Frameworks and Lord Darzi's report *High quality care for all.*[3] The recently published review on tackling health inequalities by Sir Michael Marmot challenges the government, individuals and organisations to assess their contributions to this agenda.[4] In this issue of *Clinical Medicine,* Kiran Patel, Peter Spilsbury and Rashmi Shukla (pages 130–3) discuss the leadership and advocacy role that doctors can play in addressing the effects of the social determinants of health and the contribution that they can make to improving the public's health.

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## Acute medical care

The journal is circulated mainly to fellows who are established consultants. We are keen to publish articles of interest to the 'younger physician' – those in training for careers in hospital medicine, newly appointed consultant physicians and our Collegiate members. To this end we have appointed three younger physicians to the Editorial Board who are developing relevant new series.

The first contribution to the new series 'Acute medical care' will be published in the June issue of the journal. The author, Dr Tahseen Chowdhury, conceived the idea and provides the first paper. Contributions may be up to 1,000 words with a maximum of five key references. They should include five headings – case presentation, differential and most likely diagnosis, initial management, outcome and discussion. Contributions are welcome and invited. Further information is available from clinicalmedicine@rcplondon.ac.uk where contributions for consideration should be sent.

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*Clinical Medicine* 2010, Vol 10, No 2: 108–9

# Consultants: a chronic problem for acutely ill patients

Matt P Wise and Paul J Frost

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has recently published its report into the care of patients who died in hospital with a primary diagnosis of acute kidney injury.[1] The strength of this and previous NCEPOD reports is that they are based on expert appraisal of the care that patients actually receive and, moreover, selecting death as a criterion for case selection inevitably highlights deficiencies in clinical care or organisation.

One of the key findings of this latest study was that nearly a quarter of patients did not have adequate senior review. These individuals were judged by the expert assessors to have less good care overall. The lack of consultant involvement has been a recurring message from NCEPOD, being implicated in adverse outcomes for cardiac patients, trauma patients, emergency admissions and acutely ill medical patients.[2] Unfortunately, this observation is not new. Over a decade has now passed since the publication of a seminal paper by McQuillan and colleagues, which called for increased involvement of consultants in the management of acutely ill patients.[3] In spite of this, the latest census of consultant physicians in the UK showed that as few as 56% undertake twice-daily ward rounds for acute admissions, with only 12% performing continuous rolling review.[4] Moreover, the majority of consultants (78%) have other duties while being responsible for acute admissions and 55% have insufficient time to support trainees.[4] These alarming figures were in the context of whole-time consultants working in excess of the average contracted 11.3 programmed activities. Undoubtedly these data reflect an improvement over what would have been recorded a decade ago but still fall short of best patient care. It would without question make no sense to an impartial observer why the sickest patients are seen by the most inexperienced clinicians first and only seen by the most experienced at the end of the admission process.

Historically, consultants have been insulated from directly managing acutely ill patients by teams of experienced junior

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doctors. Over recent years, a series of initiatives and legislation, including Hospital at Night, Modernising Medical Careers and the European Working Time Directive, have fundamentally altered the role of junior doctors. Medical training has moved from apprenticeship with a mentor to a studentship with teachers, and there has been a concurrent loss of teamwork, continuity of care and ownership of patients.[5,6]

Reports from the National Institute for Health and Clinical Excellence (NICE) and the Royal College of Physicians (RCP) have largely obfuscated the central role that consultants should have in the management of acutely ill patients. NICE guidance entitled *Acutely ill patients in hospital* attempts to address some of the deficiencies of care by recommending a graded response strategy to patients identified as at risk of deterioration by a physiological track and trigger system.[7] Although it is recommended that decisions to admit patients to critical care should follow a dialogue between referring and critical care consultants, there is no explicit suggestion that consultants should have hands-on clinical involvement and little emphasis on diagnosis, timeliness of investigation and treatment or the recognition of futility.[7] The RCP's recent publication *Acute medical care: the right person, in the right setting – first time* addressed many of these concerns but it avoided terms such as consultant, registrar or senior house officer and defined doctors as either competent or senior clinical decision makers.[8] The model is that patients should be seen initially by a competent clinical decision maker, and reviewed by a senior clinical decision maker at the earliest opportunity.

The emergence of acute medicine as a specialty may improve the care of acutely ill medical patients. Indeed, many hospitals have developed medical admission units with dedicated acute physicians, which improve outcomes and reduce length of stay.[9–10] Additionally, innovative modifications have been made to consultant surgical practice; for example, the introduction of an emergency surgeon at one large acute UK hospital facilitated increased daytime operating, reduced out-of-hours surgery and increased early discharges of acute surgical admissions.[11] However, these models are predominantly restricted to daytime working and do not address care of the acutely ill patient at night.

Adoption of a resident, consultant-delivered 24-hour service is emerging in some specialties and may be accelerated by recent changes in junior doctor working including the reduction of the working week to 48 hours.[12–13] Implementation of resident working for consultants is likely to be unpopular, especially with those who have spent long periods of their career working in excess of 80 hours a week on onerous on-call rotas. Critics of this model of practice argue that it reduces training opportunities, although experience suggests otherwise.[12,13] There are also a number of potential social benefits including less time spent working in a shift system than traditional on-call rotas, which can improve work–life balance and job sustainability. Challenges remain, not least ensuring appropriate remuneration, avoiding burnout and limiting the effects of age on out-of-hours work performance. However, unless all consultants responsible for acutely ill patients consider changing the way they work, these patients will continue to suffer adversely.

## Conflicts of interest

MPW was a clinical advisor, NCEPOD, *Acute kidney injury: adding insult to injury* and *Death in acute hospitals: caring to the end?*. MPW and PJF work a resident on-call system in critical care.

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