

David Williams Lecture 2008

25.9.2008

The College of Emergency Medicine



12 seconds of drumbeats

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Fanfare – 26 seconds

Presidents, Dr Williams, distinguished guests, Fellows and members, ladies and gentlemen.

When Aaron Copland composed “Fanfare for the Common Man” in 1942, he hardly had in mind either our patients, or the practitioners of our art, although it strikes me that it applies very well to both groups.

David Williams, on the other hand, is most uncommon and I am deeply touched and greatly honoured, to be allowed to speak to you today in his honour, on a subject that many of you will know is dear to my heart.

David Williams Lecture 2008

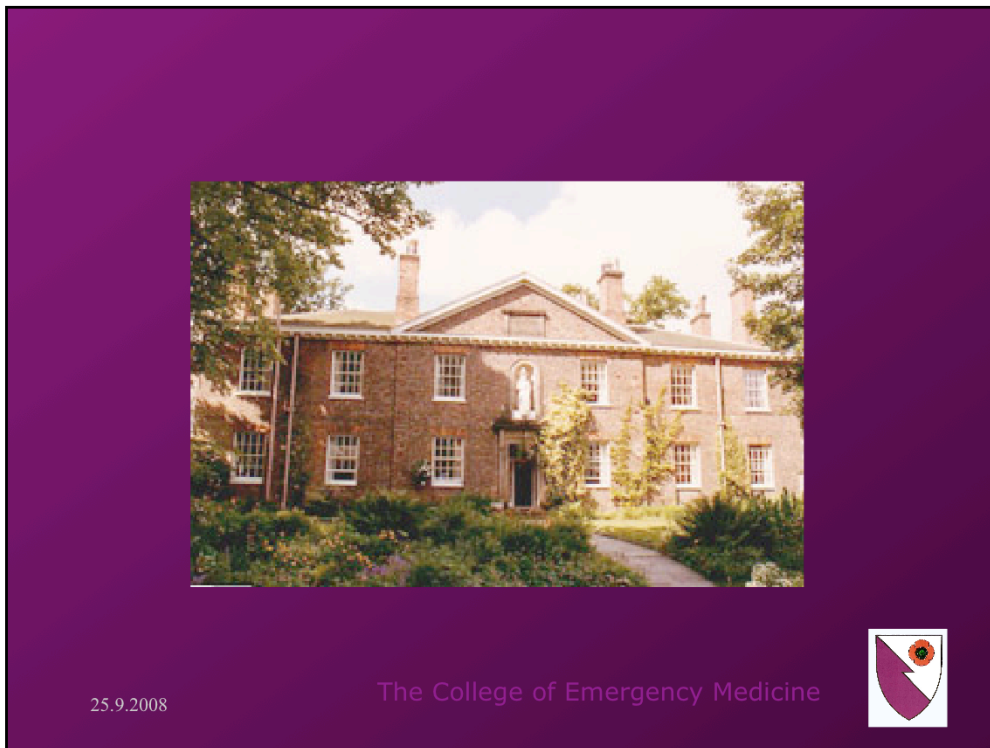
If Emergency Medicine didn't
already exist,
it would have to be invented

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I intend to make this a very personal historical approach, from the Middle Ages through Recent History to Modern Times, interleaving matters of public record with aspects of my own life and practice which I expect will have a resonance for others here today. Parts of my material will be known to some of you, but I hope you will all come away with a greater understanding of our speciality, and as deep a pride in it as I feel.



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Before I begin the meat of my subject, let me reflect for you on my relationship to David Williams, whom I first came to know when I was a senior registrar in Accident and Emergency Medicine in Manchester twenty-five years ago.

Each year the Emergency Medicine Research Society, or EMRS, held a meeting in a quaint old building in York, known as the Lady Ann Middleton Hotel. This was, truly, the academic beginning of an already well-established practical specialty. The prime movers in EMRS, all very wise and a bit frightening to me and my peers, included David Yates, Keith Little, Rod Little, Tony Redmond and that uncommon man, David Williams.

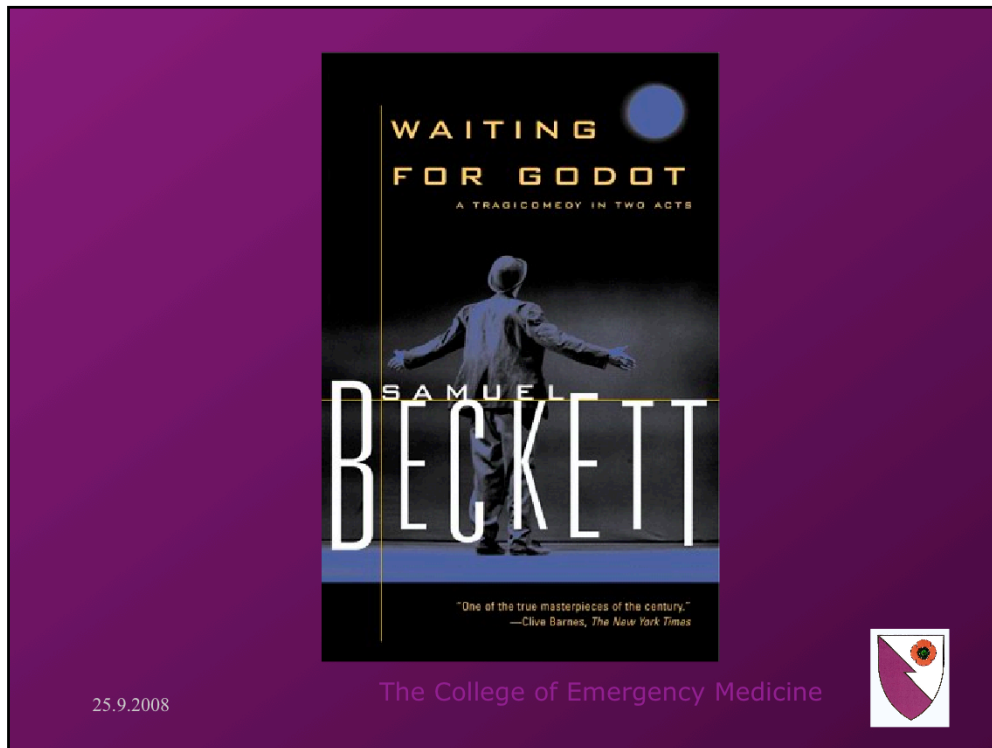


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In 1993, out of the EMRS rose a veritable phoenix, The Faculty of Accident and Emergency Medicine. At its inception, David Williams, then a Consultant in A&E Medicine at St. Thomas's Hospital in London, was the president of the Faculty.

David had a beautiful speaking voice with the overtones of his Welsh forebears superimposed on the undertones he had developed during his undergraduate years in Cambridge. Mellifluous would be an understatement. His voice was a suitably sophisticated vehicle for carriage of his thoughts, which I found to be inspiring, awesome and very often highly amusing. To attempt to emulate his style today would not alone be disrespectful but would be profoundly dangerous, as it requires a much better grasp of the English language than I could ever aspire to. His literary and classical allusions were always apposite, often profound and occasionally extremely obscure.



I had not understood just how much of this might be related to his love of amateur dramatics until I learned recently that, in 1956, he played the role of “Gogo” in the first amateur production of “Waiting for Godot”, by Samuel Beckett, a graduate of Trinity College Dublin, and one of four Irish Nobel Prize winners for Literature. Beckett himself needed emergency intervention for a chest stabbing in Paris, in 1938, in bizarre circumstances. I cannot imagine a play more evocative of the Emergency Department waiting room than this one.

Emergency medicine

- a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioral disorders.

It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical systems and the skills necessary for this development.

International Federation for Emergency Medicine
1991

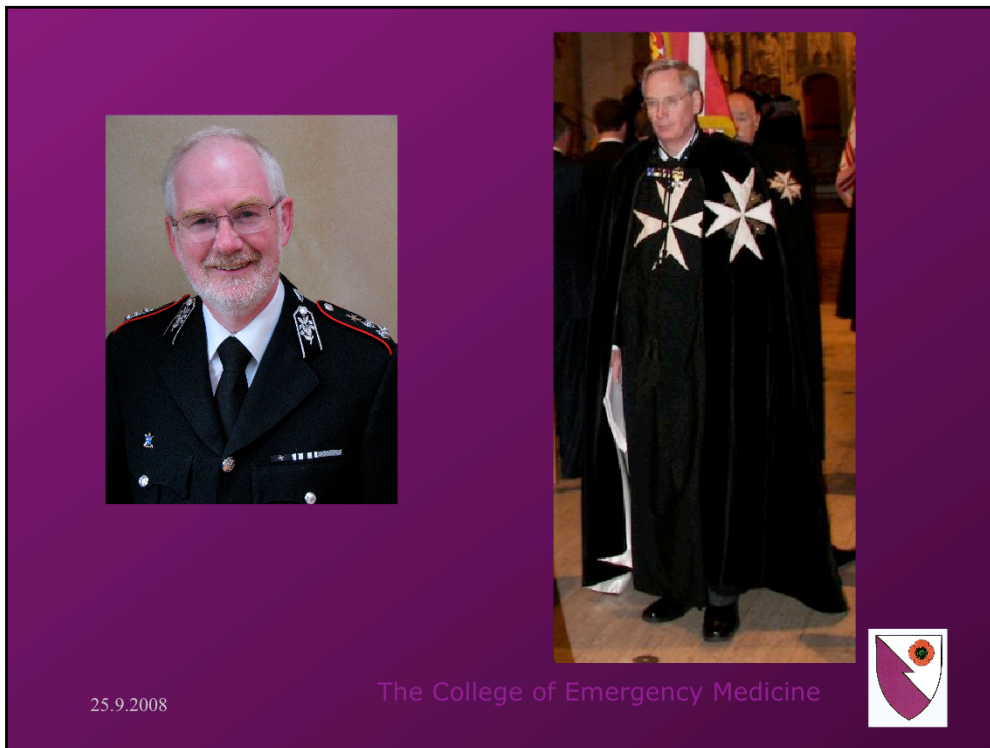
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Moving from the eponym to the subject, I will allow you to refresh your memories on the definition of Emergency Medicine, by reading this descriptive piece.

