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Medical generalists and specialists: time for proportional representation?

Author: Paul F Jenkins[A]

The architecture of a healthcare service should be dictated by the needs of the population it serves and this tenet applies equally to both the bricks and mortar of the system and the skill-mix of the workforce that delivers it.

Most will agree that this statement is intuitively correct but does it reflect the paradigm of infrastructure and workforce of the NHS as it stands today?

A previous edition of *Future Hospital Journal* adopted 'integrated care' as its theme. Many believe that integrating services offers the greatest potential for salvaging our steadily failing NHS, and that this strategy will deliver the quality improvements, holistic patient management and coordination of health and social care that are the essential foundations of NHS recovery. The laudable battle cries of 'treatment close to home', 'care strategies that avoid hospital admission' (rather than defaulting to it) and 'parity for mental health service' all seem most likely to be realised by an espousal of the concepts of integrated care, but significant hurdles remain. The apparent lack of evidence for benefit and cost-effectiveness of most of the integrated care initiatives researched and tested to date is a significant concern. It is likely that a progressive move to individualised, rather than institutionalised, patient care will incur added costs. Moreover, the potential for quality improvement should not be stifled by the concomitant pursuit of cost savings. It is highly unlikely that any radical initiative will achieve both. A significant proportion of the additional cost incurred from pursuing care integration will stem from the requirement for workforce expansion. Put quite simply, integration of services will demand more of us (certainly in numbers and perhaps in commitment) and that will be expensive.

It isn't just about numbers though. A radical comparison between the current health professional workforce and that needed to support the proposed pattern of clinical responsibility (throughout primary, community and secondary care) is an urgent next step. This is most apparent when the optimal complement and ideal skill mix of senior NHS hospital medical staff is considered. An overwhelming clinical demand facing the NHS (and indeed the developed world) arises from patients presenting to hospital and primary care as 'emergencies' – many with complex medical disease and many more with a mix of clinical and non-clinical problems. This situation argues strongly for a significantly large cohort of general physicians who can provide the holistic management that is fundamental to caring for these patients. Further, within the traditional boundary of general medicine there exists a spectrum of clinical needs, each of which would be best served by one of a group of subspecialties. This spectrum ranges from management of the acutely ill and physiologically unstable at the hospital front door (acute medicine) to caring for frail elderly members of society who often present with a complex mix of medical, cognitive, mobility and social problems (medicine for older patients). Slap bang in the middle of this spectrum is a need for senior doctors trained to look after younger patients with complex disease and it is here that we see a serious hiatus in training. There are increasing numbers of younger patients with complex comorbidities who are all too often cared for in a manner that is far from holistic, and commonly fragmented between multiple hospital specialty teams. There is no conductor of their orchestra; overall patient supervision and communication is lacking and the disconnected situation that results is regularly compounded by inadequate and delayed sharing of clinical information with primary care colleagues. If we are to realise any holy grail of care integration, then these deficiencies have to be corrected. Specifically, we should take a long hard look at how we intend to educate physicians to care for patients with complex disease in the future, recognising that fundamental aspects of their training must include teaching leadership of multidisciplinary teams and the ability to work across the traditional boundaries of primary, secondary and community care. This cross-boundary working is pivotal to the ethos of integrated care and embraces far more than merely sending a secondary care consultant into the community to undertake two or three specialty clinics per week.

The spectrum of subspecialties that comprise general medicine necessitates training different cadres of physicians with the acquisition of varying emphases of clinical skills, knowledge base and competencies. For example, if a graduate wishes to follow a career in acute medicine then his or her training will have much in common with that of trainees in critical care medicine, while including relatively less experience in outpatient management. This emphasis will be reversed for

Author: [A]Winthrop professor of acute medicine (retired), University of Western Australia, Perth, Australia, and consultant physician (retired), Norfolk and Norwich University Hospital, Norwich, UK

those choosing to train as complex disease physicians and there will be additional and different training essentials for those intending to practise medicine for older patients. Underpinning this focused educational approach is the philosophy that the choice of a generalist career path is actually a choice of specialty, not a fast track to becoming a 'jack-of-all trades' with a probability of becoming a 'master of none'. There is no prestige and little professional fulfilment in the latter approach but, instead, huge potential for exploitation of generalists by the system.

