Acute & General Medicine

Chair:  Dr Alistair Douglas
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Welcome to Bristol
The Future of Generalism

Dr Frank Joseph
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Fig. 1. The vicious circles in the acute medical specialties.
Inpatient care: should the general physician now take charge?

Varo Kirthi, R Mark Temple and Linda J Patterson

ABSTRACT – In an ageing population, patients are living longer with one or more chronic disease, and with acute illnesses increasingly extending outside the boundaries of a single medical specialty. Therefore, is it time for the general physician to take charge?

KEY WORDS: generalism, secondary care, general physician, older people

Introduction

The National Health Service (NHS) is under unprecedented pressure to meet an ever-increasing demand for healthcare. An important influence is the ageing population, with individuals now living longer with one or more chronic condition. The rising burden of chronic disease means that patients presenting to hospital with an acute illness increasingly have needs that fall beyond the remit of a single system specialty. Despite this, postgraduate medical training, with its focus on specialism, has remained largely unchanged. One notable exception has been

Evolving requirements for inpatient care

Since the inception of the NHS in 1948, life expectancy has increased by 18% to 78.4 years for males and by 16.7% to 82.4 years for females. An estimated 15 million people in England now have a long-term condition, accounting for 64% of all outpatient appointments and 77% of all hospital admissions. Approximately half of those aged over 60 have a chronic illness and this will increase over the next 20 years, with the population of those aged over 85 set to double.

Meanwhile, the provision of acute-care services continues to be tested by a relentless increase in the number of attendances in emergency departments and unscheduled hospital admissions. Despite the restructuring of urgent care services and alternatives to admission, emergency attendances in England increased by 46% between 2003–2004 and 2009–2010, and emergency admissions by 11.8% in the four years to 2008–2009.

One of the most striking changes is that the acute medical take has increasingly become a service for older patients. This patient cohort accounts for a growing proportion of NHS hospital beds and is responsible for a substantial proportion of medical intensive care unit (ICU) admissions.
Impact of specialist care on clinical outcomes for medical emergencies

Stuart Moore, Islay Gemmell, Solomon Almond, Iain Buchan, Isameldin Osman, Andrew Glover, Peter Williams, Nadine Carroll and Jonathan Rhodes

ABSTRACT – General hospitals have commonly involved a wide range of medical specialists in the care of unselected medical emergency admissions. In 1999, the Royal Liverpool University Hospital, a 915-bed hospital with a busy emergency service, changed its system of care for medical emergencies to allow early placement of admitted patients under the care of the most appropriate specialist team, with interim care provided by specialist acute physicians on an acute medicine unit – a system we have termed 'specialty triage'. Here we describe a retrospective study in which all 133,509 emergency medical admissions from February 1995 to January 2003 were analysed by time-series analysis with correction for the underlying downward trend from 1995 to 2003. This showed that the implementation of specialty triage in May 1999 was associated with a subsequent additional reduction in the mortality of the under-65 age group by 0.64% (95% CI 0.11 to 1.17%; P=0.021) from the 2.4% mortality rate prior to specialty triage, equivalent to approximately 51 fewer deaths per year. No significant effect was seen for those over 65 or all age groups together when corrected for the underlying trend. Length of stay and readmission rates showed a consistent downward trend that was not significantly affected by specialty triage. The data suggest that appropriate specialist management improves outcomes for medical emergencies, particularly amongst younger patients.
An adequate workforce is key. We must make sure that careers in general medicine and the specialties are as attractive for women as they are for men. The female intake into medical schools in the UK peaked 2 years ago at 61%, this year it is falling but we now are seeing the consequences of the gender shift. There is a rhyme “Jack of all trades, master of none”. Importantly, in this day and age, it needs to include “Jill of all trades” as well. There is a less well known second line to this rhyme: “Jack of all trades, master of none, is certainly better than master of one.” Clearly, recognition of the limitations of pure specialist practice.
About the specialty:

Many consultant physicians practice general internal medicine in addition to their medical specialty, and many patients are cared for under the umbrella of general internal medicine. These include the full range of adults admitted as emergencies with acute medical problems, ranging from the young fit person with a severe acute illness, to the frail elderly with multiple disorders. Patients with problems that are not clearly within the remit of a particular medical specialty are referred to outpatient clinics for the opinion of a general physician.

Nearly all trainees following the GIM curriculum to CCT will be doing so in parallel with training in another medical specialty. The GIM curriculum defines the competencies needed for the award of a CCT in general internal medicine, which are needed to allow participation at a senior level on the acute medical take, and to provide advice on the investigation and management of inpatients and outpatients with acute and chronic medical problems.

