Diabetes and general medicine: to couple or uncouple?

Camaraderie and the break up

The ownership of general medicine continues to be a perennial issue within acute trusts. Over the years, there has been a steady progress towards specialism but, as the world has moved on, patients are older and have multiple disease morbidity; the recent clamour has been to move away from single organ disease to, once again, a more generalist approach.

General medicine used to be reasonably simple with all specialists being part of the on-call rota, sharing out patients and using their general medicine accreditation. Though perhaps not enjoyed by all, it certainly generated a sense of camaraderie and the job was shared by all, not by a few.

The direction started to change when cardiology as a specialist made the case for becoming a specialty in its own right – with door-to-needle targets becoming an important part of trust requirements. Over time, as has been borne out, this move has had its pros and cons. The pros indeed have been for all to see: better cardiovascular outcomes, especially in relation to myocardial infarction outcomes, and better resourced cardiology units across the country. The benefits for patient care have been many. However, the cons have included the break-up of a sense of camaraderie. Suddenly, one specialty was more special than others. Suddenly, the patient with an acute myocardial infarction or angina had preferential care, and their own specialist rota and carers; this was intrinsically different from, say, someone with a severe asthma attack or diabetic ketoacidosis.

Not surprisingly, others started to follow suit. The gastroenterologists made their, not unjustified, case for ‘bleeding rotas’, the need to have hepatologists, and a separate gastroenterology rota. Elderly care physicians ran the risk of being consumed by the sheer volume of patients, with admissions starting to skew and reflect the ageing population; thus they began to set their own trammles and criteria. The bond between all physicians appeared to have been broken. We all now existed in silos, wrapped in our own specialties – all correct in their own view, yet incorrect when the bigger picture was taken into account.

In between all of this, there still existed the need to see and review patients who did not quite fit into any criteria, and the label ‘general medicine’ was used. That left the respiratory physicians and diabetes specialists being given the burden and the concept of being the teams who looked after patients beyond narrow specialism – and this started to grate as time passed by. The question, quite rightly, was raised about the patients of their own specialism – did they not deserve care better than or at least as good as that of a cardiology patient?

Caught in the middle?

There has been a plethora of data published – whether it be the national inpatient diabetes audits or the national diabetes audits. These audits have shown time and again a simple fact of diabetes care: we are delivering care which is patchy – great in some places, average in most and poor in a few. Take the example of inpatient diabetes services. We have enough evidence of harm and/or errors within hospital inpatients, but, with the pull on specialty teams to do general medicine, there are insufficient resources to see patients with diabetes admitted within hospitals. The irony is stark.

Coupled with this is the fact that, quite rightly, diabetes specialism is now based within the community, with the role of an educator and support for primary care being eulogised. Thus, within acute trusts, it seems diabetes specialists’ existence is being tied in with general medicine. Part of this could perhaps be due to diabetes specialists failing to explain or showcase to all what roles they can play (foot clinics, insulin pump services, inpatient diabetes services), coupled with a possible reluctance on the part of some specialists to consider the option of going into the community. Better the devil you know – with training exclusively in the past being in hospitals – than venturing out into the unknown. Throw in recent surveys of trainees – where the commitment to general medicine has reduced their training time in specialist areas such as pumps – and a heady cocktail is produced.

General medicine and diabetes: an opportunity arises?

As ever, in every situation, an opportunity arises and perhaps diabetes as a specialty has a once in a lifetime opportunity to change the paradigm of diabetes care while the jostling for ownership of general medicine (or the lack of it) continues. Indeed, there are specialities which have already been ahead of the curve and are looking at putting their case forward for involvement in general medicine.

From my personal viewpoint, there are perhaps three ways to go about this – but, no doubt, there will be hybrid versions of the three models outlined below. The essence of each rests in diabetes as a specialty seizing the initiative rather than, once again, accepting changes to their careers and ways of working foisted upon them.

