

# General medicine in the future perfect

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## Introduction

Those of sufficient seniority are able to look back and reflect on the profound changes that have occurred over the past two decades to influence the way we deliver care to patients in the NHS. Consequently, this issue of *Future Hospital Journal* attempts to provide some proper accounting of losses and gains to the provision of medical care over this period, with particular relevance to the essential and yet recently neglected role of the general physician. It is unlikely there was any coordinated plan to pull down a former pillar of the medical establishment. However, the unintended consequence of the fortification of parts of the medical superstructure has certainly been the weakening of others. It is perhaps a source of disappointment to some that we have come so far and that it has taken so long before the return to generalism was proposed by the report of the Future Hospital Commission.<sup>1</sup> We have yet to hear what changes to medical training may emerge as a consequence of rebalancing of specialist and general roles.

## What happened to general medicine?

A detailed account of the events that have led to our arrival at this point, even if we assume we can identify any, is beyond the scope of this editorial. Chaos theory suggests that even the smallest changes may have profound consequences. Rather than a butterfly raising storms through the flapping of its wings, your editor prefers the introduction of troponin testing and unfractionated heparin at the end of the 1990s as a possible trigger. Overnight, the need for the many patients presenting with chest pain and uncertain ECG changes to wait for three days for a creatine kinase measurement, while tied to an infusion of heparin and suffering 6–12 hourly venesection for APTT assessment, was gone. The time from admission to safe discharge for these patients fell from 3 days to 12 and latterly 6 hours – a large cardiology bed base thereby became redundant. It is not too fanciful to suggest that this eased the withdrawal of cardiologists from the general medical take, while parallel advances propelled them into the catheter lab. While this transition is the most extreme example, other specialities have moved in a similar direction. In many cases, the demands placed on those with what are increasingly

specialist skills has resulted in a reduced commitment to general internal medicine (GIM). The traditional general medical outpatient clinics ministering to patients with uncertain diagnoses, or complex care needs and multiple comorbidities are increasingly rare. Training programmes directed and administered by specialists and for specialist trainees have compounded the problem. Doctors at the very beginning of their careers no longer receive a broad practical education in GIM. General medical rotations in a single hospital, with doctors training in multiple medical disciplines, have been fractured into a variety of disconnected posts often in several hospitals and even based in the community. Whatever the multitude of causes, the ultimate consequence of changes over the last twenty years has been to shift the balance from fewer physicians providing general care to a larger number of specialist physicians providing specialist care. For many patients with illness which falls into a single speciality categorisation this is undoubtedly a benefit, leading to improved clinical outcomes. By contrast, for those with chronic or multiple illnesses, the benefits of a move away from generalism is less certain.

## The acute phase response

A welcome and arguably essential response to this movement has been the extremely rapid establishment of the new speciality of acute medicine. While there is no universal national model, such physicians are increasingly responsible for the care of patients admitted to hospitals with any acute illness. This has profound benefits for the acutely unwell, in that appropriate care can be instituted at an early stage with timely senior review and coordination of care. The speciality has prioritised guideline-based care, focused training resources on the identification and management of sicker patients and has been active in leading quality improvement. A focus on patient flow and the multidisciplinary discharge process, with the development of ambulatory care clinics have all allowed significant reductions in hospital length of stay for medical patients, enabling hospitals to better cope with increasing numbers of admissions. However, acute medicine has not replaced all the functions of the general physician. Acute medical care is often limited to the first 48 or 72 hours of a patient's stay. Those admitted for longer are often transferred on to specialist teams who may or may not be the most appropriate or enthusiastic receiving service. Further, patient discharge after initial treatment and correction of physiological disturbance may precede definitive diagnosis. While this may

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lead to shorter lengths of stay, in the absence of robust general outpatient clinic arrangements, general practitioners may be left struggling to cope with the investigation and management of complex medical patients in the community. While acute care has most definitely been improved, the weighting of services at the front door may have again contributed to the loss of focus regarding the more complex patient requiring longer hospital admissions.

### Who, how or what?

Any attempt to anticipate the findings of the *Shape of Training* review<sup>2</sup> seems a vain exercise given the wealth of evidence that will be considered in arriving at the final conclusions of that process. For now, who exactly provides general medical care in the future and how they balance their commitments with duties in a medical specialty seems less important than recognition by all of what patients need in 2016. This understanding should inform the training review but should also allow all of us responsible for providing general medical care, whether specialist or generalist, to think about how current services can be strengthened and supplemented so that all of the needs of medical patients are met.