The curriculum reflects the contexts in which GIM is performed, from the admission avoidance clinic to the admitting unit to the inpatient wards and the outpatient clinics. It emphasises the skills and competencies that need to be acquired in these settings and indicates how these will be assessed as trainees progress through the syllabus.

Entry into general internal medicine training is possible following successful completion of both a Foundation Programme and a core training programme. There are two core training programmes in general internal medicine:

- Core Medical Training (CMT)
- Acute Care Common Stem - Acute Medicine (ACCS-AM)
Acute internal medicine and general internal medicine

Dr Rhid Dowdle OBE MB BChir FRCP FEFIM FSAM Consultant physician and cardiologist

1 Description of the specialty

I have heard the fear expressed that in this country the sphere of the physician proper is becoming more and more restricted, and perhaps this is true; but I maintain . . . that the opportunities are still great, that the harvest truly is plenteous, and the labourers scarcely sufficient to meet this demand.

Sir William Osler, 1897

General interna...
Do we need more generalists in our hospitals?

Anna Dixon  
Former Director of Policy

12 October 2011  
2 comments

Related tags:
Integrated care
Quality of care

Medicine is becoming increasingly specialised: there are now almost 30 sub-specialities within the Royal College of Physicians alone. This is partly in response to the exponential rate at which scientific knowledge is produced – it is simply not possible to stay on top of the latest developments beyond a limited scope of practice.
Greater standardisation and new knowledge management tools could change this in future, but for now there are benefits to specialising. Once you have a diagnosis you are probably better off seeing someone who has expert knowledge and up-to-date skills in treating your condition. But is ever-increasing specialisation in the best interests of patients?

I was part of a commission on the state of medical generalism, set up by the Royal College of General Practitioners and the Health Foundation, that considered just such questions. Its report, *Guiding patients through complexity: Modern medical generalism*, was published last week. The Commission sets out one of the key principles of generalism as 'seeing the person as a whole and in the context of their family and wider social environment'. While patient-centred care is a feature of all good medical care, the particular value of a generalist is the ability to provide holistic care. Generalists have an important role in helping to co-ordinate input from a range of professionals and to ensure that patients' wider needs are met.

Increasingly, patients within hospitals have multiple conditions that need the care of several specialists. The loss of generalists in hospitals means that patients often find themselves being shuttled from one specialist to the next, with no one taking overall responsibility for their care. There is also a real risk that important aspects of patients' care are neglected – for example their mental health needs or basic requirements such as diet, hydration and urinary function. These aspects of care are vital to patients' recovery and mobility while in hospital, and to a timely discharge.

So do we need to bring back general physicians in hospitals? I would suggest that rather than bringing back the old model of general medicine we need to reinvent generalism in a hospital setting.
The Commission was interested in the role of 'hospitalists' in the US who actively manage patients while in hospital. Studies have shown that hospitalists reduce the length and average cost of a hospital stay, but do they also improve outcomes for patients? While a senior nurse could take on a role similar to a case manager or care co-ordinator within the hospital, extending the role of the general practitioner to follow their patients into hospital would be a more radical approach. This would only be possible with a radical rethink of the role of GPs and the skill mix of the primary care team.

However, generalism is not just something delivered by an individual. Given the growing complexity of some patients' needs it might be more appropriate to develop multi-disciplinary teams, similar to virtual wards in the community but within the walls of hospitals, who case manage complex patients holistically during and immediately after discharge. These different models need to be tested and evaluated. Patients need support and care from specialists and generalists regardless of where they are being cared for. We need to find ways of integrating specialist and generalist care so patients benefit from excellent clinical outcomes and holistic care.

This blog was also published on the British Medical Journal website
I would be interested to know what proportion of patient with multiple conditions fall into the older age groups. I suspect that the generalists you propose are already here in the form of our Elderly Care colleagues. They do a superb job at seeing the bigger picture and actively managing the multiple conditions with which so many patients present. We should be growing their numbers and not re-inventing the general physician.

In order to maximise specialist productivity we should be looking to quickly remove patients from the specialists beds once the main condition has been treated. An example may be a 90 year old with multiple falls and heart block. Once the pacemaker is implanted there is a need for rapid rehabilitation and optimisation of other conditions. Cardiologists are not usually good at this. Such patients are often suitable for some form of intermediate care but tend to languish in acute beds whilst awaiting community services.