Each word was chosen carefully, so each must be considered as vital to the whole concept.

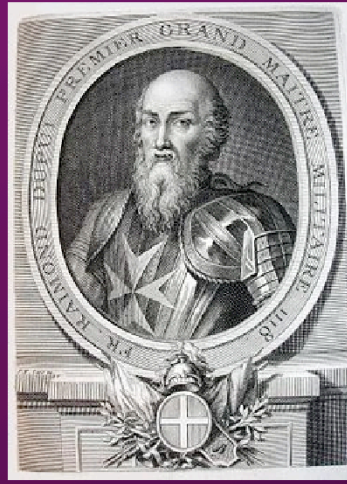


Those who know me since childhood, or my undergraduate days, and there are a number here today who can claim that knowledge, will be aware of my involvement with the St. John Ambulance Brigade of Ireland and in latter years with the Venerable Order of the Hospital of St. John of Jerusalem, whose Grand Prior, His Royal Highness, The Duke of Gloucester, you see here on the right.

This is the modern continuity of the English language of the Knights Hospitaller of St. John of Jerusalem, of Rhodes and of Malta. It is with those Knights of St. John that my story of the development of Emergency Medicine begins.



Founder



1st Grand Master

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In the year 1096, Pope Urban II authorised a crusade to free the Holy Land from the clutches from the Moslem hoards, as it was then viewed.

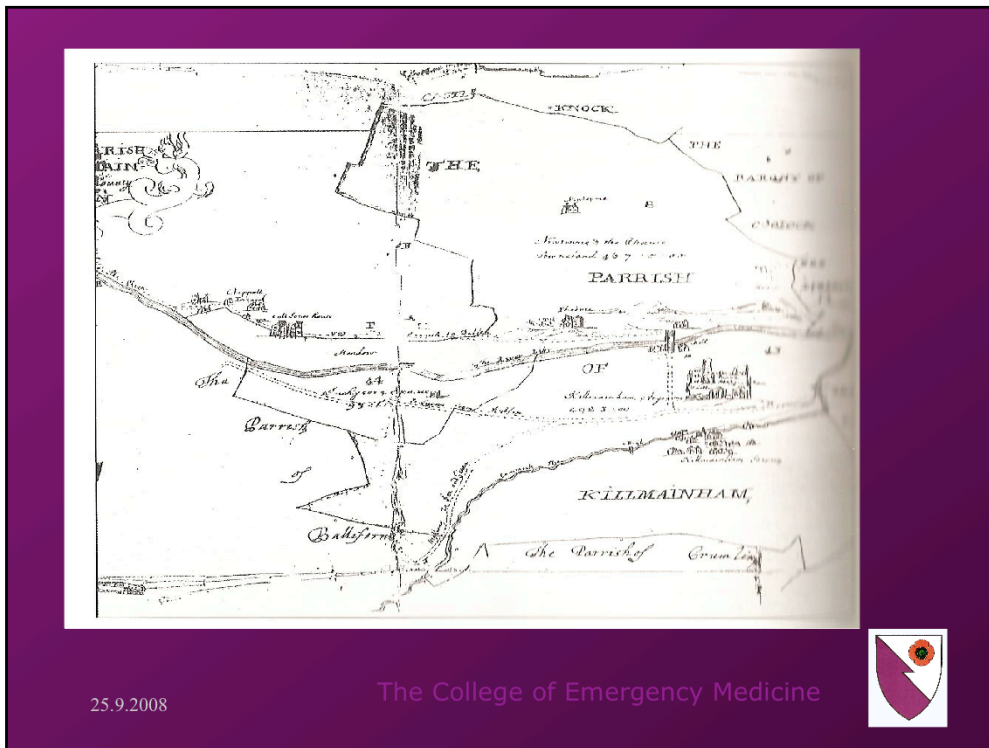
Blessed Gerald Thom founded a monastic order to provide care to pilgrims and acquired land in Jerusalem. The Knights Hospitaller were dedicated to St. John the Baptist. They were initially unarmed and wore a simple religious mantle with the eight pointed cross of the Amalfi Republic on their breast. It is presumed that this was because Blessed Gerald came from Amalfi, close to Sorrento, where the last Mediterranean Congress on Emergency Medicine was held. A hospice founded by his successor, Raymond de Puy, was confirmed by a Papal Bull in 1113.

The four arms of the cross represent Prudence, Justice, Temperance and Fortitude, whilst the eight points represent the Beatitudes.



A separate, more bellicose, organisation of Knights Templar was founded in 1129 , and had a huge supporting network of lands throughout Europe, providing them with an enormous income stream to allow them to fight in the Crusades.

In 1312, the Knights Templar were viciously suppressed and many of their possessions were ceded to the Knights Hospitaller, who became very rich indeed .



In Ireland, the priory of Kilmainham was the principal holding of the Order, stretching from the Camac river near what is now St. James's Hospital, across the lands where the Royal Hospital is now, that lovely setting where we had dinner last night, then across the River Liffey, to include the Phoenix Park where the President of Ireland now resides in what used to be the home of the viceroy, when this country was ruled by royalty based on our neighbouring island.

With the Protestant reformation and the dissolution of the monasteries by Henry VIII, the Order of St. John was suppressed, but was later reinstated by Mary Queen of Scots. Elizabeth 1st on her accession to the throne failed to appoint to the Order and allowed it merely to fall into abeyance, without formal suppression.



Coincidentally, Elizabeth 1st granted a charter in 1592 , which started the institution we are in today, and where I am proud to be a member of the Faculty of Health Sciences, although the School of Physic did not begin until 1711. The tercentenary celebrations will take place just before the 14th International Conference on Emergency Medicine in our new conference centre – so I hope you will all come back to the 14th ICEM in four years time.

I want now to move forward in time to the 17th and 18th centuries



As Galenical humours evaporated and the logic and the experimentation of Da Vinci , Vesalius, and Harvey transformed medical care, it was once again amongst the military that the seedling of emergency medicine was nurtured.

Emergency Medicine exists at that interface between medicine and surgery which acknowledges, but does not necessarily accept, rigid boundaries,



At that time, the British Empire had begun a marked expansion and the need for surgeons and physicians to minister to the sailors, troops and merchants was great. There was an increasing diversity of surgery capable of very major intervention, despite the relative absence of anaesthesia, although the beneficial affects of alcohol and opium were recognised.

I might say that alcohol and opium remain of importance to emergency physicians today but possibly for other than beneficial reasons.

In any event some difficulties then, as now, were head count and value for money. As the navy of King George expanded, the demand for surgeons and surgeons' mates rocketed. The Royal College of Surgeons of Ireland responded well to the need for such personnel, and effectively developed a method of fast-tracking the necessary training and experience. Better a rapid training for a semi-literate person, than none at all for the lob-lolly boys who took away the amputated limbs .

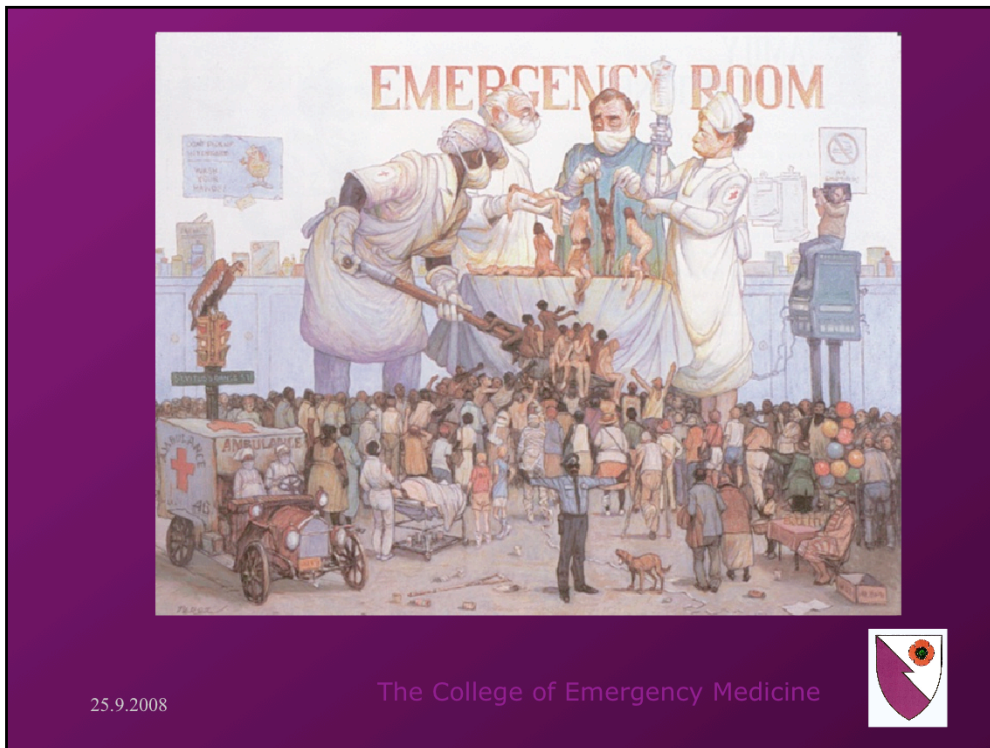


There is a perception outside our field that trauma is our entire *raison d'être* and that we do not need to have any other knowledge, most particularly with regard to medical emergencies. Nothing could be further from the truth.

The same misunderstanding applied to the military and naval surgeons.

