Acute medicine: making it work for patients

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Last month saw the publication of the Royal College of Physicians' most recent report on the delivery of acute medical services.[1] The tensions between increased specialisation and the need to retain high quality general medical skills to manage the emergency workload are well recognised. These pressures, coupled with an aging population and rising numbers of medical emergencies, have led the Medical Royal Colleges to consider how the needs of patients might best be met in several reports over the last few years.

In 1996 the Royal College of Physicians of London (RCPL) reviewed different models of care[1] and concluded that emergency care provided by specialist teams would only be possible in very large hospitals covering large populations. The report recommended that in the majority of hospitals, care would continue to be provided by consultant physicians with specialty training, who participated in the on-call rota for acute medicine and practised their specialty in parallel. Interestingly, an alternative possibility was outlined: 'a new type of physician with specific responsibility for the care of medical emergencies'. This was noted to be 'a radical proposal which requires specific study and thorough evaluation in initial trials before it could be implemented.'

In 1998 the Scottish Intercollegiate Working Party outlined recommendations for 'Acute medical admissions and the future of general medicine'.[2] It suggested that large hospitals might consider appointing 'physicians in acute care medicine' and that the Colleges should consider setting up a working party to address career structures and training issues, as well as a working party to liase between medicine and the Faculty of Accident and Emergency Medicine. The report also emphasised that dual accreditation and regular practice in General (Internal) Medicine (G(I)M) and a specialty in all but the most refined tertiary situations was a critical element in maintaining high quality acute and general medicine. In 2002 the RCPL published a report entitled 'The interface of accident and emergency and acute medicine',[3] emphasising the importance of strong clinical leadership for acute medicine, as well as a report on 'The interface of acute medicine and critical care'.[4]

In 2000 the Federation of Medical Royal Colleges published the report Acute medicine: the Physician's role – proposals for the future.[5] This working party addressed the questions of how best to provide acute medical care in hospitals and what type of physicians were needed to provide the care. Once again the importance of dual accreditation and training in acute medicine as part of G(I)M training was emphasised, as was the importance of consultant physicians in providing leadership to medical admissions units and of ensuring adequate consultant time to undertake emergency care. However, the report concluded that emergency patients should continue to receive care from experienced general physicians with appropriate specialty training and that 'the appointment of physicians solely to provide acute care without links to a speciality should be actively discouraged'.

Why then, did we need yet another report on the delivery of acute medical services? The last couple of years have seen an unprecedented and rapid change in established working patterns, driven by the imperative to meet the European Working Time Directive and compounded by the changes in training set out in the Chief Medical Officer's report 'Unfinished business' and in the Department of Health's (DoH) response 'Modernising medical careers'. Shift work and fragmentation of the team due to the reduction in junior doctors' hours have led to poor continuity of care for patients and a loss of learning opportunities for trainees at a time when the importance of direct and early senior supervision is increasingly emphasised.

These pressures have led many trusts to develop a range of non-training grade posts, including a plethora of advertisements for consultants in acute medicine, with wide variation in the job descriptions, roles and responsibilities and in the training of appointees. Concerns regarding the variation in standards of care for patients have been reported to the RCP and increasing numbers of consultants and specialist registrars (SpRs) have voiced their desire to give up their acute medical commitment and concentrate on speciality care. Conversely many of the increasing number of consultant physicians in acute medicine reinforced the view that acute medicine can be a rewarding career, and result in improved patient care and use of resources. It was indeed timely that the President of the RCPL invited the New Consultants' Committee to lead a working party to review and update the 2000 Report.

This report addresses these issues by focusing on acute medicine as a new specialty but it provides guidance for all those who deliver acute care. The Working Party took evidence across a range of specialties and healthcare professionals including consultants, trainees, non-consultant career grades and nursing staff working in teaching hospitals, in district general hospitals and in general practice. They took evidence from advisors to the DoH representing emergency care, medicine and primary care as well as medical and clinical directors, and consulted individuals with expertise in training, personnel and workforce planning, both from within the RCP and externally. They discussed the strengths and weaknesses of different models of care and the training and manpower implications to support them.

The Working Party reviewed previous reports and endorsed many of the recommendations. Thus the current report draws together and builds on previous work and reinforces the key messages. It goes further, and one of its great strengths is that it makes precise and practical recommendations for improving the standards of care, by defining the time, manpower and facilities required to manage acutely ill patients. These standards for the delivery of services will be of value to both clinicians and hospital managers and to those planning health care services.

