# Acute medicine: making it work for patients

*Carol Black*

***The report of a working party of the Royal College of Physicians,* Acute Medicine: making it work for patients*, seeks to improve hospital care of patients who are acutely ill and highlights the developing role of consultant physicians in acute medicine.***

## INTRODUCTION

Modernization and the drive for improvement have called for re-examination of established forms of clinical service, with imaginative thinking about service design and delivery. One area of particular concern is the care of people who become acutely ill. This has become pressing in the UK because of the relative shortage of doctors, both trained and in training. This shortage has been aggravated by changes in working patterns that are a consequence of the European Working Time Directive (EWTD), and the difficulties faced by medical staff in meeting the simultaneous needs of patients with acute illness and those requiring other non-acute forms of care.

The report of a working party of the Royal College of Physicians (2004), *Acute Medicine: making it work for patients*, brings together recent thinking and experience (Armitage, 2004). It seeks to advance the development of this crucial area of patient care. The report draws on evidence from a wide range of service interests and provides authoritative opinion on a way forward.

The recommendations are addressed to various bodies whose responsibilities are directly relevant to the delivery of acute care. The working party makes it clear that its recommendations comprise a programme of development that will take a decade or more to implement fully, but insists that there must be no delay. Already there has been progress in key elements, notably establishment of acute medicine as a specialty. But this only the beginning and there is much more to be done.

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## ACUTE MEDICINE

Acute medicine is concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies. The care of acutely ill patients is a large and increasing part of medical work in hospital. The purpose of the report is to improve the quality and safety of care of these patients. A focus on the new specialty of acute medicine and its place in service provision marks a significant step towards strengthening that care.

Although much of acute medicine is delivered in acute medicine units, some is delivered in accident and emergency (A&E) departments, high dependency units and on hospital wards. This calls for close working between those working in acute medicine, A&E departments and critical care units to give unity to care for the acutely ill. It includes sharing clinical guidelines and best practice, as well as integrating the work of medical and nursing staff, and facilitating staff rotation between the various aspects of the work.

The working party examined each element needed to construct a comprehensive modern clinical service and the steps that should be taken to establish such a service throughout the NHS. They looked at:

- The organization of service and the facilities necessary to support it
- Standards of care
- Undergraduate and postgraduate medical education and training
- Careers and job plans of doctors who are drawn to this field.

They point to the need for an academic base to ensure high quality teaching and research to underpin continuing development of the service.

In comparison with elective care the medical input required to provide acute medical care has not been sufficiently recognized or measured. Naturally it requires doctors who are skilled and experienced in the rapid assessment, diagnosis and treatment of acutely ill patients. At present in the UK most acute medicine is delivered by physicians who combine this work with their specialist care of patients with non-acute illness.

For a number of reasons, in many hospitals this is not ideal. Emergency medical care has been fitted around such elective activity but, as the volume of emergency work has risen, the specialist time available to deal with each patient has fallen to levels that challenge safe practice.

Caring for people who are acutely ill calls for undivided attention. The course of acute illness is often unpredictable. The doctors involved should not be diverted to patients with other kinds and levels of need. Specialty work in outpatients can clash with the care of patients who are acutely ill and junior doctors faced with acute problems must be able to call on a senior colleague who is skilled in acute medicine, confident that they will receive unreserved support.

The development of acute medicine as a specialty has captured the interest of acute trusts, and of a growing number of physicians. It should serve both to reinforce this crucial area of patient care and to counter the trend where

physicians wish to concentrate effort on the work of their chief specialty.

## STANDARDS

Alongside development of the specialty, with training programmes leading to acquisition of the skills and competencies necessary for practice in this field, there is also a set of standards against which the quality of acute medical care patients receive can be assessed (*Table 1*).

The report spells out the standards judged necessary. For example, it indicates the amount of time required for adequate assessment and review of patients, by junior doctors and by consultants. It highlights the need for a specialist registrar (SpR) with sufficient competence in acute medicine – and no other commitments – to be available 24 hours a day in acute receiving units to deal with the critically ill, to review cases and receive referrals.

