Future Hospital Journal 2014 Vol 1, No 1: 52–5

The future hospital: a rewarding place to train and work? A perspective from the shop floor

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ABSTRACT

The provision of medical care for the next 40 years lies in the hands of the trainees of today. In order to deliver the care our patients deserve in the way in which they wish to receive it, this future workforce needs to be trained appropriately and to be supported and encouraged to develop into the doctors needed to fulfil this mission. This personal view authored by a trainee of today discusses some of the likely demands placed upon the physician of tomorrow, placed in the context of the Shape of Training report commissioned by the GMC, and the report of the Future Hospital Commission of the Royal College of Physicians, to which the author contributed. To achieve the visions set out in those reviews and maximal satisfaction for the patients served the enthusiasm, experience and innovation of trainees will be of fundamental importance.

KEYWORDS: Medical education, medical trainees, multi-disiplinary working, work patterns, partnership working, medical leadership

What do patients need from its doctors in the future?

The changing demographics of the population of the UK demand a fundamental change to the practice of medicine. By 2035 23% of the population is estimated to be over 65, and there will be 3.5 million people over the age of 85.[1] Some 58% of people over the age of 60 today have at least one chronic medical condition[2] – most commonly heart disease, diabetes and dementia – and these numbers are predicted to rise. Even now, older patients with multiple co-morbidities account for 64% of all outpatient visits and 70% of all inpatient bed days.[3] Additionally, 30% of people with long-term conditions also have mental health problems, which adds to the burden of disease and the cost of treatment.[3] There is little evidence yet that schemes able to avoid hospital admissions in these groups play any meaningful role in current models of service.[4,5]

One of the challenges for patients living with a chronic medical condition is coping with its daily management, as the vast majority have limited exposure to medical services. The relevant professionals and the systems in which they work need to extend their influence beyond face-to-face consultation time and empower patients to manage their condition within their daily routine. Second, for those that require admission, there is increasing evidence that the current hospital model, with wide variations in staffing is not only inefficient in terms of length of stay, but exposes patients to increased risk at nights and weekends and other when levels are lower.[6,7] The system of the future must provide a 7-day-a-week service where patient safety is prioritised.

Finally, patients want care delivered with compassion as close to home as possible. This fundamental tenet has emerged in numerous publications of the past 1–2 years, including the reports of the Francis Enquiry[8] and the medical director of the NHS, Sir Bruce Keogh,[9] and those of Don Berwick[10] and the Rt Hon Anne Clywd MP.[11]

What do trainees need?

The RCP has recently investigated the attitude towards providing the kind of general medical care required by patients who lie outwith the single organ failure paradigm – historically those seen by the general medical registrar and core medical trainees. Surveys suggest they are demoralised, poorly supported by senior staff and ill-equipped to undertake what they perceive to be an unmanageable role.[12,13] CMTs express frustration at the limited time and exposure they receive for formal education and the acquisition of procedural skills. Research shows that there is a direct link between the standard of care given and the morale of the healthcare providers delivering this. To achieve excellent, compassionate care we need a motivated, supported, satisfied work force.[14]

Change is inevitable

Patients demand services designed for their needs, provided by teams of individuals trained to deliver those services safely and with kindness; trainees need to be supported and nurtured to acquire the skills they need and the autonomy and confidence to improve the system. The service must provide comprehensive care delivered by multi-professional teams in conjunction with patients 7 days a week. The patient should be offered more services closer to home, some using technology with which they are familiar in other areas of their lives, reserving admission to a hospital bed for those situations where there is no alternative.

The physician will work across the health economy, providing direct patient care in both acute and chronic scenarios as well as supervising, teaching and quality-assuring care provided by alternative healthcare professionals. The physician will also be responsible for working with other professionals to ensure that the service is appropriate to the health needs of the population. Trainees must therefore be trained to deliver truly patient-centred care to individual patients, to co-ordinate

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multispecialty care with their medical colleagues and to provide leadership, quality assurance and support to other disciplines of healthcare provider and will be encouraged to develop the skills to assess the quality and safety of the service they are responsible for and to adapt it while measuring the impact of change.