Option 1: the ‘embrace model’

In this option, the diabetes team proactively engage with trust management and offer to take over all general medicine patients within the hospital. This would enable all other specialities to concentrate on their own specialism. Diabetes teams could look upon this as an opportunity to expand the workforce by the use of robust business cases looking at expansion of programmed activities (PAs) and job plans incorporating general medicine and specialism work.
Diabetes and general medicine: to couple or uncouple?

The Derby inpatient model
Derby serves a population of over 25,000 patients with diabetes. The Royal Derby Hospital Diabetes Department has eight consultants and nine diabetes specialist nurses. By maintaining a small specialist ward base we can specifically work to enhance the knowledge and skills of a small number of ward nurses to ensure best practice care for patients admitted with primarily diabetes-related problems.

Seven-day consultant led service
There is an 18-bed ward dedicated to patients with diabetes, endocrinology and metabolic diagnoses where a consultant led ward round takes place seven days a week. In addition, there is daily consultant input to the medical assessment unit for emergency admissions as well as regular review of patients under shared care on the vascular and renal wards or ITU. Two consultants provide continuity of care during the working week for a month at a time. During this period all other clinical commitments are cancelled, facilitating expert assessment and care of all inpatients and a rapid response to new referrals. Patients suitable for a bed on the diabetes ward are usually identified and transferred, ideally on the day of admission.

Pros
- Seven-day consultant led specialist service.
- Daily consultant review for all inpatients admitted with diabetes-specific problems.
- Increased support and education for junior doctors, ward nurses and diabetes specialist nurses.
- Foot multidisciplinary team review of all inpatients with diabetic foot disease.
- Regular review, rapid identification and turnaround of:
  - Diabetes emergencies
  - Diabetic foot patients on outpatient IV antibiotic regimens.
  - Electronic prescribing which has reduced errors in insulin prescribing.

Cons
- Reduction in specialist registrar independent management of diabetes inpatients, although this is offset by increased consultant availability and support.
- No 24-hour on-call availability.
- No diabetes specialist nurse availability at weekends.

Personal view
The move in Derby to reduce the inpatient bed numbers to 18 inpatients, combined with the reduction in our contribution to acute medicine (only two of our eight consultants do ward rounds on the medical assessment unit), has enabled the consultant team to move their focus from general medicine to the specialist management of the patients who need us most: those with a diabetes or endocrine disorder as their primary diagnosis. This is the case both for inpatients and the community as a whole. Integrated community diabetes care is a national priority. Derby has a nationally recognised award winning unique model, the development of which would not have been possible if the team had had their time and location restricted by the ongoing care of a large number of general medicine inpatients. While some may advocate a further reduction in inpatient numbers, we feel 18 is optimal in our hospital because it provides us with enough turnover to be able to ensure our patients with diabetic ketoacidosis, foot ulcers etc are quickly moved to our ward for specialist management.

The South West model, Bath
In the Royal United Hospital in Bath, we have four consultants who take part equally in general internal medicine (GIM), diabetes and endocrinology. GIM is run in the traditional model. All specialties (except cardiology) contribute towards the acute take and have GIM ward beds. Care of the Elderly have a separate defined take. The diabetes team contribute four out of 15 slots to the acute take with subsequent post take wards rounds; the acute medical team manage the take until 8pm but do not do post take ward rounds. The diabetes team also manage a 28-bed medical ward with outliers on a further three wards. There is consultant input daily to this ward. Diabetes and endocrine patients are preferentially triaged to this ward but the majority of patients are general medical patients.

Two consultants at a time manage the ward patients for a period of two months. Outpatient work is maintained during this period as is the contribution to the acute take. The other two consultants continue the usual outpatient work and the acute work.

Pros
- The current model engenders inclusivity and fairness around GIM which is generally perceived as a shared responsibility by medical teams within the trust.
- The consultant body work well together and support other specialties effectively – ‘we are all in this together’.
- Maintenance of skills in general medicine which is valued by the trust and colleagues.
- Increased influence within the trust as a major contributor to the trust’s core business.

