Current Trends and Issues in Emergency Medical Care

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General Trends

In the last 20 years, we have witnessed the growing importance of emergency rooms in community health care, particularly in large metropolitan areas. Almost imperceptibly at first, and then with incredible momentum, public demand for urgent and emergency medical services expanded with population growth and the disappearance, maldistribution or unavailability of family physicians.

The impact was felt by metropolitan teaching hospitals and by private and community hospitals in cities, towns and rural areas, particularly in the evenings and on weekends and holidays when the incidence of highway and home accidents, family quarrels and alcoholism reached unprecedented levels.

Overworked family physicians began to depend more and more upon emergency rooms to cover their off-duty hours while patients became less inclined to bother their physicians after office hours. It seemed also that more and more patients had no particular family doctor and arrived in the emergency room without being referred there. In many non-teaching and private hospitals it became necessary to employ full-time emergency room physicians in group practice arrangements which usually specified that patients were to be referred back to their own doctors for after-care and continuing medical supervision. Since family physicians could now direct their patients to emergency rooms without fear of offending or losing those patients, the presence of full-time physicians in the emergency rooms increased rather than decreased the work load. Administrators accepted or encouraged this trend to ensure income from emergency services adequate to cover the remuneration guaranteed under contracts with the emergency room physicians.

This arrangement, by and large, has worked well at the non-teaching institution and represents a distinct improvement over the earlier situation in which physicians on the hospital staff, or with hospital privileges, took turns to cover the emergency rooms. In some rural areas and even in towns of considerable size, the emergency room of the local hospital even now is supervised only by a nurse who often has difficulty finding a physician for an emergency, particularly when the patient wants his own doctor. This situation is becoming a subject of public concern as evidenced by articles in newspapers and magazines questioning the idea that medical care in the United States is uniformly of high quality.

Problems of the Teaching Hospital

Whereas non-teaching institutions were generally able to renovate or rebuild their emergency rooms and staff them with experienced, full-time physicians, teaching hospitals usually had to accommodate the augmented work load in aging and disreputable facilities while continuing to depend for staffing upon interns and residents, for whom the experience is essential.

The revamping of emergency services in private hosptials often affected a teaching hospital, located in the same area, in two major ways. In the first place, the teaching hospital enjoyed a temporary decline in the emergency work-load; there was at least a decline in the rate at which patient visits had been increasing up to that point. In most instances the respite was brief because population growth and other factors continued unchecked. In the second place, the overcrowding and unpleasant atmosphere in the teaching hospital's emergency rooms contrasted so markedly with the dignity of the private hospital's emergency service, that the more affluent and medically insured members of the community began to avoid the teaching hospital altogether. In numerous instances the teaching hospital

experienced a disproportionate rise in the percentage of indigents in its patient population with serious implications for its financial well-being, its educational programs and job satisfaction among its employees.

When conditions in the emergency rooms preclude the entry of an appropriate variety of patients into the hospital, the repercussions are many. Students and housestaff may gain experience predominantly with patients lower in the socio-economic scale and with the patterns of disease and psychosocial maladaptation in that group. Opportunities to diagnose and treat early disease, to enter into intelligent therapeutic planning with receptive and educated patients, to practice preventive medicine and to participate in elective surgical procedures decrease as the emergency rooms deal overwhelmingly with indigent patients, with advanced disease among the elderly, with the recurrent problems among the chronically ill, with alcoholism and all its attendant problems, and with the injured. A dearth of paying patients wreaks havoc with an institution's financial picture and precipitates many administrative headaches, not least among which is the lack of money for emergency room reconstruction.

In some centers the pressure from emergency admissions is so great that the availability of hospital beds for elective procedures has been reduced to an intolerable level; orthopedic services and training programs may be cited as examples, for it is not uncommon to find this department almost wholly preoccupied with trauma surgery.

Morale among the nurses and job satisfaction for other employees may suffer when a hospital's inpatient population is largely indigent, elderly, and chronically ill. Patient turnover rates may also decline when disposition and discharge arrangements are blocked by social and economic difficulties, and the hospital takes on many of the characteristics of a nursing home.

The Teaching Hospital's Role in Community Health Care

As a result of these problems, teaching hospitals have begun to examine their role in community health services. Arguments in favor of even greater involvement with the health needs of the community are supported by the thesis that teaching hospitals, insofar as they may be supported by tax revenues, represent public investments in health care facilities and have an obligation to yield to the pressures. Counterarguments view the teaching hospital as a source of future physicians and advances in medical science from which the public benefits ultimately, and stress that unlimited patient care is not the primary objective of an educational institution.

