



Opinion

Why the NHS needs adult generalists: A call for single certification in general internal medicine

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ABSTRACT

As the UK NHS faces growing challenges of the ageing population and escalating healthcare costs, we examine the role of the general internal medicine (GIM) consultant in inpatient medicine. We argue that the reintroduction of GIM could provide a sustainable and valuable contribution to high-quality, cost-effective inpatient care drawing on parallels from the GIM hospitalist model in the USA. Additionally, GIM expansion could contribute to improved outcomes for complex medical patients and surgical patients, as well as safety and quality initiatives.

The UK NHS is undergoing tremendous challenges that call for adaptations in the healthcare workforce. The population is ageing with increasing medical complexity. Patients are increasingly presenting acutely with undifferentiated problems that do not fall within the confines of one organ system.¹

Healthy outcomes for patients are now recognised to arise not just from specialised medical knowledge and advanced biomedical science, but from skilful collaboration, effective communication across inpatient and outpatient services, and attending to social factors that drive health. Simultaneously, the NHS has a pressing need for clinicians who can participate in the stewardship of cost, safety and quality of care.

Royal College of Physicians (RCP) and General Medical Council (GMC) reports dating back over a decade have made strong recommendations for an increased focus on generalist training to address these issues.^{2,3} While this has led to changes to the shape of UK training, including the development of the internal medicine year 3 and the internal medicine training (IMT) stage 2 curriculum, there is still significant dissatisfaction among consultants with the GIM component of their job compared to their specialty work.⁴ Generalist capabilities are an essential part of medical specialty training, but do not remain the focus of practice after training completion.

We propose the reestablishment of general internal medicine (GIM) as a specialty with a distinct training path in UK graduate medical education, with the aim of training physicians who excel at coordination, communication and collaboration in the acute care setting and function as expert diagnosticians.

The complex patient in a complex system

The experience of a patient with complex intersecting medical issues illustrates the dilemma of current UK practice:

A 55-year-old woman with multiple sclerosis, type 2 diabetes, suprapubic catheter and multi-drug resistant urinary tract infections is admitted to the hospital with worsening right leg weakness, sepsis and acute kidney injury. She is evaluated in the emergency department (ED), referred to the acute medical unit, and reviewed by the acute medicine consultant, who determines which specialty should manage her subsequent care.

Under the current system, the acute medicine consultant must choose among many reasonable options. Infectious disease might identify the best antibiotic regime, while diabetes and endocrinology may most effectively manage her blood sugars, and neurology would be best positioned to determine whether her leg weakness is related to her multiple sclerosis or represents an acute stroke. Nephrology would most accurately characterise and address her acute kidney injury.

Often the specialist team is chosen based on what is felt to be the most pressing medical concern. But the expertise of the specialist may come at the cost of overreliance on referrals to other specialties to support aspects of the patient's care that are outside the scope of their specialist work. This can lead to disjointed care, with no single team having oversight, contributing to a prolonged hospital stay and unfavourable patient experience.⁵ The current system asks specialists to practise beyond their areas of expertise to support the day-to-day management of inpatients and coordinate their aftercare.

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Holistic generalist care in the acute setting

One workforce model to consider is the internal medicine hospitalist⁶ who specialises in the comprehensive care of hospitalised patients, including diagnosing and managing a wide range of acute conditions, coordinating treatment with specialists, and facilitating communication between multidisciplinary teams. Patients who are seen by a hospitalist following referral from the ED are cared for by a hospitalist for the entirety of their admission. This model of generalist care from admission to discharge is established in many healthcare systems including the USA, Australia and many parts of Europe. As the hospitalist's primary focus is acute GIM conditions such as sepsis, diabetes and acute kidney injury (as seen in our example), there is less reliance on referrals for additional input.⁷⁻⁹

Hospitalist-directed care in the US has demonstrated several benefits, including reduced hospital length of stay, lower healthcare costs, improved patient outcomes and satisfaction, enhanced efficiency in patient care management, and better coordination of care during hospital admissions.¹⁰⁻¹² In addition, many hospitalist teams provide consultation and co-management services to surgical specialties^{13,14} as well as early post-discharge follow-up care.¹⁵

The major drawback of the US hospitalist system has been a lack of continuity between inpatient and outpatient settings.¹⁶ Before hospitalists, the outpatient primary care physician would continue to direct their patient's inpatient care (with the help of nurses, trainees and specialists). Although the GP-in-hospital model is not prevalent in the UK, the importance of information transfer between inpatient and outpatient providers warrants increased attention under any new scheme.

