Development of Acute Medicine
the Journey so far
Reflection on Bournemouth Story since 1997

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Consultant Physician Acute Medicine
Provision of acute care

The challenging issue
Traditional model for provision of acute care

- Medical emergencies presented through A&E departments
- A team of junior doctors delivered the service
- Almost all Consultant physician practiced Acute medicine alongside an organ based speciality
- No specific time assigned to provide acute care
- Emergency work fitted around elective activities like OPD, procedures etc
Challenges of Acute Care as perceived in the 90s

- Most medical admissions are as acute medical emergencies
- The number of acute admissions continue to increase relentlessly
- Acute admissions increased by 59% between 1991-95 in Scotland (Mulholland and Muir Health Bulletin 1998;56(2):576-85)
Challenges of Acute Care
as perceived in the 90s

- Increasing trend towards organ based specialism
- Competing demands for specialty work and Acute medicine
- Difficulties in keeping skills up to date
- Difficulties in managing acute medical emergencies
Challenges of Acute Care as perceived in the 90s

- Increasing public expectations
- Changing patterns of junior doctors working
  - Reduction in working hours
  - Structured training and education
- Drastic reduction in the number of beds
- Unpredictable nature of acute medicine
Situation in Bournemouth (in the 90s)

- A new DGH opened in 1992, serving a population with very high proportion of the elderly
- 15 consultant physicians worked in 5 teams
Situation in Bournemouth
(winter of 1995/96)

- Over 400 medical inpatients (288 beds!)
- Acute patients scattered over 13 wards
- Doctors unable to review all their patients
- Long delays in investigations and treatment
- Unacceptably long times on the trolleys
- Regular cancellations of surgical lists
- Constant Bed crisis
- Effect on the morale of the front line staff
Other pressures

- Data suggesting sub-optimal care of severely ill medical patients
- Lack of senior medical input at initial presentation
- Poor recognition of physiological deterioration  *(BMJ 1998 & JCRPL 1999)*
Search for solutions
Search for solutions

- A new type of physician with specific responsibility for the care of acute medical emergencies (RCP London working party 1996)
- Creation of Acute medical admission wards
Bournemouth story

- Ward 30 converted into 22 bedded medical admissions ward (Nov 1997)
- Situated next to A&E
- Re-designed to take acute admissions
- Facilitate rapid turnover of patients
- Provision for OPD consultations
- Higher level of nursing support
- Dedicated clinical leadership --- Consultant Physician
Graduated in Lahore 79
SHO and Registrar posts in NE, Yorkshire and Wessex in 80s
Back in Lahore from 1989 to 1997
Joined Bournemouth in November 1997 for a six month locum!
Acute Medicine and Medical Education
Bournemouth story

- **Staffing in 1997**
  - One consultant physician
  - H - Grade ward sister
  - Nurses with extended roles

- **Staffing in 2018**
  - 9 Consultants
  - 3 Registrars
  - 4 CMT/SHOs
  - 2 F1s
  - Matron with 3 sisters and 12 deputy sisters, Pharmacist, Therapy team etc
Search for solutions

Hospitals should:

• Recognise level and complexity of work to provide adequate care for medical emergencies
• Allocate sessional time to supervise and develop Medical Admission/Assessment units
• Ensure twice daily senior ward round
• Provide 7 day access to investigations and support services
• Discourage physicians to work only in Acute Medicine

*Acute medicine: the physician’s role*
Proposals for the future

_Federation of the Royal colleges of Physicians report 2000_
Search for solutions
Birth of a new medical speciality

ACUTE MEDICINE
Acute Medicine

- In July 2003 Specialist Training Authority recognised Acute Medicine as a sub-speciality of General (Internal) Medicine
- Emphasis on skills and training in rapid assessment and treatment of acute medical conditions
Acute Medicine

“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 to hospitals as emergencies”

“Acute medicine differs from Emergency medicine as it does not deal with surgical conditions, trauma and minor injuries or paediatric emergencies”

RCP working party Report March 2004
Role of Consultants in Acute Medicine

- Have expertise in rapid assessment, diagnosis and management of patients with acute medical conditions
- Manage Acute Medicine services
- Lead multidisciplinary clinical teams
- Educate trainees as well as consultants in other specialities
- Support colleagues in A&E, HDU and general wards
Qualities of Consultants in Acute Medicine

- Leader
- Manager
- Co-ordinator
- Communicator
- Negotiator
- Educator
Bournemouth story
A consultant physician in acute medicine: The Bournemouth Model for managing increasing numbers of medical emergency admissions

Mary Armitage and Tanzeem Raza

ABSTRACT - Consultant-led medical admission units have been developed as one method of managing the increasing number of acute medical emergencies. The need to document such innovations and to evaluate and analyse the role of an acute care physician in meeting the problems of acute care has been emphasised. We therefore report our experience of an acute admissions unit led by a consultant physician in acute medicine in a district general hospital.

KEY WORDS: acute admissions unit, acute care physician, emergency medical admissions

The problem

The relentless rise in emergency admissions over the last 15 years has coincided with a reduction in hospital beds and junior doctors' hours, resulting in severe problems in most acute hospitals, and the attendant miseries will be familiar to all. There is also increasing public expectation that senior doctors, ie consultants, will be directly involved in the acute care of emergency admissions. Evidence that specialist

should start on admission. Early home visits after discharge may reduce readmissions.

Many hospitals have introduced an acute admissions area for initial management of emergencies followed by early triage of patients to specialist wards. This creates an opportunity to find a bed in the appropriate specialist area and provides a focus of clinical care for the junior medical staff rather than having their patients spread across several different wards. It also makes post-take ward rounds easier and facilitates the contribution of nurses with extended roles. However, unsurprisingly, hospitals found that when takes were busy the admissions unit became blocked, and no longer functioned effectively. The importance of a regular consultant-led post-take ward round has been emphasised by the RCP and the model of 'physician of the week' has been used effectively in some hospitals to provide this senior cover.

The Bournemouth Model: a consultant physician in acute medicine

The Royal Bournemouth Hospital is a district gen-

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Trend in monthly discharge rates in % of admissions from AAU/CDU since Nov-1997
Total number of admissions and discharges over the last 20 years

Admissions
Discharges
Personal reflections

- Team work – Whole system approach
- Dedicated senior leadership
- Closer liaison with A&E and critical care teams
- In acute settings rapidity of decision making and prompt resuscitation make a big difference
- Acute physicians are best placed to provide teaching and training for junior doctor
Personal reflections

- Acute Medicine offers most fulfilling career
- Provision of acute medical care require specific expertise
- No burn out in Acute Medicine
- Leadership, excellent communication and negotiation skills
- Data based evidence essential to win argument
Finally

- Acute Medicine is a well established speciality
- Acute Medicine has rapidly expanded and continues to expand
- Acute Medicine offers an exciting career for physicians of the future
Thank you for your attention