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The future of general medicine

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ABSTRACT

It is a truth universally acknowledged that there is a problem with general medicine. Physicians have become increasingly specialised over the past 30 years or so, and specialist care has produced increasingly better outcomes for some patients. The patients left behind are looked after by general medicine, where demand is increasing, operational priority within hospitals is low, there is little professional kudos and recruitment is suffering. Three recent reports – *Hospitals on the Edge?*, the Future Hospital Commission report, and the Shape of Training report – have described the problems, but not articulated compelling solutions. Here, I discuss what is good about general medicine, what is bad and make suggestions for improvement. These involve getting specialities to take responsibility for care of appropriate admissions automatically and without delay, giving general physicians control over the service that they provide, and using well-chosen financial drivers to support movement in the right direction.

KEYWORDS: General medicine, specialty, *Hospitals on the Edge?*, medical registrar, Future Hospital Commission, Greenaway report, Shape of Training

Introduction – the 'problem of general medicine'

Growing numbers of increasingly frail and older patients, with increasing complexity and intractability of both medical and social problems, are presenting to hospital emergency departments. Specialists of all sorts, medical and surgical, are producing increasingly better outcomes for patients with 'their diseases', and they are rightly being lauded (and sometimes commissioned) for doing so. They do not want to be involved in 'general medicine', pragmatically defined in many hospitals as caring for all nonelective admissions not positively claimed by any specialty. These patients are often the largest single group of nonelective admissions, yet they are typically accorded low organisational priority within hospitals, the lowest professional kudos is attached to caring for them, and physicians trying to do so can often feel that they are working hard in circumstances that do not help (and indeed often hinder) the provision of good care (at least that is how I feel about it). Given this, what sensible and able specialist would have anything to do with general medicine? Is it any wonder that the words 'general medicine' and 'problem' seem inextricably linked?

The response to the problem so far

If religion is the opium of the people, then reports are the equivalent for governments and colleges. Most notable in the context of general medicine are three: *Hospitals on the Edge?* (September 2012),[1] *Future hospital: Caring for medical patients* (September 2013)[2] and *Shape of Training* (October 2013).[3] *Hospitals on the Edge?* found that over 70% of the Royal College of Physicians (RCP) fellows and members thought that being a physician now was harder than it had ever been, and a survey by the RCP Medical Workforce Unit[4] found that 'many doctors…are being deterred from general medicine by the perceived unmanageable workload and poor work–life balance of the medical registrar'. *Future hospital* and *Shape of Training* both recognise the same situation, and their logic seems to run as follows:

- The problem: there are lots of patients with multiple and complex problems for which the 'specialist model' is not the most appropriate (and most specialists do not want to look after such patients). These patients are being looked after by general physicians, but the service that they provide is struggling to meet demand.
- The proposed solution: we need more 'generalists', at both registrar and consultant level, and (given financial constraints) the overall length of training must be shortened, which will have to be at the expense of specialist training.

I do not have any substantial objection to this statement of the problem, but I do think that the proposed responses in both the *Future Hospital Commission* and *Shape of Training* documents are naïve. I find it truly remarkable that *Shape of Training* feels able to sketch out a training plan for doctors, without any clear articulation of the medical workforce that is to be produced at the end of the day (how many generalists; how many specialists; what can a generalist do or not do?) Both proposals will fail to address the problems, and their adverse knock-on consequences for specialties would be tremendous. Although Henry V (according to Shakespeare) advocated '[closing] the wall up with our English dead', the problem of general medicine will not be solved simply by throwing more bodies at it, and I suspect that most of the bodies in Henry's wall would have preferred to be elsewhere if given a choice in the matter. Before considering what might be done to improve the situation, it is worth considering what is good about general medicine and what is bad. At the moment, the bad clearly outweighs the good, and general medicine will never prosper unless this balance is redressed.

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What is good about general medicine?

