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Emergency medicine scenarios: Where do we stand?

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"Wide open entrance, probably open all the times, leads us to a congested room with a counter and a bed at the side. The counter is busy admitting patients for different wards and the bed stands single and naked without even an oxygen cylinder beside it. To our surprise this emergency runs without an endotracheal tube or a cervical collar." This was the picture one month back of the emergency department of Koshi Zonal Hospital, Biratnagar. It is a 333 bedded hospital with about 445 staffs in total. And this is probably the best of the emergency services provided in the three zonal hospitals of eastern Nepal.

The history and development of Emergency medicine

Emergency medicine is a field of practice based on the knowledge and skills required for the prevention, diagnosis and management of acute and urgent aspects of illness and injury affecting patients of all age groups with a full spectrum of undifferentiated physical and behavioural disorders. It further encompasses an understanding of the development of pre-hospital and in-hospital emergency medical system and the skills necessary for this development[1]. The basic principle is being available at any time for any patient for any complaint.

Emergency Medicine as a discipline does not have a very long history. It was between 1950's and 60's that a group of physicians, mostly located in mid western U.S.A. realised that the procedures and techniques developed for the injured during the Korean and Vietnam war could be used to save hundreds of people back home. Thus the concept of emergency care came into being. But it was only in 1989 that emergency medicine became a primary speciality in medicine in the U.S.A.[2]

In these 40-45years Emergency Medicine has evolved to a great extent. It is now one of the most popular components of healthcare system in developed countries. Three models of Emergency care system have been recognised. The most commonly practiced is the speciality model where doctors become trained to be specialist Emergency physicians to look after the emergency department. In other model called super specialty model, specialists from other departments are trained in Emergency medicine and they take care of their cases in a separate section under the emergency department. And there is a multidisciplinary model where specialists from other departments work partly for the emergency department. Depending upon the resources, different models are being practiced in different counties and centres.

Multidisciplinary model does not recognise emergency medicine as a separate speciality. Other specialists like the surgeons, physicians and anaesthesiologists divide their time between emergency and their department. This is comparable to the emergency practice in big centres of Nepal. It doesn't help much the process of training, education and research in emergency medicine and so is waning out.

Super specialty model is in practice at places but it requires resources and expertise beyond the scope of developing countries. It may somehow apply to big national centres but it is hard to justify a whole team of different specialties just waiting in emergency in medium centres. It further raises questions about who will look after the whole patient and refer the cases to concerned department. In this complex process of referral patients are likely to suffer and fall pray to the tendency of avoiding. As an example, if epigastric pain is always shown to the surgeon first, some of the MI patients are likely to die while waiting to be referred. Further, since the specialties are expected to be more devoted to their own specialty, the development of emergency medicine as a specialty is not ensured.

The specialty model answers most of these questions. First, patients presenting to hospitals with undifferentiated acute medical conditions receive emergency medical care from physicians who are predictably competent in the management of all types of medical emergencies. Second, healthcare systems only have to provide one group of physicians for the management of all medical emergencies 24 hours per day.

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Third, the recognition of EM as a medical specialty helps to attract students and retain practitioners, which provides the necessary leadership and manpower to improve emergency care delivery systems. Finally, the academic recognition of EM helps to supply the healthcare system with EM specialists who can then improve EM research, education, and training. The specialty model is the most rapidly spreading model in the world today[3].

Countries all over the world are in different stages in the development of emergency care systems. A number of countries still have along way to go to establish an emergency care system. Depending upon certain criteria like national organisation, recognition as a speciality, ongoing residency training in emergency medicine, publication of journals, the qualification of staff physicians and department head of emergency, pre hospital care system etc. they have been divided into 3 stages, underdeveloped, developing and mature[3].

It has been observed that development of emergency care system follows a certain pattern. Initially a group of people trained in emergency care establish an emergency department in the country; an emergency physician society is formed. They now work for the recognition of emergency medicine as a separate specialty and residency training is started. And finally the national emergency care system is established.

Emergency care system in Nepal, where do we stand?

Moving back to the scene described at the beginning of the essay, the situation in our country is bleak. The organisational emergency care system as defined and as it has been established internationally is certainly underdeveloped. Even in established centres, emergency cases are looked after by a house officer or a family physician. However, most centres in the country are run by health assistants or even less qualified ones. An objective assessment of the quality of emergency care in centres all over the country would pull the curtain off the appalling situation. In spite of its immense importance, the component of emergency care is very much lacking in the national health care system.

Almost all emergency centres in the country are bare rooms which are not even capable of securing the airway. Lack of resources and paucity of physicians is the readymade answer, but not enough to explain the situation of centres like Biratnagar zonal hospital. The answer rather is that the emergency services have not been given enough importance in the national health care system. It was the same in other parts of the world, which have changed, but we remain at the same place. For a breakthrough there should be a group of health professionals trained in emergency medicine, from within or outside the country to advocate for development of the specialty and the service.

Much can be done with what is available. It would be too late if we were to wait for enough physicians to be produced to reach every nook and corner of the country. Short term training courses can be of great help. Emergency staff in all important centres will have to be trained. No doubt, small efforts will bring about significant change. Taking, for example, Koshi Zonal Hospital, the emergency is currently best functioning as a centre for admission and observation. It is plain that the hospital administration has regarded it as less significant than other parts of the hospital. It is mandatory to manage it as a clean, closed compartment for emergency cases, with properly placed triage bed, resuscitation trolley, basic emergency drugs, instruments, appliances, and emergency laboratory services. It cannot be called an emergency centre unless it can secure airway, breathing, circulation and prevent the disabilities when possible. It is very sad to know that this emergency department is unable to intubate a patient in case of immediate need. We can imagine how other emergency departments of the country are probably managed. There is no value of minutes and seconds in these centres, they are emergency departments in name only and the meaning of emergency is entirely lacking.

As the awareness among the public is rising and the number of patients seeking emergency care increasing speedily, the need of emergency services will keep on mounting day by day. And soon the public will become aware that they have been deprived of the genuine emergency care.

Thankfully, situations are not similar everywhere. The emergency centre in the B.P. Koirala Institute of Health Sciences can be seen an example for the whole country. The only other hospital to use a triage system is Patan Hospital, which has one of the best managed and efficient emergency care centres in the country today. Various hospitals in the valley are providing good service. Probably, the future of emergency care in Nepal is being groomed in these exemplary hospitals. But this is hardly significant for the country as a whole. The hospitals that come in contact with the cases first, should be equipped and enabled. Let's hope that in the near future we will be able to observe the establishment of the first

residency training programme in emergency medicine; a new vista which will open up newer horizons.

References

1. International federation for emergency 1991
2. http:// www.dcmsonline .org/jax-medicine / 1999 journals/march99/erhistory.htm
3. http://www.Medicine.com/emerg/topic/839. htm