



Acute medicine or emergency medicine—where are we going?

Few people working at the front line in today's NHS can be unaware of the huge impact that "acute medicine" has on the ability of the remainder of a hospital to function. The progressive rise in the numbers of medical admissions over the past decade has been accompanied by a gradual decline in the number of available beds; furthermore the difficulty in recruiting and retaining nursing staff in this demanding area has led to difficulties in expansion, even when resources have been made available. As a result most hospitals frequently experience an overspill of medical patients into beds of other directorates. In the accident and emergency department this effect is particularly evident, with long waits in corridors for medical beds now common in some units throughout the year.

Alongside this pressure has come the need to reduce junior doctor hours, and a greater emphasis on structured training, with protected teaching time away from the ward. This reduction in service commitment among junior staff has led, in part, to the development of medical admissions units (MAUs), enabling better organisation of the medical take by concentrating the available medical staff into a smaller area of the hospital. Such units are now widespread, but their development needs to be accompanied by increased consultant involvement in acute medicine, to ensure appropriate junior doctor supervision, along with efficient organisation and development of the unit. In order to achieve this, some trusts have adopted a "physician of the day/week" model, whereby consultants cancel specialty and outpatient commitments to provide a presence in the MAU. Other hospitals have taken the more controversial step of appointing consultants with a specific interest in acute medicine.

The appointment of an acute medicine consultant has a number of potential advantages. Firstly, consultant involvement at the front door can be provided without a significant impact on specialty and outpatient workload. There may be further benefits in coordination of training, development of guidelines, and providing emergency outpatient review and follow up in order to expedite discharge. Such individuals are also likely to have skills in the management of acutely unwell patients, including practical procedures, with which many existing consultant physicians may be unfamiliar.¹

However, there may also be disadvantages to this approach. Countrywide, consultant-led, 24 hour, seven day care in acute medicine would be difficult to achieve without the continued strong links to general (internal)

medicine (G(IM)), unless there is significant expansion in this area. Even if resources were available to achieve this, finding the personnel might be difficult in the absence of a specific training programme. Encouraging the separate development of acute medicine could also cause a drift towards further specialisation, and see more physicians opting out of the acute medical take, possibly resulting in difficulties with revalidation in G(IM).

In 1998 the Royal College of Physicians convened a working party to examine the role of the consultant physician in acute medical care. The report, published in June 2000 expressed reservations about the development of acute medicine as a separate specialty.² However they did recognise that consultant physician leadership was essential in the management of an MAU, and went on to propose that combined training in medicine and accident and emergency might produce individuals with the appropriate skills to provide this. An alternative model, combining MAU and administration sessions alongside traditional specialty sessions was also suggested, and it has been on this basis that most of the subsequent appointments in acute medicine have been made.

The need to examine the interface between acute medicine and accident and emergency led to the convening of a further Royal College of Physicians' working party in 1999. Although a report from this group has yet to be published, it appears that it is likely to recommend co-location, single management and organisational structure, common audit processes, and documentation.

Invigorate your CV with six months in Sydney!

Registrars wanted to work in a retrieval service based in the emergency department/major trauma centre at St Georges Hospital, Kogarah, Sydney. There are 750 interhospital transfers and 150 prehospital missions per year including rescue (cliffs, water, wilderness). Rotations for 6–12 months in 2002 and beyond. Suitable for a senior trainee with good airway, procedural, and diagnostic skills. Interested? Email Dr Gary Tall (G.Tall@unsw.edu.au) for more details. Probably more interesting than HEMS with less competition to get a job!

So is acute medicine soon to be swallowed up by accident and emergency? This would seem unlikely. While there may be those within accident and emergency who would wish to take control of their local MAU, this would clearly not be feasible or desirable in most hospitals, considering the volume of work, available staff, and geographical factors. Furthermore our skills, while complementary, are certainly not identical. Consultants in acute medicine are expert in the management of a much narrower range of conditions than would be expected of a consultant in accident and emergency. On the other hand, a background in G(I)M enables provision of more ongoing care and follow up of medical patients. Care in the MAU may continue for up to 48 hours in some cases, which is far longer than is possible in most accident and emergency departments.

Clearly it is important that we avoid duplication of work, and where feasible a common portal of entry would be one means of achieving this. Ultimately, hospitals will have to find a local model for the delivery of acute medicine which fits in with local facilities, traditions, and staffing. In some hospitals, this may involve the appointment of one or more consultants in acute medicine, who will need to work closely with their local accident and emergency team. In others, rotational involvement of the specialty physicians in the on-call commitment is likely to require greater input from

accident and emergency in defining management protocols and driving forward developments in acute medicine.