Wander around military cemeteries and read the headstones, such as these in the Trafalgar Cemetery at Gibraltar. Read memorials in churches the length and breadth of these islands. Consider the difficulties encountered by Florence Nightingale at Sevastopol and Scutari, where infectious disease was by far the greatest killer. Trauma killed then, as now, by infection at least as much as by anatomical derangement and haemorrhage. The military or naval surgeon had to manage cholera, typhus, abscess formation and in the hotter parts of the far-flung British Empire, bladder calculi.

Such a mixture of disease processes and trauma are clearly within the realm of the modern emergency physician.



The over crowding of the ship's sick bay, the screaming on the orlop deck, the need for triage to enable early return to the ramparts of those capable of defending the fort - aren't they reflected in today's over crowded emergency departments with access block?

Perhaps this is no longer so in England with supposed 99% compliance with the four hour standards but it certainly is in Ireland, Australia and the USA .

My focus on military medicine in the context of Emergency Medicine, going back to the Knights of St. John, stems from the close links between the two prime areas of expertise, medicine and surgery, which, as I have previously said, are NOT mutually exclusive.



In 1684, a home for retired soldiers, known as the Royal Hospital, was built at Kilmainham, close to where the Priory of St John had been. Bully's Acre, source of bodies for anatomical dissection in the 18th century lies within the same area. The Royal Hospital, Kilmainham, remained in active service until 1922. It was said to be modelled on the cloistered courtyard of Les Invalides in Paris.

Though often thought of as imitating the Royal Hospital, Chelsea, home of the Chelsea pensioners, the RHK actually predates the London institution.

Last night's formal dinner took place in the Great Hall which was the communal area for the inmates, as they were described at the time.



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A nearby institution, also built round a cloistered courtyard, and again said to be modelled on Les Invalides, was Dr Steeven's Hospital.

This was first mooted in 1713, was begun in 1717 but was not able to accept its first patient until 1733, all due to funding difficulties.

That sounds a sadly familiar story to the modern emergency physician.

My first visit to an Emergency Department was to Dr Steeven's Hospital almost fifty years ago. I recall struggling with a number of local girls who tried to carry me home covered in blood from a forehead wound, following an adventure I should not have been involved in, in the first place.



A week later another misadventure, this time in the school room, led to my second visit to an Emergency Department, at the Royal City of Dublin Hospital, for re-suturing of my head wound. At that stage I declared an interest in becoming a doctor, which was politely listened to.



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My teacher gave me 2 shillings for an Easter egg, because I was so brave!!

I sometimes wonder if there is any link between my early visits and the fact that both these hospitals have since been closed and assimilated into St. James's Hospital?




1962

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In 1962, a Manchester orthopaedic surgeon, Sir Harry Platt, made his now famous recommendations to re-label and revive the Casualty Department. It is hardly surprising that he recommended supervision by Orthopaedic Consultants, as there was no other obvious type of person available at the time AND the committee was heavily weighted.




MEMBERS OF THE SUB-COMMITTEE

Sir Harry Platt, Bt., F.R.C.S., M.D., M.S. (Chairman)	Orthopaedics
Professor H. J. B. Atkins, D.M., M.Ch., F.R.C.S.	Gen Surgery
S. Whately Davidson, Esq., M.D., F.R.C.P., F.F.R.	Radiology
F. W. Holdsworth, Esq., F.R.C.S., M. Chir.	Orthopaedics
F. N. Marshall, Esq., M.D., B.Sc., D.P.H.	Public Health
Rainsford Mowlem, Esq., F.R.C.S.	Max-Fac
D. W. C. Northfield, Esq., M.S., F.R.C.S.	Neurosurg
G. A. Phulp, Esq., T. D., B. Com., F.H.A.	Soldier
A. Talbot Rogers, Esq., M.B., B.S., M.R.C.S., L.R.C.P.	GP
J. C. Scott, Esq., M.A., M.D., M.S., F.R.C.S.	Orthopaedics
Miss D. Stringfellow, M.B.E., S.R.N., S.C.M.	Nurse
Professor R. E. Tunbridge, O.B.E., M.Sc., M.D., F.R.C.P.	Physician

1962

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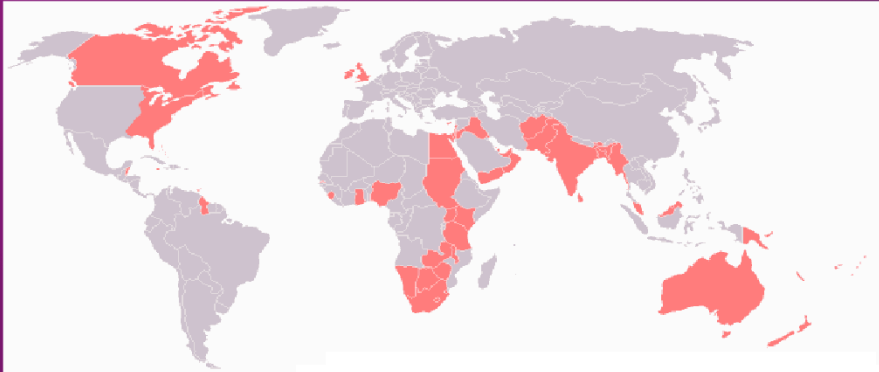
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Mr Scott, in a BMJ review of a book entitled “The Casualty Department” in 1955 stated:

The one thing that this book demonstrates most clearly is that the department organised to treat ‘ ‘ what nobody else wants ‘ ‘ should no longer have a place in the well organised hospital service. If the general practitioner service is working properly it seems unnecessary to have a hospital department devoted to the “ casual “ patient. It is to be hoped that the name, which still means exactly what the author says in many hospitals, will soon begin to disappear.


Needless to say, the proposed solution failed to resolve the problem, despite the fact that Sir Harry was also a Knight of the Order of St John!



British Empire at end of 19th C



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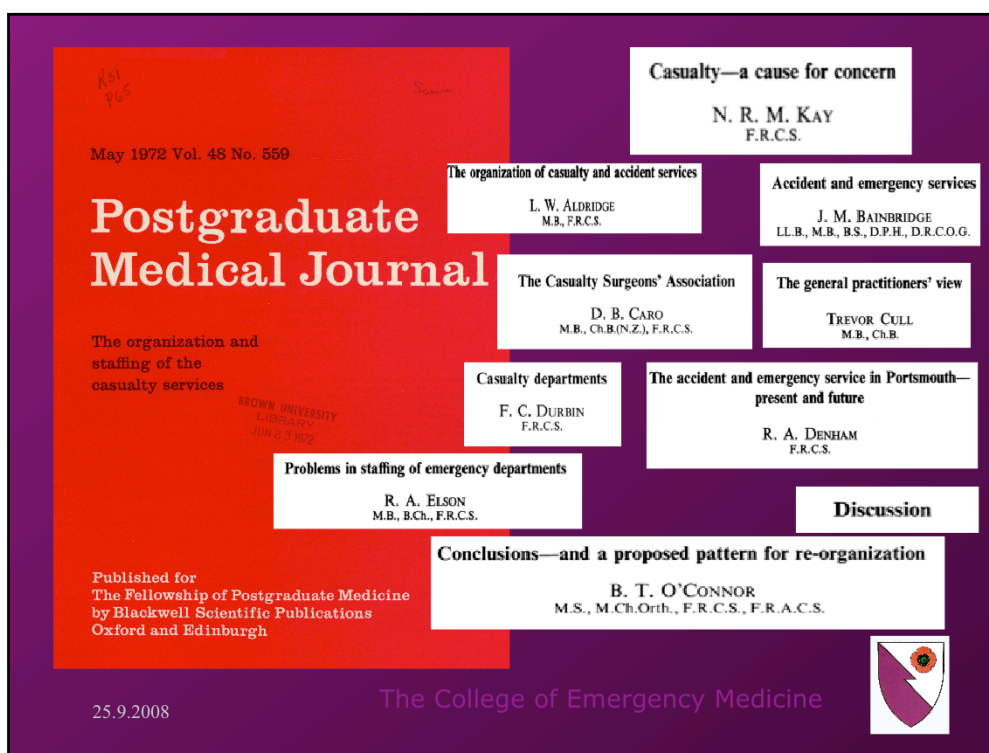
In the period after the 2nd World War, India gained her independence in 1947, and most of the African countries during the 1960s. During that twenty year period, the contraction of the British Empire led to the return to the United Kingdom of a unique group of people, amongst them, William Rutherford, whom we honoured earlier today.



These were mainly doctors who had worked in Christian missionary stations throughout the empire.

They dealt with infectious diseases, trauma, surgical emergencies, obstetrics and the anaesthesia required for any procedure they carried out. On their return, which smacks of the return of the Knights from the Crusades, they were misfits in British medical society. Although very skilled they had effectively stepped off the career ladder, so the only way they could survive was to take posts as senior medical officers in casualty departments.

