Society for Acute Medicine

The recognition of Acute Medicine as a clinical entity and its early development as a medical speciality

Part 1

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Introduction

This document is written from my viewpoint and recollections, with significant additional input from:

- Prof Derek Bell OBE – Professor of Acute Medicine, Chelsea and Westminster Hospital NHS Foundation Trust and Imperial College London
- Prof Paul Jenkins – Emeritus Winthrop Professor of Acute Medicine, University of Western Australia, Perth, W.A. and Consultant Physician, Norfolk and Norwich University Hospital
- Dr Mike Jones - Consultant Acute Physician, County Durham and Darlington NHS Foundation Trust, GIRFT National Clinical lead for Acute and General Medicine, Medical Director for Training and Development, Federation of Royal Colleges of Physicians JRCPTB
- Dr Chris Roseveare - Consultant in acute and general medicine, Lymington New Forest Hospital, Southern Health NHS Foundation Trust, former editor of the Acute Medicine Journal from 2001 to 2017
- I am Dr Rhid Dowdle OBE – Retired Consultant Physician and Cardiologist, Royal Glamorgan Hospital, Cwm Taf Morgannwg University Health Board, Archivist of the Society for Acute Medicine

We were all early enthusiasts in improving the care delivered to the acutely ill medical patient. Together we made up the medical membership of the first Committee of the Society for Acute Medicine (SAM)

Prologue

Medicine has changed remarkably over the last 50 years. In the 1960s the vast majority of consultant physicians were involved in the care of acutely unwell medical patients, who were admitted to their wards on the acute medical intake. Consultant physicians specialising in single system disorders and not involved in acute patient care were a clear minority, almost entirely confined to teaching hospitals and a small number of specialist hospitals.

Consultants at that time did indeed mainly consult. The majority of day-to-day care was provided by junior doctors in training – House Officers – supervised by more advanced trainees, the Medical Registrars, who might provide cover for more than one hospital at any one time, even for the medical intake. Similarly, many consultants also had patients in more than one hospital.

It was unusual for consultant physicians to visit their wards every day, and some might only be present for the twice weekly consultant ward rounds. Contacting a consultant out-of-hours occurred rarely, even when on intake, and the medical registrar made the vast majority of decisions on day-to-day patient management.

It is therefore striking to consider in retrospect how little the medical consultants, the most experienced medical clinicians, were involved in direct care of acutely unwell patients. Indeed, several days might pass before an acutely admitted patient was seen by their consultant.

Problems in accommodating acute medical admissions were substantially less in the 1960's, though there were always episodes when the system was stressed by pressure on beds and there was much variability from place to place. The numbers of hospital beds available were very different then. In 1974 the total number of NHS beds in England was around 400,000, by 1988 it had fallen to 299,400 and it fell a further 53% to 141,000 in 2020.

So much for the good old days.

Evolution

With the passage of time changes gradually occurred in acute medicine, usually as a response to changing circumstances and seldom due to considered planning. The first change was the inexorable increase in the number of medical admissions. In Scotland, emergency admissions increased by 45% between 1981 and 1994 and there was a similar, 42% increase in England between 2006 and 2018. The reasons for this were, and still are, multifactorial, including increasing patient demand for medical care, which was often entirely justified, and increasing discomfiture in primary care in managing acutely unwell patients at home. This in turn may well have been influenced by awareness of the technical improvements in care available in hospital and the increasing publicity given to adverse events in patient care everywhere.

The increasing numbers of admissions produced a series of changes in hospital medical practice. In earlier days it had been usual for medical consultants to have all their patients on a single ward. This worked well for patient care as all those involved were familiar with that team's policies. Members of both the nursing and medical teams became well acquainted personally and were well aware of each other's strengths and weaknesses.

A consultant was therefore used to having designated medical beds, available for their own patients. These beds would have been sufficient to accommodate the patients admitted during that consultant's medical intake, with internal bed management by the relevant medical team ensuring vacant beds before expected periods of intake. As admission numbers increased, this formal bed holding became inadequate, and patients admitted on the acute intake spilled over into the beds designated to other consultants. Often this did not go down well with cries of "Get your patient out of my bed!" being not uncommon.

Once the inflow of patients had increased to the point where some admissions had to be accommodated on wards outside the admitting consultant's domain, familiarity with both that team's policies and staff declined, a situation obviously not conducive to best patient care. It also meant that the admitting team were now working in more than one location and time was spent in corridors that could have been better spent at patients' bedsides. Additionally, the admitting team found themselves increasingly engaged in often difficult discussions regarding the placement of patients in beds allocated to other consultants.

If the overflow of acute admissions remained within the beds allocated to the Department of Medicine, there was some comfort in knowing that the ward staff would have current knowledge of the care of medical patients and would be able to manage the new patients at least satisfactorily. However, when all available medical beds were occupied and acutely

unwell medical patients had to be sent to non-medical wards the situation deteriorated significantly, both in terms of direct patient care and in the increasing discomfort of the ward staff faced with these patients, whose problems and needs were unfamiliar to them.