Cons
- Heavy GIM workload when on wards.
- Outpatient work is cancelled to accommodate acute medicine work.
- Disproportionate contribution to Acute & GIM work by the smallest medical department.
- Very few resources to develop or expand diabetes and endocrine services beyond the current model despite demand.
- Currently no community model is in place.
- Not sustainable in the medium term with current resources – other specialties reducing commitment to GIM.

Personal view
There are many benefits from having an active role in GIM. However, the sustainability of this model is in some doubt. The demand for GIM is growing at the same time as other specialties are reducing their commitment to general medicine. There is increasing pressure from the trust to offer a more comprehensive seven days a week GIM service, and other medical specialties are offering a limited seven-day specialist service in return for a reduction in the contribution to the acute take. Acute Medicine and Care of the Elderly departments have embraced GIM and their numbers are expanding rapidly.

Ninety percent of diabetes care locally is delivered in the community but specialist input into this is very limited. Referrals into our service are growing at 20% per year. There are numerous opportunities for us to improve our services to our diabetes and endocrinology patients, none of which will be possible without a significant increase in resources or a re-evaluation of our role in GIM.

Box 1. The Derby inpatient model. (Details provided by Dr Emma Wilmot and Dr Fran Game, Consultant Diabetologists, Derby, UK)

Box 2. The South West model, Bath. (Details provided by Dr Marc Atkin, Consultant, Diabetes & Endocrinology, Royal United Hospital, Bath, UK)
Embracing general medicine: a perspective from Wolverhampton

A few years ago, Wolverhampton had two diabetes consultants; we now have six full-time posts and are looking to expand further.

We currently deliver inpatient care to general medicine inpatients in a dedicated ward, a variable number of medical ‘outlier’ patients, a specialty referral service and supervision for a non-referral pathway which proactively targets inpatients with diabetes through a list generated in-house from the hospital pathology system for glucose outliers. This is enabled by two consultants sharing the ward and a third consultant taking referrals and looking after the outliers. This in effect releases three of us at any given time to fully concentrate on outpatient work, administration, research etc. We also participate in the acute medical take in conjunction with respiratory, geriatrics, renal and acute medicine colleagues with the acute medical unit being run by the acute medicine team.

Inpatient work in our trust is shared not only with acute medicine and care of the elderly but also with respiratory and renal medicine, and all these specialties have chosen to increase their ward base and have recruited more consultants.

**Pros**
- Effective seven-day consultant delivered service which promotes safer patient care, increased quality and efficiency, and improved support to nursing and junior teams.
- Time and resources for more specialist care delivery including combined clinics.
- Maintenance of general medical skills, which the medical colleges decry have been lost. Maintenance of these skills reduces the tendency to silo-based care.
- Resources to focus on our diabetes integration project which has recently been one of the five models show-cased by Diabetes UK.
- Allowed us to expand our reach with more specialist care referrals coming from surrounding CCGs and neighbouring counties.
- Kudos from the trust and support to pursue a specialist agenda.

**Cons**
- Continued general medical work and an element of frustration when social medicine becomes rife, although having inpatient beds has allowed us to effectively direct diabetes and specialty patients to these beds and directly admit patients (e.g. those with foot problems).
- External perception of being hospital oriented although our work to date belies this and we now have more effective vertical integration with the community and an improved working relationship with GPs.
- ‘Perceived’ dilution in specialist care work. However, it has been acknowledged that diabetes care across the country needs to improve, and resources and time to effect this need to be enhanced.

**Box 3. Embracing general medicine: a perspective from Wolverhampton.** (Details provided by Dr Rajeev Raghavan, Consultant Physician, Diabetes & Endocrinology, Wolverhampton Diabetes Centre, New Cross Hospital, Wolverhampton, UK)

**Pros**
- Secure position within acute trusts.
- Done proactively thus unlikely to result in loss of morale or feeling of being ‘dumped upon’.
- Increase in workforce, thus helping also to give time to impact and improve on diabetes care within and outside hospital.
- Aligns with the Royal College of Physician’s view of more generalism – diabetes helps to show the way.

