medical record documentation, risk management and health care economics for every new hospital recruit. Several years ago I met a former resident who had just completed one of these courses. 'I've become a billing machine!' he told me proudly. In the US fee-for-service environment these skills are vital. The hospitalist is often under the gun from his or her employer (whether a hospital, a national chain or a local group) to consistently bill to the highest level that can be supported by their notes (electronic health records have been an enormous help) and to see as many patients as possible. For most hospitalists, a part, if not all, of their salary is determined by the number of fee-for-service relative value performance units (RVUs) they clock up.[3]

Like emergency room physicians, hospitalists are shift workers who generally do not have the opportunity to form significant personalised bonds with patients. They manage only hospitalised patients and have absolutely no outpatient responsibilities. They work in a very focused and efficient manner, recording medical history, carrying out physical examinations, writing discharge summaries and progress notes, checking results of investigation and carrying out the suggestions of the various consultants on the case. However, there is, quite frankly, no expectation of the hospitalist consistently providing significant clinical insight into individual patients. Moreover, when a patient needs to be transferred from the regular medical ward to an intensive care unit, hospitalists are generally out of their depth, and provision of comprehensive clinical care is transferred to the intensive care specialist.

In the past, hospitals looked to hospitalists to shorten length of stay. Now, as the Affordable Care Act starts to roll out, the key missions for the hospitalists will be to keep readmission rates as low as possible and to achieve, in every patient, compliance with 'core measures' (such as making sure that every heart failure patient is on a beta blocker and ACE inhibitor at the time of discharge). Hospitalists are very good at achieving the latter goal; their effectiveness in reducing readmission rates is less certain.

Accordingly, and in full agreement with the opinions expressed in your editorial, I feel that US-style hospitalists are unlikely to improve delivery of patient care in the NHS.

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In order to encourage general internal medicine (GIM) as a specialty we must learn from our peers outside the UK

Editor – It was heartening to read Kirthi *et al's* article (*Clin Med* August 2012 pp316–19) concerning the debate surrounding the role of the general physician in the UK.

Amongst others, the UK is facing two main challenges in healthcare provision: an ageing population and an obesity epidemic. Both old age and obesity are associated with increasing comorbidities such as diabetes and hypertension. However, it is not only within the confines of the inpatient setting that this demographic will be seen. Outpatient and primary care services will likely be dealing with the majority of people with complex multiple comorbidities. Moreover, it is not only physicians who will be affected, but allied healthcare and social services professionals as well.

As Kirthi *et al's* article rightly reflects, shared care and pooling of resources – as has occurred on orthopaedic wards with involvement of geriatricians – is an important step forward. However, roll-out of 'shared care' requires a body of generalists and support for the general physician as a specialist that appears to be thriving in countries such as the US and others within Europe, but is absent in the UK.

Having recently attended a European Society of Internal Medicine conference (ESIM 2011), it was encouraging to see the pride that certain EU countries (eg France and Spain) take in becoming a generalist in its purest sense, ie *not* a geriatrician, *not* an acute medical physician, but a 'general internal physician'. This distinction will be essential in shaping an evolving healthcare provision for those with multiple comorbidities, as will a potential redefining of what constitutes 'geriatric medicine' – an excellent specialty in its own right – in the modern day of longevity of life span. Where would be the arbitrary cut-off for review by a generalist as opposed to a geriatrician? Aged 75 years? Or would a generalist see patients of all ages?

In order to encourage general internal medicine (GIM) as a specialty we must learn from our peers outside the UK. Essential conditions for promoting GIM would include:

- viewing it as an 'ology' – a specialism in its own right – and according it the prestige it deserves
- educating medical students about the role of the generalist in hospital medicine
- involving role models for medical students and junior doctors to look up to in order to consider pursuing a career as a generalist
- ensuring reasonable working conditions to avoid the job dissatisfaction, noted in Kirthi *et al's* article, in medical registrars who are essentially on-call, albeit acute, generalists
- promoting and fully utilising such GIM bodies as the Royal College of Physicians and ESIM.

Future provision of care for an ageing population will require not only the above but also a bridge between hospital and community services that incorporates cohesive multi-disciplinary team input. We must put behind us the days in which a patient with multi-system complaints and health needs may be passed between multiple specialties prior to any formal diagnoses due to their condition 'not being my specialty'.

