Coping with pressures in acute medicine.

THE ROYAL COLLEGE OF PHYSICIANS CONSULTANT QUESTIONNAIRE SURVEY

ABSTRACT - Objectives: To assess the impact of reduced junior doctors’ hours and increasing emergency admissions on patterns of acute medical care, and to evaluate recent innovations.

Methods: Questionnaire survey of all 2,980 consultant physicians in England, Wales and Northern Ireland potentially involved in acute medicine. The response rate was 63%, with 1,632 respondents undertaking unselected takes.

Results:

Workload - The median average number of admissions per 24 h was 20–24, but 25% of consultants admitted ≥30. The median frequency of take duties was 1 day in 5.

Composition of resident medical teams - The most common permutation was one specialist registrar (SpR), senior house officer (SHO) and house physician (HP), coping with 20 admissions on average. However, the teams of 25% of respondents did not include a SpR, and 9% consisted solely of one SHO and one HP, with an average 17 admissions.

Partial shift rota - Forty-two per cent of consultants had introduced these. Most were critical of them because of their adverse impact on continuity of care and junior staff training, and their unpopularity with trainees.

Patterns of care - Only 10% of consultants indicated that myocardial infarction patients were managed exclusively by a cardiological team. Forty per cent operated an age-limit (varying between 65 and 85) for admission under care of the elderly physicians. Seventy per cent had introduced an admissions ward.

New initiatives to cope with admissions - These included twice-daily consultant take rounds, use of nurse practitioners and staff-grade doctors, 12-hour takes and ward-based admission schemes. Measures to expedite discharges included ‘discharge lounges’, nurse facilitators, low-dependency wards and ‘hospital at home’ schemes.

Several factors are severely straining the provision of acute emergency services in general medicine throughout the UK. These include: the reduction in working hours of doctors in training required by the New Deal; the shift from apprenticeship to more structured training for specialist registrars (senior trainees); the inexorable rise in the number of emergency medical admissions; the increasing problems in arranging the discharge of elderly patients back into the community; and the shortage of acute beds and funds. Recent publications from the Royal College of Physicians of London (RCP) and the NHS confederation1-3 show how these problems threaten the maintenance of safe standards of patient care. In response, consultant physicians in most acute hospitals have adopted new working practices, such as admissions wards and partial shifts for junior staff, and have shown a commendable flexibility and capacity for change. However, physicians have generally tackled these problems in isolation, and have been unable to learn directly from the experiences of colleagues in other hospitals faced with similar difficulties. This questionnaire survey was undertaken under the auspices of the RCP, to share information and views on various topical issues relating to the provision of acute general medical services.

Method

The questionnaire, entitled ‘Coping with pressures on acute emergency services’, was distributed by the RCP in August 1997 to all physicians in England, Wales and Northern Ireland who were thought to be participating in acute emergency intake duties. Of the 3,010 questionnaires that were posted, 30 were returned marked ‘gone away’; 1,688 (63%) of the remainder were returned. The respondents were asked Does your firm participate in the acute ‘take’ rota?, 1,632 answered ‘yes’, 136 ‘no’, and 100 gave no answer. The 136 who said ‘no’ included 52 rheumatologists, 30 cardiologists, 12 nephrologists and others working at tertiary referral centres with no unselected medical intake. The 1,632 consultant physicians who confirmed that they were participating in the emergency take rota form the basis of this report; they were working at 285 acute hospitals, an average of 5.7 respondents per hospital. A subsequent audit has shown that at least one consultant responded from 100% of the hospitals with an unselected acute medical intake. The specialty interests of the 1,632 physicians were: care of the elderly (371), gastroenterology (288), respiratory medicine (278), diabetes and endocrinology (275), cardiology (193), rheumatology (66), renal medicine (65), clinical pharmacology (29), infectious diseases (23), haematology (2), neurology (1), clinical immunology (1), palliative care (1), and 39 described themselves as general physicians. Some respondents did not answer all questions so the total number of respondents shown in the text and tables is not always 1,632. Copies of the questionnaire are available from the author.

