PAUL COLLINS
Consultant gastroenterologist

MELITA GORDON
Reader and honorary consultant gastroenterologist

JONATHAN RHODES
Professor of medicine and honorary consultant gastroenterologist

Royal Liverpool Hospital and University of Liverpool, UK

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Response

We agree with Collins *et al.* about the importance of specialist pathways in delivering improved outcomes and high quality care to medical patients admitted as emergencies with clearly defined conditions, including stroke and myocardial infarction.

The focus of our article was on the delivery of care to older in-patients with multiple co-morbidities and whether generalists, particularly geriatricians and general internal medicine (GIM) physicians, should have a greater role in their ongoing care. Despite the rise in the proportion of elderly frail patients admitted on the acute medical take in the last two decades, postgraduate medical training has remained largely centred on single organ system specialism.

Our concern is for those patients aged over 80, who may comprise up to a third of the acute medical take and whose presenting problems often do not fit neatly within a single-organ-defined medical specialty. The pressure on acute medical services is such that many of these patients are allocated to the first available bed in a specialist medical ward loosely aligned to their perceived major illness. However, in this ward setting there is little tolerance of GIM problems[1] and a continuing risk of transfer out to another ward (and clinical team) to make way for patients deemed more appropriate for the specialist bed. It is not uncommon for older patients to be moved up to four or five times during a hospital admission, causing considerable distress and compromising patient safety, with each transfer adding up to two days to the length of stay[2]. Physicians report that lack of continuity of care is their principle concern, trumping budgetary constraints and staff shortages[3].

The changing profile of hospital inpatients requires health services that have championed increasingly specialised medicine to evolve to meet the care needs of the rising numbers of older patients. Organising care so that a generalist (ideally a geriatrician or alternatively a GIM physician) can consistently ‘take charge’ of continuing care in this cohort of elderly, vulnerable in-patients, would deliver more holistic, safer care and shorter lengths of stay.

VARO KIRTHI
ACCS anaesthesia CT1 doctor, North West London

R MARK TEMPLE
Acute care fellow, Royal College of Physicians, London, UK

LINDA J PATTERSON, OBE
Clinical vice president, Royal College of Physicians, London, UK

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