Acute medical emergencies: the physician's role

Medical emergencies are an important and growing component of medical practice. The past 6 years have seen a year-on-year annual growth of 4.4% in non-elective admissions. Thus, in 1992–3, 3 577 266 patients were admitted to acute hospital beds, a number that rose in 1998–9 to 4 642 382 (excluding psychiatry and maternity) (NHS Executive, 2000).

Some of the causes are known, such as increased public expectation fuelled by the media and the Internet, improved technology and treatment, and the ability to do more for patients. People are living longer but are often less fit, placing even greater demands on acute services.

Variation in the availability of traditional, surgery-based, high-quality primary care out of hours and the use of NHS Direct could also be factors. People today are arguably more risk-averse — which is paradoxical given that the fear of illness is increasing at a time when the population has never been healthier.

RECENT CHANGES

The past few years have also seen more structured training for junior doctors with protected study time and rest time, and a welcome reduction in working hours. These measures increase the expectation of a more consultant-delivered acute service. The demands of clinical governance and a culture of greater accountability rightly underscore these expectations. However, greater specialism as a result of modern medical advances has led to a reduction in the number of consultants who wish to undertake general internal medicine and contribute to the acute 'take' in addition to the demands within their own specialty.

Faced with a 47% increase in acute workload over 6 years, hospital trusts and clinicians have responded in several ways. Measures taken have varied according to the size and type of hospital, but several have gained widespread acceptance. Dedicated medical admissions units have proved very successful, provided that effective bed management ensures that the unit is used for the first 24 hours only, and does not simply function as extra bed capacity. Introduction of post-take consultant ward rounds once or twice during the 24-hour period has improved quality, training and risk management.

OUTPATIENT CLINICS

Availability, for example, of more direct access 'urgent' outpatient clinics for the elderly patient unable to cope at home — or for specific conditions such as chest pain — has helped to avoid unnecessary admission to hospital. Outpatient treatment of conditions that previously needed hospital admission, such as deep venous thrombosis, is effective clinically and has helped further to reduce demand for inpatient beds (O'Shaughnessy et al, 2000).

Development of the 'hospital at home' concept and supported discharge programmes, exemplified by chronic obstructive pulmonary disease, have also shortened hospital stays (Killen and Ellis, 2000). Far from being forces of conservatism, physicians carrying the burden of acute medicine have initiated and led radical change in medical practice, both locally and nationally.

The difficulties of managing increased emergency admissions over recent years have been compounded by a substantial reduction in the number of beds. Acute beds have decreased from 169 910 to 135 000 over 10 years (a 20% decrease overall, excluding maternity and psychiatry). In periods of peak activity, there are simply not enough beds despite ever-shorter lengths of hospital stay and imaginative new working practices.

THE FUTURE OF ACUTE MEDICINE

In response to these problems and pressures, the Royal College of Physicians recently raised a range of fundamental questions about the future of acute medicine (Royal College of Physicians of London, 2000): how can acute medicine best be provided? What type of physician is needed to provide this care? And should the established method of physicians who are providing both specialist and acute care be changed?

Several hospitals have appointed emergency physicians — a new type of physician specializing in emergency care, whose duties have included running a medical admission ward, developing protocols and guidelines for common medical conditions, and assigning appropriate patients directly to specialties. These posts have allowed a designated individual to organize and run the medical admissions unit with no competing specialist interest or continuing inpatient load.

Although these measures have worked well, a number of disadvantages have now been identified. One is the 'de-skilling' of other physicians. Withdrawal of specialists from general medicine can alter an individual physician's recognition, interpretation and management of problems not specific to their own specialty. A potential problem of moving to a service provided by an 'acute care physician' is how to provide cover during weekends and holidays. And there is also a

lack of clarity about how these posts will evolve and how attractive and sustainable a consultant's career would be if it were made up entirely of acute medicine.

Provision of high-quality acute care, the Royal College of Physicians' report argues, is integral to all specialties managing acute medical problems, and should be seen as the priority of all physicians. The report also recommends that trainees in the eight main specialties — respiratory, gastroenterology, cardiology, geriatrics, cardiology, endocrinology/diabetes, renal medicine, infectious diseases and rheumatology — should train in general internal medicine on top of their specialty and seek dual accreditation. Those physicians with a particular interest in acute medicine are best placed to supervise and develop further the medical admissions unit.

This development could be done via several routes. One would involve the allocation of sessions to one of the physicians with a special interest who could organize and lead the admission unit and supervise training. Such a physician would have an on-take commitment, rotating with other on-take physicians and junior staff, and some specialist responsibility. Another route would be through a 'physician of the week' approach, whereby one consultant is elected to have overall responsibility for all admissions that week.

INTEGRATING ACUTE ADMISSIONS WITH OTHER SERVICES

The report also considered the development and integration of acute admissions with other key services such as geriatrics, intensive care and primary care. A role for dual training in accident and emergency medicine and general internal medicine is suggested, with the possibility that such physicians could have a role to play in medical admissions units. Assessment of the interface between the general practitioner and acute care is identified as an important area for further study, being under-explored at present.

All those involved in the care of acutely ill patients are concerned with inappropriate delays, which often occur because of bed shortages. The further development of successful medical assessment/admissions units will help reduce waiting times and improve the quality of acute medical care. The physical proximity of accident and emergency units to medical admissions wards, good operational links between the two departments, and the availability of out-of-hours 'fast-track' support services will all be key factors in the success of individual units. Hospital trusts should adopt measures that would improve both patient throughput and quality of care by providing 7-day access to clinical investigations, psychiatric services, care of elderly services, improved transportation, and better availability of social services.

CONCLUSIONS

The Royal College of Physicians' report is timely and provides relevant and useful recommendations to hospital trusts, health authorities, physicians and trainees on how better to organize and provide acute medical care. HM

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KEY POINTS

- The appointment of physicians to provide leadership to medical admissions should be encouraged, but should be done by means of the improvement of existing structures.
- To protect the quality of acute medicine being delivered, all trainees should be encouraged to obtain specialist registration in both general internal medicine and their own specialty.
- Provision of high-quality acute care is integral to all specialties managing acute medical problems, and should be seen as the priority for all physicians.

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