One solution to this situation would have been to have closed the hospital to further medical admissions, but this denial of service was considered unacceptable for a variety of reasons. Accordingly, a strategy was put in place which improved, but did not resolve, the problem. That strategy involved the creation of a new post - that of Hospital Bed Manager - whose main function was to arrange accommodation for the incoming acute medical admissions.

With the passage of time the ever-increasing presence of medical patients on surgical wards itself led to changes. In some hospitals some surgical beds were re-allocated to Medicine and were staffed by medically experienced staff. Surgical Day Units allowed surgical activity to be maintained in the face of a falling number of surgical beds.

Whilst the creation of the post of Bed Manager took some of the heat out of the relationships between the medical and non- medical wards, the medical admitting teams were still walking the corridors to visit and revisit their increasing numbers of patients on "safari ward rounds", wasting time that could be ill afforded. The rational solution to this problem was to admit all new admissions to a single admission area, from which they might be discharged home after a short stay or transferred to the place where they would stay for the remainder of a more prolonged admission. Such a facility also improved the quality of patient care at the time of admission as now all patients could be assessed in an appropriate environment by appropriate staff.

By the early 1990s a number of such units, variously called Medical Assessment Units, Medical Admission Units (MAUs), Acute Medical Units (AMUs) or other similar terms had been established. Derek Bell recalls an overnight medical admissions facility being in place at the Royal Infirmary of Edinburgh (RIE) in 1986-7 and an AMU being created at the Central Middlesex Hospital in 1992. Paul Jenkins recalls that an AMU was opened at the Norfolk and Norwich University Hospital in 1993 and Mike Jones reported that Ward 15 at the Ninewells Hospital in Dundee had functioned essentially as an Acute Medical Unit since its inception in 1973

Some consultant physicians were now working mainly or entirely in these new units, managing the initial care of acutely ill medical patients referred to hospital. The terms Acute Care Consultant and Consultant Physician in Acute Medicine were being used to describe them. Paul Jenkins and Mike jones were appointed Acute Physicians in 1995 with Derek Bell acquiring a similar title in 1996 and Chris Roseveare in 1999. Such appointments were thought appropriate by the Scottish Intercollegiate Working Party on Acute Medical Admissions and the Future of General Medicine which commented in 1998 that "Large hospitals might consider appointing physicians in acute care medicine".

However, not all AMUs were associated with the appointment of an Acute Physician and the majority of consultants working on the AMU remained General Physicians with other specialty interests, working as "Consultant of the day", who both admitted and subsequently managed patients of the acute medical intake. This was undertaken with varying degrees of enthusiasm.

As the volume of acute work increased, time available to work in a consultant's associated specialty decreased and a tension developed between acute care and specialty care. In parallel to this, technological developments such as fibre-optic endoscopy and

echocardiography made specialisation in District General Hospitals more practicable. This in turn led to a move by some consultants to favour their specialty over their more general work, and to withdraw from involvement in the acute take to concentrate on their chosen specialty alone. Thus there was a flight from acute medicine in favour of specialisation. Paradoxically, in some situations this encouraged the creation of new Acute Physician posts that could fill the gaps in acute care left by the departing specialists. Some of the job descriptions of these posts reflected that ambition alone. Not all of these new posts were filled at consultant level and some noteworthy early Acute Physicians started in their roles as Staff Doctors or Associate Specialists. Indeed, records from the RCPL of acute medicine post advertised between 1995 and 2000 indicate that the vast majority of such posts were advertised at Staff Doctor grade.

Many General Physicians however still remained committed to the challenging task of providing best care to the patients of the acute take, whilst maintaining their skills in their chosen specialty and this was my situation.

Our Acute Medical Unit, which comprised 16 beds and occupied half of an existing medical ward, opened in October of 1994. The immediate benefit of this strategy was that once again, all medical staff on the admitting team were working together at a single location, but there were also objections. The medical wards were unhappy about no longer receiving acutely unwell medical patients from their first arrival in hospital. They missed the excitement of initial care. They also felt that having not been involved in this initial care, they never knew those patients as well as they had done previously. This discontinuity of patient care now demanded a patient handover process, something which had never been needed previously and which itself had to evolve.

On the other hand, there were unexpected benefits. Nursing and other staff who enjoyed working in an acute care area gravitated towards the Unit and rapidly acquired new skills, whilst staff who were less happy drifted away. A strong "esprit de corps" quickly developed on the Unit.

Since all acute medical admissions now entered the hospital's administrative system through a single portal we now had good evidence of our numbers of medical admissions as compared to the previous system which only counted apparent medical discharges. There was a significant difference!

Consultant involvement in the management of previously admitted patients also evolved over the years and consultant physicians in general became more frequent visitors to their wards at times other than ward rounds

When I became a consultant I soon discovered that if I spoke to the Medical Registrar on-call before going home on intake days, we could identify patients to whose care I could make a meaningful contribution. This reduced the number of phone calls I received at home and the number of times I needed to return to the hospital, but I must also admit that my rationale was not entirely selfish as I did have altruistic aspirations to deliver the best patient care. This conversation then became more formalised to a review of all newly admitted patients at their bedside and rapidly became accompanied by a similar ward round on the morning after a day on-intake. For me the Post-Take Ward Round sprung into being in 1980. This was not greeted with great joy by all of my consultant colleagues and some in other hospitals expressed concern at my mental stability.