It is becoming increasingly clear that a teaching hospital cannot provide unlimited patient care, or assume responsibility for the entire indigent population, without going bankrupt or neglecting its educational objectives. In cities without municipal or county hospitals, the teaching hospital cannot bear the burden without assistance from local government, public health departments and existing government or voluntary agencies for health, welfare and family services. It must look to these agencies to provide nonemergency services elsewhere, to operate first-aid stations and satellite clinics in needy areas, and to subsidize the costs of indigent patient care. The burden is not easily shifted to these agencies, however, if they lack the necessary funds. In other instances the complex array of overlapping and underlapping health and welfare services make coordination, effective cooperation and area-wide planning very difficult.

Some Solutions for Teaching Hospitals

Meanwhile, teaching hospitals have had to be content with some reorganization in their emergency services without outside help. It has seemed inappropriate to employ full-time physicians in their emergency rooms because of the conflict with intern and resident training and traditional departmental prerogatives. Supervision of the emergency rooms has had to be vested in one or more faculty members or a committee of representatives from each of the major clinical departments. Neither arrangement has proved entirely satisfactory. A faculty surgeon gains little academic satisfaction from full-time supervision of an emergency service if this prevents him from doing major surgery. An internist may have little interest in surgical or obstetric emergencies and is likely to be less qualified in these areas than the residents whom he is required to advise and teach. Committee control is often unsatisfactory because departmental interests are allowed to override the well-being of the entire emergency service. Not many teaching hospitals have conferred departmental status upon the emergency service because this arrangement, again, is not in keeping with traditional academic organization.

Specialization of Emergency Rooms

One avenue out of the dilemma which, incidentally, improves patient care, is to abandon the older concept of a general emergency room for adults, children, pregnant women, alcoholics, psychotics, and the injured as well as the sick. The emergency service can be divided into separate, specialized receiving rooms, each under the full control of the corresponding clinical department. This arrangement does not necessarily require a central receiving room or triage station from which patients proceed to the appropriate emergency room. A very satisfactory system has been devised at the Medical College of Virginia

wherein ambulance personnel do most of the screening. Children are taken directly to the pediatric area, pregnant women to the obstetric receiving room and injured patients to the surgical suite. Somewhat arbitrarily, it was decided that patients with chest pain should be brought to the medical suite and those with abdominal pain or bleeding to the surgical area. In actual practice this has presented no problem because the different emergency rooms are near one another and patients are transferred quickly should they arrive initially in the wrong area. Separate receiving rooms for alcoholics and psychotic patients are envisioned at this institution but, for these patients, a preliminary medical evaluation will probably be necessary in the medical emergency room to rule out associated organic disease.

As each clinical department develops its own emergency service, further refinements become possible. A special trauma unit can be separated from the general surgical area; in the medical area, special receiving units can be developed for patients with serious cardiac and pulmonary disease, as extensions of the respective in-patient, intensive care units for those diseases.

The "Instant Care" Concept For Non-Emergencies

In order to protect the specialized emergency rooms from misuse, patients with non-emergency problems can be seen in a special "drop-in" or "instant consultation" clinic located conveniently near the emergency rooms. Operating around the clock, seven days per week, this clinic can provide adequate diagnostic and treatment facilities for any patient who believes that his symptoms may be serious. For this clinic to remain fully functional, patients must be referred subsequently to an appropriate setting for after-care—either their own family doctors or an outpatient clinic. If the patient's illness turns out to be more serious than thought initially, he can proceed to the appropriate emergency room.

Supporting Services

The specialized emergency rooms and the "instant care" clinic function much more smoothly if they are served by a central x-ray department and clinical pathology laboratory in which only emergency procedures are performed. Chest x-rays, urinalyses, blood counts, blood urea nitrogen, blood sugar and serum amylase measurements, electrocardiograms and other important tests should be available within minutes to allow adequate preliminary evaluation.

Pharmaceutical supplies should be restocked daily by a pharmacist; the variety of drugs and solutions kept on hand can be reduced to a minimum. Physicians and nurses should neither fill prescriptions nor hand out free samples. For those patients who cannot get to a pharmacy, small supplies of prepackaged drugs can be given out, properly labeled, to tide them over until a pharmacy can be reached. Aspirin, Darvon®, Benadryl®, Phenobarbital, Hydro-Diuril®, Dilantin®, Digoxin, Kaopectate®, Paregoric, Tedral® and Aminophyllin suppositories are some of the preparations which can be supplied to patients in this way.

Sterile trays and instruments should be obtained from a central sterile and supply area so that the washing, packaging and sterilization processes are eliminated entirely from the emergency areas.