Continuity of care and all that means for patients and their families should not be breached as a result of changed patterns of work, where the requirements of shift working, necessary to meet the EWTD, are reflected in the changing composition of clinical teams. There must be proper handover between teams and adequate time in which to do it.

The report declares a standard for the medium term – that consultant physicians in acute medicine should be available on site throughout the period when full support services are available (normally 08.00–22.00), and should be available for advice at other times. In the long term there should be sufficient numbers of consultant physicians in acute medicine for direct involvement in acute medical units, fully supported, 24 hours a day.

A further standard relates to the dispersal of acute medical patients to non-medical wards. This represents a failure of bed management even when there is pressure on beds. The report proposes ways of dealing with this.

## EDUCATION AND TRAINING

The importance of experience and competence in managing acutely ill patients is recognized in *Modernising Medical Careers* (Department of Health, 2004), with early experience of acute care settings in training, within foundation programmes. The report recommends strengthening preparation for this during undergraduate medical education (*Table 2*) and subsequently, and a number of its recommendations are addressed accordingly.

## WORKFORCE IMPLICATIONS

The aims are to strengthen the acute medicine presence on the one hand by developing the specialty of acute medicine as a rewarding and attractive career choice, with the academic and research base that enables every specialty to thrive, and at the same time to rekindle waning interest among consultants with another specialty to participate in acute medicine.

The recognized training programme for acute medicine was approved by the Specialist Training Authority in 2003. Significant numbers of specialists will not emerge from this programme for some years and during the next 5–10 years most consultant physicians in acute medicine will have undertaken training through a variety of routes.

At present there are about 100 consultants in acute medicine, therefore

**TABLE 1.**
**Edited recommendations of**
***Acute Medicine: making it work for patients***

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| **Definition: Acute medicine is that part of general (internal) medicine concerned with the immediate and early specialist management of adult patients with a wide range of medical conditions who present in hospital as emergencies** | |
| Recommendations addressed to medical directors and chief executives of trusts in England, to chief executives of primary care trusts, and to the Department of Health are that: | |
| Trusts admitting acutely ill medical patients have a dedicated area, an 'acute medicine unit' (AMU) where they can be managed. In some hospitals this may be a multispecialty unit | |
| A network of advisers, including lead physicians, be established to take forward the development of acute medicine in England, to include: | A consultant physician in acute medicine in every trust to lead development |
| | Regional specialty advisers to work with postgraduate deans on training |
| | A National Director of Acute Medicine appointed by the Department of Health |
| By 2008 there should be at least three consultants with primary responsibility for acute medicine in every acute hospital, and more in larger hospitals | |
| A contribution to acute medicine from appropriately trained consultants in emergency (A&E) medicine and critical care should be facilitated | |
| Appointments in acute medicine should be developed to include commitments to A&E departments, high-dependency units and intensive care units, as well as AMUs | |
| Staff dealing with the acutely ill should be appropriately trained, and staffing levels adequate | |
| An appropriately trained member of the clinical staff should assess all patients presenting to hospital as acute medical emergencies according to clinical need, and certainly within 4 hours of arrival. This should include a management plan | |
| A doctor with appropriate skills in acute medicine should be present at all times in all units receiving acute medical emergencies. This would usually be a specialist registrar or equivalent. A consultant physician who has no other scheduled commitments should support this doctor | |
| 15 minutes should be available for each new patient on a consultant's 'post-take' ward round (i.e. about one clinical 4-hour programmed activity for a consultant to see 16 new emergency admissions) | |
| A consultant physician should review each new patient admitted within 24 hours. This will require the cancellation of other commitments by the relevant consultant, and in all but the smallest trusts this will necessitate a consultant-led ward round at least twice in a 24-hour period | |
| All trusts develop an emergency admissions policy. This policy should contain a plan of action when there are insufficient acute medical beds, and a plan to provide a dedicated area, with identified medical and nursing staff, for acute medical care at times of extreme pressure | |
| There should be closer collaboration between those working in acute medicine, staff in A&E departments and those working in critical care units. A single directorate might facilitate this | |

consultants with another specialty interest will continue to deliver by far the greatest part of acute medicine. The balance will slowly change as consultants enter acute medicine through newly established routes, but sustained growth of the number of consultants in acute medicine will depend on a planned increase in subspecialty training posts.