Humans are complex organisms that, as they age, require a generalist approach. This is currently missing in UK medicine.

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Economic crisis and primary healthcare in Greece: 'disaster' or 'blessing'?

The current economic crisis hit Greece more severely than any other European country, posing a direct threat to health, but also offering the Greek health system a 'questionable' advantage – an opportunity to redesign the whole approach to healthcare. The political will to confront the interests of professional and social groups has been strengthened by the economic threats. The implementation of deep, strategic changes is critical, with the key targets being 'value for money' and effective and efficient allocation of the scarce resources.

What has been the response of the government to date? The most radical change was the merging of health insurance funds and the establishment of EOPYY, (National Organization for Healthcare Provision), a monopolistic purchaser with enhanced negotiating powers.[1] The formulation of a common package of benefits has offered the means to eliminate social inequalities. The next most important measure was the launch of an electronic prescribing system, which enables monitoring of doctors' behaviour. Clinical practice guidelines for common diseases were developed, aiming to provide evidence-based and safe practice. Other measures were imposed to tighten control over pharmaceutical expenditure.

What still needs to be done? Health coverage must become a universal right based on citizenship, rather than an employment benefit – this is essential while the unemployment rates rise. Re-orientation of the health system to primary care and public health is now more necessary than ever. A primary care network must be established which functionally integrates public and private providers. The 'family doctor' system must be implemented, with responsibility for referring patients to other health services, ensuring continuous care. Citizens must have free choice of their personal doctor. The lack of GPs can be addressed by attracting specialists to retrain 'on the job' as GPs. Physicians' compensation by the public sector must be fair, otherwise they will not abandon opportunistic practices. Changing the compensation system offers the opportunity to offer incentives to physicians to be more productive and effective. Family doctors could be reimbursed by a hybrid system of 'capitation' and 'pay for performance', linking payments to outcomes, and specialists could be paid by a combination of 'fee for service' and 'global budget'. This would foster competition among physicians, but would also discourage them from inducing demand and promote better geographical distribution in the country. The introduction of electronic medical records is critical for the enhancement of efficiency of the system and also for monitoring physicians' behavior and conformity with clinical guidelines. Auditing mechanisms are necessary. Finally, more resources should be allocated to prevention and health promotion policies – unhealthy lifestyles are popular in Greece and hamper the efficiency of the system.[2,3]

Budget cuts without major reforms will lead to a Greek 'health tragedy', but I strongly believe that the opportunity to re-engineer health service, thereby treating the inefficiencies of the past, can offer the entire population access to quality healthcare while keeping the cost in check.

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Risk of developing acute kidney injury (AKI) following the administration of iodinated contrast medium

Editor – We were pleased to see the article entitled 'Acute kidney injury: top ten tips' by Prescott, Lewington and O'Donoghue and its logical pragmatic advice for protecting patients from in-hospital acute kidney injury (*Clin Med* August 2012 pp328–32). However, we were disappointed by the missed opportunity to alert physicians to the potential renal injury caused by iodinated contrast medium (CM). While large volumes of CM are used for angiographic imaging and intervention, by far the largest volume of CM is used for enhanced computed tomography (CT). We estimate in our hospital alone, we give over 600 litres of CM to patients undergoing CT annually. Even with modern low osmolar and iso-osmolar CM, there is a risk of generating contrast induced nephropathy (CIN) in patients with already limited renal function. CIN is defined as an increase in serum creatinine of >25 μg/l over baseline, or an absolute rise of >44 μg/l. Patients with GFR <60 ml/min are at risk, which rises sharply when GFR falls below 40 ml/min.[1]

The demand for CT is steadily rising. Most radiology departments experience CT demand increasing by approximately 10% annually at present. While the high radiation dose of body CT has been a disincentive to its use, CT machine manufacturers are working hard to improve image quality, while limiting or reducing radiation dose. This means that CT will be more widely used for the assessment of acute thoracic and abdominal pathology. Cancer staging and the follow up of chronic conditions such as inflammatory bowel disease will further increase the need for CT. Barium enema is obsolete – its place is taken by CT colonography. These factors will increase demand for CT in an ageing population and physicians referring patients for imaging must be aware of the risk posed to their patients by CM administration. Good guidelines for the

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