The main attractions are:

- Breadth of practice: in the hospital setting, no-one sees more variety than the general physician.
- Diagnostic challenge: related to the breadth of practice, general medicine provides greater diagnostic challenge than any single specialty. It is a greater test of clinical skill, requiring exercise of more difficult judgement, to make a diagnosis on the general medical take of the older woman who has had a 'funny turn', and to decide whether particular investigations are warranted, than it is to determine why the function of a renal transplant is deteriorating (what does the biopsy show?)
- Treating acute illness: many patients cared for under the umbrella of general medicine will present acutely, albeit frequently on a background of long-term conditions, providing opportunity for treatment of acute illness that is rewarding for both patients and doctors.
- Opportunities for teaching and training: the core of all clinical medicine is history taking, physical examination and making a differential diagnosis to inform investigative strategy and management. There is no better place to teach the fundamentals of this to medical students and junior doctors than general medicine, and no better person to do this than a good general physician.

What is bad about general medicine?

Many things determine whether a job is perceived as attractive. As things stand, general medicine scores poorly, as detailed below.

- Not being valued: specialists are rightly credited with making advances and improving outcomes for patients with some conditions; hence, the quality agenda is quite properly driving the care of such patients to (fewer, larger) specialist centres: the specialist is king. A consequence of this, largely unintended (but not by all parties), has been the perception that the generalist is second rate, and no one likes being thought of as second rate.
- Not being in control: people find working in posts where they feel that they have no control to be stressful, and they do not like doing so. Features that contribute to such lack of control with regard to general medicine[1] include: (i) relentlessly increasing workload because of increasing numbers of acute admissions, and increasing reluctance of specialists in many hospitals to take acute admissions, with general medicine being the default 'dumping ground'; (ii) relentless time pressure, most notably 4-h targets (overall, I think that these have been a good thing, although I lament the lack of ability to apply common sense appropriately); and (iii) low organisational priority for general medicine, manifest in many hospitals by safari ward rounds and lack of appropriately organised multidisciplinary support for teams of doctors doing general medicine.
- Being blamed: people do not like being blamed, particularly for things that are not their fault. Is there a general medical registrar in the country who does not recognise as a regular on-take occurrence the scenario where they are asked to see a patient in the emergency department, with the shrill declamation 'the clock is at 3 hours and 50 minutes', and it is implied (if not openly stated) that 'it will be entirely your fault if they breach'? Is there a general medical consultant in the land who has not heard some frustrated surgical colleague express the view that one or more patients has been cancelled from his/her operating list because 'general medical patients are in their beds', sometimes (but not usually within earshot of physicians) followed by musings of the sort 'what are these physicians doing?' (unstated answer – 'nothing much').
- Having to deal with intractable problems: when everything else has failed, patients arrive in the emergency departments of acute hospitals and are admitted. A straw has broken the camel's back, but even if the straw is removed, the camel cannot get up and walk. These patients will typically be admitted under geriatric or general medicine services, which thereby acquire the most difficult discharge problems. Managing complex discharges is a core activity of geriatric teams and they are typically structured to try to facilitate this. Consultants in general medicine are not so good as consultant geriatricians in this area, and they and their teams rarely have access to the same level of multidisciplinary support: they are set up to fail. The relation between general medicine and geriatric medicine (and also acute medicine) is an interesting issue that needs to be explored, but is not within the scope of this article.

Suggestions for improvement that will not work

Future hospital: Caring for medical patients[2] recommends that 'participation in [general] internal medicine will be mandatory for those training in all medical specialties' (p 82). For consultant staff (p 36, para 3.40), it is stated that they 'will rotate through various areas of the Medical Division ... this could translate as all consultants, and specialists, spending 25% or more of their annualised job plan in undertaking clinical duties with ongoing responsibility for patient care and general medical patients'. Although there is no doubt that most of those who have successfully completed core medical training could pursue training in general medicine, it is absurd to suggest that consultants who have been entirely involved in specialist practice for many years could usefully 'rotate' into other areas of work, such as general medical duties. Whereas coal-face general physicians might be forgiven, on occasion, for thinking that a decent dose of general medicine might do some of their more arrogant specialist colleagues good, after a moment's reflection they would certainly recognise that this would not be beneficial for patients. Good general medicine cannot be provided by those who have not done it for many years and do not want to do it; in addition, specialist services would suffer if specialists were absent.