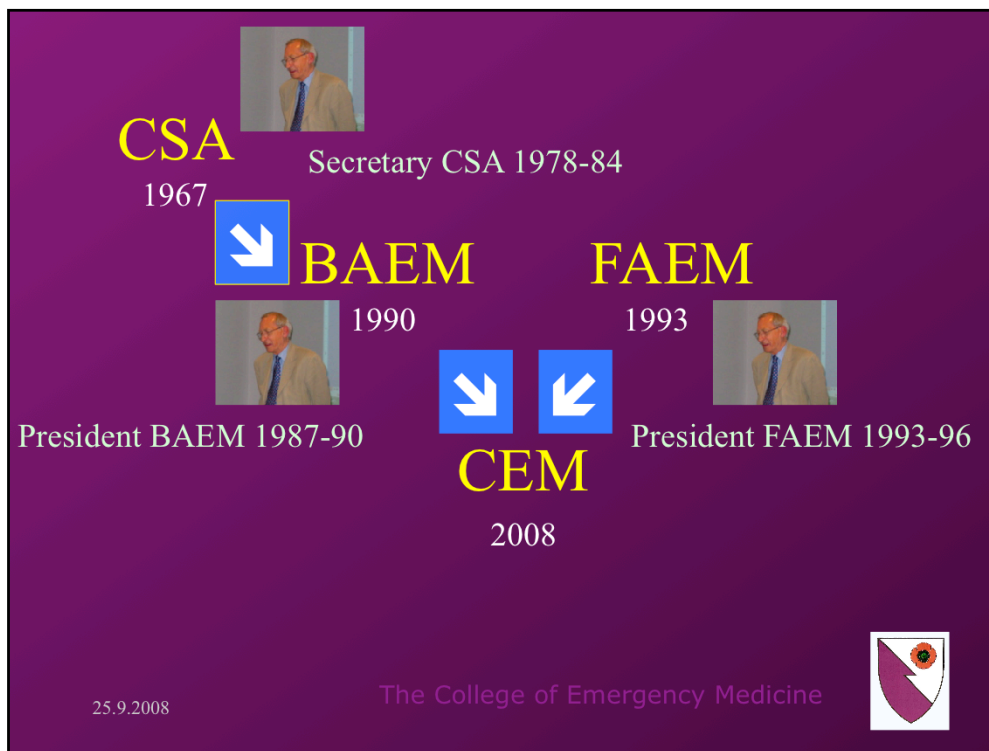
The Casualty Surgeons Association was formed in 1967, forty years ago, as a response to suggestions that these senior medical officers in casualty departments might be downgraded to medical assistants, rather than upgraded to consultants.



Indeed, the whole matter was so tenuous at the time that the senior registrars in orthopaedic surgery called a conference, the proceedings of which were published in full in the Postgraduate Medical Journal. They make very interesting reading over a third of a century later. As a result of pressure from the CSA, through the BMA, Lord Lewin, supported by a former President of the Royal College of Surgeons of England, Lord Brock, recommended a pilot scheme and the first consultants in Emergency Medicine were appointed in the United Kingdom in 1972.

Ireland caught up rapidly with a formal report in 1974, which covered the same old ground about inappropriate attenders and the need for focus on trauma. One of the authors of that report, a county surgeon called Rory Lavelle, was my Consultant when I was a surgical intern and casualty officer in Navan, thirty miles from Dublin.

Another coincidence is that he was at one stage a casualty officer at a London hospital called St James's. Despite having made recommendations which led to the appointment of Leo Vella as the first Casualty Consultant in Ireland, Rory Lavelle counselled me against staying in A&E medicine on the grounds that it was a young man's dream, which would not be long lived as a specialty. I think his views changed in later life



The CSA metamorphosed, in 1990, into the British Association for Accident and Emergency Medicine, at a time when David Williams was President. The Faculty of Accident and Emergency Medicine was formed in 1993, with David as the Founding President. In March 2008, the two organisations fused to form the College of Emergency Medicine.

No more clear ancestral lines could be imagined than those that link us back to those pioneers, many of whom have passed away to their eternal rewards.

I think that this flow chart must surely indicate just how ABSOLUTELY pivotal David Williams has been to this entire process. Since handing over the reins at the Faculty, he has been Vice President of the European Society for Emergency Medicine from 1999 to 2004, President from 2004 to 2007 and is currently the Immediate Past-president, until the EuSEM annual general meeting in Valencia in a year's time.

I pray he will be with us for many more years to come. After all, Sir Harry Platt lived to the age of 104!



In 1966, Donough O'Malley, Minister for Education in Ireland, announced unexpectedly that, in future, secondary education would be free. This hit the morning newspapers on my eleventh birthday and changed the face of Ireland forever. From an agrarian economy, we have been catapulted into a knowledge-based economy, enhanced by our total commitment to the European Union and by the technological advances of our age, the World Wide Web and microcomputers. Indeed, Ireland is now the greatest single source of software exports in the world. It was free secondary education that allowed me to achieve my ultimate dream, but the most interesting aspect to this development was that the minister announced this change without prior consultation with the minister for finance or the civil service. That was tantamount to exploding a tactical nuclear device inside Government Buildings. This mode of mandarin manipulation was also used in the year 2000 by the Minister for Health, Micheal Martin, when he tried to double the number of consultant posts in Emergency Medicine, overnight. He was, however, thwarted, somewhat by the mandarins.



During both my primary and secondary education, I had further recourse to Dr. Steeven's Hospital on a number of occasions. Traumatic division of a digital nerve in the palm of my non-dominant hand, which would nowadays lead to a microsurgical repair, was treated expectantly - some would say ignored. This has left a permanent sensory abnormality, which allows me to understand the long-term sequelae of so-called "minor injuries".

On another occasion traumatic amputation of two fingertips on my dominant hand was treated with a tube pedicle graft. I was kept as an inpatient for three weeks, whereas nowadays, I would have had two brief admissions for surgery.

During my time in hospital, I learned about the Great War from a casualty who had his left biceps shot away at the Battle of the Somme – but at least he survived! And, during my stay, the first man landed on the moon – hence this picture of Earthrise, which was published in the Daily newspapers at the time!

I learned long before I formally studied anatomy, physiology or pharmacology, the fact that local anaesthesia does not block the slow pain fibres. It has given me a great respect for the ability of a thinking physician to relieve pain. This must surely be one of the most important roles of an Emergency physician. I certainly feel our approach to the patient in pain can go along the lines of A-B-C as long as C includes cyclimorph, as soon as appropriate.

17 May 1974

17:28
Parnell St

The Charitable Infirmary
Jervis St

17:30 Talbot St

17:32 Sth Leinster St

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As a youth, looking rather gawky in the uniform of the St. John Ambulance Brigade, I learned the practical arts of suturing and knot tying even before I entered medical school.

At that time St. John volunteers used to help out in the casualty department at Jervis Street Hospital where, as I said earlier, Leo Vella was the 1st Casualty Consultant in Ireland. Although such fudging of professional boundaries might be frowned upon now, it was not unusual then.

When Dublin suffered terrorist bombing in 1974, on three separate sites within a 4 minute period, St. John Ambulance volunteers were the first on the scene, as they were already nearby, conducting their annual Flag Day appeal.

My own personal role in this was rather late as I had been at home studying for my exams, but consisted of confining all the dead bodies at Jervis St Hospital for transfer to the city morgue.

It remains as a vivid memory to this day



But let us look more at the development of Emergency Medicine into the forceful and crucial speciality it is today.

The change in attitudes probably began after the completion of the first set of senior registrar-ships towards the end of the 1970s.

The inception in 1983 of the Fellowship in Accident and Emergency Medicine and Surgery of the Royal College of Surgeons of Edinburgh, the oldest such college in the world, run in conjunction with the Royal College of Physicians of Edinburgh, paved the way.

I well remember a meeting at the Royal Society of Medicine in 1987, when that examination was being deprecated by another senior registrar. Rob Cox, Tom Beatty and myself stood up and took exception to this, as we had all been successful in the exam, which the detractor had failed.



The Irish dimension has always been well recognised in the formal development of the speciality in these islands.

Representation on the speciality advisory committee which straddled the JCHST and JCHMT, led to representation on the Education and Examination committee of the Faculty of A&E medicine after its inauguration in 1993.

Given the makeup of the faculty with its six parent colleges, involvement of the Irish Colleges at the top table would have made matters even more complex than they already were.

That educational representation however, has continued for the past fifteen years and has ensured that the standard of training and evaluation is identical for our two interdependent islands, leading ultimately to a place at the top table of the new College.



Let us look at the badge of the new College, based on the coat of arms of the Faculty of accident and emergency medicine. I am indebted to Jonathan Marrow for these words of explanation

“In the centre of the coat of arms is a shield. It is purple on one side and silver (usually shown as white) on the other. The purple and silver represent the commitment to care for emergencies by night and by day. The two parts of the shield are separated by a jagged diagonal line. This is symbolic of lightning to represent rapid action when needed, and also to refer to the use of electricity in defibrillation. In one corner of the shield there is a single poppy, to stand for the relief of pain and suffering. The poppy is also included as a tribute to all those, past and present, who have looked after the wounded in time of war. Much has been learned from their experience, so we all owe them a great debt. The shield is much simpler than the whole coat of arms. It is a bold and distinctive design. It does convey a lot about the work we do.”

I would add that the opium poppy, source of our best painkillers and part of our essential armamentarium is also the source of illicit heroin, cause of much personal and societal grief in our cities.



Growing in the hills of the golden triangle of Laos, Cambodia and Vietnam, it is also grown in Afghanistan, the old northwest frontier of the British Empire where, even today, Irishmen serving in the Royal Irish Regiment are trying to protect a legitimate government against insurgents. And that same poppy is used as a symbol of remembrance by the Haig Fund set up to look after the needs of military veterans.

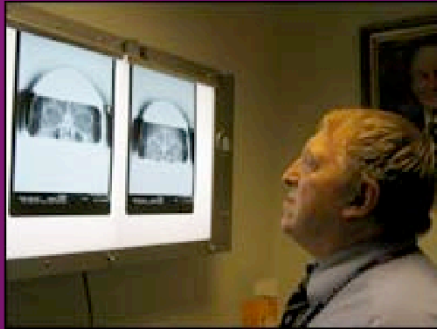
The Irish and the British Army have a long, confused and intertwined history. I earlier mentioned the role played by the Royal College of Surgeons in Ireland in providing trained personnel for King George's navy. Later, that symbiotic relationship between the RCSI and the Army Medical Corps culminated in the appointment of Mr Jolliffe Tufnall as Regius Professor of Military Surgery in 1851.



Subsequently, that function was transferred to a Joint Professor of Military Surgery at the RAMC and Royal College of Surgeons of England.

Coincidentally Jim Ryan, a graduate of Trinity College Dublin and an honorary Fellow of the College of Emergency Medicine who held that post in the 1980s, is also a member of the Venerable Order of the Hospital of St. John of Jerusalem.

I was unsure which of these pictures to use, the clinical or the academic. As you can see, he tends to hang around with some very important people.



