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RCPI and the Acute Medicine Experiment

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On 13th March 2023 the RCPI's Director of Basic Specialist Training, Prof John McDermott, issued a missive to Clinical Directors in hospitals around the country. This indicated that site accreditation for RCPI training may be revoked, on the basis of patients being triaged to medical BST trainees without having been "reviewed and appropriately worked up by the Emergency Department doctors".[1]

There followed a letter from the HSE CCO Dr Colm Henry on 21st March 2023 to all Hospital Group CEOs and Clinical Directors, indicating a 'significant degree of concern regarding overcrowding in our EDs'. It went on to say that 'where there were significant concerns with delay in reviewing triaged patients, that specialist teams can be contacted to review patients directly, working within their scope of practice.'[2] The IAEM issued a press release on 24th March 2023 referring to the RCPI's communication as a 'tone deaf circular coming at a time of unremitting, unprecedented demand'.[3] It emphasised the apparent contradictory nature of this statement to the Acute Medical Assessment Unit model, which first proposed such streamlining as part of the National Acute Medicine report in 2010.

So, how has such an apparent disconnect between RCPI trainers and the needs of acute medical patients emerged? This, in part, is connected to how medicine has evolved over the last 2-3 decades. Its evolution is an interesting one. There was a time when all physicians were expected to be competent in both the immediate and subsequent management of all common medical disorders, and thus were 'general physicians'. Formalisation of medical training in the 1970s defined 'specialty training', and facilitated the development of the physician with special interest in a particular specialty. With this subspecialisation came the development of specialist societies, and many physicians became more committed to their specialties than to the general needs of their acute call. General take has become a nuisance and a distraction from their main job. Such 'specialists' are still expected to deliver the same level of care of their generalist predecessors.[4]

The Irish National Acute Medicine Taskforce report was published in 2010.[5] There is some broad overlap between its objectives and that of Emergency Medicine: to optimise quality of timely patient care, to improve access to appropriate senior decision making and to optimise flow and reduce inefficiencies and costs. But its performance metrics are different. Rather than attendances and admissions, the laudable focus in acute medicine is on discharge metrics. The programme emphasises quality improvement to optimise efficiency as well as safety and quality of care.

It is evident that specialist care of acute medical conditions yields better outcomes than non-specialist care.[6] However, no hospital in Ireland currently has systems to facilitate such subspeciality admissions on a 24/7 basis. As a result, most patients admitted acutely continue to come under the care of consultants not specialising in their presenting conditions. In theory, medical admissions would be admitted to the ward of the physician on call, but with the inexorable rise in the numbers of emergency admissions, ward based admissions don't exist, with patients being admitted initially to any available medical bed, and later to virtually any bed in the hospital. The inefficiency of this process, with the admitting team spending almost as much time rushing from ward to ward continues. Medical admission units (MAUs) were intended to help with this. However, it failed from the opening in some simple mathematics. Let's take some very basic figures: Say a busy University Hospital (or Level 4 institution as the AMP would recognise it) sees 100,000 attendances in its ED per annum. Admissions would typically average 25% in such units, and let's take it that 60% of these unscheduled admissions are acute medical. That averages at 41 acute medical admissions/day. Taking a crude average length of stay of 5 days, this hospital would require an AMU with a minimum capacity of 205 beds. Allowing for 85% occupancy brings this minimum capacity to 242 acute medical beds. Most AMUs would be lucky to have 10% of such capacity.

A counter-argument that might be put forward is that acute medical pathways should be focused on ambulatory care rather than increasing beds, with a move away from reliance on hospital admission.[7] It is this aspect of Acute Medicine and medical training that is undoubtedly crucial in acute healthcare sustainability: the ability of a physician to be able to safely manage and coordinate and empower such a patient's care without reliance on having them in a hospital bed. Such a system requires huge focus of efficiencies, and shifting from traditional models of inpatient care to community based supported models, and outreach type models. Yet, it would appear that the RCPI trainers have concerns in this regard. The shift to higher specialist training has sought to off-load the role of the 'General Medic' to the Acute Medicine physician, and wall it off as a speciality. Dr Armstrong's missive focuses on medical trainees 'not being trained to discharge acute patients'. Yet, this is the emphasis of what acute medicine performance metrics are based upon.

So are there solutions to this acute care conundrum and RCPI trainee needs? The training process at present recognises the need for medical NCHDs to be exposed to patients requiring acute medical admission, but after they have been seen and only after fully worked up by an Emergency Medicine doctor. This involves their clerking a patient: a process that currently adds hours to a patient journey. Patients cannot even booked for a bed, moved to a ward, or given any regular meds until this clerking by a trainee is performed. As a trainer, what is the real return on investment of such a 'training activity' for the trainee or patient? It's not history taking, or clinical examination, or booking diagnostics. It's not making decisions. It's not communication. It's not timely care for the patient. Some cling to a notion of safety without any evidence base to support it. It is difficult to envisage any point to this practice, other than tradition. Many centres internationally have now shifted to use a process

of 'single clerking' of patients by the EM physicians, who are empowered and resourced to decide to admit and commence treatment on patients from ED. Such single clerking alone reduced time to full clerking and bed booking by 60% in the UK, with time to senior medical physician review reduced by 60%.[8] Such processes empower EM clinicians as part of the acute patient's clinical journey. So, why are we not doing this in Ireland? Why are RCPI persisting with an arguably outdated model of 'basic specialist training'?

Our national college of physicians need to step up to the needs of our future trainee physicians and their patients. Training need to the empower clinicians to be able to facilitate safe acute medical ambulatory care, and to be able to collectively achieve the discharge metrics proposed in the National Acute Medicine's Report, rather than relegating it to yet another remote subspeciality.

Declarations of Conflicts of Interest:
None declared.

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