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Results

The distribution of specialist registrars

In response to the question Do you have a specialist registrar(s)?, 1,193 consultants (74%) replied 'Yes' and 421 (26%) 'No'. The proportion of consultants in the main specialties without a specialist registrar were: 35% of rheumatologists, 31% of physicians in care of the elderly, 30% of cardiologists, 26% of diabetologists or endocrinologists, 24% of respiratory physicians, 16% of gastroenterologists and 8% of nephrologists.

Numbers of acute admissions per 24 hours

Consultants were asked What is your average number of admissions per 24 hours? The answers ranged from below 10 to 70 (Table 1). The busiest 'takes' were found in a few large city hospitals. Virtually all those with fewer than 10 admissions per day were in specialist units or care of the elderly teams rather than in acute unselected medicine, and so have been excluded from subsequent analysis of patterns of medical staffing.

Numbers of resident staff in training on the acute medical team

Consultants were asked How many staff (including care of the elderly staff) are compulsorily resident on call on the acute medical rota in the evening and weekends?, and to list the numbers of non-consultant career grade staff, specialist registrars (SpRs), senior house officers (SHOs) and pre-registration house physicians (HPs). Eighty physicians had one career grade doctor on the team and four had two. The teams described by 1,051 (75%) of 1,395 consultants with 10 or more admissions per day had at least one SpR on the acute medical team and 80 had two or more. However, there was no resident SpR on the acute medical teams of the other 344 (25%) physicians and 319 (23%) also had no non-consultant career grade input.

The various permutations of junior staff on acute medical teams are shown in Table 2 with the corresponding average number of admissions. The 84 teams with non-consultant career grade input, and those with an average of <10 admissions per day, have been excluded from this analysis. The most common permutation – one SpR, one SHO and one HP – was found on the teams of 296 physicians with a daily average admission of 20 patients. However, staffing levels varied widely and the teams of 129 physicians consisted solely of one SHO and one HP although their average workload of 17 admissions was only slightly less than that of teams which also included an SpR. The teams of 190 physicians had three or more junior staff (SHOs and/or HPs) but did not have SpR support; some of these were in large acute general hospitals, including 17 teams with 3 SHOs and 2 HPs coping with an average of 34 admissions. Applying these analyses to entire hospitals is difficult because of their differing work patterns, but 31 hospitals had at least 2 teams with no resident SpR on the acute medical team. This figure is almost certainly an underestimate because of the incomplete response rate.

Frequency of acute admissions duties

Consultants were asked How often is your firm on take?, the responses are shown in Table 3. These data are difficult to interpret, because all the '1 in 3' rotes were in care of the elderly or other specialised services, or in tertiary referral centres with few admissions, and it is often unclear whether a rota reported by one medical team applies to all such teams in the same hospital. Nonetheless, 170 of 820 consultants with an average of 10 or more admissions per day, and who had not adopted partial shift systems, had a 1 in 4 rota. Considering hospitals with at least 2 such physicians in different specialities (to exclude the possibility of a separate care of the elderly rota) and who had not adopted 12 hour shifts (to exclude larger hospitals with 8 teams on take), there were at least 31 hospitals with a 1 in 4 rota for

### Table 1. Numbers of acute admissions per 24 hours.

| No. of admissions | No. of Respondents |
|-------------------|--------------------|
| <10               | 139                |
| 10–14             | 233                |
| 15–19             | 312                |
| 20–24             | 345                |
| 25–29             | 163                |
| 30–34             | 170                |
| 35–39             | 56                 |
| 40–44             | 75                 |
| 45–49             | 13                 |
| 50–54             | 31                 |
| >54               | 25                 |