**Cons**
- Convincing colleagues within the department.
- The risk of being asked to stop further specialism work in cash-strapped environments – thus compromising diabetes care further.
- Not aligned with the ‘Five Year Forward View’ report which suggests further specialists working in the community.

**Option 2: the ‘cardiology model’**

In this option, diabetes withdraws from having any general medicine patients and job plans are shrunk to reflect a drop in activity and to concentrate on core specialism. Specialists would have inpatients similar to those of other chronic disease specialists – for example, rheumatology and dermatology – and have cases relating to their own specialism.

**Pros**
- Concentrates on core activity – and improves care within hospital and the community.
- Learns from the cardiology model and also helps to deliver care modelled on the ‘Five Year Forward View’ report.
- Enhances the role of educator and support for primary care – thus enabling better relations with clinical commissioning groups (CCGs) and primary care.
- May open up a brave new world of teams being employed by primary care trusts or community trusts.
- Enhances speciality training, thus preparing a better workforce plus helping to attract quality candidates to the speciality.

**Cons**
- Convincing those colleagues who are concerned about their position within the trust to step back from general medicine.
- Alienation of other specialty colleagues within the trust.
- Expansion of the workforce will take time – while community-based models of care develop.
- Poses the question for trusts: who does look after general medicine patients any more?

**Option 3: the ‘status quo model’**

In this model, the status quo continues whereby diabetes teams have a set number of patients with outliers added on. The diabetes teams share the general medicine load along with whoever is left.

**Pros**
- Keeps the status quo.
- Diabetes keeps its ‘hand’ in generalism.
- Consultants who are not keen on change stick to working patterns.

**Cons**
- In cash-strapped environments, the battle to improve care in hospitals or community continues.
- Within trusts, there is a risk of creep development taking more as others withdraw, or of a need to justify the existence of diabetes within trusts.

---

**Embracing general medicine: a perspective from Wolverhampton**

A few years ago, Wolverhampton had two diabetes consultants; we now have six full-time posts and are looking to expand further.

We currently deliver inpatient care to general medicine inpatients in a dedicated ward, a variable number of medical ‘outlier’ patients, a specialty referral service and supervision for a non-referral pathway which proactively targets inpatients with diabetes through a list generated in-house from the hospital pathology system for glucose outliers. This is enabled by two consultants sharing the ward and a third consultant taking referrals and looking after the outliers. This in effect releases three of us at any given time to fully concentrate on outpatient work, administration, research etc. We also participate in the acute medical take in conjunction with respiratory, geriatrics, renal and acute medicine colleagues with the acute medical unit being run by the acute medicine team.

Inpatient work in our trust is shared not only with acute medicine and care of the elderly but also with respiratory and renal medicine, and all these specialties have chosen to increase their ward base and have recruited more consultants.

**Pros**
- Effective seven-day consultant delivered service which promotes safer patient care, increased quality and efficiency, and improved support to nursing and junior teams.
- Time and resources for more specialist care delivery including combined clinics.
- Maintenance of general medical skills, which the medical colleges decry have been lost. Maintenance of these skills reduces the tendency to silo-based care.
- Resources to focus on our diabetes integration project which has recently been one of the five models show-cased by Diabetes UK.
- Allowed us to expand our reach with more specialist care referrals coming from surrounding CCGs and neighbouring counties.
- Kudos from the trust and support to pursue a specialist agenda.

**Cons**
- Continued general medical work and an element of frustration when social medicine becomes rife, although having inpatient beds has allowed us to effectively direct diabetes and specialty patients to these beds and directly admit patients (e.g. those with foot problems).
- External perception of being hospital oriented although our work to date belies this and we now have more effective vertical integration with the community and an improved working relationship with GPs.
- ‘Perceived’ dilution in specialist care work. However, it has been acknowledged that diabetes care across the country needs to improve, and resources and time to effect this need to be enhanced.

