Viewpoint: is there a role for a diabetes specialist on the AMU?

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Many specialists have taken time to adjust to the development of acute medicine and Acute Medical Units (AMUs). As these concepts have evolved, so has the understanding of how specialists can better interact with their new acute medicine colleagues and how they help to ensure the smooth running of one of the most vital cogs of the hospital 'machine'. For some specialties (Cardiology , Respiratory Medicine etc), it has been relatively straightforward to integrate into the new model - perhaps due to the sheer numbers of acute patients relevant to those specialties. However, for the chronic disease specialties such as diabetes, it has been less easy to understand how to optimize the interface with acute medicine.

In this *Viewpoint* article I am going to consider what could be done to improve the care of patients with diabetes in an AMU using the existing resource of diabetes specialists. An increasing number of physicians, trained specifically in Acute Internal Medicine (AIM) are now being appointed; however there are many AMUs in which the hands-on consultant presence is provided by, or shared with, physicians who have trained in diabetes / endocrinology and General Internal Medicine (GIM). This piece looks at how we might use these skills more effectively.

What clinical support could a diabetes specialist provide on the AMU?

The major causes for admission directly related to diabetes, broadly, are the cases of ketoacidosis (DKA), hyperosmolar coma and acute hypoglycemia. Although the initial management is often protocol driven, easy access to a specialist who could provide advice for more complex cases, and even arrange for the patient to be discharged earlier with quick follow up appointment slots could be beneficial. Taking this forward, could the diabetes team provide a service which is responsive, on demand, for review of such patients? For this to happen, there needs to be greater recognition and appreciation from commissioners of the need for inpatient diabetes. If inpatient diabetes was a specifically commissioned role, benefits to the AMU might include:

- A daily presence on the AMU
- A direct phone consultation service
- Designated outpatient slots to enable admission avoidance or early discharge

For some patients, management in an ambulatory setting may be feasible; with good patient education, DKA can sometimes be identified early enough that overnight stay can be avoided by a few hours of intravenous fluid and observation. Many AMUs have well-developed ambulatory care areas, and access to senior specialist diabetes expertise could enhance this model of care. An alternative might be to consider providing ambulatory care within a specialist diabetes unit or ward, provided that a suitable area and appropriate staffing can be identified.

A system to highlight such patients who get admitted on AMU can also be helpful; locally, we have agreed with the ambulance services that any callouts being generated due to diabetes problems are flagged up to the diabetes unit, whether or not the patient is admitted to hospital. If admitted, then the team can pick this up as a priority and review the patient within 24 hours. An IT-based system whereby patients whose primary cause for admission is diabetes can be immediately highlighted to the diabetes team would also be hugely beneficial.

Education, education, education…?

Another area where a diabetes team can help is by providing regular, dedicated teaching for AMU staff. The turnover of junior doctors and nursing staff is often high, and teaching sessions therefore need to be repeated at regular intervals. However the benefits can be substantial, with the potential to improve the quality of in-patient care, shorten length of stay and reduce likelihood of readmission. For example, the 82 year old lady who comes in with a hypoglycaemic attack may need treatment with dextrose, but will also need a review of her usual treatment regimen. While this may sound simplistic, I have seen many examples of the 'dextrose and discharge' approach – often driven by bed pressures - leading to early, and preventable, readmission.

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Staffing and 7 day working – the biggest challenges?

As with so many aspects of acute care, one of the biggest challenges is how to provide adequate numbers of staff to provide a responsive service when the patient needs it; moves towards 7 day working are clearly necessary, but threaten to dilute further the staffing of specialist services during weekdays. Enhancing the skills of acute medicine trainees in chronic disease management might be one way to deliver the necessary workforce required for the future. Currently acute medicine trainees are required to spend designated blocks of training in cardiology, respiratory medicine, critical care and geriatrics. Although there are many diabetes related competencies listed in the AIM and GIM curricula, these will usually be acquired during placements on the AMU and in other medical specialities, as there is no requirement for dedicated diabetes training.

One option for future consideration could be a chronic disease or long term conditions placement within the training for acute physicians. This could involve a combination of diabetes, rheumatology, dermatology and neurology. While none of those have the case load to justify a full 4 or 6 months placement, together it may be possible to provide a significant enhancement to training. From a diabetes perspective, a month of focused time spent learning about the new drugs, different insulins, how to avoid hypoglycaemia, why hypos could be an early indicator of renal dysfunction, and how to manage the "risks" associated with early discharge, could have enormous benefits for the future care of patients admitted to the AMU.

So where do we go from here?

The diabetes specialty team can play a role but we perhaps need to think differently. From the AMU perspective, an identification system of relevant patients and incorporation of diabetes training in the departmental educational programme and the formal training programme could have huge benefits for patient care. In turn, diabetes specialists need to become more receptive to the idea of being accessible to AMU on demand, look at novel ways of creating clinic slots and consider development of ambulatory services.

There continues to be debate amongst primary and secondary care as to where diabetes consultants fit into our modern and changing health service; models being developed in Derby or Portsmouth are trying to answer these questions. We must avoid territorial debates erupting between acute medicine and diabetes and instead come up with more innovative ways of sharing best practice.

In the words of Henry Ford: *"Coming together is a beginning; keeping together is progress; working together is success"…* it is up to us to ensure the beginning of the process – and to look forward to the success this will, one day, provide.