### Table 2. Combinations of junior staff on acute medical teams.

| No. of consultant teams | No. of SpRs | No. of SHOs | No. of HPs | Average admissions per 24 h* |
|-------------------------|-------------|-------------|-----------|-----------------------------|
| 296                     | 1           | 1           | 1         | 20                          |
| 186                     | 1           | 2           | 1         | 23                          |
| 168                     | 1           | 2           | 2         | 24                          |
| 129                     | 0           | 1           | 1         | 17                          |
| 83                      | 1           | 1           | 2         | 21                          |
| 70                      | 0           | 2           | 1         | 20                          |
| 56                      | 1           | 3           | 2         | 34                          |
| 55                      | 1           | 3           | 1         | 23                          |
| 42                      | 0           | 2           | 2         | 28                          |
| 22                      | 2           | 2           | 2         | 26                          |
| 18                      | 0           | 1           | 2         | 23                          |
| 17                      | 0           | 3           | 2         | 34                          |

*Teams with average admissions <10 per 24 h or with resident career grade staff excluded.
Table 3. Frequency of acute admission duties.

| Take rota (days) | No. | Respondents |
|------------------|-----|-------------|
| 1 in 3           | 53  | 4           |
| 1 in 4           | 311 | 22          |
| 1 in 5           | 383 | 27          |
| 1 in 6           | 280 | 20          |
| 1 in 7           | 67  | 5           |
| 1 in 8           | 182 | 13          |
| 1 in 9           | 46  | 3           |
| 1 in 10          | 91  | 6           |
| 1 in >10         | 20  | 1           |

acute general medicine. Again, this is almost certainly an underestimate because of the incomplete response rate.

Partial shift systems: views on their success

Consultants were asked Have you introduced a partial shift system for doctors in training on your acute general take rota? 665 consultants (42%) replied ‘Yes’ and 925 (58%) ‘No’. When asked If yes, is it currently in operation?, 586 (37%) of those who had introduced a partial shift system replied ‘Yes’, while 79 (5%) indicated that it was no longer in operation. They were also asked to rate the success of their partial shift system on a scale of 0 (unsuccessful) to 10 (very successful). The replies from 647 consultants are shown in Fig 1. Their responses were remarkably diverse; the mean score was 4.9 (SD±2.7) and 129 physicians (20%) gave a rating of 8 or more whereas 148 (23%) scored it 2 or less.

Consultants were also asked Have you any specific comments on how it (has) worked in practice? Altogether, 504 consultants gave free-text replies, 94 of which were descriptive or non-committal, including 13 who had introduced partial shifts too recently to give an opinion. The remarks of the other 410 respondents were largely adverse, some strongly so, even when they had given a neutral score of around 5/10 in answer to the previous question. Of these, 208 (51%) stressed that the partial shift system had a deleterious effect on continuity of patient care, causing problems with handover of patients and lack of knowledge about patients on ward rounds, and preventing doctors in training from following the course of their patients’ illnesses. Eighty-five said that the system was disliked by junior doctors, 13 said it was ‘hated’ and 17 that it was ‘very unpopular’. Seventy-eight felt that education and training had been diminished as the system had reduced the opportunity for doctors in training to learn from the consultant’s review of their admissions and prevented them from attending teaching sessions. The disruptive effect of partial shifts on the team structure was mentioned by 35 respondents, who claimed that it reduced cohesion and loyalty and increased isolation of junior staff. Thirty-four said that cover for day time work by doctors in training had been reduced, sometimes to a dangerous level, of whom 19 felt this had reduced the standard of patient care. Reduced experience and education of junior doctors in outpatients was mentioned by 18 respondents, and 10 said that the work intensity for junior staff had increased significantly. Ten felt that partial shifts had produced a clock-watching ‘9 to 5’ mentality and had reduced the sense of responsibility or vocation. Nine physicians emphasised problems in coping with absence due to annual or study leave. Other descriptions included the terms ‘disastrous’ (14), ‘awful’ (4) and ‘terrible’ (4).

In contrast, 24 stated that partial shifts were popular with their junior staff and 15 emphasised the better sleep pattern and decreased exhaustion. Whilst 9 were resigned to the system as the ‘best of a bad job’, 10 stated that it was working well or was ‘not as bad as we had expected’ and 4 said that they would not like to return to the old system. Eight referred to the wide range of opinion among their junior staff over this issue.

