Accident and emergency services

Radical restructuring is needed

Earlier this year the magazine *Socialism and Health* looked at London accident and emergency services and asked a series of questions.¹ One of these needs an urgent answer: given largely similar populations and geography, why are the North East and North West Thames regional strategic documents for accident and emergency services so fundamentally different?

The organisation of health care within the NHS is such that almost all of its hospitals provide all acute services. At the centre of this comprehensive service is the accident and emergency department—the hospital's shop window. The specialty of accident and emergency medicine inherited a network of "casualty" departments, some of which (sensibly) have been closed. Each department is now required to provide a full diagnostic and resuscitation facility for acutely sick and injured patients 24 hours each day, 365 days a year. This readily available service has inevitably been abused by the public because it is usually more accessible than the general practitioner's surgery or outpatient department.² The quality of service provided has, however, improved over the past decade, and most units are now led by an accident and emergency consultant.

North East Thames's draft document states that "the A&E service appears to be appropriately distributed and providing a good service to the public." The ways it proposes of further improving the quality of service include nothing more radical than closing a few small departments—a head in the sand approach as every consultant in accident and emergency knows of acutely sick or injured patients who have suffered under the present system and paid with their lives.

The North West Thames strategic document, drawn up by Richard Warren after consultation with most of the accident and emergency consultants in the region and others, suggests a radical option. It deals with the real problem—that very recently registered senior house officers see overtly or, more dangerously, covertly seriously sick or injured patients unsupervised or, at best, supervised at a distance. All accident and emergency consultants know that most of the disasters would be prevented if they were always in the department. Warren suggests that to concentrate the available senior staff "in the short term the number of A&E departments should be reduced by 50% and in the medium to long term to four departments" (reduced from 21).

Warren's arguments for such a reduction are logical and based on the concept of matching experienced doctors with sick patients. Other, consequential changes would be needed. The overall number seen in accident and emergency departments must be reduced by about two fifths—the proportion that we know would be better managed by an available general practitioner.³ The great gain would be the concentration of available, particularly senior, medical manpower into four departments, which would provide sufficient senior staff, employed on a rota, to deal promptly with those patients needing skilled resuscitation and treatment. There would even be scope for a reduction in the number of senior house officers needed, the North West Thames document suggests. A major trauma centre (as recommended by the Royal College of Surgeons³) would also be needed, and interestingly, though

wrongly in my view, Warren suggests that it should not be sited at one of the four accident and emergency departments, not least because "it would be difficult to find any meaningful service role in the Major Trauma Centre for the A&E consultant." I believe that accident and emergency consultants must, with their specialist colleagues, be pivotal in resuscitating the trauma victim.

In order that patients may safely be transferred over greater distances and, if necessary, allocated by triage to a major trauma centre the ambulance service would need to be upgraded substantially. An elite of highly trained paramedics would be required whose only duty would be to transport patients for continuing care after triage and resuscitation. This concept is already in practice at centres of excellence in the United States: it requires only the will of senior ambulance men and hospital doctors for it to occur in Britain.

If four fifths of hospitals in the region were deprived of their accident and emergency departments their work would become "cold" rather than acute—a concept that many orthopaedic and general surgeons, particularly in London, would applaud.

What opposition will Warren's radical option face, for few specialists could argue that care would not be improved? Clearly, such a drastic measure must be considered in detail, but there is no reason why one region alone should not opt for this solution. There may be some effect on other local regions, which is why many in London are arguing for a unified London strategic unit. The natural reaction of the public is always to see closure of an accident and emergency department as a reduction in service—and who would blame them in the current setting? Many consultants in Warren's survey had reservations about working with a colleague of equal rank, let alone four or five consultant colleagues, but such attitudes are hard to justify. Many also disliked the notion of shift work as a consultant after years in the junior ranks. Such arguments may win the day and allow the status quo to survive—but with an increase in accident and emergency consultant numbers. Yet any increase must imply a shift system to address the problem of the sickest patients being seen by the most inexperienced doctors.

A less radical solution, which I favour, would be to link groups of four or five accident and emergency departments in collaborative night cover (6 pm–9 am) to concentrate senior staff in one department. This would require close liaison with the ambulance service but could work. What cannot be denied is the need for change; I believe that the specialty of accident and emergency is young enough to accept that and bold enough to ensure that the hurdles to implementation are cleared.

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1 Watership P. Which way for accident and emergency—is there safety in numbers? *Socialism and Health* 1990 May:1.

2 Driscoll PA, Vincent C, Wilkinson M. The role of the accident and emergency department. *Arch Emergency Med* 1987;4:77-9.

3 Royal College of Surgeons. *The management of patients with major injuries. Report of the Working Party of the Royal College of Surgeons*. London: Royal College of Surgeons, 1988.