It is crucial that the recently formed Society for Acute Medicine (UK) works closely with the BAEM to ensure that our common goals are met. Over one hundred delegates attended our most recent meeting in Southampton, which included sessions dedicated to clinical issues, organisational issues, and training. The large number of accident and emergency consultants and trainees in the audience was particularly encouraging, and a clear reflection of the interest in medicine that exists within accident and emergency. Hopefully this is the beginning of a close relationship between our specialties, from which acute medicine and emergency medicine will each benefit, for the sake of the patients whom we both treat.

Further information about the Society for Acute Medicine (UK) can be found on web site www.acutemedicine.org.uk or by writing to Ms Audrey Deuchars, Medical Assessment Unit, Royal Infirmary of Edinburgh, Lauriston Place, Edinburgh EH3 9YW.

- 1 Royal College of Physicians of London. *Future patterns of care by general and specialist physicians. Report of a working party.* London: RCP, 1996.
- 2 *Acute medicine: the physician's role.* Federation of Royal Colleges of Physicians of the United Kingdom, 2000.

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Highlights of the BAEM Executive/AGM, April 2001

- The recent referendum produced a 94%:6% majority in favour of the Association and Faculty merging. Discussions with the Faculty regarding the logistics of this are to start shortly.

The timescale is estimated at two years, sooner if possible. In view of this relatively short period, it was decided not to proceed with changing the name or logo of the Association in the interim.

- Dr John Gosnold was awarded Honorary Life Membership of BAEM.
- Paul Middleton from St Mary's London, has won the Maurice Ellis award to study cardiovascular function using plethysmography.
- The Association will be developing links with the National Association of GP Cooperatives.
- The Association and Faculty are working to produce a document on workforce planning. This will be circulated to members in the near future.

- Arrangements for the 9th International Conference to be held in Edinburgh from 17–21 June 2002 are progressing well. There will be a full scientific and social programme. The initial flyer has now been circulated and the conference web site is available through the BAEM site.

Any suggestions regarding the content of the conference would be most welcome and should be forwarded to John Heyworth, Conference Committee Chair.

- New regional representatives—Mr K Chew, Northern; Mr A Harris, re-elected for South Western; Mr S Bhattacharyya, North Western.

Officers of the BAEM following the AGM—John Heyworth, President; Roger Evans, Immediate Past President; Steve McCabe, Honorary Secretary; Peter Burdett-Smith, Honorary Treasurer.

- A constitutional amendment was approved that the Clinical Services Committee and Academic Committee merge to form the new Clinical Effectiveness Committee.

The Third Chelsea FFAEM Course

20–21 September 2001 at Chelsea & Westminster Hospital, London

Following the success of the previous courses, this two day course provides an intensive preparation for the Fellowship of the Faculty of Accident and Emergency Medicine examination. The faculty have all recently passed the examination and there is always a high ratio of faculty to attendees. It will include:

- Advice on answering OSCE questions and at least two full mock exams.
- Advice on answering management questions and a mock exam.
- Advice on critical appraisal and a mock exam.
- Feedback on both clinical topic reviews and a mock exam around one of them.
- Feedback on recent examination questions.

For details please contact: julia.harris@chelwest.nhs.uk or Jredhead@EHT.org.uk or write to: Ms Julia Harris, Consultant in Accident and Emergency Medicine, Chelsea and Westminster Hospital, London SW10 NH.

News from BAETA

BAEM Conference, April 2001

The BAEM Conference in April was well supported with about 100 trainees in attendance. As well as an excellent social programme, there was, as always, business to attend to. The BAETA meeting was unfortunately held on the first evening, so the young racing snakes were unable to give the crusties a run for their money in the 5 km race. After an update from our committee representatives, topics raised included:

- Election of new committee members as detailed below.
- Faculty regulations are that FFAEM examiners are unable to run courses specifically targeting the exam. Clarification of the Faculty's position on informal teaching by examiners was requested.
- The trainees fully support the move to establish a single College of Emergency Medicine as our parent body.

The full minutes of the meeting are available via the BAETA web site.

New BAETA officers

Big changes have been afoot in the BAETA Committee. Thanks to all the outgoing members for their past efforts, and congratulations to those below who were elected to post in Bournemouth.