### The future of the acute and general medical services

Those responsible for the development of acute models of care in the past decade should be applauded for the rapid and beneficial transformation of care for acutely unwell medical patients. Acute medical units (AMUs) have demonstrated significant benefits for both patient mortality and hospital length of stay (LOS).<sup>3</sup> Nevertheless, current services require augmentation. The integration of critical care services through co-location of AMU with higher dependency areas, and if possible staffed by physicians trained and working in both acute internal medicine (AIM)/GIM and intensive care medicine, would expedite appropriate management for the sickest medical patients to prevent organ injury, and thus need for escalation of care and transfer to ICU, producing gains in mortality, morbidity and LOS.<sup>4</sup> Similarly, incorporation of care for the elderly physicians, and in particular those with interest in the care of patients with frailty, should be an important next step in the evolution of the acute medical service.<sup>5</sup> First, the provision of a hot clinic referral service aimed at prevention of admission and consequent deconditioning is an obvious gain. Second, facilitation of an urgent supported discharge service coordinating multidisciplinary care with community services seems a key target, benefiting not just patients but overburdened admission services.

As important as the coordination of complimentary services with acute medicine is the development of robust referral pathways for the hospital transfer and follow up of medical patients. While those presenting with single-organ illness or who clearly meet the criteria for referral to elderly care are easily triaged to appropriate services, many others fall between two or more clinical stools. Imagine who might best provide continuing care for the diabetic patient with ischaemic heart disease and epilepsy admitted with aspiration pneumonia, pulmonary oedema and acute on chronic kidney injury

following a seizure; an exaggerated but perhaps not unlikely presentation. Step forward the generalist. As long as this role is recognised as essential to the functioning of both hospital and community services, whether such doctors should be recruited from the ranks of specialists or a separate speciality of GIM is largely irrelevant.

The potential benefits of promoting a dedicated general physician role include, but are not limited to, the following.

First, the benefit of coordination of inpatient care for medical patients with multiple comorbidities and complex care needs. This not only allows the appropriate early transfer of such patients, therefore unburdening acute services, but also promotes the timely recognition and management of change for these patients. All physicians caring for inpatients should be able and available to respond to physiological disturbance in their patients regardless of organ system. Too often delayed recognition or treatment of deterioration contribute to patient morbidity and extended length of stay. This model requires that senior clinical and managerial teams recognise the potential real benefits of this role, and prioritise time away from speciality clinic and intervention services for specialists working for the general team.

Second, the supervision and coordination of holistic medical care provision to medical and non-medical specialities. The general physician is surely best placed to ensure that all hospital patients receive the best treatment of medical comorbidity, irrespective of the service (surgery, gynaecology, mental health services) under which they have been admitted. This role incorporates the need for coordinated, hospital-wide standardised quality improvement. While it is inevitable that each speciality will tend to perform audit and quality improvement pertaining to their own service provision, the direction of similar improvement for all patients has to be the aim. Further, the general physician can be a champion for the delivery of value-based care for medical patients, both in hospital and in the community, allowing services to meet tightening budgets and avoid unnecessary costs.

Third, the decline of the general physician role has undoubtedly had an adverse impact on the medical education of junior doctors in training, and reduced the number of role models for those seeking to learn the practical skills required for the delivery of holistic care. Clinical decision-making entirely reliant on radiation cannot be good for patients and potentially introduces delay in diagnosis and management. General physicians also educate their colleagues-in-training in the synthesis of unifying and differential diagnoses, through the use of astute history taking and thorough clinical examination supplemented with investigative information. Only a broad experience of managing multiple-organ illness can refine judgement of the precise balance of comorbidity most likely to be contributing to the current disturbance of a patient's function, and therefore how to respond most appropriately and quickly.

Finally the report of the Future Hospital Commission<sup>1</sup> suggested the appointment of a hospital chief of medicine. All of the innovation described above would be strengthened by the implementation of a strong leadership role for general physicians; not necessarily dedicated to the evolution of strategy, thus avoiding overlap with the role of medical director,

but dedicated towards improving the coordination of medical service provision and integration with all other services.

These four benefits loosely describe the role of the hospitalist in the US but the absence of US-style community-based 'primary physicians' demands an extended community role for general physicians in the UK.<sup>6</sup> However, discharge management, follow up and integration of hospital care and that provided through community services are equally relevant. Currently patient care is often transferred back to general practitioners (GPs) prior to definitive diagnosis, with requests for further community investigations and subsequent re-referral depending on the outcomes of these tests. While this model is said to suit commissioners it can hardly be to the benefit of patients, potentially introducing unnecessary delay into the diagnostic pathway. General medical outpatient clinics, whether in hospital or the community, would allow early discharge with subsequent diagnosis and management for complex patients; therefore unburdening primary care services. These community-facing roles would also offer dedicated referral pathways and respite for GPs struggling to care for complex patients over longer periods. Again, integration with community services should be primarily aimed at providing best care for patients and also preventing hospital admission.

### Conclusions

None of the opinions expressed above should be interpreted as challenging to workforce planners, Royal Colleges or Joint

Speciality Committees; rather it is intended to hint at what has been lost and which gains might be had for all patients if the balance between speciality and general care is redressed. The development and prioritisation of roles for general physicians, either to replace specialists who are constrained by their other commitments or more likely to supplement those specialists who continue to provide general medical care, is long overdue. ■

### References

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