

Organisation of the emergency care chain in Spain or the search for the missing links

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The emergency care chain in Spain is currently a mere chimera. It consists of a series of links that are basically the continuous care in out-of-hospital posts (CCP), the Emergency Care Teams (ECT) and the hospital Emergency Departments (HED). This chain has the important aim of ensuring that quality emergency care is provided to citizens in a nimble, effective and efficient manner. In order to perform optimally, these links must be properly connected and in gear. However, in practice, the emergency care chain in our country is an abstract entity with a large margin for improvement due to multiple factors¹. The links have themselves and among them, different organisation models, different administrations, different functional plans, different information systems (very frequently not linked among them) and... "different differences" that mark their heterogeneity which is frequently described in literature^{2,3}. Besides, the link receiving more users, HEDs, are frequently overcrowded, due more to external factors but also because of intrinsic ones.

However, there are solutions for this bleak situation and one is the integration of the different links that interact in the emergency care chain which, in itself, constitutes a differentiated level of healthcare. In this issue of EMERGENCIAS, García Bermejo et al⁴ evaluate an integrated management model for the different emergency care areas of a Healthcare Department with the HEDs and the CCPs in Primary Care, including a new link: the integrated health centre (IHC). Moreover, in their model, they include current elements present in the 21st century HED such as a structured triage system, fast response centres and the computerisation of information systems. Among the results obtained, a 30% reduction in the fre-

quency of attendance to the HED stands out due to the IHC's capacity for response. This proves that integration of emergency care services results in at least a more adequate redistribution of healthcare needs. In the current healthcare system, the deficiencies in each of the links in the emergency care chain – which depend on different Administrations – are minimised or toned down frequently by attributing the cause to the next link. As we can observe, a large percentage of attendances to the HEDs – up to 40% with low priority levels – are health problems that could be solved within the primary care system, by attending with a regular appointment or by visiting a CCP. In fact, ICHs in the García Bermejo et al⁴ study are just what every health centre or at least every CCP should be in terms of resources and capacity of response. Otherwise, the usual overcrowding would have no solution and we would need HEDs that are increasingly more optimised, not just in terms of structure but also in relation to human and material resources, for treating not only emergency healthcare problems but also to continue to be, in part, true "hospital health centres with a zero delay". Besides, all of this would go to the detriment of the clinical capacity of primary care doctors – whose specialisation training has already been increased by one year – who are more and more focused on the implementation of health programmes with very low impact in the population's health and in bureaucratic tasks that occupy a considerable amount of their working time⁶.

HEDs constitute the link of the emergency care chain in which most healthcare processes end. For the general public, HEDs are the paradigm of overcrowding, collapse and chaos. However, this

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does not seem to put a limit on the number of attendances, as their progressive increase shows⁷. On the other hand, although both the high number of attendances and the inadequacy of resources in HEDs to manage them – with inadequate services to support emergency diagnosis causing delays⁷, insufficient staff, excessive support needs from doctors who are normally inexperienced, etc.^{8,9} – are relevant factors that have an effect on HEDs, there are external factors that seem to contribute more to explain the collapse or overcrowding in HEDs³. In these situations, we are not really stopping patients from entering but we are rather blocking their exit through long stays in the HED, mostly waiting to be admitted. Paradoxically, we look for survival solutions – as a ventricular escape rhythm in an AV block – from inside the HED and not from the outside, which would be the reasonable thing to do. In this sense, in this issue of EMERGENCIAS, Sánchez et al³ present an excellent review of organisational changes in HEDs¹⁰ and alternative options to hospitalisation – which can be dependent or independent from the HED itself – that have been carried out in the search for solutions, none of which has been successful despite virtually all of them entailing a costly increase in resources. These fruitless efforts made by the healthcare administrations are a reflection of the fact that healthcare managers attribute the cause of the problem to deficiencies in the HED itself and not to inadequate planning of hospital resources. Regardless of the HED being a bottleneck that takes in a large amount of the healthcare system's deficiencies and where users go in search of solutions that they frequently find – otherwise they would not attend massively – the collapse or overcrowding of the HED is a problem of the hospital and not of the HED. An adequate planning of scheduled admissions – it is paradoxical that peaks in emergency care demand coincide with peaks in scheduled activities in hospitals – an adequate management of outpatients departments, a planning of the number of available beds for emergency admissions that are perfectly predictable or possible to schedule¹¹, would largely mitigate the mini-disaster situation that the HEDs experience on a daily basis.

The everyday fight for survival in HEDs has a high cost that should not be ignored. Besides compromising healthcare quality¹², it has direct repercussions in the most important element of the department, which is the staff. In addition to the repercussions in their effectiveness and efficiency, the continuous feeling of frustration that

frequently affects HED staff turns everyday work into a hardly bearable burden that has clear effects on their quality of life and that prevents scientific and technical development of the professionals and of the Department itself. Despite all of this, the fact of surviving indicates that “if there's a will there's a way”, which was the slogan for our recent national conference. We must also highlight that this paradigmatic image of chaos does not help in the case of medicine students and junior doctors who, while having a vocation for emergency medicine, do not accept to always be surviving as they might have other professional and personal expectations. This can compromise the generational refill and produce generational leaps in professionals of HEDs that would not contribute to their progress and improvement.

The future of HEDS, the future of the emergency care system and the future of the emergency care chain in Spain will undoubtedly include interventions in different areas – professional, academic and institutional– which, starting from the unavoidable creation of the specialty of Emergency Medicine, constitute a teaching body that finally leaves powerpoint and printed text and forms a reality that makes the complex gears of emergency care organisation stop creaking and start working in a nimble and effective manner with the perceived quality that not only users but also surviving professionals expect and demand.

The point is not adapting and of course it is not surviving. The point is thinking seriously about a strategy aimed to finally consolidate an Emergency Medicine in Spain which is not only “surviving” but that is properly structured and resourced and that lets its professionals “live and progress”. We will now keep searching for the missing links.

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