Specialty care in the community

Specialty care in the community: the birth of a new discipline

J F Mayberry, P de Chazal, T Moshkovska

Will the majority of healthcare services be delivered by specialists in the community?

The delivery of healthcare in the UK is coming under the intense scrutiny of politicians.[1] Central to their argument is the concept that good quality diagnosis and management can be moved out of large hospital facilities and brought closer to patients. The philosophy behind such an approach is both that it is more user friendly and more cost effective.

This rapid and determined quest for reform means that many of the core traditions and values of the National Health Service will need to be reassessed. For hospital-based consultants and specialists this will present a very specific challenge. Will they need to be based in large hospital units? Should they continue to have a commitment to patients outside their specialist expertise?

Just as acute medicine emerged as a distinct specialty during the past decade, specialist care in the community will be the emergent specialty of this decade. The concept that such care can be provided by general practitioners (GPs) alone is probably unsound because they are generalists who cover a wide range of conditions and have not received specialist training in the management of chronic diseases.

In this new world, the linear model of primary and secondary care will no longer apply. In the future, GPs with a special interest and specialists with a community interest are likely to merge and become the new intermediate care specialists or specialists in the community. New, community-based specialist clinics and ''policlinics'' will provide the majority of healthcare services for patients. These will be staffed by both generalists and specialists. They will cover populations of 30 000–40 000 and provide diagnostic and treatment services. Only the unusual and/or difficult case will need referral to an acute hospital. Such an approach will lead to a significant reduction in the need for hospital beds as patients will be largely managed on a daycase basis. These clinics will seldom be based in traditional healthcare settings but rather in shopping malls and leisure centres. These new locations will also act as centres for effective health education directed at obesity, smoking and excess alcohol intake.

The current move towards providing care closer to patients is paralleled by the emergence of independent healthcare providers. Such companies will deliver care dealing with perhaps one chronic disease, such as heart failure or diabetes. The service will be protocolled, high quality, consistent and cost effective. Healthcare providers will come from traditional healthcare backgrounds and from commercial organisations and retailers more commonly associated with the high street.[2]

This new strand of service delivery will inevitably affect the working patterns of doctors. As care is devolved to the community, the future for large hospitals staffed by a large number of doctors looks uncertain. Logic dictates that if only complex cases need treatment in hospital, then the size, nature and geographical location of these hospitals within the UK will be closely examined. The requirements for hospital doctors, in terms of numbers and skills, will receive similar attention. It seems likely that these hospitals will be staffed by a relatively small number of super-specialists. Indeed, the new training programmes would suggest that this agenda is already underway.[3]

This new vision requires a new type of community specialist trained to traditional high standards within his or her specific specialty and trained in the values of community care. Such specialists will need to be aware of community health issues and the problems of providing treatment within the home environment, and have the ability to develop and contribute to programmes of health education and disease prevention. Training must supplement the traditional specialty-based clinical programmes and be targeted at developing other skills, such as entrepreneurial, legal, audit, leadership, teamwork, communication, presentation, and the basics of finance and business management. Only through such an approach will doctors be able to survive and indeed thrive in this new, competitive environment. Doctors who are now in training will need to function in both hospital and community environments and must develop skills that will allow them to use new technologies as they come on stream and to move between disciplines as the need for medical care changes.

Alongside training programmes, a knowledge base must be built. This will chart innovations and processes associated with specialty healthcare in the community and provide the building blocks for the future development of the discipline. It is critical that this new specialty is based on sound, evidence based research.

This new specialty has yet to acquire an established name. Should it be termed intermediate care, which tends to be used for the provision of integrated services in order to prevent unnecessary acute hospital admissions, specialty care in the community or community-based specialist care… or something else? The correct choice is important to help establish this discipline among traditional forms of practice.

The *PMJ* has recognised the need to be part of this revolution. The Journal is keen to publish contributions in this new and important area of healthcare provision and welcomes submissions from both the UK and overseas. We would like to see a spirited debate unfold, so please send your views to us via our website at http://submit-pmj.bmjjournals.com.

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Correspondence to: John F Mayberry *Postgraduate Medical Journal*, Gwendolen Road, Leicester LE5 4PW, UK; pmj@bmjgroup.com

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