Suggestions for improvement that might work

There is no quick fix to the problems of general medicine. Solutions will need to recognise the complexity of issues and depend on a mixture of cultural, organisational and operational changes. Given the analysis of what is bad about general medicine, I think that the direction of travel must be to give general physicians increasing control over the service that they

provide. Doing this will drive quality, efficiency and morale in the right direction. However, what could be done in practice? There is no 'one size fits all' answer: hospitals vary enormously; the teaching hospital with its tertiary specialist work and vital research and educational agendas is not the same as a small district general hospital, and neither are the physicians who work there. Depending on the hospital, some or all of the following should be considered, but none will be sufficient on its own.

- Greater specialist involvement in the general medical take: not all patients arriving in the emergency department need to be seen by an organ-based specialist. However, those patients who the team based in the emergency department (be they led by an acute physician, a physician doing the general medical take, or an emergency physician) think need to be admitted, and think would best be admitted under the care of a speciality team, should be admitted directly under the care of that specialty team if they arrive during 'daylight hours', or be handed over to them the first thing next morning. Poor care is not good for patients, and knowing that you are providing poor care is dispiriting for general physicians. There are many examples: the best care of a patient admitted with headache, or increased frequency of fits, or deterioration of Parkinson's disease, can be provided by the neurological team; the rheumatology team is best for the patient admitted with exacerbation of long-standing back pain; the oncology team should deal with the patient newly presenting with clinically obvious cancer (in the rare circumstance that the diagnosis proves to be something else, the patient can be referred onwards appropriately). One predictable and fair response of the specialists to this will be to say 'give us the extra staff, time, money, etc', or 'tell us what you want us to stop doing, etc'. However, it is reasonable to point out that we have got to a situation where general medicine has been 'dumped on' and forced to take on increasing amounts work without the extra staff, time, money, and so on, and this is about trying to turn things around to provide better care for all patients (not just 'specialty patients') and relieve pressure in a part of the service that is really struggling.
- Give general medicine good organisational and operational support: to run a high-quality service for patients admitted on the general medical take requires appropriate ward placement of these patients (no more safari ward rounds) and appropriate multidisciplinary teams, including colleagues with physiotherapy, occupational therapy, discharge planning and/or community liaison expertise, that are organised congruent with medical teams and report to the physician in charge and not in one or more parallel management structures.
- Use financial drivers to support general medicine: most physicians do not like financial drivers, but whether we like it or not, they do have an effect and, if they are not aligned with what we would like to achieve for general medicine, then I would not be optimistic about our chances of improving matters. Something to consider: the best practice tariff for stroke care requires that the patient be admitted directly to and spend most of their stay in an acute stroke unit, that they have brain imaging done in a timely manner, and that they receive alteplase if clinically indicated according to National Institute for Health and Care Excellence technology appraisal guidance.[5] This rewards good process on the basis that it will lead to better outcomes and, if a stroke patient receives care in the proscribed manner, then in this financial year the trust will get £1,425 more for their admission than if they do not. How about best practice tariffs for patients admitted with other conditions that would best be looked after by specialty teams? How about using this sort of driver to discourage the placement of medical outliers on surgical wards? What if there was financial incentive to have multidisciplinary teams reporting directly to the physician in charge? I do not wish to advocate a blizzard of new targets or best practice tariffs, but I do think that a few well-chosen ones could usefully encourage appropriate specialty involvement and lead senior hospital management to consider seriously how it should support general medicine. I think that this would be of benefit to many patients. It would also improve the lot of physicians currently staggering under the heavy burden of the general medical take, and enable them to begin to enjoy the good things about general medicine again. ■

Acknowledgement

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