1. Introduction

The management of emergency medical admissions and critically ill medical patients has undergone considerable scrutiny in recent years. There is a body of work that supports the view that the needs of this group of patients are poorly served by the current system [1,2,3].

In a confidential inquiry into quality of care before admission to the Intensive Care Unit (ICU), two external reviewers assessed the quality of care in 100 consecutive admissions to ICU [1]. 20 patients were deemed to have been well managed and 54 to have received suboptimal management, with disagreement about the remainder. Case mix and severity were similar between the groups, but ICU mortality was worse in those who both reviewers agreed received suboptimal care (48% compared with 25% in the well managed group). Admission to the ICU was considered late in 37 patients in the suboptimal group. Overall, a minimum of 4.5% and a maximum of 41% of admissions were considered potentially avoidable. Suboptimal care contributed to morbidity or mortality in most instances. The main causes of suboptimal care were failure of organisation, lack of knowledge, failure to appreciate clinical urgency, lack of supervision and failure to seek advice.

In another UK study of patients either dying unexpectedly on a general ward or requiring admission to the ICU during a six month period, 317 of the 477 hospital deaths occurred on the general wards of which 20 (6%) followed failed attempts at resuscitation [2]. 13 of these unexpected deaths were considered potentially avoidable: gradual deterioration was observed in physiological and/or biochemical variables, but appropriate action was not taken. During the same period, 86 hospital inpatients were admitted on 98 occasions to the ICU, 31 of whom received suboptimal care before the ICU admission either because of non-recognition of the severity of the problem or inappropriate treatment. Mortality rates were significantly higher in these patients than in well managed patients in both the ICU (52% v 35%) and hospital (65% v 42%), $p<0.0001$. The authors concluded that patients with obvious clinical indicators of acute deterioration are not infrequently overlooked or poorly managed on the ward.

Even more disturbingly, studies of events leading to 'unexpected' in-hospital cardiac arrest indicate that many patients have clearly recorded evidence of marked physiological deterioration prior to the event, without appropriate action being taken in many cases [4,5].

The difficulties of providing care to emergency medical admissions and acutely unwell inpatients and the deficiencies that have been highlighted above are recognised by the Royal College of Physicians [6,7,8,9]. Over the past few years a number of reports have been produced by the Royal College of Physicians that have made many recommendations in this aspect of acute care. Reports pertinent to this area are: *Interface of accident and emergency and acute medicine* [6], *Interface between acute general medicine and critical care* [7], *Acute medicine: making it work for patients. A blueprint for organisation and training* [8], and *Good medical practice for physicians* [9].

Some time has elapsed since the publication of some papers showing problems in acute care [1,2] and subsequent reports suggesting improvements [6,7]. Thus, the situation may or may not have improved [3]. In addition, there is a widely held belief that the relatively recent changes in junior medical staff working, as a result of the European Working Time Directive and changes in the structure of training, are resulting in fragmentation of the team structure and loss of learning opportunities. These changes have obvious potential impact on patient care and the need for consultant supervision. As NCEPOD is in a unique position to examine the process of care and identify remediable factors, it was therefore felt that the care of acutely unwell medical patients was a very important topic for further study.