Managing the Acute Medicine – Specialty Interface

The Specialty Perspective

Dr John Firth
Consultant Renal Physician
Deputy Medical Director
Cambridge University Hospitals FT

Previously Clinical Director for MAU
Hospitals undertaking the admission of acutely ill medical patients should have a consultant physician on-site for at least 12 hours per day, seven days per week, at times related to peak admission periods. The consultant should have no other duties scheduled during this period.

Job plans will need to reflect correctly the extra work undertaken by consultant physicians and must include arrangements to ensure adequate rest.
Cambridge – where are we coming from? - the ‘conventional model’ for on-take medical admissions

Junior doctors see patients in the ED / MAU

Medical consultants rarely involved

Consultants see those who’ve survived until the next morning

Poor quality care immediate care

Poor quality subsequent care … 24 hour take followed by safari ward round; massive fluctuation in patient numbers looked after by a team
Cambridge – philosophy for managing acute medical admissions

Specialist teams provide the best care …

Acute physicians and supporting teams – ED and short stay medical ward

Organ-based specialists and supporting teams – should do what they do best

Geriatricians and supporting teams – lots of elderly people with need for rehabilitation and supported discharge
Where are we now? ... the point of entry …

Emergency Department

Medical team in ED

• Consultant - Acute Medicine consultant sessions in ED (±40 / 168 hr); on-call medical consultant at other times.

• Middle grade – 1-3 medical SpR covering ED (+ Gen Med on wards)

• Junior grades – 2-5 FY/CMT covering ED

Patients sent from ED to the (most appropriate) wards
Where are we now? ... Triage, followed by ‘specialty’ rounds ...

Morning Report
08.15-08.45h, every day
Chaired by Acute Medicine consultant

‘Short stay’
  • Acute Medicine
  • Acute MFE
‘Organ-based’
  • Cardiology
  • Diabetes/Endo
  • Gastroenterology
  • Hepatology
  • Infectious Diseases
  • Renal
  • Respiratory
‘Complex-discharge based’
  • MFE
Morning Report

What actually happens?

‘Rules of engagement’
Specialty teams - consultants present  Almost always

‘Aggressive’ triage to specialty  Supported by peer pressure

‘General medical’ patients admitted to medical wards - looked after by ward specialty team  No arguments

‘General medical’ patients on outlying wards – allocated to specialty teams depending on their running total (not their number of inpatients)  Helps to keep people honest
What happens in practice?
Good Friday, 23 April – Tuesday, 27 April

‘Short stay’
• Acute Medicine 33
• Acute MFE 18

‘Organ-based’
• Cardiology 20
• Diabetes/Endo 9
• Gastroenterology 9
• Hepatology 13
• Infectious Diseases 17
• Renal 19
• Respiratory 15
• Stroke 8

233 patients seen by Medicine in ED
• 53 sent home
• 180 admitted

Tuesday, 27 April
• Medical patients 414
• Badged as Gen Med 48

‘Complex-discharge based’
• MFE 19
Acute medical admissions – numbers and length of stay …
Do we like this system?

Yes, it works for us
• More patients under the care of specialists
• Better care – falling Hospital Standardised Mortality Rate (HSMR)
• More efficient care – falling lengths of stay

Would it work for everyone?

No, probably not
• Depends on high level of input from medical consultants every morning: 30 mins morning report; then ±15 mins / patient

What are we going to do next?

More of the same – get rid of ‘general medicine’
• Expand Medicine for the Elderly
• Expand Acute Medicine