Job plans must be designed to allow them to do this to the required standards. Initially a rebalancing of specialist input between the care of acutely ill patients and those requiring other forms of specialist care by the same consultants will incur some reduction in their non-acute availability. This rebalancing is for the safety of patients and the quality of their care. Over time, as more doctors complete specialist training the reduction should be made good.

A growing number of doctors wish to train and work flexibly. The sessional and shift-based pattern of work in acute medicine makes it ideally placed to accommodate flexible and part-time working. This should promote imaginative approaches to training and service appointments, and to job plans in acute medicine at a time when such factors complicate service arrangements in other domains.

## RECOMMENDATIONS

The report makes comprehensive recommendations that are summarized in *Tables 1–3* and set out in detail on the Royal College of Physicians website (Royal College of Physicians, 2004b). Those addressed to trusts and the Department of Health include recommendations on standards of care (*Table 1*). The standards are derived from the experience and judgment of clinicians, supported in many instances by audit findings. Among them are minimal standards. They represent the reasonable expectations of patients and their families. The recommendations are consistent with proposals for acute cover designed to overcome the consequences of further implementation of the EWTD (Royal College of Physicians, 2004c).

There are recommendations that aim to give the necessary weight to experience of and training in acute medicine from the medical undergraduate stage onwards, and therefore are addressed to undergraduate and postgraduate deans, and to the Postgraduate Medical Education and Training Board (*Table 2*).

Of particular importance are the recommendations about arrangements to facilitate the further training of consultants in acute medicine who, at some stage, might wish to change career direction and re-enter specialty training. This mirrors concerns among doctors in training generally that subsequent career development and the flexibility and training opportunities necessary to make it real should not be unduly subservient to service needs. Training arrangements that demonstrate a commitment to full and continuing professional development for doctors at all stages of their careers will be necessary to restore confidence. As thousands of career grade doctors can testify, such arrangements are not yet in place.

Further recommendations, addressed to the Royal Colleges of Physicians of

**TABLE 2.**
**Edited recommendations addressed to undergraduate and postgraduate deans and the Postgraduate Medical Education and Training Board (PMETB)**

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| Deans of medical schools ensure that dedicated time in the undergraduate curriculum is devoted to acute medicine, with teaching by consultants in acute medicine, and experience in AMUs |
| Postgraduate medical training attachments to AMUs should last for 1–4 months. Rotas that provide experience in AMUs only in sessions of one shift, 1 day or 1 week, without such blocks, should be discouraged |
| PMETB ensures that trainees in acute medicine receive dedicated experience in AMUs, coronary care units, high-dependency units, intensive care units, A&E departments and in geriatric medicine. It is further recommended that trainees in acute medicine undertake the Royal Colleges' IMPACT (Ill Medical Patients' Acute Care and Treatment) course, and receive training covering the key clinical, management and organizational skills described in the acute medicine curriculum |
| Pathways are developed to facilitate higher specialist training in acute medicine for doctors with a background in emergency (A&E) medicine and critical care, who have appropriate basic specialist training, but do not necessarily have the MRCP (UK) Diploma. Equivalence should be determined for other relevant postgraduate qualifications |
| PMETB considers putting in place arrangements to facilitate the further training of consultants in acute medicine who wish to change career direction and re-enter specialty training |
| There should be opportunities for flexible training and flexible working in acute medicine |

A&E = accident and emergency; AMU = acute medical unit

**TABLE 3.**
**Recommendations addressed to the three Royal Colleges of Physicians of the UK**

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| The General (Internal) Medicine Committee of the Royal College of Physicians (RCP) of London be reconstituted as the Committee for Acute and General Internal Medicine |
| The three Royal Colleges of Physicians and the Society for Acute Medicine work together with the Council of Heads of Medical Schools to establish a secure academic base for acute medicine |
| The RCP Workforce Unit, on behalf of the three Royal Colleges of Physicians, collects and monitors accurate data on the numbers of consultants and trainees working in acute medicine and on the contribution from consultant physicians who also work in other specialties. |
| RCP regional advisers and specialty advisers review and advise on job plans for new consultant posts in acute medicine in the light of the working patterns recommended in this report |

the UK, identify their part in the development of acute medicine, academically, educationally and in monitoring implementation (*Table 3*). HM

