

# Hospitalists and consultant physicians in acute medicine

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Articles in this issue from San Francisco in the USA<sup>1</sup> and Bournemouth in the UK<sup>2</sup> describe new approaches to the hospital care of acutely ill patients. Although from historically different systems of health care, each addresses familiar concerns. Baudendistel and Wachter<sup>1</sup> consider the development and evaluation of the relatively new specialty of the hospitalist, who is identified by the place of practice rather than by expertise with diseases of a particular organ or system. Armitage and Raza<sup>2</sup> describe and evaluate their experience following the appointment of a consultant physician in acute medicine in a district general hospital.

In the USA, responsibility for primary care lies variously with a family physician, a paediatrician or a general internist, who refer patients to specialist colleagues. Primary care doctors also undertake inpatient care, although increasingly they transfer that responsibility to a hospitalist, thus coming closer to UK practice, where the general practitioner (family physician) refers to a consultant for both inpatient and other specialist care. American primary care physicians once spent half their time providing inpatient care. But changing conditions have encouraged the development of a new inpatient practice, based chiefly on the needs of acutely ill patients.

In the UK, where most specialist practice integrates outpatient and inpatient work, other influences have provoked a similar response. The common factor is the need to ensure that acutely ill patients are attended by physicians who are skilled and experienced in the assessment and management of acute medical disorders.

Separation of acute internal medicine from medical specialty practice seems to have been accepted in the American system described. UK physicians have been reluctant to follow this route. This largely stems from a conviction that hospital medical practice is grounded in experience in general internal medicine (G(I)M). Moreover, most general practitioners wish to be able to refer patients to general physicians as well as specialists. In the UK, G(I)M encompasses acute medicine and the inpatient and outpatient care of patients with multiple disorders or ill-defined conditions. Although it is usual for a general physician also to have a specialty, the converse does

not always apply and physicians in a number of specialties do not practise acute medicine<sup>3</sup>.

Specialisation to the exclusion of acute work increases the workload of physicians who shoulder these duties, often to the detriment of their specialty work and other responsibilities. The consequences are particularly pronounced in the UK, for the plain reason that there are far fewer consultant physicians in relation to population compared with the US and other developed countries. Even among physicians who regularly undertake acute work, there are many who would willingly reduce or even relinquish this duty. Other familiar factors compound the problem: each year there are more emergency admissions, fewer hospital beds, fewer experienced junior staff, as well as shorter junior doctors' hours resulting from the EC directive.

In the UK, many consultant physicians are in a sense hospitalists who practise acute medicine within G(I)M, and have a specialty<sup>3</sup>. But their on-take work for unselected acutely ill medical patients is intermittent – though often burdensomely frequent – and until recently it was uncommon for acute work to be the continuing predominant activity of a physician.

In 1996, the RCP proposed that studies be conducted to evaluate the role of an acute physician, a physician who would specialise in the first 24 hours of acute care<sup>4</sup>. Such a physician would also provide support to a medical assessment or admissions unit, assign patients to appropriate specialties, teach and train, co-ordinate the use of guidelines and protocols, and provide an outpatient department (OPD) service for follow-up of some patients from the acute take. A Scottish Intercollegiate Working Party<sup>5</sup> endorsed the proposal.

Before evaluative studies could be set up, trusts proceeded to appoint acute care physicians (ACPs). They have diverse job descriptions and come (as do hospitalists) from various clinical backgrounds. Some work as general physicians with a specialty, with time allocated to work in the medical assessment unit. They may have on-call commitments. Some have jobs with regular working hours based in the medical assessment/admissions unit, with outpatient sessions. Teaching and research rarely appear in the job descriptions.

A working party report of the Federation of

Medical Royal Colleges, *Acute medicine: the physician's role*<sup>6</sup>, recognised the value of acute care physicians but at that time did not feel it appropriate to create a new specialty with a specialist training programme. Among the concerns were the lack of career structure, the risk of burn-out from relentless acute work, the dislocation of acute medicine from subsequent inpatient care, and the deskilling of other physicians.

However, the continuing problems faced by hospitals that must provide acute medical care have encouraged closer examination of the organisation of care, and of the training of doctors and other health professionals who undertake this care. The planned increase in consultant numbers<sup>7</sup>, the concept that a consultant's career has three natural phases in which successive roles are more closely matched to experience and vigour<sup>7</sup>, the recommendations of a new report on consultant careers<sup>8</sup>, and the planned restructuring of senior house officer and specialist registrar training<sup>9</sup>, all address the problems and the concerns.

Meanwhile, given the broad arena of inpatient care, colleagues in the US are working to define the scope of work proper to the hospitalist, and the training and experience necessary. Their suggestions include a major commitment to research, to the care of surgical patients outside the operating room, care of the dying, and possibly intensive care. Much of this lies outside the scope of work of ACPs in the UK.

Studies reviewed by the San Francisco group have shown that within the American system the hospitalist model can improve the efficiency of care by reducing length of stay and hospital costs without compromising quality or patient satisfaction. Thirteen out of 14 studies found either no change<sup>9</sup> or a decrease<sup>2</sup> in hospital mortality rates with hospitalist care. Nine out of ten found either no change<sup>7</sup> or a reduction<sup>2</sup> in rates of readmission.

Apart from the Bournemouth study, there has been little comparable published research from the UK – a situation that should be remedied<sup>6</sup>. But there is much information on the range of problems encountered among patients who are referred with acute medical conditions<sup>10</sup>. This should guide judgements on the training, experience and skills required by physicians who undertake acute care, and the facilities and supporting services they need.

Armitage and Raza reiterate the view that an acute medical service requires continuing consultant leadership<sup>9</sup>. In most hospitals in the UK, consultants on take not only keep their fixed outpatient sessions but also provide cover both for their junior colleagues on take and for those who have responsibility for ward patients. This makes it difficult to provide an uninterrupted strong clinical lead for the take of unselected patients with acute medical illness. Their paper emphasises the very important function – that can only be fully exercised by a senior, experienced clinician – of avoiding unnecessary admission. The authors also remark on the strong team spirit that has developed across the entire medical directorate, observing particularly that junior doctors value having a consultant physician on the admissions ward.

Acute care physicians seek to demonstrate that their concentration on acute clinical management, including referral for outpatient care, is reflected in the safety, quality and efficiency of

care, and the intangible but crucial benefits of strong clinical leadership.

Research is central to the development and evaluation of these new forms of service organisation and delivery. There should be support for similar necessary research in other places, especially when acute care physician posts are established.

These papers serve to refocus our attention on issues that physicians and their trusts must address as they seek to meet the needs of patients with acute medical illness. Local provision of acute medical services depends on many factors and it is most unlikely that a single model of acute medical care will suit every service. Organisation and working in a hospital are strongly influenced by its culture, its staffing and professional relationships, and the personalities within. But whatever the particular circumstances and characteristics of a service, its development should be informed by the best research available.

## References

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