The changing face of acute medicine

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Those involved in the provision of acute medical care are suffering from work overload, change overload and information overload[1]. If we were enzymes (and at one level that is all we are), we would be saturated with substrate and at, or approaching, our V_{max}. We all know that our acute services cannot continue in their present form and that something has got to change, but we are less certain about what should change and how. Most physicians see the long-term solution as evolutionary, involving more doctors, more nurses and more acute beds[1], but are uncertain about how to maintain the service until these become available. Others, including the outgoing Past President of this College, Professor Sir George Alberti, believe that 'we need completely new thinking to solve the problem – not just refinements of the present system'[2].

Some managers would like to turn the present system upside down, with all emergencies being admitted to small, local hospitals which are bristling with technology and networked to larger district general hospitals (DGHs)[3]. Practising physicians who are, by nature, cautious (but not, as is sometimes claimed, reactionary) are largely unconvinced by arguments for quantum leaps into the unknown. They are also suspicious that such changes might be introduced without prior evaluation[4]. The Royal College of Physicians has published various reports which relate to the practice of acute medicine[5–7] and has now produced three more, one on the practice of acute medicine in hospitals which lack other acute services such as acute surgery, critical care and on-site diagnostic services[8], and another on the interface between accident & emergency (A&E) services and acute medical services[9]. The third, on the interface between acute general medicine and critical care[10], was the subject of an editorial in a previous issue[11]. All three reports are in the category of evolutionary rather than quantum-leap change, so do they contribute to the current debate or are they just a further addition to the information overload?

The report on *Isolated acute medical services*[8] is based on a questionnaire survey of 59 acute medical services in England, Wales and Northern Ireland which do not have one or more of the following services on site for 24 hours each day: acute general surgery, an A&E department taking unselected admissions, resident cover for anaesthesia, and an intensive care unit or coronary care unit. Most also lack on-site diagnostic services. Some of the findings give cause for serious concern. For example, 13 hospitals admit patients with acute gastrointestinal haemorrhage even though there are no on-site facilities for cross-matching blood, and nine of the 13 have no resident surgical service. Thirty-two of the respondents report concerns about the lack of critical care facilities or anaesthetic cover or both. Patients in these hospitals experience delays in obtaining surgical opinions and diagnostic investigations, and are frequently inconvenienced by having to travel to a neighbouring DGH for opinions and for imaging investigations. Supervision of trainees by consultant physicians is often suboptimal because in 42% of hospitals the consultant on call is also responsible for patients on another acute site. The report provides compelling evidence that acutely ill patients should not be admitted to hospitals which do not have critical care and appropriate diagnostic services. It recommends that such hospitals should be re-configured to provide intermediate or step-down care after a definite diagnosis has been established, the patient's condition stabilised and a management plan formulated in a hospital with full acute services. The report also makes recommendations for interim arrangements (eg outreach critical care services, criteria for admission) during the transition phase of conversion of these hospitals to intermediate care centres.

The report on *The interface of accident & emergency and acute medicine*[9] has features in common with the report on *The interface between acute general medicine and critical care*[10]. The first report's recommendations can be categorised under the headings of organisational, facilities, training and staffing. Most of those relating to organisation and facilities are uncontroversial and many are not new. The recommendations for 24-hour critical care and diagnostic services echo those in the isolated services report[8], and medical admission units (MAUs) are already almost universal. The introduction of a new post of health care practitioner to complement the work of doctors and nurses has already been recommended by the College[6] and is being introduced in an increasing number of hospitals. The recommendations for a common clinical management structure for all elements of the acute service and the appointment of a consultant physician or consultant in A&E medicine as clinical

director of acute medical services might well improve the service, though no evidence is presented to support this proposal. The proposal for a generic clerking record to collate information collected by both doctors and nurses in A&E and on the MAU (and perhaps more ambitiously the referring doctor and ambulance personnel) sounds sensible but will only work if someone can create a practicable document. The same applies to the proposals for RCP databases of clinical standards for acute medicine and regularly updated clinical management protocols. The mention of the axiomatic and yet apparently unattainable requirements for better IT support and for 7-day, 24-hour access to patients' health records will produce a collective sigh of 'If only' from every quarter.

Both this report and the one on critical care recommend that all senior house officers (SHOs) training in general internal medicine should spend part of their rotations training in an A&E department and in critical care. The critical care report specifies that both of these attachments should be in the first year of the rotation and envisages that each attachment should be for three months, whereas the A&E report recommends three months in intensive care and six months in an A&E department. Perhaps these and other issues will be clarified when the long-awaited report of the Chief Medical Officer's working party on the SHO grade finally sees the light of day.

More controversial will be the recommendation in both the A&E[9] and critical care reports[10] that designated consultant physicians on take must cancel all other commitments, including those that are normally fixed and, in the A&E report[9], that they must do so not only for their own scheduled takes but also when they are cross-covering for absent colleagues. Perhaps it was not within the remits of the working parties to consider the non-acute responsibilities of consultant physicians, but the reality is that the conflict between the emergency take and other duties, particularly a physician's specialty workload, is one of their most pressing and urgent concerns[1]. The critical care report does recognise that the proposal 'will take several years to realise' but makes no suggestions for interim solutions[10]. Meanwhile many physicians, particularly those in smaller hospitals with perhaps a daily intake of 20 admissions (of whom more than half are often admitted outside normal working hours), will continue to question whether this proposal is really necessary and whether it represents the most effective use of their time.

In 2000, a College report recommended that the existing posts of acute care physicians (ACPs) should be thoroughly evaluated before a new specialty of ACP with a separate training programme was created[5], and in 2001 the College advised that although ACPs 'seem to have met a real need to improve the quality of acute care', 'the appointment of physicians solely to provide acute care without links to a specialty … should be discouraged'[7]. Even then, this recommendation was being overtaken by events as trusts continued to appoint ACPs, and there seems to be a tacit recognition of this in the recent reports on A&E medicine and critical care[9,10]. However, the College should make more explicit recognition of these posts, which have a variety of duties and responsibilities, and should publish guidance on the appropriateness of job descriptions.

The recommendation that the acute on-take team should not have simultaneous responsibility for patients already in hospital and that each department must therefore have two teams on call[10] will raise a hollow laugh in most hospitals which are already struggling to staff just one team and which face increasing problems with the further implementation of the European Working Time Directive. The A&E report[9] also reiterates the College recommendation that an on-take team should not have responsibility for more than 20–25 acutely ill patients[7], but this takes no account of the composition of the on-take team which, excluding the consultant, can vary from two to six doctors[1]. Some physicians, particularly those in DGHs, have questioned whether the College is taking proper notice of their views and opinions[1], and they may have a point: most emergencies are admitted to DGHs, but of the 37 physicians on four recent working parties involving acute medicine[5,6,9,10] only nine (24%) came from non-teaching hospitals.

It is always easy to find fault, but there is also much that is good and useful in these reports. Most importantly, they focus on the quality (or lack of quality) in acute medical care and on what must be done to improve it. Who else but the Royal Colleges are really concerned about the quality of patient care at this time, and who else knows more about the issues than the fellows and members of those Colleges? Education, training and service are inseparable components of the profession of medical practice: the General Medical Council and the new Medical Education Standards Board must not exclude the Colleges. If ever there was a time when clinicians and their patients needed the support of the Colleges – and the Colleges needed the support of their fellows and members – it is now.

References

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