My vision for Emergency Medicine in Ireland

Orla Kelly

An ambulance pulls into the bay at a tertiary hospital. Its gurney is met by a triage nurse and wheeled into a single bay. Its patient is triaged appropriately, analgesia given, friendly word spoken. A doctor attends, has time, space, and privacy to take a careful history, perform a thorough examination, perhaps utilising the nearby ultrasound. Any preliminary management is initiated. The patient is transported for any necessary investigations, diagnosed, and an appropriate disposition decided. A brief and courteous discussion between specialities is had, and the patient admitted to an appropriate ward for appropriate ongoing management.

It is commendable that although the above passage reads like a Ladybird book of 'My Trip to the Hospital', and despite the supply and demand mismatch that is currently in play in all Emergency Departments in the country, many of the above steps do occur. In fact, all of the above steps occur.

An ambulance pulls into the bay in between multiple others. Its gurney joins the queue, like shopping trolleys that people haven't stacked together. It is wheeled to a single bay where it is squeezed in between a second trolley and a blue plastic chair, both housing patients, sharing a drip stand. The patient is triaged appropriately, analgesia given, and a friendly word spoken. After some time, a doctor attends. The other two inhabitants of the bay are politely asked if they wouldn't mind to please acquiesce to being moved, just temporarily, into the middle of the floor. Trolleys are shunted to make way, and patients are slotted in like a game of Tetris, except when the line is full, they don't disappear. With this newfound space and semblance of privacy the doctor performs a careful history and examination. The nearby ultrasound needs to be found, charged, cleaned, and rebooted. Any necessary management is initiated. Any investigation more than a plain film is ordered, discussed, and likely discussed again. Porters with process engineer-level ability manoeuvre the patient through ED to the relevant department, the patient is diagnosed, and an appropriate disposition decided. There is a brief discussion between specialties. There is likely a further brief discussion with a different speciality which has a vague relation to the presenting complaint, or once saw the patient in a clinic. This is followed by a longer discussion with the initial team. The patient is admitted electronically to a ward for appropriate ongoing management or investigation.

Emergency Medicine is enjoying the dynamic state that comes with being a new speciality. It is exulting in the revolution that is FOAMed with some of the most passionate and experienced senior clinicians creating high quality free online content for trainees. Robust studies like CRASH-2 are leading the way in evidence based resuscitative care. Trainees and consultants are championing evidence based intervention and research. New skills such as ultrasound and regional anaesthesia are improving patient care and experiences. But just as the dynamic state of the speciality has positive inflections, it also has negative ones.

Our presentations are increasing, our wait times longer, our patients older and more complex, or younger and more demanding. These factors coupled with increasing 'metrics' pressure on medical performance is impacting patient care and physician satisfaction. The omnipotence of 'The List' is difficult to ignore. I have found myself grateful for deranged LFTs, markedly raised CRP – an easier referral, a quick turnover, a safe disposition for the patient. That isn't medicine, it's Whack-a-Mole. It also negatively affects our skillsets. Procedures that with the time and equipment could be done by Emergency physicians, are instead referred to speciality teams. It does not take a plastic surgeon to recognise the Vermilion border, yet it is beyond the scope of many Emergency Departments. Referral to a speciality again might be a safe disposition for a patient, but referral without intervention isn't medicine: it's painting by numbers.

An ageing and increasing population is stretching the entire Health Service as well as the Emergency Departments. This gives rise to the necessity in many cases to admit for investigation rather than for treatment and is frustrating to both in-house and Emergency teams. For the Emergency doctor we are happy for a safe outcome for the patient, yet eternally cognisant of the burden of a hospital stay on the patient, on the on-call team, and on the hospital. Irritation on both sides can make for unproductive interactions. The sheer overcrowding of the system and not just the department make OPD referrals for acute presentations unrealistic. Clinical pathways, decision rules, and Clinical Nurse Specialists are important in relieving this pressure but do not address the underlying structural deficiencies.

My vision for the future of Emergency Medicine in Ireland then is not a multi-bay trauma centre with a helipad, CT in resus, and ultrasound in every cubicle. My vision is a department that is staffed appropriately where patients are seen in a reasonable time with dignity and privacy. That we continue to champion our speciality and its exciting new avenues with simulation of rare conditions and once-in-a-career procedures, and also continue to strive for better outcomes for our frequent attenders, frail patients, and common illnesses. That we have time to spend with patients, to discuss their case and management with senior clinicians, to comfort their families. That we have a relationship with other specialities who themselves are appropriately resourced. That we are placed not in the centre of the Health Service as an access to tertiary care but rather one stream through which acutely ill patients flow.

My vision is through this a provision of Emergency care that benefits both patients and clinicians. Our speciality is one to be proud of. There is an ending to the phrase Jack of all trades master of none … but oftentimes better than master of one.