Emergency

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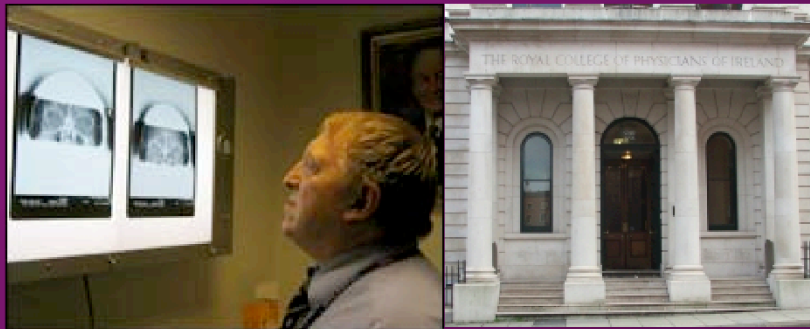
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As I previously mentioned, in Ireland and the UK, the name of our specialty began as Accident and Emergency Medicine, taking its lead from Sir Harry Platt's view of what our Departments should deal with. In other parts of the world a somewhat different focus has led to the use of the title "Emergency Medicine".

Stubbing your toe on a chair leg may be classed as an accident but is rarely an emergency. Furthermore the collision that occurs when a car drives through a red traffic light into the path of a truck is entirely foreseeable and therefore cannot be reasonably described as a accident, although it will probably require emergency medical care.

I well remember Laurence Rocke, (known to us as Rockie), from Belfast at the Casualty Surgeons Association Annual General Meeting in Manchester in 1990, proposing this change but having to accept the halfway house of British Association for Accident and Emergency Medicine as the new title of the Association. Even at that, some of the founder members of the CSA walked out in disgust.



Emergency –V– Acute

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When we tried to modernise our name in Ireland there was a marked resistance to change. This was led virtually entirely by the officers of the Royal College of Physicians of Ireland. They had formed a view that this would interfere with their plans for the development of acute medicine as a speciality, and felt that their sister college in London would be particularly offended. I can say that, in recent times, they seem more keen to have us inside the tent, rather than outside.

What are the differences between acute medicine and Emergency Medicine?

First and foremost acute medicine is essentially an inpatient speciality, confined to the medical problems of adults.

Emergency Medicine on the other hand deals with adults and children, medical, surgical, psychiatric, social and obstetric emergencies; these are the bread and butter of our speciality.

If it is an emergency and one has never had to deal with such a problem previously – That's tough!

One must rapidly develop a safe and effective approach to its management.



THAT is a critical requirement to be a good emergency physician, the ability to think outside the box, to adapt generic responses into specifics and never to panic.

Resuscitation is a case in point.

Anatomical derangement may be involved but it is physiological derangement which will finally kill the patient. Loss of airway due to a foreign body, direct traumatic disruption or anaphylactic swelling will each lead ultimately to hypoxia, hypercarbia, acidosis and breakdown of cerebral and cardiac processes.

It is the role of the Emergency physician to stop the process, allow time for the root cause to be identified and be effectively treated, prior to discharge, or transfer of the patient.



Take for example the fact that anaesthesia is useful to allow painful procedures to be performed. What if, like this man, you are trapped for hours from the hips down by a trench collapse. Your colleague has been rescued and sent to hospital but the ischaemic pain in your legs is unbearable. It's too painful and physically impossible anyway, to lie down. However, anaesthesia in the current position will reduce your cerebral blood flow and make your airway difficult to manage. The firemen predict a further two to three hours hand-digging, unless more aggressive methods are used. What would you want done?

In this particular case, I had to anaesthetise him whilst I was sitting on a beam 5 feet above the floor of the trench, rapidly lie him back onto a scoop stretcher laid across two beams and intubate him then. That allowed for more aggressive digging around the legs, which took another twenty minutes, rather than the prolonged period of agony predicted, and then ongoing anaesthesia through to the operating theatre for fasciotomy.

To the best of my knowledge none of this is documented in textbooks but it needs to be embedded in the Limbic system of the true emergency physician. To ask an acute physician, or even most anaesthetists, to handle such a case would not lead to an adequate solution because it is not within their field of expertise.



EuSEM Council 2008

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Whilst David Williams was president of EuSEM from 2004 to 2007, the membership grew and he developed the European Federation of National Societies for Emergency Medicine.

EuSEM, through that federation, currently has thirteen thousand affiliate members. As each country in Europe looks at its emergency medical care delivery, the trend is towards the model we have had in these islands for the last one third of the century.



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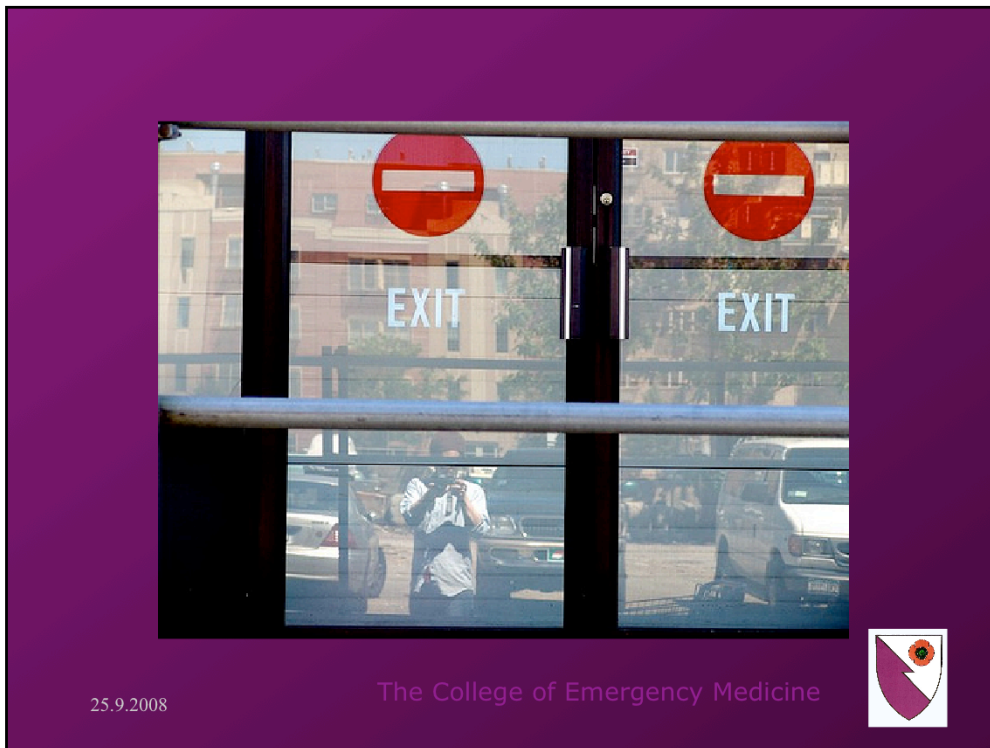


Bring the emergency patient to a central site with a emergency physician waiting for the patient!

The days of doctors flying around the streets of Paris, Rome or Berlin in ambulances are numbered.

It does not make economic sense to send a doctor to every single patient, as he might deal with several other patients during the time it would require to deliver him to the patient. Once the patient has been delivered, a much greater team effort for resuscitation can be fit into the emergency department than into the confines of an ambulance.

Furthermore, one risks losing a valuable asset, if unlucky.



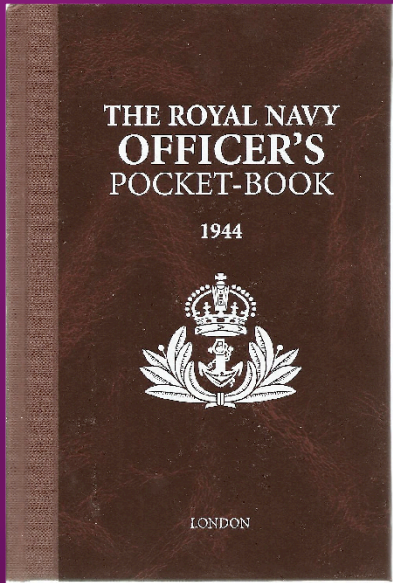
It is however, fascinating to see how in the evolutionary process the same barriers recur and the same internal prejudices rear their ugly heads.

Some critics want to know why a patient with abdominal pain should not be sent directly to the surgeon, but what if the pain is due to diabetic ketoacidosis, or acute porphyria?

What if the person with pleuritic pain, shortness of breath, hypotension and tachycardia is seen only as having a pulmonary embolus and is anticoagulated, but actually has spontaneous splenic rupture as a result of infectious mononucleosis? My colleague, Geraldine Mc Mahon, saved yet another life by responding promptly to such an unusual event only weeks ago.

Sending the patient directly to a specialist in a non emergency situation is fine – but it can be dangerous if the emergency has not been adequately identified and stabilisation begun.

It is almost like letting a self-locking door close behind the patient with no mechanism to return through that door. It may be a terminal concept.




... ..*it is my intention*

... ..*any reluctance to disturb*

... ..*will be misplaced !*

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It is vital that, where any doubt exists, the fully trained specialist in emergency medicine is involved in the management of the individual patient, or the department as a whole.

I feel it is sometimes difficult for outsiders to understand just how important a concept continuing responsibility is to us. It is often said that we have no responsibility for ongoing care. I would disagree.

As a consultant in emergency medicine I regard myself in the role of the captain of the ship. I have faith in those I leave on duty whilst I sleep. But I retain a responsibility.

It is my decision whether my skills are needed in any particular instance. I need to be made aware of the issue before I can decide. If I decide to leave it in the hands of my SHO, Registrar or Nurse Practitioner, I am still sharing in the care of the patient and accepting responsibility.

