Training the generals of the future

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ABSTRACT

The Future Hospital Commission acknowledges that the principal challenge for healthcare organisations and professionals is to accept the fundamental requirement that patients must be treated with compassion, kindness and respect while having their physical and emotional needs met at all times. The recognition that clinical outcomes alone are an insufficient guide to the adequacy of health service provision demands cultural, organisational and individual change. In the Future Hospital Forum we scan the world literature for papers on systems of care that might best ensure these principles are delivered, and to critically evaluate their potential impact. The theme in this edition is generalism.

Prospector is hard at work in the hospital of today. To acknowledge the broadening readership of *Future Hospital Journal, Aspirant*, a colleague in training, has been asked to review the recent published evidence and opinion regarding the future of general medicine.

> *Please note you cannot apply directly to general internal medicine (GIM) at ST3 level. Nearly all training in GIM will be done in parallel with another medical specialty. To gain access to ST3 training in GIM it is necessary to apply for one of these specialties.*
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> Joint Royal College of Physicians Training Board ST3 Recruitment Website[1]

When asked about her future career plans, *Aspirant* feels dismayed; coming to the end of core medical training, it is time to choose a 'specialty'. However, the desired specialty of general medicine does not exist, at least not in the guise of a structured training programme. The reason for this unexpected omission from the list of career pathways is somewhat unclear. There is undoubtedly an overwhelming need for general physicians; the Future Hospital Commission recommends the development of a hospital care model that meets the needs of patients, and it is well documented that the requirements of our patient population are changing.[2] We have an increasingly ageing and obese demographic who suffer from multiple, complex comorbidities. The majority of patients do not slot neatly into a 'specialty box', so a holistic complex care coordinator (cue the general physician) is needed. The Future Hospital Commission and Shape of Training have explored this patient–doctor mismatch, determined to find a balance between general medicine and speciality training.[2,3]

There is a shortfall in the 'medical take' as individual specialties opt out of general medicine, to focus on their substantial specialist responsibilities. The Shape of Training review attempts to answer this predicament with increased flexibility, by making training programmes 'broader within their specialty'.[3] This reflects the need for education and training to service the needs of the local population, however some specialists are concerned that this will leave their trainees underprepared for a specialist consultant post.[4] Speciality patients need effective specialty care to improve outcomes, so diluting this workforce may not be the best answer. The needs of the patient population should drive medical training and it is clear that both specialist and general medical care are needed. But do they need to come from the same pool of doctors? As the popularity of general medicine declines among specialists, is it time to attract a new set of trainees and make general medicine a speciality in its own right? Indeed, the Future Hospital Commission suggests that a more structured training programme in general internal medicine will be developed.[2]

If a training programme is to be created, then the question of how to nurture it must be asked. Do trainees want a career in general medicine?

Within the current system, any trainee who has a specific interest in caring for complex general medical patients cannot, at present, apply for a specialty training post in general internal medicine.[1] It is clear that speciality focus has shifted and reflecting this, training programmes have altered, meaning general physicians are no longer viewed as specialists. General medicine has therefore become an unattractive prospect, simply because it is undervalued. Trainees who do not want to specialise in a physiological system, but take a broader multisystemic and holistic approach, in reality, have to choose between geriatrics (limited by age) and acute medicine (limited by time).

The specialties of acute medicine and geriatrics are struggling to attract and keep their trainees. Could this be solved by introducing a general medicine training programme? A general medical training programme could lessen the impact of the time pressures of acute medicine and highly social slower-paced geriatrics on the trainee. If the general physician was seen as a figure of reliability and continuity, instead of a 'dumping ground', the trainees would be valued and general medicine would be an attractive training prospect. The role of medical registrar is feared by many, largely due to heavy responsibility at a relatively early stage and high workloads.[5] As always education is key and a dedicated training programme to hone the mix of skills required to deliver expert general clinical care would go some way to discharge this.

If the role of general physician is to be encouraged, then the question of what it will entail must be raised. What will their place be in our current healthcare system and where can we look for guidance?