The Working Party identified clear objectives, which are outlined in the report, including the definition of the new specialty of acute medicine (the preferred term) and ways of raising its profile. The Working Party recognised the importance of a strong national voice to aid the development of acute medicine. The report recommends that a network of advisors be established, with a consultant physician in acute medicine as lead clinician for the service in every trust. Regional specialty advisors, appointed jointly by the RCP and the Society for Acute medicine, would support them. It recommends the appointment of a National Director of Acute medicine by the DoH, who would work with the Medical Royal Colleges, postgraduate deans, the regional specialty advisors and the National Director for Emergency Access. It must be expected that the latter in particular should warmly welcome this initiative! The Report also recommends that the General Internal Medicine Committee of the RCPL be reconstituted as the Committee for Acute and General Internal Medicine, with appropriate membership from the Society for Acute Medicine, the Faculty of A&E Medicine and representatives from the Scottish Royal Medical Colleges.

The Medical Royal Colleges should work together with the deans of medical schools to develop a sound academic base for acute medicine. Training in acute medicine should be routine in undergraduate medical studies, with dedicated time for formal teaching and clinical experience in acute medicine units. At postgraduate level changes in medical training are imminent and the two foundation years plus subsequent basic medical training should afford improved exposure of trainees to A&E and primary care and should include fixed attachments to acute medicine units. These attachments should be sustained over blocks of at least one month, and up to four months, and shift sessions only should be discouraged.

Following the recognition of acute medicine for subspecialty training by the Joint Committee for Higher Medical Training in July 2003, all trainees in G(I)M continue to require appropriate training in acute medicine, but those wishing to acquire subspecialty accreditation in acute medicine will require one extra year on completion of higher specialist training in G(I)M. The responsibility for assessing training will shortly move to the Postgraduate Medical Education Training Board, which should ensure trainees in acute medicine receive dedicated experience in acute medicine units, cardiac care units, high dependency units, intensive treatment units, A&E and in geriatric medicine. The report recommends that trainees should undertake the College's ill medical patients' acute care and treatment (IMPACT) course as well as management training, to cover the key clinical and organisational skills described in the acute medicine curriculum.

The report looks at the workforce requirements to deliver acute medical services over the next 10 years. It notes that consultants with another specialty interest deliver the majority of acute medicine at consultant level and that this is likely to be the case for at least the next 10 years. There will be increasing support from consultants in acute medicine, currently numbering approximately a hundred, but at present the number of trainees in acute medicine is very small and there needs to be a planned increase in training posts in the subspecialty to sustain growth. The report recommends that the aim should be to provide at least three consultants in acute medicine in every acute trust within four years (by 2008), and more in larger hospitals. As the training scheme is new, many will enter by other routes, including non-UK specialists, and working across the A&E medicine and critical care interface should be encouraged. The Workforce Unit of the RCPL should collect and monitor data on the numbers of trainees and consultants working in acute medicine, including contributions from other specialities.

The report devotes a section to making careers in acute medicine attractive. This section is of particular importance in setting out specimen job plans for physicians practising acute medicine with a specialist interest and for consultant physicians in acute medicine. These job plans detail the direct clinical care programmed activities recommended and will assist regional advisors and trusts in drawing up appropriate models for new and existing consultant posts. Evidence from both trainees and established physicians in acute medicine suggested that most wished to remain in acute medicine for the duration of their careers and that burn-out was not a problem, provided job plans were satisfactory and support staff were in place. However, opportunities for consultant career development should be available to physicians in acute medicine, as indeed they should be for all specialists. Increasing roles in education or medical management are options, and there should remain the possibility of re-entering specialty training, or expanding expertise in defined specialist areas with appropriate competency assessments.

The section 'Maintaining standards of care' is excellent, pragmatic and practical, and should be read carefully by all clinicians and managers working to deliver acute services. The report sets out specific guidance for delivering high quality care to patients requiring acute medical services. It emphasises the importance of

rapid assessment by appropriately trained and supervised healthcare staff, and early review by an experienced doctor according to clinical need. Staffing and resources should be sufficient to formulate a management plan within four hours for a patient presenting as a medical emergency. A doctor with recognised experience in acute medicine should be present at all times in acute receiving units. This would usually be an SpR, or equivalent, in medicine or a medical speciality, with MRCP(UK) or equivalent and at least two years acute medical experience. A consultant should review all patients within 24 hours of admission.

