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EDITORIAL

General internal medicine: acquiring clinical acumen from bedside to front door with opportunities for undergraduate and postgraduate training

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Abstract

A general physician's training and experience enables them to manage a variety of acute and chronic medical conditions with multi-system pathology, while specialising in one specific area of medicine.

In every illness there are other problems outside the specialty, requiring the wider expertise of the generalist as patients have multiple comorbidities and the multitude of disease pathology presenting are quite complex requiring a multi-faceted approach. The horizons of general internal medicine have broadened with a wide landscape of acute illnesses that are now being admitted under general medicine which is the path of least resistance. As we strive relentlessly while working on the ward at the bedside and in acute portals, we ought to remind ourselves of what are the attractions of general internal medicine and lead by example for the undergraduates and postgraduate doctors in training who see us as role models for doing clinical medicine, teaching, training and research.

Key words: Bed pressures; Discharges; General medicine; Medical registrar; Teaching; Training

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A general physician's training and experience enables them to manage a variety of acute and chronic medical conditions with multi-system pathology, while specialising in one specific area of medicine (Ward, 1996). In every illness, there are additional problems outside the specialty, requiring the wider expertise of the generalist as patients have multiple comorbidities and the array of disease pathology presenting to the front door is often complex, requiring a multi-faceted approach. The horizons of general internal medicine have broadened with a wide landscape of acute illness now being branded to be classed as 'admit under medics', which is the path of least resistance in the National Health Service (NHS).

General internal medicine, which was once looked and considered the top position in the hospital hierarchy, has slipped down the priority list and is being overshadowed by specialist interests and immediate triage of patients into organ-based silos. Nonetheless, the reality is that patients present with undiagnosed illness and general internal medicine remains in the front line (Vallance, 2005). The challenge in making a diagnosis and the need to think laterally about what will make the patient better and get them back home is often intriguing.

The pressures at the front door as well as the general feeling that medicine is being increasingly viewed as a default referral option by other specialties who are becoming even more sub-specialised has not helped alleviate the perceptions of general internal medicine nor the perspective of the overall situation. The medical registrar in the acute on-call and out-of-hours setting is usually considered to be one of the busiest and most challenging hospital jobs in the NHS. The medical registrar can be the dynamic action-orientated problem solver, charged with leading the acute medical on-call, the referring doctor for the entire hospital, a general practice helpline, counsellor for distressed relatives and gatekeeper of the medical assessment unit (Grant and Goddard, 2012).

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Some view the on-call day as the highlight of the working week, seeing more people and going the extra mile to look after acutely ill patients. They translate their efforts into a positive effect which is demanding and challenging but rewarding. However, general internal medicine is increasingly viewed as a 'dumping ground' by other specialties (Grant and Goddard, 2012), and that has not changed over the years. Medical registrars were once described as the 'workhorses' of NHS hospitals, being at the interface between delivery of care for acute and chronic health conditions and junior colleagues were also being deterred from general medical specialties by the prospect of becoming the medical registrar (Blake and Whallett, 2016). Medical registrars collectively felt that leading the take team was one of the most important and enjoyable roles they provided whilst on-call, and they embraced the opportunity to foster a collaborative approach with different team members.

In 2013, the Royal College of Physicians published 'The medical registrar: empowering the unsung heroes of patient care' (Goddard, 2017). This report demonstrated that the predominant factors in influencing job satisfaction and morale for medical registrars were:

1. Workload
2. Teamwork among medical trainees
3. Training opportunities
4. Flexibility around the routine daily working pattern.

Since the report, progress has been made in each of these areas. However, when many trainees were making decisions about their own future careers, attractive features were being outweighed and taking on the on call role of the general medical registrar appeared to be a major deterring factor for potential candidates (Chaudhuri et al, 2013). Trainees were mainly discouraged by their own perception of an unmanageable workload and a far from ideal life-work balance in general internal medicine (Fisher et al, 2017). This viewpoint still remains based on trainees' experience of working with medical registrars on the take.

