Acute Medicine

Guest Editorial

A personal journey in Acute Medicine

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This article describes my personal journey through Acute Medicine from the late 1980's and incorporates the development of Acute Medical Units (AMU's), co-establishing the Society for Acute Medicine (SAM), as well as involvement in the development of training curricula, research and audit. I am deeply indebted to a great number of professional colleagues over the last three decades, who have been pivotal to the development of the Acute Medicine specialism, and many of whom in turn became presidents of SAM.

I qualified in 1980 and eventually began focusing on training in respiratory medicine and working as an acute take medical registrar. Prior to my leaving the Royal Edinburgh Infirmary (RIE) in 1988, as Junior Doctor Body Representative, I was involved in setting up an overnight medical admissions unit (co-located with toxicology unit and led by "Consultant of the day"), driven by junior doctors' hours working to minimise disruption to other wards.

On moving to Central Middlesex, as medical registrar I went back to admitting patients to different medical (and occasionally non-medical) wards, particularly overnight. I was struck by how time-consuming and occasionally unsafe this was, due to the geographical distribution of patients, staff availability and equipment resources such as monitoring. My involvement in intensive care led to me becoming a consultant in Intensive Care and Chest Medicine. I realised as both medical registrar and intensivist, I was at times "rescuing patients" from other ward areas, which felt inappropriate. My early experience in RIE, coupled with intensive care developments in London, made me recognise the need to provide a single, safe area of care; not an easy task. This involved designing and establishing an AMU which incorporated coronary care. Working with senior nursing staff, we developed a multi-professional workforce and established relationships with key departments including imaging and pathology, to create priority diagnostic pathways for early diagnosis and treatment, leading to shorter length of stay and safe discharge. This was one of several AMU's developing throughout the UK, creating the foundation for the development of Acute Medicine and AMU's. The association of Acute Medicine with the geography of an AMU was to some extent based on the historical development of coronary care and intensive care units and in my view, remains an essential feature of the specialty, and one of the main differentiating factors from the hospitalist programme developed in North America.[1] Whilst there are similarities, the AMU is a defined geography with defined staff and appropriate equipment and resources to support early senior decision making, diagnosis and treatment.[2]

Acute Medicine is indexed in PubMed and EMBASE and cited in Medline

Published by
Rila Publications Ltd.
73, Newman Street,
London W1T 3EJ, UK
Tel: +44(0)20 7637 3544
Website: www.acutemedjournal.co.uk

Design & Production
Georgina DaCambra

Enquiries
Circulation and Foreign
Distribution rights contact
Rila Publications Limited

Advertising
Tel: +44 (0)20 7631 1299

Subscription Rates:
Personal
Print & Online: *UK £100* *Overseas £140*
Online Only: *Personal:£60* *Students: £45*
Institutional/Library
Print Only: *UK £140* *Overseas £180*
Online Only: *£500*

ISSN: 1747-4884

"Acute medicine has developed over the last decade in response to the increasing number of medical admissions, concerns over quality of acute care and other pressures including the European Working Time Directive."[3]

In the mid 90's, I returned to the RIE to lead the design and development of Acute Medicine as an essential feature of the new Royal Infirmary in Edinburgh hospital. In 1998 I contributed to the "Acute Medical Admissions and the Future of General Medicine" RCPE report, for which I was especially consulted and gave key evidence. Shortly thereafter, I established the Society of Acute Medicine (SAM) in 2000, of which I was the inaugural president.

Several key components of the design of the Acute Medicine service began to take shape at the old RIE. This included reducing the number of consultants participating in acute unselected medical receiving, at the same time as increasing the robustness of senior medical cover, which involved creating a team of consultants, operating with two consultants on call per day for a period of several days, with aligned junior doctor rotas. Further, in recognition of the patients' complex needs, we moved to establish multi-professional support 7 days per week, particularly in relation to physiotherapy, occupational therapy and pharmacy. Having established a workforce targeted to patient needs and demand, the next stage was to design the new hospital building. This involved working with the hospital design team and the senior executive team to pilot new ways of working and establishing professional and geographical relationships, in the existing building prior to the move to the new hospital. Key elements fundamental to the success of the new unit were convincing the senior management team to create a new AMU on the old site which was adjacent to Accident and Emergency. This involved building a 2-storey portacabin AMU including a separate toxicology and self-harm area. Another essential step was creating a combined medical and surgical HDU, managed by a subgroup of Acute Medicine consultants. By undertaking this significant programme of work, we were able to assess and monitor processes, which influenced both the design of patient pathways and patient flow to inform the new AMU.

The move to the new RIE site was undertaken in 2003 and allowed the incorporation of two clinical consulting areas within the AMU, to support the development of Ambulatory Care, direct access for General Practice and pre-determined ambulance referrals. This required the development of a group of advanced nurse practitioners who were able to pre-assess patients and order routine investigations to facilitate patient flow. The move to the acute unit also allowed us to establish a robust small group of part-time GPs, who were dedicated to the AMU, whilst still working in local general practices. This proved beneficial to the management of patients with complex needs, as part of the multi-professional team.[4]

In 2006, while supporting the growth of Acute Medicine throughout the UK as part of SAM, I was pursuing a career in senior clinical management, when the opportunity developed to return to a clinical academic career with the development of a Chair in Acute Medicine at Imperial College London, based at Chelsea and Westminster Hospital NHS Foundation Trust. I was fortunate enough to be appointed, providing opportunity for further research and audit in relation to Acute Medicine.

