My vision for Emergency Medicine in Ireland

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The familiar call of sirens filled my ears as my eyes, barely open, recognised the flicker of blue lights. I felt pain like I had never felt before, the sort of pain I had treated but never experienced. How ironic that I would have an accident that night on my way home from an IAEM60 event. A year had passed since I retired as an Emergency Medicine consultant and I wasn't prepared to be the one on the trolley. But there was no alternative – I was groggy, I was vulnerable and I was about to rely on the system that I helped to shape back in my day.

After my accident the first help to arrive was a pre-hospital emergency medicine consultant and SpR along with a paramedic crew. They decompressed my tension pneumothorax, placed a pelvic binder and gave me blood. They planned my transfer meticulously and took me by helicopter to the nearest major trauma centre where a full trauma team had assembled despite the late hour. Even prior to my arrival they had accessed my electronic healthcare record so that despite never being a patient in that hospital before, they had my full medical history and medication list. It struck me that the layout of this resus cubicle was identical to those in the hospital I had worked and I considered how that must be invaluable for trainees regularly moving between hospitals. My memory of that night is fuzzy but I recall thinking how lucky I was that I had been taken to a major trauma centre. My burns, head, pelvic and chest injuries could be treated in the one hospital. When I was training, this catalogue of injuries would have caused consternation as the treatment would have been spread across four different hospitals – how dangerous things were back in my day.

The team caring for me was led by an EM consultant – it was past midnight and she told me that she would be there until 8am. Her team were able to care for me uninterrupted – there were enough staff to continue seeing the other patients so the team could place my lines and truly engage in critical care. I had often longed to do this for my patients as a trainee but the pressures of a busy ED didn't allow it and those tasks were usually delegated to the ICU doctors. As I lay on the trolley I noted how well the various teams were communicating and cooperating. I was admitted under the trauma team who oversaw my ongoing care delivered by the various specialties. I didn't hear anybody attempt to push back or argue the fact that I needed their help. There had been a shift in attitude – the EM doctors were well respected rather than viewed as an interruption to a quiet night on call like we were back in my day.

As they wheeled me out of the ED I could only think how vast and empty the corridors seemed when they weren't lined with trolleys. When I started my career in EM patients stayed on corridors for days while waiting for a bed. It struck me just how different things were now and how much had changed in EM over my career. While EM physicians are still the gatekeepers of the hospital, there is no longer a crush towards that gate everyday. The patients of 2049 have easy access to primary care. GPs have been empowered with access to diagnostics and waiting lists have been decimated so patients in need of secondary or tertiary care can access it in a reasonable timeframe. EM is no longer the last stop for desperate patients in need of care that they cannot reach elsewhere. A patient with osteoarthritis of the knee requiring a total knee replacement does not attend ED seeking a hidden back door into the orthopaedic theatre. Patients with subacute hearing loss can access ENT clinic via their GP rather than attend ED. Parents are not forced to take their child to ED in the middle of the night because they couldn't get a GP appointment. The patients of 2049 have access to care I could have only dreamed of back in my day.

Of course these changes did not come easy. There were protests, there were strikes, there were arguments. Leaders had to be brave and bold. The public were not happy to have local services downgraded until it was explained to them in a way that they could understand. There was opposition from within our own specialty too. Many colleagues felt consultants should not have to work nights, indeed that's what we looked forward to as trainees – the holy grail of no more nights at work! However, the unpredictable nature of EM requires 24 hour consultant presence for care to be truly consultant led. In all honesty the introduction of 24 hour consultant cover was not as bad as we had anticipated because the significant increase in consultant numbers made it so much more manageable than it would have been back in my day.

I was very lucky to walk out of hospital a few weeks after my accident with nothing more than some scars and a whole new appreciation for Emergency Medicine. I'm not sure I would have been so lucky if I had sustained the same injuries thirty years ago. I'm eternally grateful to IAEM for striving for change and growth 30 years ago just as they continue to do today. They fostered a culture of quality improvement and assurance supported by a strong academic foundation and ongoing education. They rejected the temptation to accept the working conditions and patient care delivered in the past and looked forward to a new day where things could be better for patients, for staff, for all. That's exactly what my vision was for EM back in my day.