As a consultant physician, the details surrounding the logistics of ownership, accountability, and the rationale for initiating, continuing, or discontinuing treatment become critical, and then the real sensation of being a 'dumping ground' may take precedence. Whether it is a patient with an abscess who does not need surgery and therefore 'can stay under the medics' or a patient who has been given immunomodulator treatment and developed an infection, there comes a point when the generalist needs to negotiate with a specialist to take over the patient's care, which remains a considerable challenge.

Increasing consultant physician experience has been shown to be associated with early safe discharge after an acute admission, and these data suggest that support and retention of experienced clinicians is vital if escalating pressures on unscheduled medical care are to be addressed (Lyall et al, 2023). This must be interpreted in conjunction with the Royal College of Physicians census suggesting that nearly 50% of the consultant physician body is over 50 years of age. All these factors would have directly and indirectly contributed to the results of the Royal College of Physicians survey demonstrating the variation in practices among consultants that undertake research according to their specialty and, in particular, how much care for general medical patients they do and where in the UK they work (Chandrapalan et al, 2023).

Amid all these, the routine working day in general internal medicine entails identifying patients for the virtual ward, 'your next patient', 'home for noon', identifying outliers, chasing specialty referrals and trying to get the right patient on the right ward under the right team.

In between the intense activity, what one can give back to the next generation of trainees is the wealth of knowledge acquired from the shop floor experience as a jobbing physician in general internal medicine. Therefore in summary, there is no better place to teach the fundamentals of medicine to medical students and postgraduate doctors elsewhere other than in general internal medicine, and there is no better person to do this than a good general physician (Firth, 2014).

Conclusions

There are several positive aspects to consider in general internal medicine:

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- The depth of medical practice in the hospital setting and understanding the decisions of other multidisciplinary teams is very educational as nobody sees more variety of acute pathology than the general physician.
- The diagnostic dilemmas related to the breadth of clinical presentations in general internal medicine offer a lot more therapeutic challenges to train for the world renowned MRCP PACES (Practical Assessment of Clinical Examination Skills) conducted by the Federation of the Royal College of Physicians.
- The general physician must make an astute working diagnosis on the medical ward rounds that requires the benefit of clinical acumen acquired gradually over the years from the bedside to the front door and this cannot be underestimated in routine practice while treating acute illness.
- Several of the patients cared for under the label and tag of general internal medicine present acutely, frequently on a background of chronic long-term conditions, multi-system pathology and multiple comorbidities and enables us the opportunity for treating acute medical illness and seeing the positive impact and outcome is pleasing both for our patients and postgraduate doctors in training as well as undergraduate medical students and allied health professionals.
- There are ample opportunities for teaching and training in the fundamentals of clinical medicine, such as history taking, physical examination, and differential diagnosis, which inform well-planned, targeted investigations and management plans for ill patients.

Key points

- The specialty of general internal medicine has no managed entry or exit criteria as the role of the generalist is not quite well defined and physicians are under enormous pressure to deliver the fundamentals of care while striving relentlessly to drive improvement with changing services.
- Many generalists are specialists in their own specialties and all specialists have the skills of a generalist within their specialism.
- The default of admitting patients with several non-medical conditions like abscesses and post-operative collections as the patient does not necessarily need immediate surgical intervention poses further challenges on medical beds with the logistics of medical outliers in surgical wards.
- We work effectively within the remit of a multi-professional, multi-disciplinary team fostering a collaborative approach with other niche specialists with a can-do attitude when we treat our patients holistically.
- Several conditions such as complications of novel immunomodulator treatments that we manage in general internal medicine as a general physician nowadays are not necessarily what we ourselves use in routine clinical practice nor have we had the experience of treating during previous training and our roles have evolved requiring enhanced generic skills.
- While we need to redefine the role of a generalist in a broad context, there are vast opportunities to provide excellence in teaching the art of history taking, clinical examination skills, identifying physical signs, improving communication styles, and acquiring clinical acumen for our allied healthcare professionals, undergraduate medical students, and postgraduate doctors in training.

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