In 2007, I was involved at co-chair in the development of the pivotal "The Acute Medicine Taskforce" document in 2007, which helped put Acute Medicine on the map. A significant output of the Acute Medicine Taskforce was the intention to standardise the development of early warning system to assess illness severity, now known as a NEWS score,[5] which did in fact build on some of my earlier work for the Scottish Early Warning Scoring system.[7]

During this period, SAM established a research sub-committee, with I initially chaired, and the concept of an annual cycle of audit of AMU's was developed, as the Society for Acute Medicine Benchmarking Audit (SAMBA), which has continued to grow and actively contribute to an improved understanding of Acute Medicine.[8,9] This also provided an opportunity for Chelsea and Westminster Hospital to establish a forward-thinking, multi-professional team to adapt to growing demand and provide innovative ways of delivering acute medical care. Many developments could be described, but I shall name two of significant importance. First is the creation of a large defined Ambulatory Care area, capable of delivering same day emergency care as part of its remit, which was operated both clinically and managerially by the Acute Medicine team. The other is the establishment of an Acute Medicine pathway for the initial management of patients with fractured neck of femur, to support the prompt medical assessment and minimise theatre delays for this vulnerable group of patients. This represents Acute Medicine beginning to provide specialist patient pathways to improve care.

The above, in part, describes my personal journey and involvement in the development of Acute Medicine as a specialty. There are too many other touchpoints in my career to mention in this short piece. Areas which I must mention include the development of training programmes for Acute Medicine over the years. Dr Mike Jones must be given significant credit for leading on this and creating this essential foundation for Acute Medicine as a medical speciality nationally and internationally. Without going into details, we and others, were involved in robust political and professional discussions which proved successful, with an ever-growing number of Acute Medicine training posts throughout the United Kingdom being created. The other area which requires mention is research, which has grown under the auspices of SAM, with increasing numbers of research submissions to the SAM Conference. Establishing a stronger research-facing programme for SAM, must remain one its key goals, both nationally and internationally. On this front, I am

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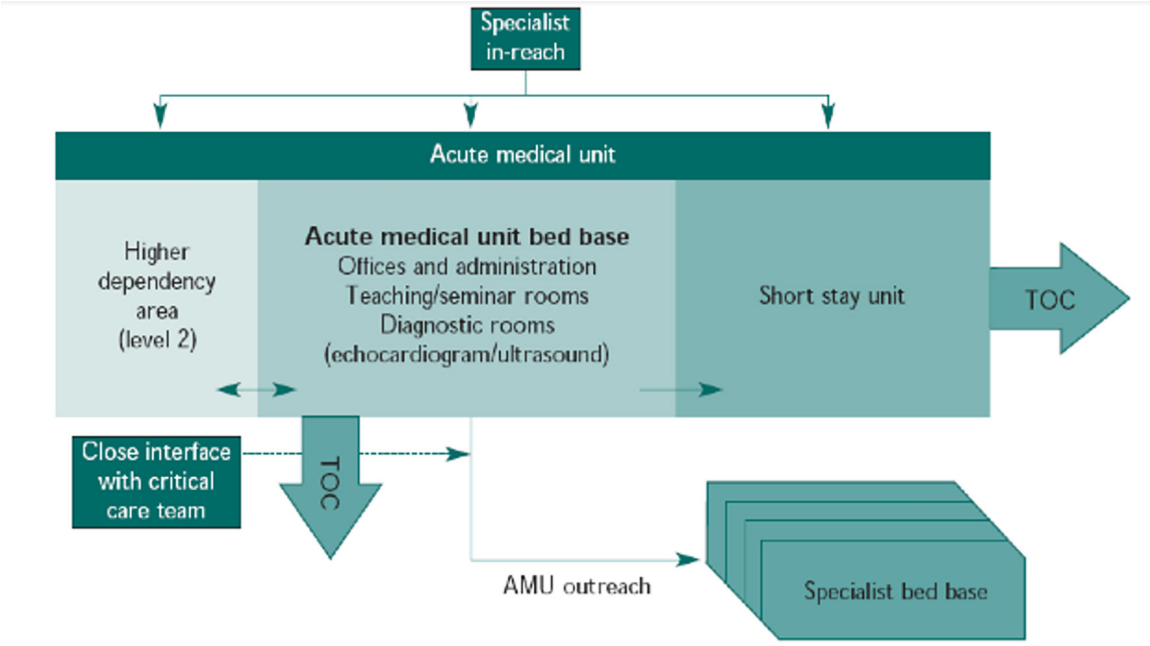

Figure 1. Acute Medical Unit Design: Example Configuration.[6]

particularly indebted to our colleagues in Amsterdam who have supported both joint conferences as well as research collaborations. While President of the Royal College of Physicians of Edinburgh, this also offered me the chance to visit AMU's abroad, where I witnessed the many similarities in the development of Acute Medicine and AMU's. This has also fostered a great number of long-standing relationships and friendships between acute physicians in different countries including Australia, Singapore, Bangladesh, Nepal, Malaysia, Netherlands, Pakistan.

As of December 2021, my clinical career has come to an end but I feel deeply privileged to have been part of the development of Acute Medicine as a specialty and remain indebted to many for my opportunity to be involved in such an exciting specialty. Acute Medicine is, and will always be, a demanding speciality, in terms of acuity and rapid clinical decision-making, however it can also be intensely rewarding as an individual and for the patients that we serve.

Figure 2. Prof Derek Bell and Dr Gary Davies with colleagues in Pakistan

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