Additional views on partial shifts were provided by 111 consultants who had no personal experience of them. Of these, only 3 were in favour of their introduction, while 47 stated that junior staff opposed their introduction because of their own or their peers’ negative experience at other hospitals, and 39 stated that they would actively resist their introduction. Seventeen consultants thought that partial shifts would have an adverse effect on continuity of patient care and 8 described them as ‘awful’, ‘bad’ or ‘disastrous’. Nevertheless 6 stated that they were considering introducing them, under pressure from their Regional Task Force (the body that ensures that doctors in training do not work excessive hours).

Fixed or rotating weekday ‘take’ rotas

Consultants were asked Do you have a fixed weekday ‘take’ or does this vary each week in rotation? Which option would you prefer? and Have you any specific comments? Four hundred and seventy-six (32%) had a fixed day and 994
(68%) rotated; 636 (47%) would prefer a fixed weekday ‘take’ and 711 (53%) rotation. This delicate balance in their stated preference, and the specific comments of the 795 who proffered them, indicate the difficult choice between the two systems.

In favour of fixed day takes, 54 thought that they caused less disruption to clinics and endoscopy sessions; 43 that post-take ward rounds could be planned more effectively, and 39 that it was much easier to plan work and domestic arrangements. Forty-seven said that Fridays could be rotated if there were 4, 8 or 12 colleagues in the rota, leaving Monday to Thursday fixed; 15 described rotas with only Tuesday to Thursday fixed; and 11 said that the fixed days allocated to consultants could be re-arranged every few months to balance the workload. Fixed day takes were considered by 7 consultants less disruptive to educational activities, such as SpR teaching programmes.

On the other side, 97 found it difficult to decide who should have Monday or Friday on a fixed system because of the much heavier workload on Mondays and the need for a Saturday ward round after a Friday take; 13 found this problem virtually insuperable with rotas of 1 in 5 or 6. The rotating system was judged fairer by everyone by 54 respondents; 18 said that clinics could be adjusted in advance to allow time for emergency admission duties and post-take ward rounds; 14 thought that rotating caused less disruption to educational programmes since each team missed only a small proportion of regular meetings. Fourteen consultants complained of being stuck with the Monday take, of whom 2 said that they had had no Monday Bank holidays for 9 and 4 years respectively. Interestingly, colleagues from their hospitals thought the fixed system was working well! Fourteen respondents had previously had fixed days but had switched to rotation in the interest of fairness.

**Use of an admissions ward**

Consultants were asked *Does your hospital have an admissions ward for emergencies?*, 1,123 (70%) replied ‘Yes’ and 481 (30%) ‘No’. Those who answered ‘Yes’ were asked to rate how successful it had proved in practice on a scale of 0 (unsuccessful) to 10 (very successful). There was a favourable consensus (Fig 2); the mean score of 1,108 respondents was 7.4 (SD±2.1), 632 (57%) scoring it 8 or more and only 39 (4%) 2 or less. Asked *How often is it difficult to transfer patients from the admissions ward to other wards?*, 27 of 1104 respondents (2%) indicated ‘never’, 570 (52%) ‘sometimes’, 436 (39%) ‘often’ and 71 (6%) ‘always’.

There were 837 responses to the question *Have you any specific comments on the value of the admissions ward?*. Most made favourable but non-specific comments. Thirty stated that it increased efficiency by focusing skilled nursing and other resources in one centre and facilitating post-take ward rounds; 19 thought that the concentration of all admissions in one location was highly beneficial to doctors in training; and 11 emphasised the value of frequent consultant ward rounds (at least twice daily) in ensuring that patients were rapidly assessed and decanted to other wards as appropriate. However, 19 were concerned that the system might interrupt continuity of care and 11 said that there were never enough beds in their admissions ward.

**Policies for managing myocardial infarction**

The question *What is your hospital policy re the admission of patients with acute myocardial infarction?* had three alternative answers. ‘Admitted and subsequently managed by the general firm of the day’ was selected by 928 respondents (70%). Admitted under the general firm but transferred to the cardiology firm later by 267 (20%) and ‘Admitted and managed solely by the cardiology firm’ by 127 (10%), largely drawn from 14 teaching hospitals and tertiary referral cardiothoracic centres.