As laid out in this manual, the Captain's Standing Orders for HMS Duncan in 1943 read: *"After a period of constant wakefulness, or disturbed rest, a man is sometime capable of making an apparently intelligible reply, when called, without really waking up. Whenever I am called by the Officer of the Watch, it is my intention to come to the bridge unless I consider the cause of the call not to be of immediate importance, in which event I shall say so. I rely on the OOW to assist me in carrying out this intention, and any reluctance on his part to disturb me, however well meant, will be misplaced."*

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The use of the accident and emergency department

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SUMMARY


Many studies have shown that a high proportion of patients attending accident and emergency (A&E) departments have only trivial or non-surgical complaints. A&E staff treat these inappropriate attenders while recognizing that this detracts from the care given to more serious cases. Dwindling resources and higher attendances make it a matter of necessity that inappropriate attenders be treated by general practitioners or equivalent primary care services.

In this study the authors examined the feasibility of methods of reducing inappropriate attendance. The authors investigated patients' ability to accurately assess the urgency of their condition and, hence, their need for A&E services. The authors concluded that there is probably no practical way of reducing inappropriate attendance that does not involve risk to a proportion of patients. The possibility of extending the role of the A&E department to provide more general primary care is discussed.



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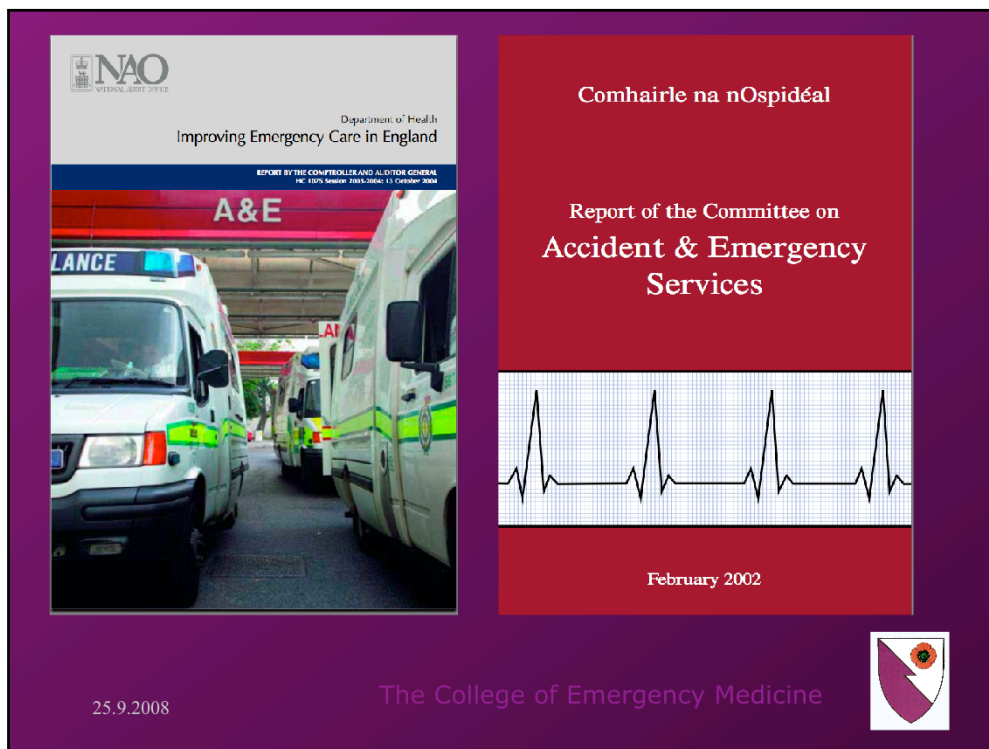
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Another area of learning for neophytes in Emergency Medicine and for those outside emergency medicine lies in regard to the deflection of so-called “undeserving cases”. This pejorative approach leans on the post-hoc validation of the patient's perception of an emergency by their exit diagnosis, or plan of management. Such diagnosis can only come after a full clinical consultation.

In the society in which we live, our patient must be listened to and their worries allayed, rather than rejected because they do not immediately fit the preconception of the physician regarding emergencies

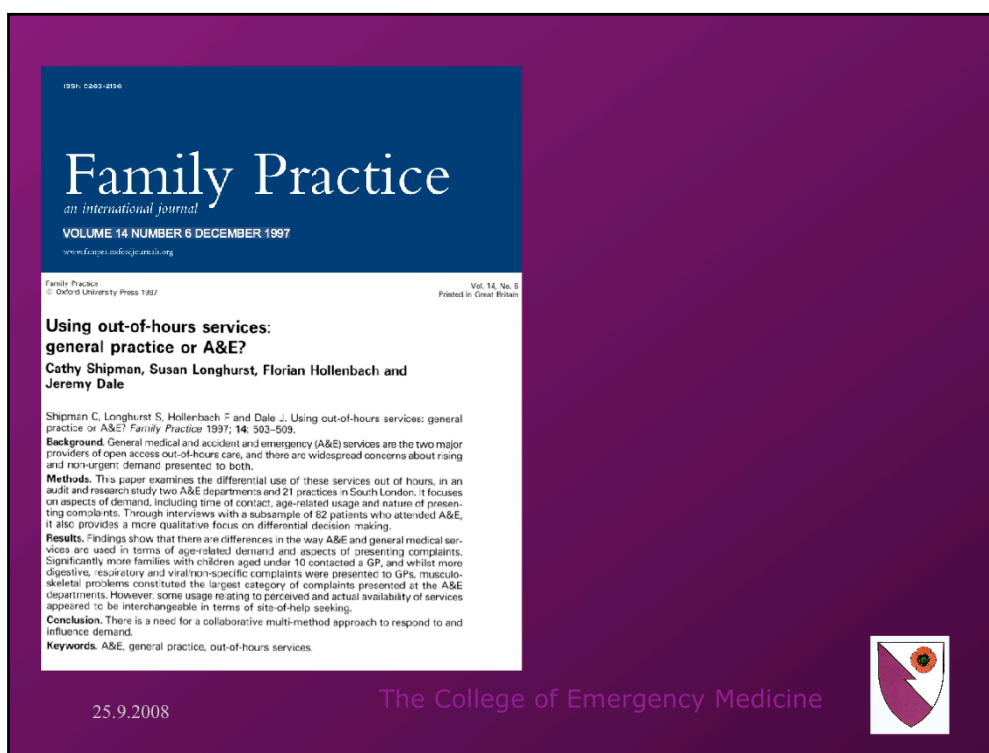
I well remember when I was an intern working for Peter O'Connor, the second consultant in Emergency Medicine appointed in Ireland. A fifty year-old man came in complaining of constipation. He had been virtually savaged by the receptionist who wanted him to go to a GP. When the nurse heard that he had been to another department two days previously and had been given an enema, she was most aggrieved and felt that he should “shown the door”. I merely listened to his story, which indicated that he had been to his GP first, to no avail, had an enema which was partially successful, but still felt miserable and wanted me to sort out his constipation once and for all. The history was alarming with altered bowel habit, ribbon-like faeces, double-defaecation and tenesmus. Rather than putting my foot in it, I examined him properly. His AP resection three days later sorted out his constipation once and for all.

It is vital that emergency physicians don't prejudice the outcome for their patients by prejudging them without hearing their story first. I believe it was Sir William Osler who said “If you listen carefully to the patient, they will tell you the diagnosis”.



Deflecting emergency patients to primary care, urgent care centres or directly to specialists will work only for a handful of patients. Scientific literature on this issue is relatively sparse, but consistent worldwide . Each patient will accept the concept that only those with an emergency should be in the Emergency Department.

However, HE is here precisely because he sees his problem as an emergency and that the Emergency Department is the ONLY place capable of dealing with him effectively.



It is often claimed, incorrectly, that King Canute thought he could hold back the tide. What he actually did was to show his sycophantic supporters that even the king is subject to the laws of nature. The flood of patients attending Emergency Departments worldwide will not be deflected by the requirement for GP referral as in Holland, or co-payments as in the USA or Ireland. They know precisely where they can access good care twenty-four hours per day .

I am unaware of any definitive process which has been shown to reliably persuade patients to avoid their Emergency Department.

Quality of care is dependent on a patient's perception and an independent verification of outcome. My major concern about quality initiatives is that they appear to focus excessively on the process of defining, recording and reporting, rather than on ensuring the provision of high quality care leading to good outcomes.

Outcomes for emergency medicine are rarely captured, predominantly for logistical reasons. The number of patients that leave the same day and never need to return exceeds 95% of attenders. That represents those with self-limiting illness sent home and those admitted for secondary input from another specialty. The 70% who go home cannot have their outcomes captured in any cost effective manner. Those who are admitted have such input from others that it is very difficult to capture whether the improvement, or decline, is due to emergency medicine, or to the other specialty.

Annals of Emergency Medicine

Health Policy and Clinical Practice/Review Article

Systematic Review of Emergency Department Crowding: Causes, Effects, and Solutions

Nathan R. Hoel, PhD
Dimitri Aorosky, MD, PhD

From the Department of Biomedical Informatics (Hoel, Aorosky) and the Department of Emergency Medicine (Aorosky) University Southern California, Los Angeles, CA

Emergency department (ED) crowding represents an intractable crisis that may affect the quality and access of health care. We conducted a comprehensive PubMed search to identify articles that (1) define causes, effects, or solutions of ED crowding; (2) describe data collection and analysis methodology; (3) occurred in a general ED setting; and (4) focused on emergency crowding. The independent reviewers identified the relevant articles by consensus. An explicit 4-level quality assessment tool to guide the methodology of each study. From 4,277 abstracts and 188 full-text articles, the reviewers listed 50 articles meeting the inclusion criteria. A total of 35 authors of 41 studies, 27 studies studied effects, and 40 articles studied solutions of ED crowding. Commonly studied causes of crowding included no urgent visits, "time-out" patients, influenza season, influenza staffing, patient boarding, and hospital bed shortages. Commonly studied effects of crowding included patient mortality, transport delays, treatment delays, ambulance diversion, patient experience, and financial effect. Commonly studied solutions of crowding included additional personnel, triage area, hospital bed, access, no urgent referrals, influenza observation, destination control, crowding measures, and queuing theory. The results illustrated the complex, multifactorial etiopathogenesis of the ED crowding problem. Additional high-quality studies may provide valuable contributions toward better understanding and alleviating the daily crisis. The structured overview of the literature may help to identify future directions for the crowding research agenda. *J Am Emerg Med.* 2008;15:239-256.