The path to general internal medicine

The NHS has existing opportunities for doctors interested in generalist practice in the inpatient setting. Most hospital trusts employ general paediatricians and geriatric consultants to manage inpatient care at the extremes of age. In 2009 the GMC formally recognised acute internal medicine as a specialty of adult medicine, endorsing the need for physicians skilled in urgent medical care. Although this has improved transitions from the ED, the focus on the first 24-72 h of admission overlooks the needs of complex patients who will require prolonged hospitalisation. Many patients are then assigned any available medical bed and cared for by the specialty that manages the ward, rather than a specialty based on patient need.

We propose the development of the GIM specialty to care for adult patients who remain in hospital for longer than the remit of acute physicians and do not come under the care of geriatricians. Patients identified by emergency or acute medicine physicians with risk factors for prolonged admission would be admitted under the GIM team as early as possible.¹⁷ Patients with a clear single organ dysfunction would also be eligible for admission to GIM, while specialists would remain responsible for admissions of patients presenting with an illness relating to a complex specialist condition.

To develop the GIM inpatient specialty workforce, a training pathway must be established. Training this workforce would include development of specific skills such as those outlined in Table 1.

Inpatient generalists and specialists: a new equilibrium

This gradual shift in the workforce will lead generalists and specialists to re-evaluate their roles in the NHS. Some specialists may be grateful for the opportunity to reduce the amount of inpatient care they provide and focus on areas of expertise such as procedures and specialist clinics. Others may be concerned about the de-skilling of specialists in generalist capabilities. However, we anticipate specialists will continue in managing multimorbidity in the many inpatients for whom they have direct responsibility. Generalists may be concerned that this change may

Table 1

Skills of the generalist: adapted from Society of Hospital Medicine Core Competencies in Hospital Medicine, *Journal of Hospital Medicine*¹⁸ and JRCPTB internal medicine (Stage 2) 2022 Curriculum.¹⁹

Management of commonly presenting medical conditions ('unselected take')
Care of the older patient: Addressing the issues of an ageing population
Multidisciplinary collaboration and communication
Diagnosing undifferentiated problems
Medical educator and supervision
Leadership and management practices
Medical consultation and co-management
Palliative care
Patient safety and quality improvement activities
Care coordination across inpatient and outpatient care, urban and rural settings
Understanding social determinants of health
Bedside procedures: lumbar puncture, thoracentesis, paracentesis, point of care ultrasound
Collaboration with specialists

lead to a reduction in specialist availability for consultation in the hospital. Ideally, any reduction in the direct inpatient workload for specialists would lead to increased availability for inpatient consultation.

Attracting physicians with the relevant knowledge, skills and attitudes to general medicine may be challenging initially. For instance, the lack of private practice potential may dissuade young physicians evaluating general medicine as a career path. Skill and knowledge development and maintenance will require specific educational pathways. An early pilot programme has demonstrated the feasibility of such training. In February 2023, an NHS England-supported GIM training programme was established following the IMT stage 2 curriculum.²⁰ Early trainees demonstrated enthusiasm for GIM careers, but lacked a clear identity for their future careers.

Significant investment in supporting GIM trainees and educators will be essential to ensure the ongoing success of this programme. This new cohort of hospital-based generalists may become engaged in quality and safety initiatives within hospitals, as happened in the USA over the past two decades.²¹ While costs are inevitably incurred with adaptations to care models, we anticipate that improvements in length of stay, utilisation of resources, and quality of care would offset these expenditures. Such cost saving was the major driver for the US transition to hospitalist care,²² although it took several years to be actualised.

Conclusion

The pilot GIM training programme has now expanded to 15 sites across England. This momentum needs to be sustained to enable generalist practice to be adopted widely across the NHS. The success of the US hospitalist movement has been driven not only by the economic and quality outcomes, but also by the development of national societies, journals that advance the science of the field, and specified educational competencies and programmes. UK-based GIM will need to achieve similar milestones if it is to realise a vision of being a career of choice for young doctors, a partner to specialists and other healthcare professionals, and a part of the solution to the challenges facing the NHS.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Elizabeth Estabrook: Writing – review & editing, Writing – original draft, Conceptualization. Gurpreet Dhaliwal: Writing – review & editing, Writing – original draft, Conceptualization. Philip Bright: Writing – review & editing, Writing – original draft, Conceptualization.

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