**Policies for managing elderly patients**

To the question *Do you have an age-limit for admitting patients under the care of the elderly firm?*, 630 (40%) replied ‘Yes’ and 944 (60%) ‘No’; 42 of the latter said that the care of the elderly service was fully integrated with general medicine. This was a spontaneous comment, since the question was not asked; it is likely that the remainder who answered ‘No’ but did not comment also had integrated services. Those who said ‘Yes’ were asked to specify the age limit. The results are shown in Table 4; several hospitals had surprisingly precise age-limits of 71, 73, 76, 77 (twice) and 79, and 35 physicians said that in practice the age-limit was flexible.

‘**Physician of the week**’ scheme

Some hospitals have introduced this novel scheme, in which one physician is responsible for all medical emergencies
admitted during a week, while all other routine commitments are cancelled. In response to the question *Has your hospital introduced a 'physician of the week' scheme?*, 101 said they had done so, but 34 of these were either in specialised services in tertiary centres or in units for care of the elderly, and these have been omitted from further analysis. Sixty-seven consultants from 12 hospitals whose general medical service had adopted this scheme rated the success of the scheme on a scale from 0 (unsuccessful) to 10 (very successful). Their mean score was 7.4 (SD±2.2); 35 gave a score of 8-10 and only 10 a score of ≤5.

Invited to make specific comments, 8 emphasised the benefits of emergencies being seen almost immediately by the consultant, 10 stressed the crucial importance of cancelling all other activities for a week, which was often difficult in practice, 10 said there were problems with continuity of care after admission, 12 found it exhausting, and one said that it took him 4-5 weeks to recover from his week on duty.

Comments were also made by 534 consultants who had not adopted the scheme: 117 were unwilling to try it; 109 emphasised the effects of cancelling perhaps a sixth to a quarter of all their clinics and endoscopy sessions; 66 stated that they had too few consultants to operate the scheme; 52 thought their hospital was too busy to adopt it since their weekly admissions could exceed 200; 25 felt it would be exhausting; and 22 thought it would be detrimental to continuity of care. On the other hand, 71 physicians were actively considering it and 16 were planning to introduce it in the near future.

**Table 4. Age threshold for admission under 'care of the elderly' team reported by 621 physicians.**

| Age threshold | Physicians reporting threshold No. | % |
|---------------|-----------------------------------|---|
| 65            | 95                                 | 15 |
| 70            | 41                                 | 7  |
| 71-75         | 333                                | 54 |
| 76-80         | 128                                | 21 |
| 85            | 24                                 | 4  |

**Frequency of external teaching sessions for specialist registrars**

Physicians were asked *How often does your SpR leave the hospital to attend teaching sessions?* The responses of 1,147 physicians are shown in Table 5. The external teaching programme for 196 SpRs (17%) had not commenced by the time of the survey (August 1997). Four hundred and seventy of 869 respondents (54%) said that sessions lasted for a morning or afternoon and 399 (46%) for a whole day. For 81 (30%) of the 269 SpRs who received weekly teaching and 191 (44%) of the 414 who received fortnightly to monthly teaching, the sessions lasted a whole day.

**The impact of specialist registrar teaching programmes on acute services**

Physicians were asked *Have these arrangements led to problems in maintaining cover for acute services in your hospital?*, and given four choices: of 983 who responded, 482 (49%) said 'No', 394 (40%) 'Occasionally', 88 (9%) 'Regularly' and 19 (2%) 'Invariably'. They were then asked *If you have had problems, how have you managed to maintain your acute services?* and given three choices: 194 answered 'SpRs have missed sessions', 244 'SHOs have acted up' and 33 'by employing locums'; some gave more than one choice.

Aimed to describe any other methods they had used, 83 replied that they had provided the extra cover personally, 67 that SpRs from other teams had helped, 8 used research fellows and 27 reduced clinics and other services. Several said that the teaching sessions had been introduced too recently to assess their impact.