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EDITORIALS

Access block: problems and progress

We need a coordinated approach to address the underlying problems in the health system

THE EFFECTS OF ACCESS BLOCK on acute hospital services are most dramatically reflected by patients who develop acute myocardial infarction (MI) in the emergency department (ED) corridors and ambulances unable to reach waiting to enter hospital patients. The Australian College of Emergency Medicine and the Australian Council on Healthcare Standards (ACHS) have defined access block for emergency patients as the percentage of all patients admitted, transferred or dying in the ED where their total ED time exceeds eight hours. For elective patients, access block is reflected in ballooning elective waiting list numbers and lengths of time spent waiting.

Access block has been with us since the 1940s, but in recent years, in Australia, it appears to have become both endemic and critical across all our major cities.^{1,2} There is now evidence that access block causes poor patient experience and interferes with efficient hospital functioning.^{3,4} In the case of the hospital, poor patient experience of access block across Australia and potentially worldwide is well documented.

Increasingly, the workforce model required in hospitals is team based, with multidisciplinary teams and multiple levels of expertise, even within disciplines.^{5,6} Training programs for doctors, nurses and allied health workers do not yet reflect this need. This imbalance between career aspirations, specialty needs and actual working environments results in dissatisfied workers or staff who still seek necessary skills. These factors contribute to low morale, which further reduces workforce flexibility.

Shared care: The desire of the extended family and changes in the demographics of training and childbearing have led to more elderly people living alone, and with greater deterioration of the condition "over time" can be cared for.^{7,8} Population projections indicate that the number of informal carers in the community (largely middle-aged women) will decline sharply as the baby boomers age and require care themselves. The default solution for many suitable dependent people is often still to be seen in hospital.

Funding models: Payments to hospitals are healthcare providers covered and covered from government resources.

Access block is the scourge of the modern emergency physician .

In a sense, we are victims of our success, or at least the success of modern society and modern medicine in keeping people alive.

Good nutrition, good housing and good sanitation have all led to a marked improvement in population longevity. As infectious disease has been eliminated in western society as the main killer of children, adolescents and adults, degenerative, inflammatory and neo-plastic disease have had the opportunity to establish themselves in the population.

To die of a myocardial infarct and dysrhythmia at 55 years of age presupposes survival beyond the teens. This is not the situation yet in other parts of the world, but it may still come to them.



An episode of pneumonia, septic shock and acute renal failure in a 65 year-old woman was a death sentence when I was a child but now we resuscitate such a patient using modern tools and drugs.

She can usually return to society but the strain on her somewhat ischaemic myocardium may then lead to recurring episodes of congestive cardiac failure and intermittent attendance with acute pulmonary oedema.

The modern emergency physician can use non-invasive ventilation to make her feel better. A brief respite in hospital will enable her to return home yet again.

Not surprisingly, as shown in Alasdair Gray's 3CPO paper in the New England Journal of Medicine recently, non-invasive ventilation will not make her survive any longer than conventional treatment but she will feel a lot better much faster and isn't that what we want in Emergency Medicine?

Do Relatives of Elderly Patients Block the Discharge Process?

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Abstract

There is a perception that relatives of older patients "block" their discharge from acute hospitals, thereby compounding the capacity crises of Ireland's A+E departments. This study prospectively analyses 1,240 consecutive referrals to the discharge co-ordinator of an acute general hospital over a two-year period. The number of bed-days consumed by all patients whose discharge was delayed was calculated, in addition to reasons for delay and whether or not patients' relatives were opposing discharge. There were 90 cases of delayed discharge resulting in 2,436 bed-days consumed over the study period. Reasons for delays principally centred on access to long-term care facilities and organisation of community supports. Patients' relatives opposed discharge in 9 of the 90 delayed cases. Concerns expressed by patients' relatives reflected the paucity of community supports available for older people and their carers. Older people's relatives are patient advocates and seek appropriate facilities for those whom they represent.



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Irish Medical Journal

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I hear from time to time of yet another cure for cancer or preventing death from heart disease. I sometimes wonder if I am alone in accepting that each of us will die someday of some trauma or disease process?

I feel that my role as an Emergency Physician is to ensure that the death of my patient is neither premature nor distressing for them. I can do nothing about its ultimate inevitability. However, the postponement of death comes at a price. The fabric of the body has a limited capacity to rebound and repair. We all slow down, wear out and eventually become more and more dependent. Treatments to extend life become more expensive as development costs must be absorbed. The cost of looking after the elderly infirm and the young chronic sick increases, especially as staff costs increase. More money needed, fewer taxes paid. This vicious circle leaves patients remaining in acute hospital beds, whilst back room boys wrangle over which diminishing pot of money will support the patient in a lower-cost, caring environment.

That increases length of stay and impacts back into the emergency department where patients too sick for discharge must wait on trolleys, which are no longer available for the next sick person in the waiting room to be assessed on. That is the primary cause of access block, and emergency department overcrowding. Overcrowding has nothing to do with inappropriate attendances. To claim so is to obfuscate and disguise the true cause. What if all the emergency admissions were immediately put into beds to allow free flow in the emergency department? Who then will suffer access block? Those with cancer who need debulking surgery, who need unblocking of obstruction, who need palliative procedures for pain relief, those who need joint replacement surgery to enable them to work or walk without pain, those who have angina needing elective coronary stenting, before they have myocardial infarct. Surely it is not the role of the emergency physician to obstruct vital non-emergency care for others?



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Rationing of health care spends by imposition of queues is a well-established technique. Health care is never cheap but ultimately somebody must pay. Some say that health care in the USA is the best in the world, but there are forty million people there with no health care cover whatsoever, almost two thirds of the population of these islands. France and Germany have mandatory universal insurance coverage. Their queues are shorter than in Ireland or the UK, but they cost more.

Ultimately only the population as a whole can decide whether we all deserve equal access to high quality care. Only the population as a whole can make that clear to the politicians entrusted to control and fund the system. Three million voices on this island speaking out of turn can never give a coherent message. But who can orchestrate the timing? Who can be the conductor of the choir? There are many conductors worldwide in musical term: one hears of Barenboim, Ashkenazy and Mazur. People of that exalted ability are few and far between; it is the same in medical politics, but emergency medicine and emergency physicians are ideally placed to act as conductors.

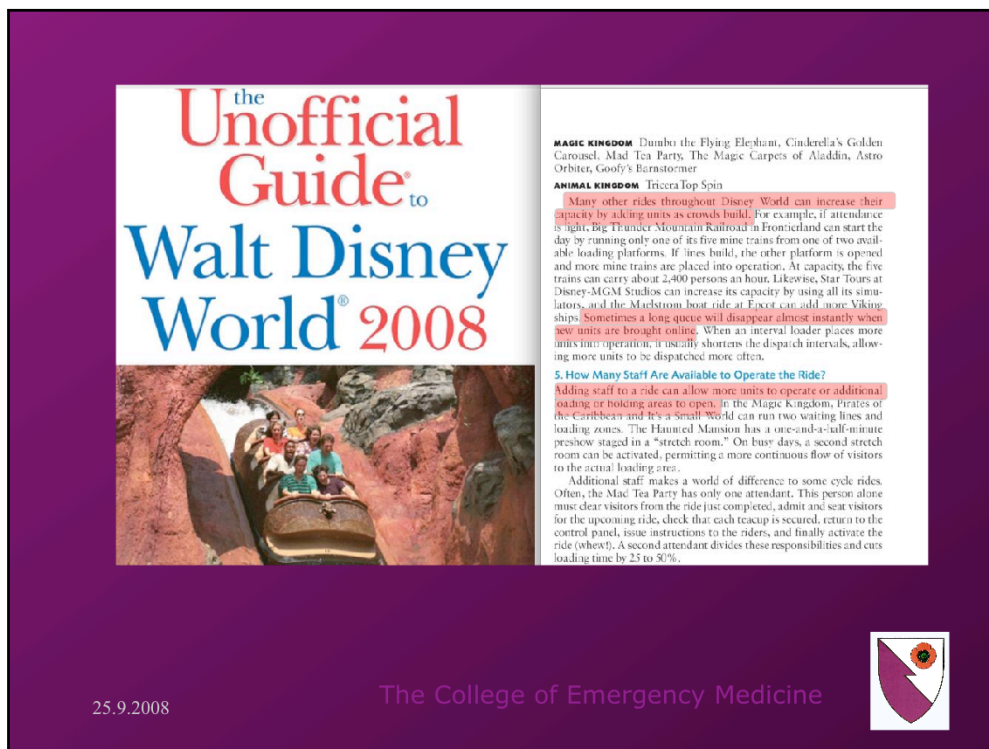


Which model of delivery of emergency medicine is best? Who knows?

Look at the USA with large emergency departments, staffed twenty-four hours a day by trained specialists, but many of the departments in small towns run by non specialists.

Look at our own systems, with the majority of medical care provided by a postgraduate trainee, supervised by inadequate numbers of specialists, spread very thinly.

Look at the Australian model. They have significant specialist cover in major cities and large provincial towns and non specialist cover in remote areas, backed up by specialist retrieval teams. Admittedly distances in Australia are huge, but the population density in the cities is similar to ours. I feel that this is the model to which we should aspire. I would love to work in such a system, although I recognise that, even there, access block remains the single greatest barrier to emergency medical care.



It has been said in Ireland that each patient being admitted by the Emergency Department is seen by twelve people and that this is inefficient, inappropriate and unsustainable. That is gross oversimplification of the process of emergency care.