Within the hospital

The increasing number of patients with multiple medical conditions means physicians need not only in-depth knowledge of a single specialty area, but also general medical skills to facilitate co-ordinated care with other specialists. This is implicitly recognised by the academic community, which is developing models to perform clinical trials in patients with several comorbidities,[15] but even when multi-condition treatment protocols are developed, there will still be a requirement for structured teaching across internal medicine and exposure of trainees to specialities beyond their own, through placements, multi-disciplinary meetings and involvement comprehensive team management of patients.

The current training in acute medicine (AM) may offer a basis for what future training in internal medicine should comprise. Trainees aiming for a CCT in AM are required, in addition to their contribution to the medical take, to acquire knowledge and skills of those specialities and conditions that most commonly affect the population presenting to hospital.[16] This means exposure to geriatrics, dementia care, cardiology and respiratory medicine. An attachment in critical care medicine ensures they are skilled to look after the deteriorating or sickest medical patients. This model to meet the shortcomings in general medicine must also include exposure to relevant specialities in the community setting and in mental health.

Within hospitals, the physician of the future will need to assume a number of clinical roles. As a specialist they will bring timely advice and intervention to any bedside within the hospital, probably in the form of a consultation service. As a generalist they will spend periods assuming the responsibilty for co-ordinating the overall care of complex medical patients placed (possibly for a week at a time) under their responsibility. In this role they may be the named leader of a multiprofessional team. This will require time to be devoted to these in-patient service responsibilities, which may extend to the care of surgical patients, thereby extending the success of this arrangement in the new discipline of orthogeriatrics.[17] Trainees are likely to have longer placements to enable them to have exposure to all the roles they must assume as a trained doctor, including advisory consultation, delivery of acute care, engagement in clinical management in the community and leadership or unit development.

The physician will also be required to supervise and lead multi-professional teams who will work within the hospital and go to the patients' homes, as task shifting and the expansion of roles for specialist nurses, physician's associates, acute care practitioners, expert patients and social workers are developed. Co-ordinating care throughout the network will therefore assume a greater priority. Evaluation of multidisciplinary team (MDT) meetings has shown that discussing cases in minuted meetings, developing a therapeutic plan based upon the and the application of guidance and protocols variation in standards of care is reduced and quality of care is improved.[18] This rigour needs to be applied throughout the care pathway (both inpatient and community-based) of patients with chronic conditions. Trainees, assigned their own patients, should be expected to attend and play an active role in these meetings.

Across the health economy

Beyond the walls of the hospital, physicians will act as a specialist for all patients in an area who currently have a condition or are at risk of developing a condition. This role, termed population medicine,[19] is at best paid lip service in current training schemes, and at worst a foreign concept, where an understanding of local disease patterns is not considered at all. However, these roles are already assumed increasingly by integrated respiratory physicians,[20] community geriatricians, community diabetologists and community haematologists.

Moreover, there are already examples of training programmes that stretch into the community. Such 'broad-based training' pilot schemes were conceived to help trainees who were uncertain about their career path as they came to the end of foundation year (FY)2 or wanted to pursue general practice but from a wider knowledge base.[21] These programmes last for two years and incorporate placements in psychiatry, paediatrics and general medicine, with a specific emphasis on community-based care. The programmes have been viewed as successful and there are plans to extend their availability.

At registrar level a number of specialities are beginning to offer experience of working within the community. Geriatric and some diabetes trainees are encouraged to work with community teams. In North East Thames a post specifically designated as 'integrated' respiratory medicine has been developed (personal communication), which incorporates working in close collaboration with local GPs, the clinical commissioning groups (CCGs) and community respiratory nursing teams.

New skills needed

The Future Hospital Commission report[22] showed that patients with chronic conditions want to be helped to manage their conditions effectively themselves, a view reinforced repeatedly in the NHS patient survey. Thus, the degree to which patients feel involved in decisions about their care is associated with increased satisfaction[23] yet current medical training reinforces the traditional paternalistic approach with its emphasis on making a diagnosis and applying what is considered by clinicians to be optimal treatment. The teaching of skills such as shared decision making and support for self-management is currently neglected, yet is vital to ensure that patients and clinicians work together to manage their condition.[24] The evidence from programmes such as the diabetes year of care programme suggests this is one of the most effective ways to achieve good clinical outcomes,[25] but requires a shift in training, for example to include exposure to systems in which where this style of care provision is commonplace. Following the publication of the FHC report, the RCP aims to introduce tuition in shared decision making techniques into the core curriculum.

