Future Hospital Journal 2016 Vol 3, No 1: 70–1

Why I don't want to continue practising general medicine and delivering the acute 'take'

Author: Marcus Harbord[A]

ABSTRACT

Unscheduled admissions to hospital are usually coordinated by the acute assessment unit (AAU), often led in rotation by physicians from range of specialties, together with specialists in acute medicine. This hybrid model is a vestige since before the specialty of acute medicine was developed. The increasing elderly population means this needs to change, enabling elderly care physicians to work in parallel with acute physicians as the needs of patients in the AAU are largely served by these two disciplines. Specialties, including elderly care, should provide support by looking after patients with diseases in which they are expert, and by ensuring that the same specialist team looks after patients in the AAU and on downstream specialty wards. A major expansion in elderly care, and new ways of teamworking are required. A model of care is proposed.

KEYWORDS: Acute medicine, algorithms, acute assessment unit, geriatrics, acute medical unit

Ladies and gentlemen, this is your captain speaking. Welcome to this British Airways flight back to London. First-officer Harry England will be flying the aircraft. Some of you may recognise him, as he was the steward serving economy on the outbound flight…

Of course, this would never happen in a well-structured, modern high-risk industry such as aviation, in which an error could put people's lives at risk. But what about the contemporary NHS? Do we enable our specialists to use their skills optimally, thereby ensuring patients have access to the expertise they need? Or do we still practise in outdated and inappropriate ways?

I trained in medicine at St Mary's Hospital, London in the late 1980s. We felt we were at the cutting-edge of modern medicine, practising in a new hospital nestled among dour Victorian buildings. Much has changed since then. Stents have replaced streptokinase, viral hepatitis has been cured and HIV is no longer a death sentence. Yet the inpatient experience is largely unaltered. While acute assessment or medical units (AAU/AMU) are now central to the medical take, their introduction has in many ways fragmented the patient journey. Patients meet one set of doctors in accident and emergency, new ones in the AAU and, if they are unlucky not to get an early hospital discharge, yet another team are involved a couple of days later after they reach a medical ward. Add this physical movement to increasingly complex shift patterns, and the patient usually does not know the doctors' names, the doctors do not know the patients' names and often don't know each other's names.

For this reason, I want out. I don't believe the current model is sustainable, and propose here an alternative, fairly straightforward solution that could provide better continuity of care and enable the application of appropriate multi-specialist involvement. First, we need the right doctors running the AAU. Medical admissions mainly comprise the elderly with multiple morbidities who require specialist geriatric care; and patients with single-organ disease who are usually younger and should be treated by specialists in acute medicine. AAUs should therefore be staffed in parallel by experts in elderly care and acute medicine. To help them promote quality, nationally agreed, regularly updated e-algorithms of care should be available that provide ready access to virtual specialty advice. An example of high-quality specialty-derived algorithms can be found at www.e-guide.ecco-ibd.eu.

Second, other mainstream specialists (eg gastroenterology, neurology, endocrinology, cardiology etc) would still remain involved, being available each morning to take over patients or provide tailored advice for those being discharged that day. This would significantly increase patients' exposure to the appropriate specialist.

Third, the specialist who cares for patients in the AAU would continue to coordinate the care of those requiring transfer to 'down-stream' specialty wards. Most of these patients would, of course, be elderly under the care of the geriatric service; but this would also mean the other specialists treat conditions in which they have expertise. This should improve continuity of care for patients, assuming adequate specialty ward capacity, and help prevent a loss of focus that can occur when AAU physicians know that an AAU patient is awaiting a specialty ward.

So how might this come about? Working patterns would need to be adjusted to avoid fatigue and ensure sustainability, facilitated by the creation of specialists of the week (be they AAU/elderly care or other specialties) and removing the latter from AAU rotas. This would be a catalyst to allow re-mapping of job plans, potentially enabling a seven-day provision of care while other team members concentrate on delivering elective or planned care. The weekly specialist would also be responsible

Author: [A]consultant physician and gastroenterologist, Chelsea and Westminster Hospital, London, UK