**Table 5. The frequency of specialist registrar external teaching sessions, analysed by specialty.**

| Specialty              | Total No. of SpRs | Weekly % | 2-4 Weekly | 2-3 Monthly | Yet to begin % |
|------------------------|-------------------|----------|------------|-------------|----------------|
| All specialties        | 1,147             | 28       | 42         | 13          | 17             |
| Cardiology             | 105               | 51       | 17         | 10          | 22             |
| Care of the elderly    | 199               | 30       | 44         | 13          | 13             |
| Diabetes & endocrinology | 160          | 19       | 45         | 21          | 16             |
| Gastroenterology       | 216               | 23       | 58         | 8           | 12             |
| Renal medicine         | 42                | 10       | 33         | 26          | 31             |
| Respiratory medicine   | 187               | 29       | 50         | 16          | 6              |
| Rheumatology           | 34                | 29       | 47         | 15          | 9              |

Note: Specialty not stated for 168 SpRs.

**Problems in filling temporary junior staff vacancies**

To the question *Have you had to fill any temporary vacancies this year?*, 463 (35%) replied 'Yes' and 862 (65%) 'No'. Asked *If yes, have you experienced any problems?,* 229 (49%) said 'Yes'. Invited to explain their problems, 79 said it was difficult or very difficult to obtain locums, particularly at short notice, 40 said that they were of variable quality and 19 that they were very expensive, especially if recruited through agencies. Thirty-nine consultants had experienced significant gaps in the provision of SpRs because of maternity leave, sickness or research commitments; 26 said that the quality of applicants for SpR or locum assistant for training (LAT) posts was frequently poor, and 12 complained about the slow and clumsy centralised arrangements for appointing SpR or LAT staff when vacancies occur at short notice.
Novel approaches to problems with admissions

Asked to describe any innovative schemes operating in their hospital, 637 physicians responded; many gave full descriptions of their junior staff rotas which are difficult to summarise in this report. Other issues raised included:

**Frequent consultant ward rounds**, two or three times daily on emergency take days, had been introduced by 54 physicians, usually at 5 pm and the following morning. These were invaluable in preventing unnecessary admissions and clearing the admissions unit or the A&E department, but many stressed the deleterious impact on their other specialty-based activities.

**The use of nurse practitioners** to assist the acute medical team, mainly at night, by undertaking phlebotomy, intravenous cannulation, electrocardiograms and other routine duties, was described by 42 physicians. In some centres, specialist nurses or other professionals were clerking admissions, certifying expected deaths and taking calls from general practitioners requesting admissions.

**Twelve-hour emergency takes** had been adopted by 29 physicians to cope with the increasing workload, particularly in some large city hospitals with 40–60 admissions per day where traditional 24 hour rotas would be rapidly overwhelmed.

**Ward-based admission systems** had been introduced by 27 physicians. All patients belonging to a team were in a single ward or a designated overflow ward; patients within that specialty were admitted there on a daily basis. The work of the junior staff was reduced by avoiding ‘safari’ ward rounds and the regular flow of patients minimised peaks and troughs in bed occupancy. The systems seems popular but involves a loss of continuity in care since the patient is transferred from the admitting team after initial management.

**Use of the staff-grade doctors in managing medical emergencies**, usually during regular day-time hours, was described by 22 physicians. They had proved very successful in helping junior staff to cope with the increasing workload, provided skilled support with initial management and prevented some inappropriate admissions.

**Other innovations** included: designated medical outpatient clinics for emergencies to reduce unnecessary admissions (14); a bed manager service to arrange admissions (13); a chest pain clinic (8); a rapid endoscopy service for stable minor gastrointestinal bleeds (4); and an outpatient deep vein thrombosis service with access to emergency venography or ultrasound and use of low molecular weight heparin (13). Five physicians stressed the value of an efficient laboratory providing rapid results of cardiac enzymes and other tests.

