General and acute medicine in Australasian hospitals

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ABSTRACT

The complex undifferentiated patient, often elderly, is not obviously the responsibility of a clinician who specialises in single-system pathology. A clinician with more general skills and an ability to work in a multidisciplinary team is required. New partnerships are developing for these clinicians outside the Royal Australasian College of Physicians. A workforce expert in traditional skills for patient care as well as in new skills, away from the bedside, will help the future Australasian hospital care for these complicated patients. International perspectives could be of value.

KEYWORDS: Allied health, clinical leadership, holistic, interprofessional learning and multidisciplinary

The need for generalists

Clinicians based in Australasian hospitals are managing increasing numbers of patients with acute complex care needs. This rise in clinical demand is poorly met by a subspecialty medical workforce who may have ill-defined limits to their 'comfort zones' of care and a blinkered perspective to the problems of the hospital as a whole. A widely implemented solution to this mismatch is a complementary workforce of doctors with generalist skills suited to meet these needs. Within Australasia this workforce is increasing in numbers, which seems to reflect and result from subspecialties' focus on ambulatory care, performance of procedures and the provision of inpatient consultations in lieu of holistic patient care. The 'perioperative' physician now exists to support surgical specialties and this role goes well beyond the careful management of appropriate anaesthesia.

The undifferentiated complex medical patient

The Australasian system does not lend itself to generalisations about how the undifferentiated complex patient receives care at a public hospital. Decisions regarding disposition of care differ markedly from site to site and are not just based on the hospital's size and whether the hospital is based in the city or more remotely. Local forces define the general medicine services available at any site making it difficult to define a typical general medical patient. In the emergency department (ED), acutely unwell, complex, undifferentiated patients are seen by a junior then by a senior ED-trained and -based clinician. If a patient requires admission but does not require ongoing resuscitation or intensive care, he or she is then referred to a medical registrar; often with the diagnosis and onward streaming of the patient still undetermined. The criteria for admission of that patient to a general medicine service, rather than a specialty service, vary from site to site (and even within the one site from day to day) according to the relative strength and size of the general medicine service at that site and access within that hospital to specialty services. General medicine doctors not only have a wide comfort zone of patients for whom they offer inpatient care but they also recognise the need for a multidisciplinary approach to the patient (ie specialised nursing and allied health clinicians) with clear roles for each team member and shared values.

In many Australasian public hospitals, general medical patients are transferred from the ED to an acute medical unit (AMU) (or, more accurately, a medical assessment unit) where there is a focus on expedient investigation, precise diagnosis, consultation and a plan for discharge that usually commences at the time of the admission of the patient. The function of an AMU in a public hospital lacks consistency[1] despite collegiate guidance;[2] these units rarely take patients who are physiologically unstable.[1] General medicine services often have an inclusive policy of accepting most referred admissions, thus making them a popular referral pathway for ED clinicians. Such a policy often threatens the capacity and efficiency of the general medicine service due to high workloads and large variations in patient numbers on a daily basis.[3] The outpatient follow up of these patients after discharge is not always the responsibility of the inpatient general medical teams. Such follow up and any ongoing monitoring may rest with a variety of specialty services, the referring general practitioner or may not occur at all. In Australia, public hospitals are funded by the state governments while nursing homes, general practitioners and private specialty services are supported by the federal government. This disconnect in funding can cause issues for the provision of continuity of care for the patient following their discharge from hospital.[4]

Partnerships

Hospitals' general medicine services usually have links with intensive care medicine and with the ED; both of whom also accept and distribute undifferentiated patients. These links

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may be strengthening as are general medicine's links with allied health. Australasian intensive care units (ICUs) not only take patients requiring ventilation but also those unventilated patients requiring higher levels of care. To facilitate egress from the ICU, patients' care can be shared between the general medicine physician and the intensivist while the patient is in the ICU. Such a relationship, if imperfectly maintained, can mean the acute care skills of the general medicine physician dwindle with time. Similarly, without due feedback, support and education, the ability of the general wards to recognise and care for acuity of illness (as distinct from complexity) may diminish if all acutely unwell patients are quickly transferred to the ICU.