- Anne Weaver (Mersey): BAEM Executive Representative.
- Amanda Farrow (Wales): BAETA Treasurer.
- Duncan Brooke (S E Thames): BMA Central Consultant's Committee Representative.
- David Pedley (Aberdeen): Trainee's Representative to the EMJ Editorial Board.

A full list of committee members, with contact details, is also available on the BAETA web site.

Position statements

The Faculty is considering the use of "position statements" for controversial areas of practice (for example, RSI by emergency physicians). If anyone would like to suggest an issue that needs a position statement, please contact one of the Faculty representatives.

Trainees' survey

The Trainees' Representative to the JCHT (A&E), Darren Kilroy, is proposing to initiate a cross sectional survey of current training for SpRs in emergency medicine. A structured questionnaire of about 15 items will be sent to each trainee registered with the JCHT (A&E) to investigate issues including the number of hours of teaching per week we receive, tuition given one-to-one, management training, and hours given over to research and audit. It will, of course, be entirely confidential. If we are trying to standardise training we must first establish the current state of play across the country, so please support the study by taking a few moments to fill it in when you receive it.

Regional representatives

In the continuing effort to improve communication between trainees, we are endeavouring to update the regional representative system, whereby each region has a BAETA representative to act as a point of contact for dissemination and feedback of information. If you are in a region where there is no nominated representative, please bring this up at your next regional training meeting, and forward details of the new representative to Jonathan Benger at the address below.

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JONATHAN BENGER

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Recent consultant appointments, March to May 2001

The information for the consultant appointments is provided by the Faculty and any errors should be notified to them and not the journal

<i>Name</i>	<i>Hospital</i>	<i>Previous post</i>
Dorothy Apakama	City Hospital, Birmingham	SpR, Birmingham Heartlands
Jane Brenchley	Barnsley District General	SpR, Pinderfields
Charlotte Doughty	Arrowe Park Hospital	SpR, Hull Royal Infirmary
Hugo Dowd	Sunderland District General	Locum consultant
Jane Fothergill	St John's Hospital, Livingston	Consultant, St Mary's, London
David Gaunt	Watford General Hospital	SpR, Charing Cross
John Hollingsworth	University Hospital Aintree	SpR, Royal Liverpool
Malcolm Jones	Sunderland District General	SpR, Sunderland
Gary Kitching	York District Hospital	SpR, Wythenshawe
Katherine Lendrum	Chesterfield & North Derbyshire	SpR, Russells Hall
Savvas Papasavvas	Epsom General Hospital	SpR, Russells Hall

An ophthalmology secondment

One is constantly learning throughout a training programme in emergency medicine. I found the core secondments went a long way in filling my knowledge gaps and I was constantly able to benefit from discussions on the shop floor with physicians, paediatricians, and anaesthetists. Ear nose and throat, maxillofacial, and venereology likewise were often on-site and facilitated learning and furthered clinical development.

At the start of my rotation, however, I realised that not until year 4 would I work at a hospital with in-house ophthalmology, and even then the ophthalmologists would be in a separate building with their own eye casualty. This is a situation common to many trainees and I believe our training programmes need the inclusion of a core ophthalmological secondment. Tan *et al* have identified that our SHOs have a confidence and knowledge gap when dealing with ophthalmological emergencies, and surely it is beholden to us as trainee specialists to attempt to remedy this with a period of supervised ophthalmology during our training.¹ Flitcroft *et al* demonstrated a poor correlation between A&E doctor assessment and that in the eye clinic, with frequently the basic undemanding features of the

examination, such as examination of the anterior segment of the eye, neglected.² Surely there is a need for improvement.

I was fortunate to be able to spend two weeks in the A&E department of a major ophthalmological hospital, the Western Ophthalmic. Sitting with the specialists who look through slit lamps for the majority of their working day was a revelation. As well as seeing a spectrum of morbidity that had previously eluded me, the examination and treatment of the minor eye conditions in A&E became far easier. This secondment has enabled me to confidently teach and instruct the SHOs in management of eye conditions and the use of the slit lamp. For hours invested I would say it was the most profitable of secondments. I would recommend it to all registrars, and I believe the Faculty should make it compulsory.

ANDY PARFITT

1 Tan MM, Driscoll PA, Marsden JE. Management of eye emergencies in the accident and emergency department by senior house officers: a national survey. *J Accid Emerg Med* 1997;14:157-8.

2 Flitcroft DI, Westcott M, Worwald R, *et al*. Who should see eye emergencies? *J Accid Emerg Med* 1995;12:23-7.