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Certainly a more coordinated approach from the hospital specialists is needed to deliver the care pathway and support a single care plan approach that the patient understands and can follow and on discharge can be practically translated by community and primary care specialist and generalist teams. The key concern I have is where consultants of Old Age as generalists (Geriatricians to use an outdated term) do not refer people with complex needs to specialists and put everything down to 'old age' where more explicit discussions around their options, diagnosis and future choices of care are not had. I know I am commenting generally as this is not the case in all acute hospitals, but does hinder advanced case management and choices that people may make. As with everything it is about the need to join up expertise and knowledge, around the patient rather than sending the patient here, there and everywhere. In the community, generalist district nurses and Matrons carry out this key worker function, ensuring the people and expertise is available to deliver the care plan in a timely and patient centred way and this principle, however it is delivered, is a good model for hospitals as well.
Renaissance of hospital generalists

Hospital medicine in the US and acute medicine in the UK are the fastest growing specialties in their countries. Robert M Wachter and Derek Bell examine the factors behind their rise and how the differing national healthcare systems have influenced their structure.

Robert M Wachter professor of medicine and chief¹, Derek Bell chair in acute medicine²

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Cross learning

Hospital generalists in both the UK and US have cause to look wishfully at their colleagues across the Atlantic. For a US hospitalist looking at acute medicine, the localisation of the acute medicine unit is enviable (hospitalists often care for patients scattered around the hospital), and the requirement for an additional skill and participation in specialised ambulatory clinics may add value and prevent burnout. For a British acute physician, the greater size and scope of the hospitalist’s domain seem attractive, as does the avoidance of a mandatory handover to a subspecialty ward after an arbitrary period.

It seems inevitable that hospital medicine and acute medicine will continue to grow and evolve. While recognising that they will always be shaped by local forces, we also believe that they should learn from each other’s experience. Cross-Atlantic dialogue will increase the chances that each system meets its goals.
Impact- Front of House

- ED + AMU + Acute Frailty
- Dec 2014 – 80% of all attendances discharged within 72 hours
- 60-70% of all admissions discharged within 72 hours
- >72 hours – mixture of specialty need, level of acuity, community and social care delay (cumulative increase)
Terminology, geography, resource

- Medically optimised
- DTOCs
Terminology, geography, resource

• Transitional beds
• Rapid response/Early supported discharge
• Integrated Team
• H@H
• Community Geri
Press release

Personalised GP care will bring back old-fashioned family doctors

From: Department of Health
First published: 15 November 2013
Part of: National Health Service

New GP contract for 2014/15 agreed.

Giving millions of elderly people a dedicated GP personally accountable for their care around the clock will bring back the era of the old-fashioned family doctor, Health Secretary Jeremy Hunt announced today.
Personalised care

GPs will oversee personalised care plans integrating all services, so the frail and elderly are better cared for in the community, reducing hospital admissions.

Out of five million emergency admissions last year, one third were people over 75, and more than one million could have been avoided.

GPs’ new responsibilities will include:

- offering patients same-day telephone consultations;
- offering paramedics, A&E doctors and care homes a dedicated telephone line so they can advise on treatment;
- coordinating care for elderly patients discharged from A&E;
- regularly reviewing emergency admissions from care homes to avoid unnecessary call-outs in future; and
- monitoring and reporting on the quality of out-of-hours care.

It is hoped this service will eventually be offered to millions more vulnerable people with long-term conditions that need more support.
Future Hospital development sites: supporting effective admissions

• Major theme for the programme is supporting effective care for frail elderly through early intervention and care planning.

• FH development sites:
  Worthing - new Emergency Care Hub which triages patients through appropriate pathways
  Mid Yorkshire – introduction of an older persons assessment unit on the acute care hub
Little need for more generalism

15 February 2013

Evidence gathered for a review into medical training has been undermined by a lack of clarity surrounding the concept of ‘generalism’, the BMA has stated.

The association stresses this point in its response to the independent Shape of Training review, which is examining what postgraduate medical training should look like over the next 30 years.

The review is considering the balance between specialism and generalism in medical training, but the BMA says the review has not clearly defined the term ‘generalist’.

The association says: ‘The BMA believes that the continuation of specialties such as general medicine, general surgery, paediatrics and geriatrics means there is no need to introduce a new “generalist” service delivery post or specialty to meet the needs of patients in the future. Instead, all doctors should acquire more general skills.’

However, if such a specialty is established, then it should be part of an approved training programme that ultimately leads to a consultant or GP role.

