Conflicts of interest

The author has no conflicts of interest to declare.

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Editor – we read with great interest the opinion piece concerning consultant job planning for a 7-day service authored by Dr Matthew Lewis in last issue of *Future Hospital Journal*.[1] We were each previously medical directors, with a combined experience totalling some 25 years, and found the examples of how to plan for 7-day services both clear and compelling. Lewis' conclusion that 'effective job planning allows finite resources to be used to the greatest effect' is one with which we entirely concur. Managing the way our workforce is deployed to ensure their skills are applied to best effect will ensure we are able to offer high-quality care to our patients in the most efficient way. This fundamental principle underlies the implementation of a number of the 15 recommendations of Lord Carter's report into unwarranted variations in the performance of NHS acute trusts in England.[2] Evidence of such variability has emerged previously in the report of the British Orthopaedic Association authored by TB.[3] This 'getting it right first time' (GIRFT) philosophy has led to real improvements in surgical outcomes within elective orthopaedics services and, for the first time, a fall in litigation claims – an important surrogate for quality. The GIRFT programme has now been funded to expand to more than 30 specialties. Each has a national lead, usually a clinician of national or international stature, and access to data that will ensure we know 'what good looks like' in terms of both outcomes and service delivery. Clinically conceived, clinically led and delivered by clinicians, hospital visits are already underway, at which the GIRFT leads engage face to face with the consultants and other clinical staff responsible for delivering each service 'on the ground'. This ensures they adopt best practices as defined by royal colleges and specialist societies, which have without exception expressed their support for the programme. Matching job plans for medical and non-medical clinical staff (eg allied health professionals, pharmacists) and those providing diagnostic services will be crucial to ensure best practice can actually be adopted and thereby meet the (7-day) needs of patients, the demands of actually providing the service and to maximise the beneficial impact of the NHS' physical (eg operating theatres, imaging equipment) and human resources. ■

Conflicts of interest

The authors have no conflicts of interest to declare.

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Now, where are those matches at the end of this tunnel?

Editor – 20 years ago, pretty much to the day, Professor JR Bennett wrote 'will the last one out please turn off the lights in the emergency admissions ward'.[1] I fear Paul Jenkins' matches are far too little and much too late.[2] And, anyway, we are nowhere near the end of the tunnel.

Professor Bennett is the Cassandra of this tale. His editorial, 'The general physician – dinosaur or superman?', pretty much predicted all that has come to pass.

The catastrophe that is acute general medicine is a consequence of the syzygy of four separate, not altogether unconnected, events. I will describe the Norwich experience – Dr Jenkins hails from Norwich – although I know this has been replicated in teaching hospitals across England. It is worth pointing out that district general hospitals (DGHs) have weathered the storm far better as they do not have the luxury of multiple belligerent specialists to shoe-horn into creaking general internal medicine (GIM) rotas.

First came the closure of rehabilitation/convalescent hospitals. In Norwich, the canary in the coal mine was the sudden appearance of a flock of geriatric colleagues in the acute hospital offering to take over the care of elderly GIM patients. Slightly baffled, we specialist physicians seized the opportunity at face value. Only subsequently did we realise that the geriatricians had been rendered cageless as Norwich lost all of its community beds.

Secondly, the Royal College of Physicians promised a new specialty to deliver acute medicine. Acute medicine, as part of the Acute Care Common Stem, is a necessary service; just not in its current incarnation. The trust was persuaded that this new specialty would assume responsibility not only for acute admissions – the 'front door' – but ultimately for GIM in its entirety.

Thirdly, specialists seized the opportunity to make an unseemly dash to specialisation and super-specialisation. Professor Bennett has pointed out the Kafkaesque disincentive in which training for 'generalists' is a year longer than for 'specialists', the rewards for which are: a delay in achieving certificate of completion of training; being forced onto GIM rotas; having a reduced exposure to specialty patients; and to earn the public's opprobrium – despite having identical specialist training to the 'specialist'. Cardiology were first out of the blocks and were immediately followed by respiratory medicine. Gastroenterology's solution was to arrange regional rotations such that their specialty registrars did their GIM training in regional DGHs and their specialist gastroenterology training in Norwich; thus, the gastroenterologists were lost to GIM services in Norwich. The last doctors standing – nephrology and endocrinology – looked over our shoulders to find that everyone else had taken two steps back and we had been volunteered to manage the hippogriff. I advised at the time that this flight from GIM would mean running out of the doctors to deliver it within 10 years. We did.