Acute Medicine

Editorial

Emergency Departments Corridors are the new Acute Medical Units

T Cooksley

The NHS and social care services remain under immense pressure.[1] Each part of the system continues to experience demand beyond its capacity which exacerbates the problem. This is most vividly illustrated in urgent and emergency care. Once again, this winter, media is full of pictures of patients in corridors; long queues of ambulances outside of emergency departments and stories of horrific patient experiences: reflecting the appalling situation witnessed and practiced by acute medical teams daily.

This winter the "quad-demic" of influenza, Covid-19, respiratory syncytial virus and norovirus has predictably overwhelmed already overcrowded hospitals.[2] Current occupancy levels of hospitals means that any measurable increase in attendances will tip many into critical incidents and this has predictably occurred.

Acute medical care is now routinely being delivered by teams in corridors of Emergency Departments rather than in optimal environments with older patients in particular bearing the brunt of this situation. In this issue of Acute Medicine, Barnes et al. describe a corridor cohort of acute medical patients – a "sick, elderly and sad" group.[3] This degrading care causes significant harm to a particularly vulnerable population and should never be tolerated. The discontent is felt and experienced by staff and patients with moral injury and burnout of acute medicine teams now of grave concern.[4]

The Society for Acute Medicine Benchmarking Audit (SAMBA) highlights further that the patients stranded in emergency departments, and often AMU, corridors are acute medical patients.[5,6] Often this is misunderstood by operational and political leaders; it is a fundamental concept that needs to be grasped.

Acute medicine practice remains at the heart of mitigating and recovering urgent and emergency care. The fundamental components of the specialty – well functioning, evidence driven AMUs and Ambulatory

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Emergency Care (AEC)/Same Day Emergency Care (SDEC) – alongside enhanced care areas and evolving Acute Medicine led hospital at home models are essential for urgent and emergency care (UEC) and whole system recovery.[7-11] In this issue, Broad et al. write a fantastic piece on the utilisation of point of care ultrasound in an acute medical care hospital at home setting.[12] This epitomises the innovation in acute medicine; changing practice and informing outcomes building on the immense success of FAMUS and other similar programmes. Clinical colleagues need the time, resources and empowerment to research, grow and develop their services;[13,14] an impossibility in the current climate of constant firefighting.

The future of acute medicine is bright. Whilst the trainee survey published in this issue understandably highlights concerns regarding burnout due to the immense pressures currently; many continued to find training in the specialty a rewarding experience.[15] The talent, skills and commitment of acute medicine higher specialty trainees and all members of the acute medicine remains a source of hope for future recovery and a return to high quality care.

Acute medical pressures are at unsustainable levels and current results are scant justice for the teams who continue to strive to deliver reasonable quality of care for their patients. The Covid-19 pandemic and the recent "quad-demic" expose the fundamental lack of capacity in urgent and emergency care systems. Predictable, and non-predictable, periods of excess strain in acute care are inevitable.

There is no magic bullet or quick win solution to the challenges currently faced in urgent and emergency care. Clinically-led solutions are at heart of recovery; but without long-term investment focused on delivering significant increases in workforce and thus capacity; acute medical teams will continue to face the appalling prospect of managing their patients on emergency department and AMU corridors. This cannot be allowed to happen.

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