*Conflict of interest: none.*


Armitage M (2004) Acute Medicine: making it work for patients. *Clin Med* **4(3):** 203–6

Department of Health (2004) *Modernising Medical Careers: The next steps. The future shape of Foundation, Specialist and General Practice Training Programmes.* Department of Health, Leeds

Royal College of Physicians of London (2004a) *Acute Medicine: making it work for patients.* Report of a working party. RCP, London

Royal College of Physicians (2004b) *Acute Medicine news.* Royal College of Physicians, London (www.rcplondon.ac.uk/news/acutemed.asp)

Royal College of Physicians (2004c) *European Working Time Directive (EWTD) news.* Royal College of Physicians, London (www.rcplondon.ac.uk/news/ewtd.asp)


## KEY POINTS

- The care of acutely ill patients is a large and increasing part of medical work in hospital, and the purpose of the report is to improve the quality and safety of care of these patients.
- The recommendations comprise a programme of development that will take a decade or more to implement fully. There has been progress in key elements, notably establishment of acute medicine as a specialty, but there is much more to be done.
- The report describes the elements needed to construct a comprehensive modern clinical service and the steps that should be taken to establish such a service throughout the NHS.
- It spells out the standards judged necessary for a safe high quality service and the working arrangements to ensure those standards are met; the educational and training requirements of doctors who undertake acute medicine, whether as their chief specialty or with another medical specialty; and the importance of a strong academic and research base.
- It emphasizes the growing importance of flexible training and working arrangements to enable the fullest development of this component of a comprehensive acute hospital-based service.

### IN THE PUBLIC'S VIEW...

# The prince, the professor and the actress

Two medical stories made the news on July 9. Most of the newspapers, on their inside pages, reported Professor Michael Baum's open letter to the Prince of Wales, published in the *BMJ*. To rationalists, Prince Charles has been more than a nuisance. It is arguable that his well-publicized belief in alternative medicine is an important influence on the many people who voluntarily pay for unproven treatments.

Professor Baum was quite gentle in his criticism. Prince Charles's authority is the result of his birth; Professor Baum's comes from a professional lifetime spent treating and researching breast cancer. To the green ink brigade who bombard the *BMJ*'s e-letters website, Professor Baum is arrogant and has a closed mind. Why, said one correspondent, modern medicine has only been around for at most 300 years, while Chinese medicine has lasted for 5000 years.

Minds that accept such logic are more than closed. Screaming anecdotes about the Gerson diet and other similar remedies for cancer are not good enough. If the Gerson diet works, put two matched groups into a properly controlled study and show that it's so.

E-letters to the *BMJ* show the vast misunderstanding of what medical science is about. It is endlessly depressing, almost masochistic, to read the inevitable responses to any criticism of alternative medicine. One correspondent took up Professor Baum's mention of proper statistical testing by asking why $P<0.05$ was so important. She was quite right in saying that $P<0.05$ is magic only because RA Fisher thought it appropriate, but was wrong in implying that this arbitrary choice of the risk of getting it wrong (which is what $P<0.05$ means) invalidates the use of $P$ values.

It is one thing to throw the baby out with the bath water; it is another to tear out the bath as well. But that, in effect, is what is happening here. There are large numbers of people who simply do not understand how to use the bath, and prefer instead to run about outside hoping that it rains.

One of them is the actress Gwyneth Paltrow, whose back was the subject of the other medical story of July 9. She chose to wear a backless dress, thus revealing five ugly blotches caused by moxibustion. Her story gained more prominence, and certainly more photographs, than Professor Baum's. It would be nice to report that the newspapers thought Gwyneth nice but loopy; sadly they mostly reported how she had been feeling low recently and used moxibustion because it draws toxins out of the blood. For those unfamiliar with the technique, glass cups are heated and then placed on the skin. The cooling of the air within the cups sucks hard on the skin, caused bruising and exudation. It's a bit like a lovebite but without the fun. HM


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