

The acute physician: the future of acute hospital care in the UK

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Introduction

In 2003, the Specialist Training Authority recognised acute medicine as a subspecialty of general internal medicine (GIM) for the purpose of structuring training for the future acute medicine specialists. Expansion of the specialist training posts in acute medicine since then has been rapid. The changes associated with Modernising Medical Careers (MMC) have seen acute medicine training establish itself firmly within the pathway of the acute care common stem (ACCS) alongside training in emergency medicine and intensive care.

Change in the management of acute admissions in the NHS is inevitable in the field of acute medicine. Trusts have to provide high level resources and staff 24 hours a day, seven days a week.¹ The huge increase in the number of patients admitted to hospital in the last decade has led to new admission units, and more importantly the recognition by the Specialist Training Authority of acute physicians to lead acute medical teams.² Although still in its infancy, the remodelled concept of the acute physician has thrived. Studies consistently demonstrate a clear cost benefit when this cohort of physicians is involved in the acute care of patients.³ Acute physicians are shown to be more efficient, less wasteful and speedier to respond to the needs of patients than other physicians in the hospital environment. As the principal care providers, they will be expected to treat, triage and work in all acute areas of the hospital, from the front door to critical care, thus helping to maintain the continuity of patient care. This should reduce stagnation and delay, reduce the length of hospital admission, and promote greater community care and collaboration.

As the first cohort of acute physicians joins the ranks of consultants the question is less ‘where’ they fit in but more ‘how’ will they lead acute care provision in the future – what benefits will this bring and how will it be achieved?

Historical context

The last decade has seen the rapid development of acute admissions units within NHS trusts. They have been created to meet the challenges presented by:

- an increasing demand
- pressures placed upon the service by the European Working Time Directive

- a changing attitude towards hospital admissions and discharge
- the concept of community care
- a reduction in bed availability
- MMC
- a realisation that acute patients need a high-quality acute service no matter where in the country they may be.

Running parallel to the development of these units was the new acute medicine specialty, first formulated in 2000 and which initially formed part of the GIM training curricula.⁴ Whether intentional or not, the flame had been lit for the creation of a new breed of doctor with a core range of skills that allow the patient to be managed on a day-to-day basis in the new acute admission units. At the outset, to satisfy manpower issues, the workload of the acute admission unit had been (often reluctantly) assumed by on-call teams from the medical specialties who were encouraged by the medical royal colleges to attain dual accreditation in GIM. Medical specialty consultants found themselves responsible for on-call acute take, inpatient ward work, outpatient clinics, teaching and research.

Over the past decade there has been an overwhelming increase in workload for acute trusts; a large proportion of the demand coming from the medical specialties.⁵ Some trusts introduced new units to deal with the increasing number of emergency admissions and to act as buffers in periods of pressure. The evolution of these units was highly variable throughout the country, with some trusts using the clinical decision unit or medical assessment unit as a method of reaching targets, avoiding breeches in accident and emergency, or as a place to prepare patients for discharge. Those that developed these units in the spirit in which they were planned have seen the obvious benefits for patient safety and management.⁶

In 2004 the Federation of Royal Colleges of Physicians formally recognised the emerging specialisation of acute medicine and defined its role more clearly as one ‘concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present to hospitals as emergencies.’⁷ The proposals set out key standards for the day-to-day management of patients in the unit: the number and seniority of the dedicated staff. It recognised and endorsed the need for acute medicine specialist training and, within the training mandate, it encouraged a workable interface with emergency medicine and intensive care departments. The creation of clinical adviser posts at a regional level and the reconfiguration of the committees within the Royal College of Physicians (RCP) were recommended to provide leadership and to ensure strategic and quality interests. The acute physician had arrived and their role became integral to the working of the NHS and the optimal management of acute patients.

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In 2006, the RCP working group on acute and general medicine reported on the training and shaping of the acute physicians role in the acute care provision.⁸ It provided interim solutions for care and for the first time encouraged changing the term 'general internal medicine' to 'acute medicine': an important milestone in the graduation of acute medicine as a specialty.

The recent consensus statement for acute medicine published by the Royal College of Physicians (Edinburgh) states a number of key principles.⁹ It formally severed GIM from the acute specialty definition. The paper acknowledged that the care of acutely ill patients is the core business of the NHS and that this can only be achieved by improving interaction and communication between acute and community services. It also highlighted the need for clearer cohesion between all critical care services from the emergency department to intensive care. Collaboration and integration of the acute services is deemed fundamental.

