The final straw has been the King's Fund proposal – inimical to the interests of acute hospitals – to combine the health and social care budgets. This combination has happened *de jure* in Greater Manchester but is happening *de facto* across the country as community services achieve the budgetary event horizon and completely collapse. Some years ago, I trawled the medical wards and advised this trust that there were at least four wards of medically fit 'patients' waiting for a discharge destination. These 150-plus 'patients' entirely explained – and explain – our perpetual bed occupancy of >100% (patients sitting out the night on the dialysis ward for example), our cancelled surgical lists, our accident and emergency breaches, our nursing and medical staff shortfall, and our financial predicament.

I am delighted that former poachers are looking to become gamekeepers. It is essential that they learn the lessons from history and they should start by reading Professor Bennett's editorial. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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1 Bennett JR. The general physician – dinosaur or superman? *J R Coll Physicians Lond* 1997;31:6–7.
2 Jenkins P. Now, where are those matches at the end of this tunnel? *Future Hospital Journal* 2017;4:5–6.

Response

Editor – the purpose of an editorial is to introduce and stimulate debate and the receipt of this letter is therefore welcome. The facts regarding Norwich are accurate to a degree although I have to emphasise that it was never part of the local plan that the development of acute medicine should include responsibility 'for GIM in its entirety'. This is germane to the comments that follow.

The four events detailed by the author of this letter (can the number four, rather than pairs, constitute a syzygy?) are reasonably accurate but I cannot agree that they are solely responsible for the current plight of acute medicine. My view is that acute medicine has failed to achieve its initial promise because of an unrealistic and progressive demand for it to be multi-functioning. In addition to the management of acutely unwell medical patients at the front door, there has been a progressive demand for responsibility (by default) for patients with multiple comorbidities and a mix of problems that, although urgent, are often far from acute and commonly not even medical.

Secondly, I cannot agree that Professor Bennett was the 'Cassandra of the tale' 20 years ago. A number of us took his prophecies very seriously at the time and, personally, they contributed to my view (previously stated in this journal and elsewhere) that a rebirth of generalism is not only vital but should also recognise the need for subspecialties within the traditional sphere of general internal medicine. This view posits that, in addition to the established training programmes in geriatric medicine, subspecialty distinctions should include chronic disease management as well as acute medicine with cadres of physicians trained accordingly and with different emphasis.

Finally, while retrospective analysis is important and we should, of course, learn from historical mistakes, destructive criticism alone will not solve the current problems of hospital medicine. In fact, a penchant for exclusive focus on historical mistakes and bemoaning our current plight, rather than finding ways for improvement, may be part of the reason for the existing parlous situation.

Positive contributions to the debate are welcome; delivering on the fundamental aim of the last and previous editions of the *Future Hospital Journal*. ■

Conflicts of interest

The author has no conflicts of interest to declare.

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