**Box 3. Embracing general medicine: a perspective from Wolverhampton.** (Details provided by Dr Rajeev Raghavan, Consultant Physician, Diabetes & Endocrinology, Wolverhampton Diabetes Centre, New Cross Hospital, Wolverhampton, UK)
**Working models**

Boxes 1–3 provide examples of the experience and practice in a few trusts and the views of local consultants as to how their amalgamation with general medicine works.

As a community we would do well to look into how we can seize the initiative to develop such models rather than wait.

**A local flavour: Portsmouth ... a litmus test?**

Locally, an opportunity arose when trust management put forward the option of creating a general medicine firm and this option was offered to the diabetes team. The diabetes team, however, decided to opt out, entailing a reduction in sessions and a drop in junior doctor numbers in order to incorporate an acute physician within the team. The option to do this – involving funding sessions for ‘another’ individual/specialty to take over the reins of general medicine – came from management and has been broadly supported.

However, intense negotiations have continued around the issues of redefining the presence of a diabetes team within an acute trust.

Not surprisingly, opposition has come from other medical teams, causing a period of friction mostly due to fear of being overburdened themselves, while the counter argument has been that the diabetes team is not leaving a vacuum but a relevant person in charge of those patients. The debate is indeed helping to define the importance of diabetes teams within acute trusts and to draw attention to the fact that their role is no different from that of other long-term condition experts such as rheumatologists – therefore look after patients in hospital beds if their admitting reason is the pathology itself while continuing outpatient work. I believe this could be a litmus test for other district general hospitals, showing the need for diabetes teams to concentrate on improving diabetes care within the entire system rather than being limited by organisational boundaries. The impact on training cannot be over-emphasised with creation of opportunities for trainees to develop their specialist knowledge further.

The question will be whether the withdrawal from general medicine impedes the diabetes team or helps them flourish. It is no doubt a high-risk strategy but one which could have a potentially positive impact on diabetes care and training locally.

**What of the future?**

The question is: ‘Are we are heading towards a model where acute trusts are run by acute physicians and elderly care physicians, with input from specialists as and when needed?’ Resource is certainly an issue but, with recruitment drives underway, I would not be surprised to see the above models being adapted or implemented.

In every crisis lies an opportunity – the definitive challenge for us as a specialty is to see where we place diabetes care of our patients. The ‘Five Year Forward View’ throws open new models of working which certainly give diabetes the chance to work differently, own the pathway, and work in other ways with primary care.

The billion dollar question is whether we, as a community, take this opportunity or, as has been the culture in the past, leave a few motivated, personality-driven models to evolve while the rest sit and mull. We indeed live in interesting times.

**Partha Kar,** MBBS, MD, MRCP, Consultant Diabetologist, Queen Alexandra Hospital, Cosham, Portsmouth PO6 3LY, UK; email: partha.kar@porthosp.nhs.uk

**For Derby:**

**Emma Wilmot,** MB ChB, BSc(Hons), MRCP(UK), PhD, Consultant Diabetologist, Royal Derby Hospital, Derby DE22 3NE, UK; email: emma.g.wilmot@gmail.com

**Fran Game,** FRCP, Consultant Diabetologist and Honorary Associate Professor, Derby Hospitals NHS Trust, Derby DE22 3NE, UK; email: frances.game@nhs.net

**For Bath:**

**Marc Atkin,** BM, MRCP, MD, Consultant, Diabetes & Endocrinology, Royal United Hospital, Bath BA1 3NG, UK; email: marc.atkin@nhs.net

**For Wolverhampton:**

**Rajeev Raghavan,** MD, MRCP(UK), Consultant Physician, Diabetes & Endocrinology, Wolverhampton Diabetes Centre, New Cross Hospital, Wolverhampton WV10 0QP, UK; email: rajeevraghavan@nhs.net

---

**Visit our website**

The *Practical Diabetes* website carries a wide range of additional information in support of the journal. You can access the current issue online, search through back issues in our archive or download our growing collection of ABCD position statements.

Find out more at [www.practicaldiabetes.com](http://www.practicaldiabetes.com)