The need for management of a large number of hospital inpatients has seen the emergence of 'hospitalism' in America. A young, but fast-growing specialty where physicians' primary focus is the care of inpatient adults, sometimes known as internists.[6] Mirroring the American hospitalist movement in the UK is the field of acute medicine. There are however, a few key differences; acute medicine is a specialty, almost universally limited to one ward and to only the first days of a patient's admission. Patients who do not fit into a 'specialty box' may be allocated a bed on a traditional specialist ward where their medical problems may be unrelated to their specialist team's expertise. This is not ideal for the patient or the doctor; in addition there is evidence to suggest that subspecialists working outside of their chosen specialty increases patient length of stay and may slightly increase mortality.[7]

Acute medicine has gone someway to addressing the immediate need for a generalist that many admitted patients have, but is there something to be learned from the American hospitalists? Would UK hospitals benefit from general physicians who are not limited to specific wards for a restricted number of days? The Future Hospital Commission envisions an 'acute care hub', managed by a 'clinical co-ordination centre' for acutely ill medical patients with predicted short stay.[2] Perhaps the 'physician of the week' might be the general physician? A person who can continue to care for patients once they are downstreamed to the ward, thus limiting handover and the well-documented pitfalls therein.[8] The role could evolve further than even the American hospitalists by offering complex care outpatient appointments, ensuring additional care continuity, less duplication and fewer patients 'lost to follow-up'. Currently patients are often discharged from acute medical or specialist wards back to the general practitioner, leaving them to chase and organise investigations that are not in their skill set and therefore should not be in their remit.

So the role of the general physician might be broad; a named consultant ultimately responsible for individual patient care. A doctor who could provide care for complex medical patients throughout their hospital stay; they could offer care continuity, be the specialist care coordinator and liaise with community services.

If the roles of different physicians were to evolve, then the question of whether other aspects in hospital organisation are due to change arises. Will the intrinsic hospital mechanism still remain the same?

Aspirant perused the Future Hospital Commission of the Royal College of Physicians with some attentiveness and found other themes that piqued her interest. Published in 2013 it begins to comment on seven-day working with the promise of 'high-quality care sustainable 24 hours a day, seven days a week'.[2]

The need for emergency and inpatient medical care at all times is self-evident; indeed it is obvious it is needed to uphold the good medical practice dictums that the patient must be the doctor's first concern and doctors must provide a good standard of practice and care.[9] The suggestion that patient mortality may be increased at weekends, the so-called 'weekend effect', is not a new one. For over a decade epidemiologists and researchers have been suggesting that patients admitted over the weekend are more likely to suffer.[10] It is plain that the prominent *British Medical Journal* article by Freemantle *et al*[11] has thrust the issue into the spotlight, but the original message has been altered and promoted by politicians for organisational and managerial purposes. The focus on junior doctor contracts has detracted from the stated aims, which should be to learn and determine the underlying reasons. The phenomenon is not limited to the UK; Ruiz *et al* demonstrated a similar issue in Australia, USA and Netherlands while Vest-Hansen *et al* has done the same in Denmark.[12,13] The mistake is in linking it synonymously with medical staffing without further evidence. In the USA, Attenello *et al* undertook a national analysis of 351 million patients and showed an increased number of 'never events' at the weekend, compared with a weekday.[14] As 'never events' almost always occur following a Swiss Cheese model of error, this illustrates that the mechanism is unlikely to be simply one of medical professionals. Indeed the occurrence is likely to be multisystemic, multidisciplinary and endemic in weekend support services and protocols. The fact there is no difference in outcome for patients discharged at the weekend may support this as discharge is largely a clinical decision.[15] Despite the current political minefield surrounding seven-day working, it is clear that future general physicians will provide a seven-day service (as most physicianly services already do); the need and practicality for elective outpatient clinics at these times is yet to be determined.

At the heart of evolving the role of general physician should be the drive to improve the quality of patient care and the safety of clinical practice. Whether it is analysing the needs of the population, creating a training programme, designing a hospital or improving services (weekday or weekend), evidence-based, non-sensational research and quality improvement must be the foundation. The role of improving hospital systems should be championed by all trainees, who have a unique perspective and invaluable opportunity to enact fundamental change.[16]

Call them what you will, hospitalists, internists, generalists or complex care physicians; there is an overwhelming need for well-trained general physicians; those with experience and expertise in managing patients with multi-system pathology and changing physiology. For these physicians to emerge and meet the needs of the patients and hospitals, a focused speciality training programme is warranted. Training programmes should aim to create consultants with skills to safely meet the needs of the patient population. Valued general physicians could offer safer cost-effective inpatient and outpatient care, freeing all specialists to concentrate on what they do best. ■

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