The FHC report recommended that technology be employed to support and enhance services, both in their delivery and evaluation. Trainees are likely to embrace and utilise technology with greater ease than their more senior colleagues but the skills required for a remote consultation, for corresponding

effectively with patients by email, for a networked case discussion, and for responding to telemonitored information need to be defined, taught and acquired. Involving trainees in the design of such systems is likely to enhance their value to the service and should be encouraged. The popularity of the NHS Hack (nhshackday.com) and Tully initiatives demonstrates the enthusiasm for trainees in this regard.

Non-clinical roles

The Francis enquiry[8] highlighted system wide failings that led to appalling deficiencies in the dignity and compassion of care provision. The report from Don Berwick[10] highlighted the system features and use of improvement science that will promote the pursuit of safe, high quality care. Improvement science needs to be part of mainstream medical training.

In order for the future hospital service to be delivered in an efficient, effective way, trainees need to be given opportunities to master skills in team management, leadership, quality assurance, critical evaluation and negotiation. Trainees also need to be equipped with skills previously seen as the domain of public health: disease prevention and disease mapping techniques to assess local needs. They will need to be able to plan and develop services based on a rigorous needs assessment of their populations, to work with other professionals both within and beyond the hospital and to ensure local needs are taken into consideration when re-arranging or advancing services. Leadership must be considered a core skill, as important as practical clinical procedures, and time allocated to develop it. Some of the skills can be learnt within the structure of the working environment of a hospital and the apprenticeship model, but trainees will benefit and thus give more to the NHS if these skills are given equal status to academic or clinical skills. The role of 'chief resident' described in the FHC report could enable selected trainees to gain real experience of medical leadership at an early stage. Current models for out-of-programme posts in national or local schemes such as the D'arzi fellowships[26] and the NHS Medical Directors' Clinical Fellowship scheme[27] are examples of programmes that currently give limited numbers of trainees exposure to managerial roles. Other initiatives that harness the energy of trainees to bring about change include the network (www.the-network.org.uk), a virtual platform for trainees interested in improvement science which has permitted them to share ideas for change and to equip them with skills necessary to deliver the future hospital vision. 'Learning to make a difference',[28] a scheme run from the RCP, has supported young trainees successfully to undertake quality improvement projects within their NHS trusts.

Providing education

Trainees need focused, high quality education and a cadre of high quality teachers needs to be developed. The development of educational fellowships, and increased availability and access to qualifications in clinical teaching, is necessary but not obviously prioritised at present. The enlightened future hospital will ensure staffing levels and task assignment are such that that education is built into the working patterns; indeed, a benefit of the introduction of new roles, such as physician's associates is to permit trainees to exploit learning opportunities without compromising patient care.[29]

Change in working patterns

The trainee of today will see a dramatic shift in the work pattern as the health service moves to 7-day working. Senior trainees are vital to reducing mortality at weekends, but the work pattern will also change for those who have completed their training. Across the health service there will be a move towards increased care provision by trained medical staff at weekends, which will mandate more rigorous team-working and handover to ensure seamless transitions of care from one team to another, both within a specific care setting and across traditional hospital/community boundaries. There are huge advantages to a shift pattern of working, with opportunities for additional careers (medical or non-medical) to be pursued, or for physicians to play an active role in childcare or the care of aging relatives. These changes will affect all healthcare workers so that a traditional 'medical firm' will be larger, with a wider variety of professionals who together are best equipped to meet the needs of the patients. Effective handover and information systems will be crucial to the effectiveness of working such extended hours.

Career aspirations and potential

Many people pursue medicine with the vision of a career of lifelong learning. Most consultants would agree that their job today bears scant resemblance to the posts they were appointed to, but that these changes have often been reactive and driven by factors beyond their individual control. In the healthcare system of the future it should be expected that roles will evolve with time. The balance of responsibility for different parts of the care system will shift over a career; trainees today will expect to rotate through managerial roles – either within a department or a unit, or as a chief of medicine or taking on responsibility for educational roles. These portfolio careers should be expected, planned and trained for within the physicianly career path. This approach will mean that the wisdom and experience of the most senior clinicians continues to contribute to patients up until the time they retire without compromising their enjoyment of the profession. ■

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