Similarly, there ought to be an appropriate division of labor among dietetic assistants, housekeepers, attendants, aides, transport personnel, clerks and unit managers to free nurses and physicians from paramedical tasks such as filling out requisitions, ordering diets, restocking supplies, cleaning and other maintenance duties, answering telephones, making clinic appointments and so on.

Improvements in Patient Care

In each of the separate emergency areas, patient care can be studied and improved when it is recognized that each step in patient care is susceptible to critical evaluation. Reception, registration, the medical interview, the physical examination, the formulation of a provisional diagnosis, the use of special tests to verify or amplify the diagnosis, the initiation of treatment and the formulation of an appropriate plan for admission or discharge and after-care, must each be evaluated for efficiency, acceptability to patients, cost, duration and appropriateness. Improvements can then be achieved in each step by eliminating factors which cause delays, misunderstandings, poor coordination, mistakes, inappropriate and wasteful use of personnel or equipment, poor patient-staff relationships and inappropriate staff responses or behavior.

The reception process may be cited as an example. The goals of this step are (a) to welcome the patient and those who accompany him; (b) to evaluate quickly the seriousness of the emergency; (c) to get the patient effectively into the registration process, or to bypass that step if circumstances demand it; (d) to give those with the patient the information they need about waiting and parking facilities, public conveniences, telephone facilities and sources of refreshment; (e) to prevent relatives and friends from entering and overcrowding treatment areas; (f) to keep relatives and friends informed about the patient's progress and the anticipated duration of his stay; (g) to get medical attention for relatives who become faint or hysterical; (h) to guide relatives to the patient's bedside at the appropriate time and to terminate visiting privileges discreetly so that treatment can proceed; (i) to comfort bereaved and anxious relatives and identify the need for a chaplain's services; and (j) to engage relatives or friends in

helpful activities such as recruiting blood donors, guarding the patient's valuables or making important telephone calls for him. The simple step of clearly separating reception from registration, and of employing a trained, mature receptionist who can endow the service with friendliness, understanding, sympathetic help and dignity, can remove many of the difficulties encountered by relatives in busy emergency rooms and effect a marked reduction in the incidence of complaints.

Similarly, the whole system of patient care can be speeded up and endowed with qualities which bespeak the personal interest of the staff. Personnel reeducation and training, the elimination of noise and confusion, and the logical delegation of responsibilities are some uncomplicated remedies which can be instituted.

How Much Care?

The idealists among us, who advocate comprehensive medical care for each patient in the emergency room setting, would subject patients to complete medical, social and psychological evaluations regardless of the presenting complaint. In practice, patient resentment runs high when physicians, social workers and nurses engage in seemingly unrelated interrogations and examinations despite their best intentions. It is probably better to bear down on the presenting problem in as thorough a manner as possible while remaining sensitive to the other needs which can then be dealt with in an appropriate clinic. For example, the asthmatic attack must be broken in the emergency rooms but exploration of the psychic, social and allergic background can be deferred to a more appropriate time and place.

Some of the confusion and congestion in emergency rooms results from policies which permit nonemergency work, elective procedures, delays in admitting patients to hospital beds, and lengthy observation periods. These practices tie up beds and stretchers and prevent the staff from concentrating on emergency work. Unfortunately, bed and nursing shortages in many hospitals cause a back up of patients in the emergency rooms and make it even more necessary that policies concerning admission and observation of patients, and elective procedures, be devised and adhered to strictly to keep stretchers vacant and the staff available for new emergencies.

The emergency service must maintain a state of readiness at all times for civil disturbances and other disasters that can occur suddenly.

An advantage to having separate, specialized emergency rooms is that the surgical suite and its associated trauma unit can be relieved instantly of all routine work when a disaster occurs, since patients can be transferred immediately to other emergency rooms. The most serious, salvageable casualties can be dealt with in the surgical area while minor wounds and injuries can be treated in the medical, pediatric and obstetric receiving rooms if necessary.

Predictions for the Future

It is likely that emergency rooms will play an increasingly larger role in the delivery of health services. Though efforts are under way to build new medical schools and enlarge existing ones, to graduate more physicians and encourage them into family practice, to train physician's assistants and more paramedical personnel, and to employ computers in multiphasic screening operations and other medical activities, there are reasons to view the future with apprehension.

Medical school curricula and housestaff training programs continue to emphasize specialization; there is no evidence yet that training programs for family practice, and specialty certification in that field, will satisfy the Nation's need for general practitioners. Population growth alone is likely to aggravate the present shortage of physicians, nurses and paramedical personnel because none of the remedies are being implemented on a large enough scale. There is ample reason to suspect that the proportion of aged and chronically-ill persons in the population will increase and that many of the disease-producing elements in our environment will continue unchecked.