

21<sup>st</sup> November 2008

## Position Paper on Consultant in Emergency Medicine on-call arrangements.

### Background

The Irish Association for Emergency Medicine (IAEM) published a position paper on *Reconfiguration and Regionalisation of Emergency Services* in January 2008. In the document <sup>(1)</sup> the Association supported Government (HSE/DoHC) moves to reconfigure current services, provided that the process was done in a safe and transparent way. IAEM accepts that 36 hospitals (including three standalone Paediatric Emergency Departments) cannot continue to provide full Emergency Medicine services into the future, as is currently the case.

### Current Situation

There are currently 4 levels of involvement by Consultants in Emergency Medicine in the provision of services, particularly on-call services. These are:

1. **Full on-call:** i.e. each night and weekend is covered by a Consultant in Emergency Medicine.
2. **Partial on-call:** i.e. some or most nights and weekends are covered by a Consultant in Emergency Medicine.
3. **No on-call:** i.e. no nights or weekends are covered by a Consultant in Emergency Medicine.
4. **No involvement:** i.e. some hospitals do not have input of any type from a Consultant in Emergency Medicine.

These arrangements are in addition to resident junior medical staff within the hospitals' Emergency Departments (EDs).

### 1. Full on-call:

Most larger public hospitals receive ill and injured patients in Emergency Departments (EDs) that have a continuous on-call service provided by Consultants in Emergency Medicine. Even in these hospitals, current whole time equivalent (wte) Consultant staffing does not reach minimum international standards as prescribed in the document *Staffing needs for Emergency Departments in Ireland* <sup>(2)</sup>. This document sets out the minimum numbers of wte Consultant staff required for different levels of service according to international norms. It states that 4 wte Consultants are required for a 09.00 to 17.00 hours Monday to Friday Consultant presence, with 24/7 on call availability.

#### President:

Mr. Fergal Hickey FRCS, FRCSEd, DA(UK), FCEM  
Consultant in Emergency Medicine

Sligo General Hospital  
The Mall  
Sligo  
Ireland

Tel No: +353 71 9174505  
Fax No: +353 71 9174646

#### Secretary:

Mr. James Binchy FRCSEd, Dip.Med.Tox., FCEM.  
Consultant in Emergency Medicine,

University College Hospital  
Newcastle Road,  
Galway,  
Ireland

Tel No: +353 91 542 766  
Fax No: +353 91 520 154

#### Treasurer:

Mr. Niall O'Connor DCH, DOBs, MRCP, FRCSEd, FCEM  
Consultant in Emergency Medicine

Our Lady of Lourdes Hospital  
Drogheda  
Co. Louth  
Ireland

Tel No: +353 41 9874791  
Fax No: +353 41 9874799

**2. Partial on-call:**

Some larger and mid-sized hospitals receive ill and injured patients in EDs that have two or three Consultants in Emergency Medicine based at the hospital, with a partial on-call service provided out-of-hours by these Consultants. This level of staffing is insufficient for there to be a Consultant in Emergency Medicine rostered to provide an on-call service each night and weekend, resulting in gaps in the roster.

**3. No on-call:**

Some smaller hospitals continue to receive patients with serious illness and injury, either in the absence of a full-time Consultant in Emergency Medicine (but having a sessional commitment from a Consultant(s) based in a larger ED within the same region or hospital network), or where there is a full-time Consultant who does not provide any out-of-hours cover. In this group of hospitals, Consultants in Emergency Medicine are not contracted to provide an on-call service to the smaller ED.

The 14 hospitals providing 24/7 services but without a Consultant in Emergency Medicine on-call are:

Louth County Hospital, Dundalk  
Mallow General Hospital  
Mercy University Hospital, Cork  
Midlands Regional Hospital, Portlaoise  
Midlands Regional Hospital, Mullingar  
Mid-Western Regional Hospital, Ennis  
Our Lady's Hospital, Navan  
Portiuncula Hospital, Ballinasloe  
Roscommon County Hospital  
South Infirmity Victoria University Hospital, Cork  
South Tipperary General Hospital, Clonmel  
St. Colmcille's Hospital, Loughlinstown  
St Luke's Hospital, Kilkenny  
Wexford General Hospital

**4. No Involvement:**

A small number of smaller hospitals in the country have no input of any type from a Consultant in Emergency Medicine, but continue to receive ill and injured patients.

