Emergency medicine in the UK: the future is bright!

Jonathan R Benger, Tajek B Hassan

We were intrigued by Mr Leaman's provocatively "spun" commentary on the state of emergency medicine in the UK.¹ His paper rightly addresses a range of key clinical and political subjects, but appears to contain a number of inaccuracies that motivated us to respond with what we hope is a more balanced view.

In broad terms, Leaman's criticisms span four domains: branding, modernisation, impact of National Health Service reconfiguration, and finally the vision for our future.

BRANDING

Emergency medicine is certainly in the midst of dramatic change, but is also responding to the opportunities within that change, commanding greater respect and resources than ever before. The "4 h target" and urgent care agenda are complex, and not always to our liking, but have led to the allocation of substantial resources to many emergency departments (EDs), a steady growth in staff numbers, increased efficiency and improved delivery of quality care. This is fortunate since, contrary to Mr Leaman's assertion, our patients do not seem to have been deterred by the change in specialty name (to fit with international standards), and ever-increasing numbers are attending year on year.

Indeed, it is this spiralling demand that ensures our long-term future; despite many new initiatives instigated nationally and by various primary care trusts there has been no convincing fall in patient attendances or emergency admissions.^{2,3} In common with many colleagues we have recently seen and experienced our fair share of urgent care initiatives, but struggle to find anywhere in the UK where a sustained decrease in ED patients has been achieved in an economically viable way. The idea of paying general practitioners (GPs) to provide 24 h/7 day ED front door "screening" appears attractive only until one adds up the wage bill or attempts to find a cohort of GPs willing to take on this role. It would be particularly ironic if individuals who previously bemoaned the "inappropriate" primary care patients

clogging up their emergency department now complained that primary care trusts are providing alternative pathways for this group. On the other hand, turning patients away from the ED without full assessment, which has recently been much discussed, creates clinical risks that no health care organisation appears willing to accept: it is hardly surprising that the most clinically and cost effective assessment is that provided by the ED staff who are already trained and experienced in this work.

MODERNISATION

We would agree with Mr Leaman that the emphasis of our work has changed over the past two decades, away from trauma/minor injuries and towards a broader patient focus that includes a range of medical conditions that were previously swiftly referred elsewhere. Such non-surgical patients were often suboptimally managed during their ED stay, or inappropriately sent home with resulting morbidity and mortality. Certainly we need to be wary of neglecting any part of our core work in favour of another (although it is worth noting that major trauma is rare and steadily decreasing in incidence),⁴ but broadening the scope of ED practice also serves to render the specialty increasingly indispensable to both our patients and employers. If services are to be reconfigured it is likely that EDs will take a leading role in the early management and transfer of those being admitted and, although we would wish to retain the clear distinction that has emerged between emergency and acute general medicine, it is precisely these skills that will affirm the specialty as the core of an effective emergency service. There are also clear advantages in forming links with colleagues in acute medicine to optimise understanding and cohesive working practices, particularly where an ED has developed an observation or clinical decision unit.

RECONFIGURATION

There is little doubt that some EDs will close (though this has been suggested before and has often proved politically unpalatable in practice), but the patients

will remain. Key to the process of reconfiguration will be the need to proactively and constructively engage in national and local discussions and planning. This may well lead to medical staff working in larger networks of teams that will improve service delivery and training, while reducing the frequency of on-call commitments.

Minor injuries do indeed form a core part of ED work, and require access to radiology facilities that cannot be readily provided in multiple community settings. We would suggest that provision of these services by suitably trained and experienced emergency nurse practitioners (ENPs) represents an improvement over the previous service that was largely provided by relatively inexperienced junior doctors. That said, minor injuries care will benefit from expert supervision regardless of the core provider, and such expertise still resides with consultants in emergency medicine. We agree that it would be wise to ensure that this expertise is preserved by providing suitable training for our registrars, but do not view the introduction of ENPs as anything other than a positive development. We would therefore suggest that it is a key responsibility of consultant staff and senior nurses to create an integrated and cohesive workforce that are able to deliver multidisciplinary minor injuries training, support and service delivery. Where this service is found to be lacking, of course, others may choose to fill the void.

THE FUTURE?