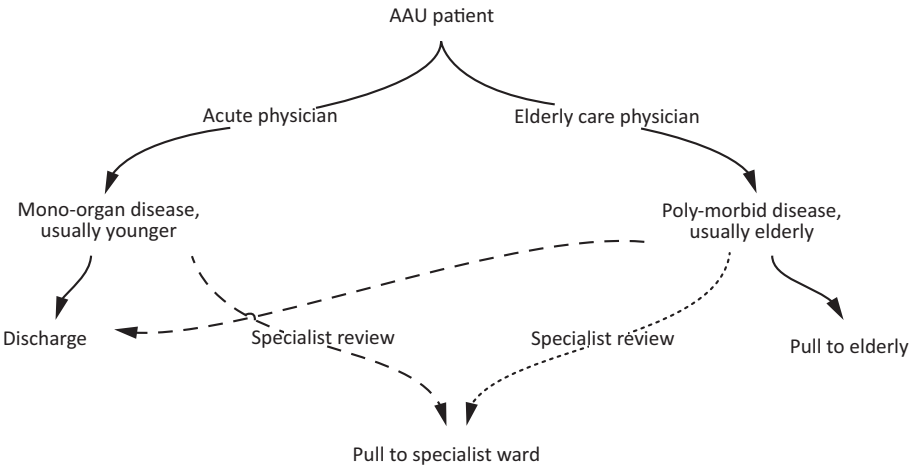

Fig 1. The AAU should be staffed by acute medicine and elderly care physicians working in parallel. Daily review by other specialists at the time of handover would facilitate the pull of patients to the appropriate wards. The proposed model would engender a daily, consultant-delivered service, allowing a patient's disease to be matched to the relevant and most appropriate specialist. Larger specialties, or conjoined smaller ones, would construct rotas for a specialist of the week. AAU = acute assessment unit.

for specialty rounds and consults, and potentially running rapid access and recent discharge clinics.

Clearly this will be much easier in services that have large teams such as gastroenterology. Smaller services could join forces (eg rheumatology and endocrinology; respiratory and cardiology) and some services may have to work across hospital sites (eg neurology, dermatology). Over time, mixed specialty teams would learn from each other, so that, for example, a rheumatologist would feel comfortable advising on endocrine issues, particularly if their endocrine colleague was available for telephone advice.

This model would reduce specialists' exposure to risk by concentrating their work in areas in which they remain skilled and thereby protect patients from the attrition in general physician skills that occurs over time. Further, it facilitates cooperation in the AAU by bringing teams together, reducing the silo mentality[1] that now permeates hospital services.[2] However, for such broad changes in working practices to be successful, unbroken trust must exist between consultants, and with hospital management. Implementation needs to be fair and respectful of individual wishes and needs by avoiding an excessively lean job-planning approach, notwithstanding the excess administration that is nowadays required of consultants.

Not everyone will agree with what I have proposed, especially those physicians who will have to undertake a more onerous on-call rota; although some hospitals already have similar models in place. Over time, more transparent cross-departmental equity in working patterns should provide more cohesive, unified teams. Clearly, matching the workforce to what patients require will take time. In the short term this can be mitigated with a greater dependence on multi-professional models to help streamline elderly care.

This more strategic way to deliver care, crucially, places the patients' needs at its centre. Now more than ever there is a requirement for a redesign of services, largely driven by the ageing patient demographic and the need to promote the twin disciplines of acute medicine and, especially, geriatric medicine, which is best placed to provide the generalist role that has been promulgated of late.[3]

In summary, a wide range of specialists should no longer be sporadically in charge of an AAU. Models similar to that described would help facilitate bringing the right specialist to the right patient. This should reduce risk and litigation, improve patient care and provide a more efficient service, reducing both mortality and length of stay.[4] This has to be done, and soon. This is why I and others want to re-design our working practices, moving from an outdated, vestige twentieth century model. The acute take will only survive and thrive if many of us leave it. ■

References

1 Tett G. *The Silo Effect*. New York, NY: Simon & Schuster, 2015.
2 Epstein NE. Multidisciplinary in-hospital teams improve patient outcomes: a review. *Surg Neurol Int* 2014;5:S295–303.
3 Dewhurst N. 10th college of physicians lecture: the challenges of reinventing medical generalism in the 21st century. *Ann Acad Med Singapore* 2013;42:708–11.
4 Bell D, Lambourne A, Percival F *et al.* Consultant input in acute medical admissions and patient outcomes in hospitals in England: a multivariate analysis. *PLoS One* 2013;8:e61476.

Address for correspondence: Dr M Harbord, Chelsea and Westminster Hospital, 369 Fulham Road, London SW10 9NH, UK.
Email: marcus.harbord@chelwest.nhs.uk