The general medicine workforce usually contributes significantly to undergraduate and postgraduate teaching in a public hospital and the specialty naturally attracts those with skills in, or an interest in, teaching. Other academic achievements, more common in subspecialties, such as acquisition of clinical research funding and publications, have, to date, been less a feature of general medicine practice. General medicine physicians often have a whole-of-hospital perspective which can be useful when implementing and maintaining any change of processes. Compared to subspecialties, general medicine clinicians are often overrepresented on hospital quality assurance committees and underrepresented on strategic ones. The links of general medicine with other medical subspecialties may be weakening despite identical basic physician training.

Any future for general medicine?

The future of general medicine in Australasia has received some attention.[5] The difficulty in defining the patient population best treated by this versatile specialty means that the potential for general medicine to be harnessed to solve hospital-wide problems, such as access block[6] or over-investigation of patients,[7] has not been fully appreciated. A significant annual turnover in hospital management, potentially unfamiliar with the local role for the general medicine physician, may explain a frequent focus on 'quick and local fixes' to problems without a long-term or hospital-wide perspective. General medicine can therefore be disadvantaged when resources are allocated by mechanisms other than according to inpatient needs and true workloads.

A recent increase in the numbers of general medicine physicians and the 'gap-filling' performed by these physicians is at least partly explained by reactive managerial strategies and the involvement of disaffected subspecialists and overseas trained physicians taking up unpopular appointments, especially in rural areas. Concerted, effective, system-wide efforts to bolster general medicine have not been obvious. At present, aspiring subspecialty trainees often apply for dual training in a specialty and in general medicine in order to safeguard their chances of a public hospital appointment. This dual training paradigm makes for some difficulty when anticipating the future supply of general medicine physicians to the public hospital system. Private practice remains, in Australia in particular, a lucrative retreat for consultants (even junior consultants) disillusioned by public hospital practice and processes.

Roles for the general medicine physician

Clear opportunities exist for this vital specialty to survive and prosper whether handling acute or chronic disease within or outside the hospital. Clinical leadership and leadership training, a greater emphasis upon teaching (including simulation and inter-professional learning) and the assembly of an evidence base for management of the complex, frail, acutely unwell, will lead general medicine out of its current lack of definition. The engagement of a thriving and curious student body, the education of hospital managers and inpatient subspecialties, the use of performance measures that reflect care quality not efficiency,[8] interdisciplinary cooperation and the fostering of skills in mentorship and self-care will all promote the morale of a workforce often viewed as second rate by other clinicians in the hospital.[5]

The specialty itself should direct its future but management processes can assist. The role for generalists in the provision of 24/7 care needs consideration and general medicine physicians could engage more with bed management, financial management and planning. Greater transparency regarding the allocation of resources to patients' needs will bolster general medicine or at least allow it to cope with its current responsibilities. Otherwise, increased admissions of ED patients to subspecialties will occur challenging skill sets and comfort zones. Allied health and nursing clinicians need more encouragement to have clinical career pathways that stimulate and encourage staff retention beyond the first five years of bedside clinical practice. Collegiate and governmental structures could be more assertive by streaming trainees into those specialties where staff are needed rather than a passive attitude allowing trainees to train in their specialty of preference. Funding structures could remove current incentives to the performance of procedures and other investigations, freeing up subspecialists to care for hospital inpatients.

International opportunities

Some health-related challenges, inherent to a large sparsely populated country such as Australia, are not readily shared with the UK. There are however some hospital-care problems (eg costs containment, hospital avoidance, communication with primary care before and after hospital admission) that are likely to have similar solutions in both the UK and Australasia. A disappointing observation is the paucity of international communication about the current and future hospital even if only to share failed strategies. Within Australia and New Zealand, national conversations are often held away from the engaged bedside clinician and, for example, shared assessment tools could greatly facilitate inter-site comparisons as well as optimise patient care. Health system modelling is one area where there has been some nascent international collaboration (http://cumberland-initiative.org/) but there is scope for more wide-ranging international discussion and action.

In summary, the strength of Australasian general medicine lies in its versatility. This specialty could be a valuable resource with which to tackle many of the issues facing the management of public hospitals now and in the future. It is therefore disappointing that many current general medicine clinicians consider themselves undervalued and underresourced. There are new unexploited roles for the Australasian general

medicine clinician that extend beyond the bedside and new partnerships that extend beyond the Royal Australasian College of Physicians. ■

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