Novel approaches to patient discharges

Although physicians were not asked to list specific problems in relation to discharge, 41 mentioned their difficulties in obtaining adequate help from social workers, often exacerbated by local political friction, 31 referred to severe problems in obtaining social service funding for patients requiring placement in residential nursing homes, 10 described difficulties in obtaining an efficient service from their pharmacy on the day of discharge, and 3 commented on the prolonged closure of social services over the Christmas holiday.

Physicians were asked about novel initiatives to facilitate patient discharge and specifically whether they had experience of a ‘discharge lounge’ where patients can wait on their day of discharge, allowing their beds to be used earlier in the day:

*A discharge lounge* had been tried by 235 physicians and a further 71 were actively considering it. Ninety-four could not express an opinion on its value as it had been only recently established, 37 thought that it had been moderately useful or successful, but 104 thought that it had been of only limited value or a total failure and had been poorly utilised. Frail elderly patients could not be left there for long periods without nursing care and they found the change of environment confusing; nursing staff regarded it as substandard care and were unable to say goodbye to their patients. Younger or fitter patients left earlier by taxi. There were major problems in co-ordinating the activities of pharmacy, ward and transport departments. Several hospitals had abandoned the idea and many suggested that patients could wait in the day-room if necessary; some had arranged for all discharges to take place by midday.

*A discharge nurse, facilitator, liaison officer or team* was mentioned by 81 physicians who all agreed on their considerable value, although the lack of social support and funding to place patients in the community remained a formidable problem. Some referred to the need to train other staff to understand the complexity of hospital discharge and to audit these procedures to identify the causes of delay.

*An intermediate level or low-dependency ward* (hotel ward, half-way home, nurse-run ward) was described by 74 respondents. Success was variable because such wards tended to fill up rapidly with ‘bed blockers’, there was not the same pressure to expedite discharge as on acute wards, and some patients found the new environment confusing.

*Support for patients after discharge*, termed ‘hospital at home’ or ‘home from hospital’ schemes had been adopted by 57 physicians. Ten referred to rapid response teams that facilitated the discharge of frail patients from A&E into the community, and five had used teams of volunteers to assist
patients within the community. The success of these various initiatives had not been evaluated, and some were expensive and reliant on scarce external funding.

The importance of regular consultant ward rounds in facilitating discharge was stressed by 19 physicians, who felt that they led to earlier discharge. Fourteen emphasised that discharge planning must begin as soon as the patient is admitted and must include consideration of social factors as well as medical care.

Multi-disciplinary meetings facilitated discharge in the experience of 19 physicians who thought that increasing integration with care of the elderly would help this process.

To reduce delays caused by the wait for drugs, respondents suggested: writing up discharge drugs the day before discharge (9), the use of pharmacists to complete the prescription (5), a fast-track pharmacy service for patients preparing for discharge, and a computer template for medical discharges that included the pharmacy prescription.

Transport delays were tackled by arranging discharge on short notice (8) or buying a dedicated ambulance for the purpose (3).

Discussion

This is one of the first surveys to obtain feedback from a large group of senior physicians about the impact on the practice of acute general medicine of recent changes in the working pattern of doctors in training (particularly those of the New Deal), and the reformed training of SpRs. There is an obvious need for this information and it is surprising in the current vogue for audit and evidence-based medicine that such information has not been regularly collected in the interests of evidence-based management. The 63% response rate by busy consultants to a lengthy and time-consuming questionnaire is adequate testimony to the importance attached to these issues.

The survey shows marked differences between hospitals in the number and seniority of junior staff on acute medical teams which are not solely related to differences in patient workload and may lead to variations in standard of care. About a quarter of acute medical teams had neither a specialist registrar nor non-consultant career grade doctor resident on duty, and 9% of resident teams comprised only one SHO and one house physician who averaged 17 admissions in 24 hours. The lack of an SpR places an additional burden on the consultant in the hands-on management of complicated emergencies, especially if the SHO is inexperienced. Although there is no evidence that this affects the quality of patient care, it raises concern as to whether this intimate involvement in acute emergency medicine can be maintained throughout the professional life of a consultant, in addition to specialist and other duties.