**Clinical Governance**

All EDs need adequate staffing and appropriate clinical governance structures. The HSE must move to ensure that Consultant in Emergency Medicine staffing is brought up to an acceptable level with a properly thought-out transparent programme of Consultant expansion over the next 10 years. This will allow the Specialist Registrar (SpR) training programme to be systematically developed to broadly meet the expected demand. Even with proposed reconfiguration, there is a significant shortfall in the numbers of Consultants in Emergency Medicine currently in the system to meet even the most basic Command & Control model of Consultant practice <sup>(2)</sup>.

### **Role of Consultants in Emergency Medicine with sessional commitments to smaller EDs**

In the case of EDs in smaller hospitals, Consultants in Emergency Medicine with sessional commitments to these smaller departments can provide or assist with the following:

- Development of clinical protocols and pathways
- Recruitment and appointment of non-consultant clinical staff
- Patient review clinics
- Responding to patient complaints
- Risk management
- Clinical teaching/induction of non-consultant clinical staff

Direct patient care may be provided depending on the number of sessions of Consultant time provided to the smaller ED.

Consultants based at larger hospitals with sessional commitments to smaller EDs however cannot provide the following to the latter:

- On-call service
- Clinical responsibility for the actions of non-consultant clinical staff outside of the times the Consultant is physically on-site
- Clinical responsibility for the actions of other Consultant staff that use the ED facility.

The Association's position is that the role of the Consultant with the sessional commitment to a smaller hospital is akin to that of professional advisor in Emergency Medicine to the management of that hospital. The Consultant's on-call commitment lies with the larger ED where the on-call service has been contractually agreed. Clinical responsibility for assistance of non-consultant clinical staff for individual patient decisions in the smaller EDs lies with the on-call consultant in the inpatient specialty most relevant to the patient's clinical presentation e.g. the on-call general physician, general surgeon etc. It is the Association's belief that hospitals need to be clear about where responsibility lies within the available on-call service for patients with problems that do not have an on-site consultant-led service e.g. paediatrics or obstetrics.

### **The Future**

Any hospital that is expected to provide 24 hour emergency care should have defined, acceptable standards of infrastructure, staffing and support services to allow it to carry out this function. This includes an adequate number of Consultants in Emergency Medicine based in the hospital. Depending on the level of service required for any given hospital, this will require differing numbers of wte Consultants in Emergency Medicine. The IAEM Staffing Document <sup>(2)</sup> outlines the different levels of Consultant staffing that will be required for different EDs depending on the extent of input into patient care e.g. a minimum of 4 wte Consultants in Emergency Medicine is required for an 09.00 to 17.00 hours Monday to Friday Consultant presence with 24/7 on call availability. Correspondingly higher numbers of Consultants will be

required to provide an extended day service on a seven day week basis. The foregoing confirms that there are significant gaps in current provision even to achieve a basic Command & Control model of Consultant in Emergency Medicine input.

The HSE has expressed its desire to see reconfiguration take place. However, it is extremely important that this is done in a clear and transparent way. In the first instance, the HSE needs to decide and publicise which hospitals will no longer have fully functioning EDs. Following this the EDs that are left open will need to be redeveloped or rebuilt, to current best practice standards, in order to deal with the increased workload. Secondly, the HSE needs to decide which model of Consultant working practice they want to provide in these centralised EDs; the normal working week or an extended working day and week. Once that has been decided, the total number of Consultants in Emergency Medicine needed nationally can be determined according to the document *Staffing needs for Emergency Departments in Ireland*. A significant expansion of Consultant numbers will be required irrespective of the working model chosen.

There is reason to believe that there are not significant numbers of appropriately trained specialists available internationally to fill an expanded number of Consultant posts. Therefore, the Specialist Registrar training programme in Emergency Medicine will need to be expanded in order to ensure a suitable supply of properly trained Consultants in Emergency Medicine to work in these expanded EDs.

## References

1. *Reconfiguration and Regionalisation of Emergency Services*. January 2008  
[http://www.emergencymedicine.ie/images/stories/statements/2008/2008\\_iaem\\_reconfiguration\\_patient\\_services.pdf](http://www.emergencymedicine.ie/images/stories/statements/2008/2008_iaem_reconfiguration_patient_services.pdf) or  
<http://www.iaem.ie/reconfig.pdf>. Accessed 20th November 2008.
2. *Staffing needs for Emergency Departments in Ireland*. November 2006.  
[http://www.emergencymedicine.ie/images/stories/statements/2006/2006\\_iaem\\_staffing\\_ed.pdf](http://www.emergencymedicine.ie/images/stories/statements/2006/2006_iaem_staffing_ed.pdf) or <http://www.iaem.ie/staffing%20EDs.pdf>  
Accessed 20th November 2008.