Future direction for the care of the acutely ill medical patient in the UK?

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With the publication recently of the results of learned deliberations of two working parties of the Royal College of Physicians (RCP),[1,2] attention continues to focus on the organisational and training aspects of the care of the seriously ill. These documents are the latest in a series of publications that have made proposals for improvement. The intensive care medicine (ICM) community has for many years been drawing attention to the plight of the critically ill, with frustratingly little response from the UK Department of Health. The Audit Commission report *Critical to Success*[3] provided independent evidence that variation in facilities and patterns of operation had important impacts on patient care and cost-effectiveness. Published subsequently were a report of the National Expert Group *Comprehensive Critical Care*[4] and an operational document from the Department of Health.[5] In parallel with these publications a series of high-profile cases drew public attention to the parsimonious provision of critical care facilities, leading to frequent system failure, cancelled planned surgery, and long-distance transfer of the desperately ill. This shambolic situation reached a peak in the winter months, when at last further resources were made available and on the back of these 'winter pressures' monies, a modest expansion of facilities occurred. The two latest RCP reports *The interface of accident & emergency and acute general medicine*[1] and *The interface between acute general medicine and critical care*[2] focus specifically on the care received by acutely ill medical patients.

There is a substantial body of evidence to show that the care of seriously ill patients is suboptimal in a variety of settings. In one study nearly half the patients admitted as emergencies to the intensive care unit (ICU) were found to have received substandard care.[6] In another, Goldhill *et al*.[7] reported that for many patients admitted to intensive care as emergencies there was documentary evidence to suggest that someone had identified a deterioration in the patient's condition; effective measures were not, however, instituted. This group had already demonstrated that patients admitted to intensive care after cardiopulmonary resuscitation had very poor outcomes.[8] From these and similar studies[9] developed the idea of an emergency response which could be activated when a deterioration in the patient's condition occurred. The reported triggers for this response vary widely, and the response also varies from the initial immediate alerting of senior clinicians[10] to intervention of an emergency medical team with critical care skills.[9,10] The results from studies of such systems appear promising. These studies have concentrated on ward patients, but recent work suggests that the early institution of an aggressive critical care process in an accident and emergency (A&E) setting produces clear outcome benefits.[11]

Comprehensive Critical Care[4] laid out a framework for the future development of critical care services, which was broadly welcomed by the ICM community. Among the recommendations was the creation of a novel classification of dependency ranging from Level 0 (normal ward care) to Level 3 (multi-system intensive care support), thus rendering the previous concept of 'high-dependency care' obsolete. The main thrust of the report was that intensive care medicine must be delivered to the patients wherever they happen to be, rather than confining the skills of the intensive care multidisciplinary team to the geographical constraints of the ICU. In other words, the report supported 'outreach'.

Thus we have data demonstrating that pre-ICU care is often improvable, and we have encouragement for ICM specialists to spend more time seeing patients outside the ICU. It is clear that if their primary teams identify emergency admissions and deteriorating ward patients early, such patients are

likely to gain benefit from early intervention, even if this intervention is a timely *Do Not Resuscitate* order. The spotlight continues to fall on early identification. Early warning scoring systems may have a role here, but I see them functioning as a secondary safety net.

What else can be done to assist early care? The RCP reports make a series of recommendations that, if implemented, would undoubtedly be of substantial benefit. From my perspective the most interesting recommendations from these reports are:

1. The development of an acute medicine unit in which acutely ill patients can be assessed and managed, and the creation of a process of care which allows the patient to move safely from the A&E department to a team with inpatient responsibility. This acute medical service must have a consultant with managerial responsibility.
2. The exploration of the concept of the acute care physician.
3. A formalisation of the acute medical 'take' as a *commitment*, such that the responsible consultant is freed of other obligations and is immediately available and involved.
4. The further development of critical care outreach and early multidisciplinary review of acute patients.
5. The improvement of 'high-dependency' facilities (now termed level 1 or 2) and the development of weaning units. There is likely to be an increased need for such facilities with the expanding use of non-invasive ventilation.
6. A strengthening of training in acute medicine in the general internal medicine syllabus, with the inclusion of anaesthetic and critical care competencies, and the development of rotations which include relevant placements to achieve these objectives.

Much of this may seem obvious, but the implementation of some of these recommendations will present challenges. Freeing physicians to concentrate on their acute general internal medical (GIM) patients will have significant manpower implications, and many medical specialists have limited enthusiasm for GIM. Furthermore, maintaining continuing professional development in GIM plus a medical specialty is an enormous task. The development of level 1/2 units will have important resource implications, as will the establishment of acute medicine units. The occasional unfortunate perception that the acute medicine unit is part of the A&E trolley area needs to be dealt with in public relations and statistical terms. Importantly, the creation of multidisciplinary training rotations seems astonishingly difficult to establish, as demonstrated by intensive care medicine itself.

The most powerful tools for improving the care of the surgical and obstetric patient have been the National Confidential Enquiry into Perioperative Death (NCEPOD)[12] and the Triennial Confidential Enquiry into Maternal Death.[13] These rolling audits have demonstrated that poor organisation and practice contribute to unnecessary deaths, and have driven the establishment of best practice principles that now have almost legislative force. This process has forced change where in many instances it was desperately needed. No such audit exists for the acutely ill medical patient. This remarkable deficit is identified by the RCP working parties and needs urgent attention.

What effects will these RCP reports have? Only time will tell, obviously, but to effect change the support of the stakeholders in the training and delivery organisations will be required. Importantly, there are likely to be substantial resource implications. The effects of any improved resource will be hard to measure without effective and complex audit tools. After all, this is a quality rather than quantity issue – a true test of political will.

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