The consultant physician and the acute medical assessment unit

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The role of the consultant physician has changed greatly over the past 10 years. Since 1996 we have seen the introduction of the Calman reforms to specialist training, the European Working Time Directive (EWTD) and the new consultant contract. We have seen a change of government, bringing with it a 'modernisation of the NHS' and a multiplication of NHS targets. The EWTD led to a reduction in junior doctors' hours, fragmentation of patient care and fuelled a growth of Trust grade posts to make on-call rotas 'hours compliant'. More recently, we have had the introduction of Modernising Medical Careers and the conversion of posts for experienced senior house officers (SHOs) into posts for the less experienced Foundation Year 2 trainees.

The turn of the millennium was marked by many patients waiting in the accident and emergency (A&E) department for more than 24 hours for a hospital bed, the notorious 'trolley wait', leading to government targets for maximum waiting times in A&E of twelve and subsequently four hours. The introduction of these targets combined with ever-increasing numbers of emergency medical admissions has led to the development of the medical admissions unit or acute admissions unit (AAU) and the emergence of the new subspecialty of acute medicine.

What has happened to the consultant physician during this period of change?

In 1996, the physician did a 24-hour on-call period with 48 or even 72 hours at weekends. This was worked with their own team of senior registrar and/or registrar plus an SHO and a pre-registration house officer. The post-take ward round took place the next day (the senior registrar having done his rounds the night before) and the consultant saw the patients with the juniors who had clerked them and then the whole team continued to look after this group of patients until they were discharged. An outpatient appointment with the same team often followed. Complaints were few and patients knew who their doctor was.

In 2006, the consultant physician does a 12-hour and occasionally a 24-hour shift, with a number of different doctors (some of whom he has met before, but many of whom he will not meet again) who are on a number of different overlapping shifts. During the shift, the consultant is present in the AAU (joined by his AAU colleague) and the post-take round occurs twice a day. The consultant is now his or her own senior registrar (and sometimes his or her own SHO and house officer too). After patients have been assessed they are then dispersed to a number of specialist wards around the hospital. The physician may only see three or four of them again. When physicians return to their own specialty ward to do a round they will see a myriad of new faces almost all admitted by someone else and wonder if things have changed for the better. Accountability is difficult to pinpoint, complaints are increasing and the patient has no clue who his doctor is.

This may seem unsatisfactory for the consultant but are things any better for the patient? An article in this issue suggests that the new system may be better for the patient (or at least no worse) and in particular patients under 65 years of age may benefit the most.

Moore *et al* looked retrospectively at patient outcomes before and after the introduction of a specialty triage system at a large teaching hospital in Liverpool in the period 1995–2003.[1] In 1999, the acute medicine unit (AMU) expanded and a consultant in acute medicine was appointed followed swiftly by four others. Patients on the AMU were looked after by the acute medicine team until they were discharged or moved to an appropriate specialty ward. In 2001, an assessment area for rapid discharge was also added to allow a patient to be assessed, treated and discharged from the AMU team without the need for formal admission to a ward.

Following these process changes there was an increase from 27% to 56% in the proportion of patients being cared for by the appropriate specialty team, for example, asthma patients on the respiratory ward or angina patients on the cardiac ward. About 74% of patients fell into a specialty group although some categories were a little tenuous, such as deep vein thrombosis being assigned to the diabetes and endocrinology category. In addition, fewer patients were discharged from the specialty wards as a consequence of more being dealt with entirely

within the AMU. Readmission rates were not affected by the changes to the admission process.

Comparison of mortality data between the pre- and the post-triage years showed that there was a significant reduction in mortality in the under-65 age group following the introduction of triage by the team on the AMU in excess of the underlying downward trend in mortality rates. There was no change in mortality in older patients – probably because this group is likely to have more comorbidities and fit less well into a specialist category or to be equally well served by a number of different specialties.

Why should there be a reduction in mortality in the under-65s who have been more appropriately assessed and triaged? Is it because the specialist team is superior to the generalist team in managing younger sick patients? Specialist wards (or wards with a specialist flavour) allow nursing staff to gain expertise in a particular field and to develop close working relations with the doctors from that specialty and in turn they are able to advise junior doctors.

Or is it that the development of the acute medicine team (medical and nursing) has led to earlier recognition of the acutely sick patient (often with the use of an early warning score) and earlier initiation of appropriate treatment and this has reduced mortality irrespective of the final destination of the patient? Perhaps the absence of the chronically tired overworked junior and his/her replacement by a fresher shift-working doctor plus the presence on the AMU of more senior staff for much of the working day has contributed to care in the first 24 'golden hours'.

Although continuity of care has been lost, the process of patient handover has been brought into focus and formal guidelines for this have been developed by the Royal College of Physicians which may lead to fewer patients 'falling through the net' and thus improve outcomes.[2]

In either case, the study by Moore *et al* lends support to the continuing development of acute assessment units and to the continuing rise of acute medicine. The role of the consultant physician continues to change. We live in interesting times.

References

1 Moore S, Gemmell I, Almond S *et al*. Impact of specialist care on clinical outcomes for medical emergencies. *Clin Med* 2006;6:286–93.

2 Royal College of Physicians. *Continuity of care for medical inpatients: standards of good practice*. London: RCP, 2004.