The report highlights the failure to recognise the medical time required to provide acute medical care, in contrast to elective areas of medical activity such as outpatient clinics. In part II of 'Consultant physicians: working for patients', each specialty sets out its recommended standards for the time required to assess or treat specific numbers of patients and the manpower required to deliver the service. Historically, emergency work has been fitted in around elective commitments. As the emergency workload has risen, the time available to assess each patient has fallen to levels that may compromise safe practice and also overwhelm clinical staff. This report makes specific recommendations both for the availability of medical staff, and for the time required to assess and treat acute emergencies. It recommends that one hour should be allowed at house officer or senior house officer level to assess, document, investigate and gather results, prescribe and initiate treatment for each new medical emergency. The SpR should be available twenty-four hours a day, with no other scheduled commitments, to review cases, deal with the critically ill and take referrals and enquiries from other colleagues. Time must be allowed for adequate handover between shifts. Finally a consultant undertaking a post-take ward round would require 15 minutes for each new patient seen.

It is apparent how current practice in the UK often falls below these standards. At present the College recommends that a consultant physician should review each newly admitted patient within 24 hours. One consultant physician can see sixteen patients in one four-hour session (programmed activity), and, in the average acute medicine unit admitting 25–30 patients daily, this equates to at least two consultant sessions per day. This may require cancellation of other commitments and in all but the smallest trusts will need a consultant-led ward round at least twice in 24 hours. Similar standards have improved care in outpatients and are long overdue in acute medicine. The sessions required should then be identified by clinical directors in job plans, and would result in better understanding of the time and resources required to manage acutely ill patients.

The medium-term standard (currently achieved in very few units), is for consultant physicians in acute medicine to be available on site throughout the period when full support services are available, usually 8 am to 10 pm, and available for advice outside these hours. These aims are similar to the manpower projections for consultant availability in A&E proposed by the Faculty of A&E Medicine. This level of service will develop as the numbers of consultant physicians in acute medicine increase. In the long-term, when sufficient numbers are in place, there should be direct consultant involvement in acute medical units, provided that this can be matched by a full range of support services, 24 hours per day, in hospital and the community.

The report highlights the epidemic of acute medical patients cared for in non-medical wards and describes the regular presence of patients in such a situation as a failure of bed management in a trust. These comments, and the recommendations that all trusts develop an emergency admissions policy and escalation plan to manage overspill patients in a dedicated area with identified medical and nursing staff, will be welcomed by all.

The report concludes by recognising that different models of care will evolve in different trusts. It recommends that the aim should be to have at least three consultants with responsibility for acute medicine in every trust by 2008. Thus the majority of acute medicine in these hospitals will continue to be delivered by consultant physicians in other specialties supported by the physicians in acute medicine. Larger trusts may eventually have 7–12 consultants in acute medicine, thereby having the potential to provide most of the sessions required for an average workload. The report concludes that it is clear that apart from in a few of the largest centres the continued contribution to acute medicine by physicians in other specialties will be essential for the next 10–15 years.

Clinical directors will be able to use the session calculations to ensure adequate consultant input for acute medicine. There should be an incentive to appoint new consultants with a contribution to acute medicine. A specialty would only be expected to withdraw from the acute medical rota if the relevant consultants were providing a full 24-hour on-call rota for that specialty and there were sufficient numbers of consultants in other specialties to manage the acute medicine commitment. In larger trusts some specialties might provide a separate post-take ward round on a daily basis, where early specialist intervention would be beneficial to patients; this would apply particularly to geriatric medicine. Geriatric medicine was identified as crucial to contributing both to service delivery and to training the next generation of physicians in acute medicine.

The Working Party has produced a timely and authoritative report with clear recommendations and unambiguous standards for improving acute medical care. The emphasis placed on the identification of adequate time and resources to provide the care for acutely ill patients and the appointment of physicians in acute medicine to develop and champion the service should help to reverse the 'waning enthusiasm of physicians and trainees for acute medicine' identified in the report. It will certainly provide a better service for patients.

References

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