The foundation programme already provides general training, the BMA adds.
Already in place

In its own response to the review, the GMC agrees the term 'generalism' already exists across a number of care settings and specialties, such as medicine and surgery, and says the review's terminology needs to be clearer. It says the need for more 'generalist medical expertise' is likely to increase.

The BMA also highlights the importance of ensuring every doctor has the opportunity to obtain a CCT (certificate of completion of training) via a GMC-approved specialty training programme.

Workforce numbers and posts should be aligned at every point of training, the BMA says, adding that a system of transferable competencies could enable greater flexibility and address some workforce issues. There should also be more flexibility to engage in clinical academic training via academic health science networks.

'Every doctor undertaking an approved specialty training programme should have the opportunity to gain a CCT. They should not be forced out of a training system due to a lack of capacity and planning,' the BMA says.

If training is made more general, a CCT — and its equivalents — should remain the only requirement to become a consultant or GP, the association says.

Post CCT-fellowships should be the 'exception rather than the norm' for some consultant posts and only to acquire super-specialist skills, not those that should be obtained via specialist training, according to the BMA. It also highlights the need to have more clinical academics working in the community to develop the research base for primary care further.
How can the next government support acute and emergency care?

1. Remove the financial and structural barriers to joined-up care for patients
2. Invest now to deliver good care in the future
3. Prioritise what works in the NHS and improve what doesn’t
4. Promote public health through evidence-based legislation
5. Adopt the Future Hospital model as a template for service redesign
Developing the Generalist Workforce

Dr Andrew Goddard
Registrar
Royal College of Physicians
What do we know about the demand?
How old are NHS in-patients?

![Graph showing age distribution of NHS in-patients from 2004 to 2012. The graph includes categories for 85+, 75-84, 65-74, and <65 years old.]

Royal College of Physicians
More GPs?  
More Community Physicians?

More Acute Physicians?  
More Generalists?  
More Specialists?  
More Geriatricians?

Securing the future of excellent patient care

Final report of the independent review
Led by Professor David Greenaway
Do you do internal medicine?

- Respiratory
- Renal medicine
- Neurology
- Geriatric medicine
- Gastroenterology
- Endocrine & diabetes
- Dermatology
- Cardiology
- Acute Medicine

- No
- Yes
What form does internal medicine take?

- Care of in-patients admitted under specialty but with ongoing general medical needs
- Care of in-patients admitted for reason not specific to specialty
- Contributing under remit of primary specialty
- Consultant on-call for unselected take
- Working as acute physician on MAU

[Bar chart showing distribution of roles with Acute Medicine in blue and Other specialties in red]
What do we know about the supply?
Changing demographics

- 27% of all consultant physicians are female
- 50% of consultant physicians under 40 are female
- 40% of female consultant physicians work LTWT compared with 4% of male consultant physicians
- The proportion of consultant physicians working LTWT has increased by 50% in the past 5 years (12% to 18%)
Where are you considering obtaining a consultant post?

- Your current Deanery
- The adjacent Deanery
- Any Deanery

Female

Male
Would you like a less than full-time post?

Female: 30% No, 50% Possibly, 20% Yes
Male: 50% No, 40% Possibly, 10% Yes
Would you consider taking up a sub-consultant or junior consultant grade as a career option?
External drivers
Training intentions

- No more hospital trainees
- More GP trainees
- Overall 20% cut in training funding
- It takes 12 years to grow a consultant
SEBASTIAN FAULKS

BIRDSONG

‘Magnificent – deeply moving’
Sunday Times

WITH A NEW INTRODUCTION
BY THE AUTHOR
Solutions

• Physicians to agree model of future delivery and ‘sell’ this to policy makers
• Build on commonality
• Develop a workforce that is flexible and sustainable
• Develop and other professional groups
• Understand what makes medicine attractive and ensure physicians are valued
Sustaining the Front Door –
The Role of the Acute Physician

Dr Hannah Skene
London
What is an Acute Physician?

- AIM trained physicians
- GIM/Other trained physicians who now work only in acute medicine
- GIM/Other trained physicians who spend regular time working in acute medicine
- GIM/Other trained physicians who do the take only
  - Operational, leadership, governance role to the AMU
  - All have their role in sustaining the front door
“Sustain”

- Strengthen or support physically or mentally (2,3)
- Bear without breaking or falling (3)
- Undergo or suffer something unpleasant (2,3)
- To continue for an extended period without interruption (1)
- To supply with necessities of life (1)
- Uphold, affirm the justice or validity of (2,3)

Reference:
1. Dictionary.com
2. Google.com
3. Oxforddictionaries.com
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What have APs allowed us to do locally to sustain the front door?

