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Why should we continue to do acute general takes?

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ABSTRACT

Specialist Physicians currently provide a substantive contribution towards acute medical takes in hospitals but there is debate as to the role of acute physicians in removing the need for this role. We discuss the benefits and advantages in continuing to provide this general internal medicine component to our patients and propose that it is an important part of most medical specialities. We argue that removing our participation will potentially diminish our overall skills as specialist physicians and advocate that we continue to provide this key component of medical care.

KEYWORDS: General, internal, medicine, acute, specialist

Background

The debate over acute medicine continues to generate arguments both for and against specialist physicians with acute internal medicine (AIM)/general internal medicine (GIM) accreditation contributing towards acute medical takes in hospitals. Although acute medicine as a specialty is now accepted, workforce considerations still mean that GIM care continues to be provided in a variety of settings in most hospitals by specialty physicians. The Royal College of Physicians (London) 2013–2014 census indicates 63% of all consultant physicians continue to participate in acute general medicine, but that satisfaction levels have decreased.[1]

In this setting, Winocour *et al*[2] have previously described the difficult issues raised within their subspecialty of diabetes and endocrinology. They outlined the multifactorial changes in delivery of care in the community, demands of the specialty, and also decreasing numbers of specialties participating in general takes that have caused difficulties for their own specialty, in terms of delivery of specialty care and also specialty training.

In this setting we put forward our viewpoint that withdrawing specialty physicians from the GIM takes and aiming to concentrate on having a specifically trained acute medicine consultant body may not be the ideal way forward as GIM is an important component of most specialities and indeed removing our ability to function in this way will diminish our skills as a whole.

In our experience true specialty medicine is increasingly being practised in the outpatient setting, with the majority of inpatient medical beds being occupied by patients with multiple comorbidities or significant frailty. The breathless inpatient rarely has pure respiratory disease but more often a combination of respiratory, cardiac and renal impairment on a background of advanced age. Realistically, four consultants are not going to be involved in these cases and the ability of one person to provide an overall, holistic approach will be key to patient experiences and outcomes.

Benefit to specialties

Specialty physicians with GIM experience are better placed to provide appropriate care when faced with a wide differential of diagnoses in the course of in- and outpatient-based work. The initial ability to differentiate and pick up multiple symptoms and signs in any setting (and beyond the 72 hours following admission) expedites triage and the initiation of investigations and treatment. Thus management and discharge are not absolutely dependent on specialist review which may be possible in the outpatient setting. In partnership with primary care, this can be utilised to augment the specialty consultation and integrate hospital and community care. The removal of the undifferentiated take from a specialist physician's experience will mean a reduction in this much needed skill. Our experience even in the setting of a post-take specialist respiratory ward means in reality we are utilising GIM skills regularly in the care of most patients who are increasingly frail and with multiple comorbidities. It is not practical or realistic to defer management decisions in each situation. Further, the involvement of a broad range of specialist physicians on the acute take also ensures effective ward triage processes, allowing not only improved continuity of ongoing general care but also, where necessary, appropriate in-hospital transfers.

Being part of the acute admission team means that the specialty physician also has an ongoing exposure to the very relevant situations faced 24 hours a day, 7 days a week by their junior doctors even within their own specialty. This has several benefits. First, governance and process of care challenges arising during the delivery of both the general and speciality care provided by trainee staff can be identified early and responded to effectively at a senior level. Second,

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trainees are able to receive education (while senior staff maintain validity) in the provision of the holistic general care of patients. This education is available not only at the front door. The maintenance of general medicine practice by specialist physicians allows the focus on holistic care to continue on the wards after 72 hours and even to discharge and beyond.

Finally, in addition to benefits to the specialty physicians, by retreating from general medicine we will be removing some of the potential opportunities in training for cross-specialty teaching that the majority of trainee registrars now have within the experience of acute takes, and additionally it is currently difficult to see how the general acute component of most hospitals would be able to be staffed without such juniors.

Improving the setting

Frith[3] has recently given insights into the real issues faced when participating in acute medicine takes and has made several useful suggestions. In our own experience, the main issue with a specialist physician on an acute take is generally not the acuity of the case but rather the ability to seek and obtain specialty advice, intensive care support or diagnostic tests in a timely manner. This is not to detract from the recognised benefits of having specific conditions immediately fast tracked to specific specialties in terms of outcomes. However, this alternative model has significant implications for specialist staffing which are unlikely to change significantly in the near future. In the setting of increased complexity, acuity and diminished beds, the duration and frequency of specialist and general commitments will need to be carefully balanced so that effective care in both roles and also work–life balance are maintained. Early and easy access to a well-staffed and diverse multidisciplinary team would also ameliorate the frustrations of being left with situations where patients with complex needs are unable to be appropriately managed because of non-medical related issues.

Summary

The continuing involvement of specialist physicians in AIM and GIM augments our ability to improve clinical care and the patient experience, particularly in specialties where a significant proportion of patients present acutely. Ideally each individual should choose whether or not to participate in this setting with appropriate balancing of the other components of their job plans and interests. We believe specialist physicians should, where possible, continue to participate in the general medicine service and be valued as an important component of delivering care in the acute setting. ■

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The views of the authors are personal.

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