One patient, one team, one place – the future

Any credible method of care provision requires a team of acute physicians with a wide range of diagnostic and management skills, coordinating the overall care of the patient in order to satisfactorily triage, treat and return the patient into the community. This will be the only way that trusts can achieve the standards expected of them while complying with the employment legislation and directives.

The acute physician and their team will play a key role in the streamlining and integration of acute services. The day-to-day management of patients will be undertaken by a team of acute physicians who have generalist skills and who make use of relevant specialist input. Sick patients often present with more than one disease process. It is inevitable that they will require regular and expert advice from a number of specialties, with an acute team managing the presentation and ensuring that the specialty advice is coordinated to achieve best outcome. The acute physicians should be on the front line of hospital admissions and, as part of their training, have working competences in critical and emergency care medicine. This is a major change to our current approach to the assessment and management of patients but one that will improve patient throughput and outcome. The current need to assess patients by several independent teams before being admitted to the appropriate specialty or dependency level is an obvious barrier to good care and management.

Ultimately acute physicians will need around half the acute medicine beds in the current hospital environment incorporating accident and emergency, critical care and a well-established and supported diagnostic centre, the acute hospital hub.¹⁰

Over the years, the increasing demand for acute care provision by hospital trusts was associated with a shift of chronic disease management towards primary care. Reviewing the hospital bed occupancy on the conventional medical wards at any one time, about half of all patients can be categorised as acute and requiring in-hospital observation and management. The others either await appropriate transfer of care to the community or diagnostic and therapeutic interventions.

The navigational pathways should be appropriately developed and a strong multidisciplinary support network implemented to allow these units to work efficiently at all times. The changes have already begun but future alteration to diagnostic centres will help reduce hospital admissions and costs. Bed occupancy will include dedicated specialty specific or elective throughputs and some as a contingency for the seasonal increase in demand.

Acute medical teams led by acute consultants are vital to improve patient care and safety. A patient who has investigations ordered and completed before review by relevant subspecialties will achieve speedier diagnosis, decisions and subsequent discharge, and much research has been undertaken in the USA that supports such findings.^{11,12} The indirect benefits include reduced hospital admission times, increased continuity of care, medical teams ideal for teaching and a clear cohort of patients that are considered acute and in need of acute management.

While this article focuses on the admission of acute medical patients there is a large cohort of acute surgical patients with similar dependency needs. Who should be responsible for this group? There is a plausible argument that these patients should come under the care of acute physicians with surgeons on hand to consult in a similar way to those in the core medical specialties. Releasing our surgeons to perform surgery has obvious implications for improving waiting times and throughput.

The MMC concept of grouping acute medics, intensivists and emergency care physicians together in the ACCS programme is a perfect platform for the future training of the acute physicians but the vision of the common theme among the specialties is limited as trainee physicians have to choose their subspecialty early on in training.¹³ This is probably unnecessary and does not guarantee the creation of an acute physician with the wide ranging skills needed to work in all areas of the acute hub. A viable solution would be to allow for subspecialist interests to be developed later in the acute physician training programme, thus providing a cohort of physicians with competencies that overcome the current barriers between acute specialties.

The core medical specialties will also be subject to major change to the way in which they work within the NHS. A hospital can only run with these specialties but there is clearly a changing attitude towards the provision of chronic care in the community. In addition to primary medical roles, the acute consultants of the future will take on the role of medical management to bring together specialties, allied health professionals and primary care to ensure effective overall health provision.

The Darzi reforms have highlighted the need to develop more services in primary care to promote greater access for elderly patients and subsequently to alleviate unnecessary pressures on secondary care trusts.¹⁴ General practitioners can no longer cope with the major demands being made upon their services, and the lack of access has inevitably led to acute admissions as a default for patients who can no longer appropriately be managed – medical specialty consultants will have a major impact on these numbers. Improved specialist services in the community will require core specialties to have accessible clinics and it will also demand a clearer understanding between the acute hospital and primary

care providers, to ensure care pathways and management plans are well established for patients before the need for admission.

The acute medicine specialty in some studies has also been shown to offer improved educational experiences for medical students and postgraduates alike.¹⁵ Given the reinforcement of the team, and the move towards central admission, there will be an improvement in the acute medical education offered to students and junior doctors.¹⁶

Conclusion

In the future, the acute hospital will be dominated by acute physicians – doctors with core skills who will manage the patient from door to discharge at all levels of clinical dependency and who will form a team responsible for the patient, in one place, with the support and expertise of specialty and allied professionals. Not only will the acute physician be the lynchpin for improved patient safety and continuity, they will also reduce the length of stay and hospital costs, and will offer a management model that will allow the modern NHS to survive in a period of increased demand on resources and the workforce itself.

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