- 2 consultants on AMU (take/post take)
- Enhanced Care consultant provision
- Ambulatory care – OPAT, hot clinics (new & f/up), virtual ward
- GP email and phone advice service
- Better surgical liaison
- Reach those acute care targets
- Continuity to unit
- Morale / Relationships – nursing, AHP, ED, GP, ICU, other specialties
- Drive QIP on AMU – use data, try something new each week
- Training
Weekly Admissions to AAU

Number of admissions

07/04/2013
17/05/2013
26/06/2013
05/08/2013
14/09/2013
24/10/2013
03/12/2013
12/01/2014
21/02/2014
02/04/2014
21/05/2014
21/06/2014
31/07/2014
09/09/2014
19/10/2014
28/11/2014
07/01/2015
16/02/2015
28/03/2015

Week Ending

0
20
40
60
80
100
120
140
160
180

Number of admissions

0
20
40
60
80
100
120
140
160
180

Medicine
Surgery
SPC: 12hr Consultant Review

% of patients seen by consultant within 12 hours

Week ending


% 12 Hour consultant assessment - AAU Admission
Average
Lower Natural Process Limit
Upper Natural Process Limit
Target
12hr % Consultant by Consultant
Should APs sustain the front door?

Yes.....

• We’re good at it
• We enjoy it
• Experts in flow
• Provide leadership to AMUs and acute MDT
• Let other specialists do their specialist things
• Acute care standards
• Develop strong relationships
• Inspire and support the next generation

But.....
All physicians have their role in sustaining the front door

• Front door is just part of the system
• Good flow is dependent on the whole system working
• Not enough APs in post to sustain AMUs on our own yet - 350 trainees in UK currently
• So thank you to those of you who work with us and help to keep it going
Maintaining the Downstream Flow: Is there a role for an Acute Generalist? Experience from Southampton

Dr Ben Chadwick
Acute Medicine Consultant, Southampton
Outline

• What we were providing
• Reasons for expansion
• Why general medical firm?
• A different model of working
• Some data
• Reflections
What we were providing in Southampton

- 08:00 to 22:00 cover on AMU from Mon-Fri
- Two shifts per day – 08:00 to 16:00 and 15:00 to 22:00
- 8 hours on site AMU per day at weekend
- With 5 consultants with 5.5 PAs of Acute Medicine in their job plans
- Total of 27.5 PAs for Acute Medicine
Why expand?

• 7 day working – needed to provide more hours at the weekend, to increase to 12 hours per day

• Our vulnerability on the on call rota, shared between 5 AMU consultants and initially 7 other generalists, but this pool declining.

• Needing to provide more cover during the week on AMU – gradually increasing demand
Why take on general medicine?

• Relates to the trust as a whole
• Big teaching hospital
• Increasing subspecialisation of specialists
• Reluctance to take on general medicine
• Increased LOS of patients
• Offered us a way to expand our numbers by taking on this work
How did we do it?

• If we had created another “traditional firm” we would only dilute junior doctor presence
• Hence opted for team with no junior doctors
• 1 AMU consultant – 4 week rotation
• 1 band 6 nurse (full time)
• 1 band 7 pharmacist (4 hours per day)
• 1 medical assistant (6 hours per day)
• Limited to maximum of 15 inpatients
How much did it cost?

- Our firm
  - 1 consultant – 7.5 PAs
    • £67,697
  - 1 band 6 nurse
    • £30,057
  - 1 band 7 pharmacist (50%)
    • £17,945
  - 1 band 3 medical assistant (75%)
    • £13,479
  - Total £129,178

- Traditional model
  - 1 consultant – 3 PAs
    • £27,079
  - 1 StR
    • £37,822
  - 1 CMT
    • £33,584
  - 1 FY1
    • £24,049
  - Total £122,534
Did it work? 4 months of data

- Our firm
  - Total number of patients = 134
  - Mean length of stay = 9.3 days
  - Median = 4.6
  - Average number of patients per day = 10

- “Traditional” GIM firm
  - Total number of patients = 139
  - Mean length of stay = 14.7 days
  - Median = 7.3
  - Average number of patients per day = 16
What has happened since?

- One colleague on maternity leave
- Unable to fill 8th consultant post
- Currently unable to run the firm
Reflections

• Work was mostly enjoyed by the team of consultants
• “A nice change of pace”
• High degree of satisfaction from the other team members
• Patients liked the continuity
• But a lower priority for us than the front door
• Wider consequences of the model?