Some medical trainees were also attracted to acute care and Paul Jenkins established an acute medical registrar post, approved and supported by the East Anglian Deanery in 1997. We submitted an application for approval of an SHO post in Acute Care Medicine in our AMU in 1998.

Meanwhile, the Royal College of Physicians of London had become aware of the ever increasing number of consultant physicians working in Acute Medicine – an unrecognised specialty – as their sole clinical commitment, and also of the report of the Scottish Intercollegiate Working Party on Acute Medical Admissions and the Future of General Medicine. In early 1999 a working party of the then Federation of Royal Colleges of Physicians of the UK was convened, chaired by Prof Carol Black, Clinical Vice President of the RCPL, to consider the status of these acute care physicians. Later that year the Federation working party invited a number of clinicians who had been identified as active Acute Care Physicians or who had expressed an interest in Acute Care Medicine, to give evidence to the working party. This meeting took place at the Royal College of Physicians of London on 29th September 1999 and included 13 of the 22 Acute Care Physicians then in post.

The conclusions of the Federation working party, expressed in a report entitled 'Acute Medicine: The Physician's Role', were somewhat at variance with the Scottish Colleges' report. It not only failed to express enthusiasm for Acute Medicine as a specialty but its recommendations appeared conflicting in a number of ways. On the one hand, it was recognised that there was definitely a role for acute physicians, who should be involved in the emergency rota for acute medical intake, whilst, on the other hand, the report did not recommend either the appointment of physicians solely to provide acute care without links to a specialty, or a separate training programme for acute medicine. It did, however, recommend the further development of medical admission units. The term "Acute Medicine" and "Acute Care Physician" were used throughout the document – an indication that the Medical Royal Colleges did acknowledge the existence of both as concepts. These inconsistencies reflect the early stage of development of a proposal that was, in many ways, a radical departure from the traditional approach to management of acute general medical patients.

After the meeting a number of attendees adjourned to The Albany in Great Portland Street to consider events of the day. After some conversation Derek Bell commented to the effect that, as we were all obviously interested in acute medicine, we should meet again. This suggestion could perhaps be considered to be the actual foundation of the Society for Acute Medicine. Mike Jones however recalls that there was a Scottish meeting on Acute Medicine, held in Stirling in February of 1999, at which it was suggested that there should be a Society for Acute Medicine, but this suggestion however was not developed further.

The further meeting of this group of clinicians was facilitated by Prof David London, previous Registrar at the Royal College of Physicians of London (RCPL) and took place at the College on November 26th, 1999. The involvement of the RCPL in setting up this meeting was encouraging, suggesting that the College was not entirely antagonistic to the development of Acute Medicine. At that meeting an interest group was formed, the Acute Medical Group, within which two working parties were set up, one to address issues of terminology, structure of units and organisational structure and the other to address issues of quality and training. I was tasked by the Group to explore the possibilities of liaison with the discipline of Accident and Emergency Medicine. Membership of the Acute Medical Group comprised:

- Derek Bell, Edinburgh
- Carole Connor, Edinburgh.
- Rhid Dowdle, East Glamorgan
- Peter Featherstone, Portsmouth
- Paul Jenkins, Norfolk and Norwich
- Mike Jones, Dundee
- Winnie Miller, Glasgow
- Graham Nimmo, Edinburgh
- Mairi Pollock, Edinburgh
- Tanzeem Raza, Bournemouth
- Chris Roseveare, Southampton
- Paul Schmidt, Portsmouth

The first formal meeting of the Acute Medical Group took place at the Royal College of Physicians of Edinburgh (RCPE) on 14th April 2000 with a clinical programme and a subsequent discussion of strategy. This resulted in the foundation of the Society for Acute Medicine (UK), with the following elected officers and members co-opted to the executive committee.

- President — Derek Bell
- Vice President — Paul Jenkins
- Secretary — Mike Jones
- Treasurer — Chris Roseveare
- Nursing Representative — Mairi Pollock, Operational Manager, Acute Medicine, RIE
- Co-opted member — Rhid Dowdle
- Administrator — Audrey Deuchars, Medical Assessment, RIE

I actively sought membership of the executive committee for two reasons, though neither was ever made explicit. Whilst the majority of the physicians making up the medical membership of the new executive committee were active Acute Physicians, the great majority of acute medical admissions throughout the UK were managed by physicians like myself, general physicians involved in the acute medical intake. I felt it vital that the Society should not be perceived as being exclusive of such physicians, but should support those of us who remained committed to acute medicine. Secondly I felt that for the Society to be representative of acute medicine in the UK, there should be representation from each nation with an independent health service. Sadly at that time we had seen no interest from clinicians from Northern Ireland. For these reasons, I was delighted to have been co-opted onto the executive committee.

The first meeting of the new Society was held at Heriot Watt University, Edinburgh on October 5th 2000.