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IAEM welcomes publication of Acute Medicine Programme

The Irish Association for Emergency Medicine warmly welcomes the publication of the Report of the National Acute Medicine Programme. This represents an unprecedented collaboration between clinicians, HSE, Department of Health and Children, healthcare professionals and the Royal College of Physicians of Ireland intended to re-organise and standardise acute medical care to deliver safer, higher-quality and more cost-effective patient care. Emergency Medicine (EM) has contributed significantly to the development of the programme and supports this forward-thinking approach. The effectiveness of the AMP will be greatly enhanced through co-implementation of the other key acute care programmes in Emergency Medicine; Critical Care; Surgery; Medicine for the Elderly and Diagnostic Imaging.

The AMP provides a framework for the delivery of acute medical care in all levels of Irish hospitals. It defines the interface between EM and Acute Medicine (AM), recognises the key role of EM and provides a basis for the collaborative development of both specialties. It emphasises the value of EDs in providing continuous access to care for patients, effectively prioritising patients according to clinical need, providing resuscitation and emergency care for those who need it and safely discharging patients who do not require in-patient care. The AMP opens a complementary pathway of care for patients who have been identified by their GP as needing acute medicine assessment or admission. The AMP and the Emergency Medicine Programme (EMP) when the latter is finalised, will each result in earlier and more effective Consultant involvement in patient care in both specialties and more effective use of diagnostics and outpatient alternatives to hospital admission.

Contrary to what might be suggested, the AMP is not anticipated to result in fewer ED attendances, as the experience in the UK (where AM is relatively well developed) has been a continuing year-on-year increase in ED attendances. AM should, however, result in shorter waiting times for medical patients and higher quality of care through enhanced physician involvement in the early stages of patient care. The AMP aims to streamline medical in-patient care, reducing the number and duration of medical admissions, thus freeing up acute bed capacity and reducing access block. Current ED overcrowding necessitates that these measures are implemented without delay.

IAEM recognises the potential for innovative training and professional development programmes for all healthcare providers working across the EM/AM interface based on the commonality of aspects of care in both disciplines.

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IAEM sees a number of potential barriers to the successful implementation of the AMP that must be anticipated and surmounted:

1. Failure of implementation:
IAEM is concerned that the AMP might not be fully implemented despite the best intentions of the programme drivers. This scepticism is largely based on the historical failure to implement previous reports dealing with ED overcrowding and EM development (e.g. the Emergency Department Taskforce Report). Partial implementation or "local adaptation" of the report would undermine the standardisation of the AMP model and equity of quality of care across the health-system. In this scenario, the AMP is destined to fail to achieve its potential. EM will collaborate with the AMP programme team to ensure full implementation nationwide.

2. Adaptation to new ways of working:
The AMP represents a new way of working for many physicians, with early review by senior clinicians, including Consultants, soon after patient attendance rather than on traditional next-day ward rounds. Consultants and their junior staff will need to be freed from other clinical commitments when on call. This represents a fundamental change in work practices for doctors in some hospitals. Changes in service delivery in other hospital specialties, particularly Diagnostic Imaging, will also be needed. The AMP will result in a reorientation of care delivery for patients with acute medical problems to a model that is significantly closer to that of EM, with the continuous availability of clinical teams and a focus on rapid assessment and early senior decision-making. The challenge inherent in delivering this should not be underestimated but success in this area is crucial to effective delivery of the AMP.

3. Failure to understand the new complementary relationship between EM and AM:
The AMP report states that EDs and Acute Medical Units (AMUs) should not compete for resources meaning that the development of AMUs should not be based on redirection of resources from EDs. Most EDs are already under-resourced and existing ED resources are likely to be reorganised to deliver improvement in ED care through the EMP. EDs and AMUs must be complementary systems of care and the concept of clinical justice espoused in the report needs to equally apply to all patients.

4. Delays in implementation:
IAEM expects all stakeholders to work together expeditiously to realise the potential benefits to patient care of the AMP. Delays in implementing the AMP will undoubtedly contribute to persistence and potentially worsening of the ED overcrowding problem and result in increased clinical risks for patients waiting for medical admission.

IAEM sees the AMP as an enormous opportunity for physicians to improve the initial care of patients with medical conditions which hitherto have been managed by them in a variable and less structured way. This opportunity needs to be grasped by all and resourced and implemented in full.