Community Emergency Medicine: The right care, at the right time, in the right place

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Dear Editors,

The deep, ongoing crisis of Emergency Medicine (EM) is, sadly, a well-recognised problem of the Italian National Health Care System.

As beautifully outlined in the editorial by Coen *et al.*,[1] the systematic disruption of Public Health Care, with progressively more significant cuts to the number of hospital beds and to primary care and community services has irreversibly changed the quality of care we can provide to our patients.

In the unfortunate attempt of finding a quick fix to long-standing, structural problems, the role of Emergency Medicine has been stretched and distorted to such an extent that many of us have been experiencing a profound professional crisis.

We were told that Emergency Medicine is "the most interesting 15 minutes of every other specialty". Indeed, our training is (or should be) focused on becoming highly qualified to care for the "undifferentiated critically ill", irrespective of the cause, before the arrival of any specialist.

From major trauma to cardiac arrest, across the spectrum of shocked patients, nothing can daunt us.

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However, over the past few decades, we have also experienced the deepest dismay of working in a crumbling Health Care System: a mixture of patients with non-urgent, minor issues, elderly and frail patients with multiple comorbidities and inadequate community support, patients affected by chronic health problems struggling to be followed up in the community, all presenting to the Emergency Department (ED), asking for solutions they cannot find elsewhere. That is why we have become a bit of anything and everything: out-of-hours General Practitioners (GPs), social carers and, most of all, helpless witnesses to a system that has failed us all.[2,3]

The situation is not limited to the Italian context, as it is unfortunately spreading across Europe and beyond. However, there are systems where the same hurdles are dealt differently.

After three pandemic waves, I have decided to move from Italy to the UK for a bit of fresh air. Having worked as an EM consultant in a busy ED in Northern Italy for the past three years, I felt disheartened and drained. I had lost my mojo, still I was not ready to give up. After all, we have the most beautiful job in the world.

Once in London, I discovered the situation was not dissimilar to my home country, but for one thing: Emergency Medicine physicians are still empowered to drive the change. And they embrace the challenge.

They make the motto "anyone, anything, anytime" true by finding alternative ways to deal with non-urgent issues, and patients with long-term disabilities and frailties. They have truly shifted from asking "What does this patient have?" to the question "What does this patient need?".[4] This is called "holistic care", and this is one of the core qualities that differentiate EM from other specialities.

This fascinating vision has been declined into different, new models of care, one of those being the Physician Response Units (PRU).[5,6] The underlying concept is intuitive, yet fascinating. The current operating model of the PRU involves a rapid response vehicle, a senior emergency medicine doctor (consultant or high-grade trainee) and ambulance clinician who attend emergency calls in the pre-hospital setting. The service sees patient of all ages with a variety of emergency presentations, truly representative of cases encountered in ED, including situations of socio-economic deprivation with difficulties to access primary and social care. By bringing senior decision making to the community and keeping the patient's interest and well-being at the center, conveyance to hospital is only one of the outcomes a PRU consultation may lead to, most of the time after the appropriate treatment has been started and a direct referral to the receiving hospital or specialty team has been made by the PRU doctor. Alternative solutions are non-urgent referrals to out-patient services (including delayed radiological investigations and medical review), initiation of treatment and follow-up in the community (via GP or community nurses), referral to social services and, last but not least, prompt initiation of end-of-life care management, whenever deemed necessary.

Some colleagues may consider this shift from dealing with the hyper-acute, life-threatening conditions toward this more comprehensive approach to the "generally-unwell" patient as a betrayal of the true mission of EM physicians. However, PRU is not merely a way to avoid unnecessary hospital admissions. Its aim is to bring a unique set of skills and senior expertise where and when it is most needed, keeping the patients' values and autonomy at the heart of what we do. Some of our interventions may not be life-saving, but they are surely quality-of-life preserving. And there is nothing more rewarding and meaningful than realizing we can make a real difference to our patients' journey.

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