Some of the most important data in this report relate to the impact of partial shifts on clinical practice. Shift working is regarded by some Task Forces as essential if the statutory working hours for junior doctors are to be achieved. The rating scores, shown in Fig 1, illustrate the wide divergence of opinion on their success. However, the free-text comments of most consultants were adverse, many of them strongly so, although a significant minority were favourable. The remarks of those who gave a low score were surprisingly forceful – this is clearly an issue that provokes fierce antagonism among physicians and between practising physicians and Task Forces. Even those who gave a neutral or high score added comments that were generally critical. An overview of the specific concerns of over 400 consultant physicians with first hand experience of partial shifts suggests that they have had an adverse effect on standards of patient care and junior staff training. It also suggests that they are disliked by many junior staff in acute medicine. However, some caveats are necessary:

1 Experience and opinions varied markedly and a significant minority favoured them. Most of the latter were working in large hospitals and some stressed the importance of having a sufficiently large number of SHOs to ensure success.

2 Many different types of partial shift have now evolved and it is possible that the newer 'hybrid' models may prove less disruptive.

3 Partial shifts seem, anecdotally, to work well in other specialties such as anaesthetics and A&E, where continuity of care is less important than in acute medicine.

Further research is now needed to evaluate the impact of the introduction of partial shifts, and incidentally, the New Deal, on standards of patient care in acute medicine to establish whether they have been unwittingly compromised in the laudable drive to reduce junior doctors' hours.

The response to the question on the management of myocardial infarction indicates that most physicians are directly involved in this important clinical area; in only 14 teaching hospitals or tertiary referral centres were patients managed exclusively by cardiological teams. A recent report indicates that a third of acute medical admissions in one large hospital had actual or suspected myocardial infarction or heart failure. Thus, experience in acute cardiology remains a fundamentally important part of the training of all physicians.

There was a solid consensus in favour of admissions wards, despite the problems commonly experienced in transferring patients to other wards after initial management. This should encourage the 30% of physicians whose hospitals do not have an admissions ward to press for its introduction. Only 12 hospitals had embarked on the 'physician of the week' scheme. Consultants from these centres were generally in favour, but physicians from other hospitals seemed largely unconvinced. It remains to be seen how well this innovative scheme operates when introduced more widely.
The effect of the absence of SpRs at external training programmes on service provision seemed reassuringly slight and most consultants coped fairly easily; but the study was undertaken in August 1997 when such programmes had either not started or only just commenced. The difficulties experienced by many physicians in filling temporary vacancies are a source of considerable concern. Both these issues need to be carefully monitored over the next few months and years.

Some consultants enquired why the questionnaire did not assess the impact of recent reforms on their workload. It is apparent that the introduction of partial shifts, the SpR reforms, the pressure to reduce patients' length of stay in hospital, innovations such as twice daily ward rounds on intake days, and 'physician of the week' schemes, increase the workload of consultant physicians in acute general medicine and encroach on their specialist duties which many regard as their prime function. A few respondents indicated that they might withdraw from acute emergency 'take' to concentrate entirely on their specialty interests, but this would only increase the burden on their colleagues. These issues have been examined elsewhere3 and require further debate within the profession.

The overwhelming impression gained from these 1,632 questionnaires is that virtually all physicians are tackling their problems in a committed manner and with a constructive approach. The different strategies that have been devised by consultants to comply with the New Deal are astonishingly complicated, and are a tribute to their flexibility and capacity for change. Similarly, the ingenuity and diversity of the innovations to cope with admissions and facilitate discharge is impressive. Several initiatives have been fairly widely adopted, such as ward-based admissions systems, low-dependency wards and 'hospital at home' schemes, and seem potentially valuable. Many have been detailed in the recent document on emergency admissions2. However, discharge lounges, though theoretically attractive, appeared in this survey to be largely unsuccessful in practice. This may apply to other innovations, which emphasises the need for detailed evaluation of each initiative to gain a broader consensus on their value. Further surveys are needed to guide consultant physicians towards the best ways of coping with the pressures on their acute medical services.

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Coping with pressures in acute medicine

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