What this vision for the future of general medicine describes is a mix of subspecialties each demanding clearly defined skill sets and competencies of its consultants and trainees and, immediately, we have a problem with terminology because there is nothing general about that vision. Instead we should change to an umbrella term (internal medicine will do) that can serve to emphasise the equal value and parity of prestige of the generalist subspecialties when compared with the established major medical specialties of cardiology, gastroenterology, neurology etc. In particular, any pejorative overtones of the epithet, general, and any suggestion of implied inferiority when compared with specialist medicine must be banished; not least if we are to solve the problem of recruitment into the internal medicine specialities.

And to complete the theme of terminology, surely the species of 'general physician with a special interest' should now be determinedly obsolete? The intensity and complexity of specialist medicine training is such that it can no longer be combined meaningfully with adequate training in internal medicine. Moreover, attempting to combine the two in an individual physician's job plan may be frankly damaging – generalist duties (especially responsibility for the acute medical intake) are seen by some, and perhaps many, specialists as a necessary evil that has to be endured while their priorities and major commitment lie with speciality clinical sessions. This observation is not intended to diminish the vital need for advancing ever stronger specialist services – quite the opposite; by arguing that specialists' work should not be diluted by a mandatory contribution to general medicine from those whose training (having followed a strict specialist direction) has been insufficiently comprehensive to allow it and from doctors who are not committed to providing it anyway.

At the moment, of course, we are experiencing real and increasing difficulties in attracting medical graduates into the internal medicine specialities – care of the elderly, general medicine and acute medicine are each suffering and have done so for a considerable time. Importantly, this applies equally, if not more so, to emergency medicine and a number of factors have contributed to the shared problem. If we are to reverse the trend, then let us consider what attributes might make a senior medical post attractive. Prestige is certainly one factor, professional fulfilment is another, and so is clearly defined, clinical responsibility. By this I mean a sense that one is contributing in a regulated manner; within boundaries, rather than being exploited as a default service for tasks that other clinical teams wish to eschew. Excessive, multifunctional demand is an arch enemy of ensuring the attractiveness of a generalist career path and must be eliminated. A classic example is at the hospital front door, where it is difficult, if not impossible, to manage a complex, frail, elderly patient while simultaneously attempting to correct the metabolic instabilities of a diabetic with diabetic ketoacidosis or the hypoxia and sepsis of someone with community-acquired pneumonia. The response to this dilemma, of course, is to increase collaborative working between differently and appropriately trained subsets of physicians in our emergency rooms along the lines already described – but, in order to do this, we have to train doctors in sufficient numbers in appropriate training programmes. Another essential factor in attracting recruitment is to ensure transparent equity of on-call responsibilities; if the clinical exigencies of a specialty demand more 'shop-floor' presence, then this has to be balanced by allowing sessional time away from the emergency room, negotiating appropriate remuneration for onerous duty, ensuring reliable specialist support etc. Some of us chose a career that inevitably combined uncertain hours with the pressure of dealing constantly with undifferentiated and unstable patients, and while the somewhat unstructured and unpredictable features of the resulting working week did not render the career paths unattractive *per se*, we should now consider mitigating them formally for trainees by matching the negatives on one side of the equation with positives on the other. Finally, underpinning all of this is an absolute requirement that each professional should feel that his or her contribution is valued equally by the system.

To summarise, the current (and foreseeable) spectrum of clinical demand for secondary care medicine makes it infinitely clear that we must train more generalists. To do this, in an environment where recruitment is difficult, we have to look at creative ways of making generalist career paths attractive. This means ensuring equal prestige, a clear perception of being equally valued, of not being asked to support an unsupportable variety of roles and of not being used as a default for unattractive tasks that specialist teams wish to avoid. Under the auspices of internal medicine resides a range of vital subspecialties – this needs clear endorsement, as well as a drive to ensure appropriately designed training programmes to support each. Terminology needs to change and not simply for semantics – semantics cease when connotations are associated with the terminology being used. There is nothing general about internal medicine. Its disciplines demand combinations of clinical acumen, intellectual capacity and practical ability that are the equal of any other medical specialty. The clinical challenges they encompass are fascinating, the professional satisfaction they deliver is huge and, with some effort, their career paths can be made both attractive and competitive. The internal medicine specialities must stop serving drinks behind the bar at the disco and, instead, be firmly invited to show their moves on the dance floor. ■

Address for correspondence: Prof PF Jenkins, The Manse, Stoke Ferry, Norfolk PE33 9SF, UK.
Email: pjenkinshealth@gmail.com