What then of our future? It is worth noting that emergency medicine is also thriving internationally. Almost every developed country in the world now has a recognisable specialty of emergency medicine, or is working to introduce this, and despite the various healthcare configurations that exist around the globe, no country has decided, or been able, to dismantle our specialty. We should not underestimate nor downplay our own expertise in the delivery of emergency care that is tried, tested and greatly valued by the general public. Others may try to tell us how to do our job, but EDs exist for a reason, and in our experience all the alternative models we have seen proposed evaporate in the face of the demands of a truly reliable and effective 24 h service. We would agree with Mr Leaman (and more importantly with the current presidents of the College and British Association for Emergency Medicine) that this is a time to engage with local healthcare commissioners and stakeholders, putting forward the advantages of proven models of ED based care that provide value for money, while

resisting poorly considered and untested schemes.

Overall, we would suggest that our specialty has never been stronger. There will always be threats to our practice and inevitable change, but we have the capacity to shape and direct that change in ways that ensure we not only survive, but prosper in the face of the many challenges that lie ahead. Critically important to this process will be hard work and constructive engagement: at a local level with healthcare commissioners, and at a wider level actively supporting our national bodies and the soon to be merged College of Emergency Medicine. We contend that emergency medicine has already come a long way

and achieved a great deal, of which we can be justifiably proud. Many challenges lie ahead, but the future is not as gloomy as Mr Leaman would have us believe—indeed, the future is positively bright!

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Authors' affiliations

Jonathan R Benger, United Bristol Healthcare Trust, University of the West of England, Bristol, UK

Tajek B Hassan, Leeds General Infirmary, Leeds Teaching Hospitals NHS Trust, Leeds, UK

Correspondence to: Dr Jonathan Benger, Academic Department of Emergency Care,

United Bristol Healthcare Trust, Bristol, BS2 8HW, UK; Jonathan.Benger@ubht.nhs.uk

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REFERENCES

- 1 **Leaman AM**. Does emergency medicine in the UK have a future? *Emerg Med J* 2007;**24**:5–6.
- 2 **Munro J**, Nicholl J, O' Cathain A, *et al*. Impact of NHS Direct on demand for immediate care: observational study. *BMJ* 2000;**321**:150–3.
- 3 **Black DA**. Case management for elderly people in the community. *BMJ* 2007;**334**:3–4.
- 4 **Lecky F**, Woodford M, Yates DW, on behalf of the UK Trauma Audit and Research Network. Trends in trauma care in England and Wales 1989–97. *Lancet* 2000;**355**:1771–5.

IMAGES IN EMERGENCY MEDICINE

An unusual cause of dyspnoea

Chih-Cheng Lai, Shih-Chang Lin

A 77-year-old woman presented to the emergency department complaining of shortness of breath. The patient reported similar, less severe episodes in the past. Initial vital signs were a respiratory rate of 30 breaths/min and a heart rate of 106 beats/min. Clinical examination was unremarkable with the exception of inspiratory stridor and an enlarged goitre over her left neck. Chest radiography revealed a right neck mass causing compression of the trachea and displacement to the right (fig 1). Computed tomography confirmed the presence of mass about 10.5 cm in size in the left thyroid gland. The patient received total thyroidectomy. Her symptoms resolved completely and she was discharged home uneventfully.

The patient with goitre and the physician frequently overlook symptoms of upper respiratory obstruction.

Conventional radiology is the accepted method for detecting upper airway obstruction in these patients.¹ In this case a chest radiograph helped to make the diagnosis and computed tomography confirmed it.

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Authors' affiliations

C-C Lai, S-C Lin, Division of Critical Care Medicine, Department of Emergency and Critical Care Medicine, Lotung Poh-Ai Hospital, Yi-Lan, Taiwan

Correspondence to: Dr C-C Lai, Av. Nan Chang 83, 265, Yi-Lan, Taiwan, ROC; dtmed141@yahoo.com.tw

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Figure 1 Chest radiograph revealing a right neck mass causing compression of the trachea and displacement to the right.

REFERENCE

- 1 **Jauregui R**, Lilker ES, Bayley A. Upper airway obstruction in euthyroid goiter. *JAMA* 1977;**238**:2163–6.