The future of emergency medicine

In 2011, the College of Emergency Medicine hosted a 'crisis conference' to discuss the mismatch between capacity and demand in the emergency departments of the UK. Then, 1 year ago, the college launched the 'CEM-10' (College of Emergency Medicine, 2013), a defining document focused on a concise, clear and constructive set of proposals. Much of the content of the CEM-10 is examined and discussed in the accompanying articles within this themed issue of the journal.

Training enough emergency doctors

Key to understanding the capacity/demand issue is a realization that, through haemorrhage of emergency medicine doctors in the last 4 years, we have lost the capacity to see 750 000 patients per annum in the UK, yet attendances and admissions continue to rise inexorably.

Some emergency medicine doctors choose other specialties, especially general practice and anaesthetics, but by far the greatest losses arise from emigration. Thus in 2013, the Australasian College of Emergency Medicine discovered over 470 emergency medicine doctors working at registrar grade in the emergency departments of Australasia who had trained in the UK and Ireland. While 95% intended to pursue their emergency medicine career, 92% planned not to do this in the UK. It is thus obvious that the problem does not lie with emergency medicine as a specialty per se.

The cost of this 'trained, brain drain' is compounded by the expenditure on locums to backfill rotas. Last year in England alone, the NHS spent £150 million on locums in emergency departments. The problem has become a vicious circle in which the unequal and never-ending struggle between capacity and demand exhausts and demoralizes staff who therefore seek alternatives. The problem is not confined to trainees. Last year, 48 consultants also emigrated. Recognition of this issue has led to Health Education England allocating an extra £50 million to increase the number of Acute Care Common Stem (Emergency Medicine) (ACCS EM) posts by 75 per year for the next 3 years. However, unless we can improve retention, we will simply increase the supply of well-trained emergency medicine doctors to the Antipodes.

Keeping emergency doctors in the UK

How can retention be restored and why do UK emergency medicine doctors leave? The answers lie in how we regard emergency departments in the UK and how we treat emergency medicine doctors. The funding structures for emergency departments are rooted in an out-of-date paradigm and ensure that all emergency departments lose money. Consequent underfunding leads to under-resourcing and staff that feel poorly valued.

Pressure also arises from the NHS 4-hour operational standard – a target that is dependent upon two key variables; capable and enthusiastic emergency medicine staff and bed availability. Neither is in plentiful supply and often the equation is in negative balance. Tariff and funding reforms are a major priority for the College and indeed without such reforms, the whole infrastructure underpinning emergency care is inadequate for the task.

Work–life balance is a major issue affecting recruitment and retention. The College is committed to emergency medicine as a 24/7 specialty but sees no reason why its practitioners should not be treated equitably with those who work few or no evenings, nights and weekends. This is not about salaries or special pleading for emergency medicine – the same is true for all high frequency, high intensity specialties. The College believes that a new contract is required for consultants, trainees and specialty doctors that restores fairness by delivering annual leave entitlements pro-rata with out-of-hours work. This will deliver a workforce fit for purpose both in terms of number and abilities, to match the needs of the UK patient population. The revenue consequences would actually save money. It cannot be over-emphasized that the combined effects of contractual arrangements that penalize both acute trusts and emergency medicine clinicians create a toxic synergy.

What is the problem?

Many have called for the 4-hour standard to be relaxed but the College of Emergency Medicine is not among their number. Tempting though it is to regard the standard as a blunt instrument and one which is only a proxy measure for more important metrics such as outcomes, quality of patient experience and resource utilization, it remains the case that these other metrics have yet to have a standardized, readily-measured data set. The Council of the College recently debated the subject of the 4-hour standard and was unanimous in its support for its retention. Currently fewer than 6% of patients in UK departments remain in the emergency department beyond 4 hours; a figure almost unimaginably better than the situation 15 years ago.

Nevertheless, the challenge of 'exit block' is a daily event in the emergency departments of the UK. In effect, the resulting prolongation of time in the emergency department is a nosocomial disease with a morbidity and mortality like any other.

Over the past few years, there have been a significant number of national bodies, think-tanks and 'armchair experts' who contend that many patients attending an emergency department do not need to be there. Quite apart from the implied criticism of millions of patients, the most obvious critique of this opinion is the lack of credible available alternatives afforded to patients. The College Sentinel Sites Study has debunked many of these myths and provided unequivocal evidence that only 15% of patients could be safely redirected from triage. This still represents over two million patients annually and is the basis upon which the College recommends a co-located primary care facility with each emergency department.

The size of the problem

The link between modest percentages and large actual numbers in the previous paragraph is obvious. Those who wish to

minimize the scale of the problem in emergency medicine always quote percentages. For example, in the year 2012–13, attendances at UK emergency departments rose by 'only' 1.7%. The explanation that this equates to 240 326 patients is often omitted, as is the corollary that this workload is equivalent to four average-sized emergency departments and a further 80 doctors. While it is clear that the College is winning the arguments, it is salutary that the necessary decisions and corrective actions have yet to be taken. Further delay can only mean that the cadre of the willing and able will be further diminished, the finances of acute trusts further imperiled and the dialogue of disabling recrimination progressed.

Set against such a background, it might be concluded that it is surprising that anyone would choose a career in emergency medicine in the UK or Ireland. Fortunately, this is not the case and emergency medicine still offers its practitioners the opportunity to positively influence patient care and outcomes across the spectrum of ages, disease and injury. On a daily basis, the potential to 'make a difference' and add 'years to life and life to years' is unparalleled. Whether it is in the 'life saved' or the respectful and attentive stewardship of a patient's final living moments, emergency medicine offers a compelling career for doctors with a wide range of skills. In many countries, emergency medicine is one of the most popular career options; only in the UK has it ranked last for 'workload' and 'work intensity' as evidenced by the annual General Medical Council training survey for the last 5 years. The College is working with undergraduate bodies, medical schools, deaneries and local education and training boards to remedy this situation and to promote emergency medicine.

Conclusions

The current system of emergency care provision in the UK is broken and expensive. A more sustainable system will be both more effective and more efficient. The *BJHM* has recognized the current problems in emergency medicine and has given voice to the evidence and expert views of the authors of the articles herein. Ignorance of the solutions may have been a credible defence in the past; it no longer is. BJHM

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College of Emergency Medicine (2013) 10 priorities for resolving the AE crisis. http://secure.collemergencymed.ac.uk/code/document.asp?ID=7515 (accessed 7 October 2014)

KEY POINTS

- Recruitment into emergency medicine indicates it is a popular field of medicine.
- Retention after year four of training and at consultant level demonstrates that the pressure of work is unsustainable for many.
- Demand and capacity are mismatched and the disparity is increasing annually.
- Funding of acute care is inadequate; cross-subsidisation from elective care disadvantages acute hospitals.
- Contract terms are grossly ill suited to high frequency, high intensity out of hours working.