We all know that the patient will see a registration clerk, then be triaged by a nurse to ensure that the most sick are seen immediately, with all others forming a queue. I note that complaints in Disneyland are few, but it is said that this is due to keeping them amused and updated on the ever-moving queue.

However, each ride has a pre-defined duration, and a specific number of people to accommodate. Such queues are amenable to mathematical calculation. And extra units can be added if necessary.

In the Emergency Department, the interference with smooth running by yet another critically ill patient throws such information flows out of predictable range. Even such matters as the physical layout of the queuing area have an impact on the psychology of queues.

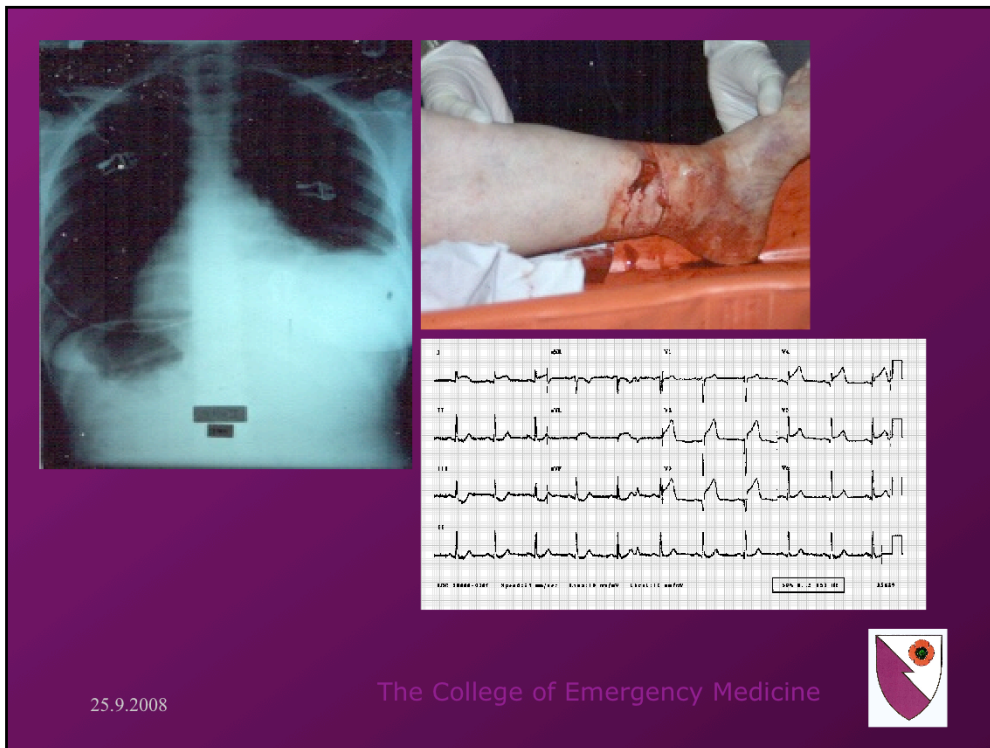


Following triage, to enable continued effective triage, a second nurse will ensure that the patient is placed on a trolley for evaluation by a doctor. If an x-ray is required a health care attendant will bring the patient to x-ray and the radiographer will perform the x-ray. The doctor in training may (or may not) require advice from a senior. Sometimes this may be a registrar, sometimes a consultant. Occasionally the registrar will need the advice of the consultant. That makes seven or possibly eight people dealing with the patient, prior to a decision to admit. Logically the patient would then be transferred to a ward bed for definitive care.

Due to difficulties with our old friend, Mr Access Block, the patient will probably be assessed in the Emergency Department by the admitting doctor to ensure that all aspects of patient care are dealt with, not merely those mandating emergency admission. Some of these patients will require further advice on management from a registrar and the admitting consultant. That makes a total of eleven staff members.

Could this be done by the consultant in emergency medicine alone or the admitting consultant alone?

Yes, but it would be grossly inefficient of their time, doing tasks which could just as readily be dealt with by a less well trained, less expensive person. And if the trainee never gets the experience of quality independent decision-making, what will happen when the consultant retires or dies in harness? All organisations have an organisational structure and work process suited to their needs. Emergency Departments are no different in this regard. When outsiders can make sweeping generalisations without a close and careful evaluation of such processes, they are being unprofessional.



Emergency Medicine is the safety net for the population at large that allows specialists in other areas of medicine to become more and more specialised. They become so specialised they are very good for specific areas of patient care but for fewer patients. The downside to such specialisation is the blunting of, or even loss of, ability to deal with other aspects of undifferentiated patients.

Very few psychiatrists would feel comfortable diagnosing pneumonia with acute respiratory failure; no cardiologist would wish to manipulate a compound fracture. A neurosurgeon asked to read an ECG and decide on the treatment of a myocardial infarct, or a dysrhythmia, would probably head for home.

But each of these doctors can spend more time doing what they do better, because the emergency physician crosses such boundaries and ensures patient safety in THE most cost effective manner.



Some may think that my links between the Knights of St John, Military Medicine and Emergency Medicine are all very tenuous. I have previously mentioned the role of the Joint Professor of Military Surgery.

I am delighted that this conference has been graced by the presence of the President of the American College of Emergency Physicians, Dr Linda Lawrence who is a military physician at Travis Air Force Base on the American west coast. More recently, indeed within the past 6 months, a Fellow of our College, Tim Hodgetts, has been appointed as the first Defence Professor of Emergency Medicine, in the British Army.

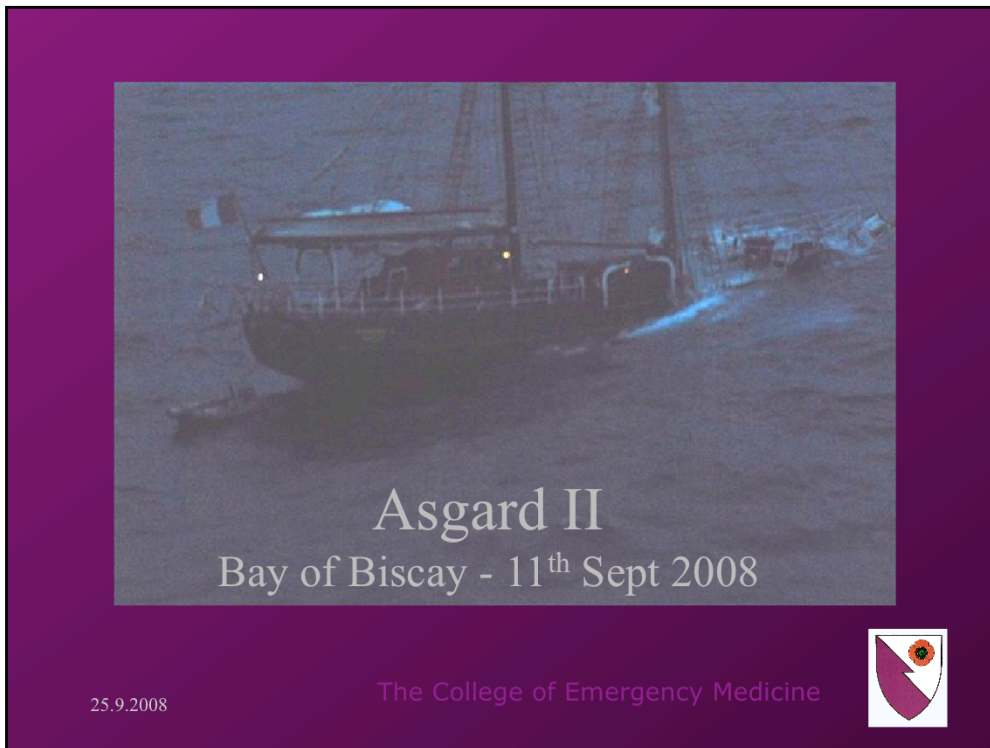
I believe that this confirms the validity of the link I suggest between military medicine and modern emergency medicine.



Sailing is a major part of my life.

It involves working as a team member in a close environment, sometimes under physical strain, nausea or pain. It is most fascinating during night watch when, regardless of the season, it is rarely black, except in the middle of a storm. Night watch allows for long minutes of silence, with lots of time for reflection.

It is quiet and calm, but occasionally the quietness is shattered by the need to take abrupt life saving measures, planned for, but never previously experienced .



Sometimes they have never previously been contemplated.

For me the parallels between sailing and emergency medicine are huge. Sailing has evolved since the pursuit of the carracks of the Knights of St. John by the galleys of the Turkish marauders.

Emergency medicine has also evolved in adversity. Neither sailing nor emergency medicine will ever be completely safe but they will both remain rewarding because they require total commitment, sharp reflexes, focussed thinking.

Terror is acceptable, panic is not.

And advance planning is vital for success.



Cost effectiveness is a key concept in modern medical care. The pot of money is finite with the demands increasing. To ensure the best value for money at a time like this, one would seriously have to consider developing a specialist capable of dealing with whatever the patient presented, at whatever time of day they came, with basic equipment only.

Indeed, having asked a management consultancy firm to report on cost effectiveness in multi system specialist delivery, their report would probably suggest a specific curriculum and evaluative process to ensure minimum spend, a cross-specialty spread of ability to care and a defining title.

Leveraging
pluri-potential
medical care
to synergise the
treatment of emergencies:
“Emergency Medicine”

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The invented title might read like this but, once again, the management consultancy would merely have reinvented the wheel.

For emergency medicine has actually existed in some form or other for the past millennium and has finally come of age.



Emergency Medicine will continue to evolve.

It is the safety raft of the modern medical system.

If it had not previously existed, we would have to invent it.

If Emergency Medicine didn't already exist,
it would have to be invented



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Thank you, David, for your contribution to its evolution.

Ladies and Gentlemen, thank you for your time, your attention and your Fellowship.