

Emergency Medical Help and Role of Emergency Physicians

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Abstract

Emergency or Urgent medical help, and sometimes the Emergency Services, is a special form of health care whose main feature is outpatient care with the aim of providing the necessary and indisputable medical help. Not providing any form of emergency would harm the health or cause permanent damage to health and endanger the life of the patient. Emergency operates in accordance with laws and regulations on health care and health insurance. It is a necessary component of the health system in each country in the world.

Injuries are the leading cause of mortality in people aged 20 to 40 and the third leading cause of death in all age groups. A quick initial assessment of the injured person and the proper conduct of first aid measures for the management of life-threatening conditions can greatly reduce mortality and invalidity caused by injury. Injuries can be frightening and can distract the members of emergency services from those conditions that directly endanger the injured person and are not visible at first glance. Therefore, access to the injured person must be fast and secure, and a review and assessment of the condition and the provision of the necessary first aid to the injured person requires a standardized approach so as not to overlook the situations that directly endanger life.

Keywords: *Emergency; Healthcare; Patient*

Introduction

An emergency is commonly defined as any condition perceived by the prudent layperson-or someone on his or her behalf-as requiring immediate medical or surgical evaluation and treatment [1]. On the basis of this definition, the American College of Emergency Physicians states that the practice of emergency medicine has the primary mission of evaluating, managing, and providing treatment to these patients with unexpected injury and illness.

So what does an emergency physician (EP) do? He or she routinely provides care and makes medical treatment decisions based on real-time evaluation of a patient's history; physical findings; and many diagnostic studies, including multiple imaging modalities, laboratory tests, and electrocardiograms. The EP needs an amalgam of skills to treat a wide variety of injuries and illnesses, ranging from the diagnosis of an upper respiratory infection or dermatologic condition to resuscitation and stabilization of the multiple trauma patient. Furthermore, these physicians must be able to practice emergency medicine on patients of all ages. It has been said that EPs are masters and mistresses of negotiation, creativity, and disposition. Clinical emergency medicine may be practiced in emergency departments (EDs), both rural and urban; urgent care clinics; and other settings such as at mass gathering incidents, through emergency medical services (EMS), and in hazardous material and bioterrorism situations.

In healthcare delivery, we attempt to meet the health and medical needs of the community by providing a place for individuals to seek preventative medicine, care for chronic medical conditions, emergency medical treatment, and rehabilitation from injury or illness [2]. While a healthcare institution serves the community, this responsibility occurs at the level of the individual. Each individual expects a

thorough assessment and treatment if needed, regardless of the needs of others. This approach is different than that practiced by emergency managers, whose goal is to assist the largest number of people with the limited resources that are available. As such, emergency management principles are focused on the needs of the population rather than the individual. When either planning for a disaster or operating in a disaster response mode, the hospital should be prepared at some point to change its focus from the individual to the community it serves and to begin weighing the needs of any individual patient versus the most good for the most patients with scarce resources. Moving from the notion of doing the most for each individual to doing the best for the many is a critical shift in thinking for healthcare institutions considering a program of comprehensive emergency management. While the initial planning for emergencies by hospitals is focused on maintaining operations and handling the care needs of actual or potential increased numbers of patients and/or different presentations of illness or injury than is traditionally seen, there is also the need to recognize that at some point during a disaster, act of terrorism, or public health emergency there may be an imbalance of need versus available resources. At this point the approach to delivering healthcare will need to switch from a focus on the individual to a focus on the population. This paradigm shift is one of the core unique aspects of hospital emergency management that allows the hospital to prepare to maximize resources in disasters and then to know when to switch to a pure disaster mode of utilizing its limited and often scant resources to help the most people with the greatest chance of survival.

The healthcare delivery system is vast and comprised of multiple entry points at primary care providers, clinics, urgent care centers, hospitals, rehabilitation facilities, and long-term care facilities. The point of entry for many individuals into the acute healthcare system is through the emergency department (ED). Since the late 1970s, the emergency medical services (EMS) system has allowed victims of acute illness and injury to receive initial stabilization of life-threatening medical conditions on the way to the emergency department. Among the many strengths of the ED is the ability to integrate two major components of the healthcare system: prehospital and definitive care. The emergency department maintains constant communications with the EMS system and serves as the direct point of entry for prehospital providers into the hospital or trauma center. Emergency physicians represent a critical link in this process by anticipating the resources that ill and injured patients will need upon arrival at the ED, and initiating appropriate life-saving medical care until specialty resources become available. In this context, the healthcare system is an emergency response entity.

Patient conditions

In most emergencies there is no time to disclose the necessary information for an informed consent [3]. Here the providers simply act according to what they think will be in the best interests of the patient. These situations frequently happen in hospital emergency rooms and when emergency medical personnel arrive on the scene of an accident or sudden illness.

The emergency exception to informed consent is often quite obvious, but this is not always so. It does not apply, for example, when personnel taking care of somebody in an emergency happen to know what the patient wants. In such a situation they would not do what they think is best for the patient but what they know the patient wants.

It is important to note that the emergency exception that allows physicians to do what they think is best for the patient without obtaining informed consent from the patient or proxy has one major restriction; namely, they cannot do what they think is best if it is otherwise than what they know the patient or proxy wants. Sometimes, for example, emergency department personnel might know from previous admissions that a particular patient from a local nursing home desires only palliative care. If that patient arrives by ambulance at the same emergency department, it is hard to see how it would be morally reasonable for physicians to take aggressive measures to keep the patient alive when, even though there is no time to obtain consent for orders not to attempt resuscitation or not to intubate, they know he or she or a proxy has decided not to have aggressive life-sustaining measures performed.

Patients accessing emergency care services can present with complaints that are extremely diverse, and the way doctors, nurses and paramedics elicit information from patients predominantly focusses on obtaining biomedical details [4]. In some cases, this approach is warranted, as the urgent need to identify signs and symptoms of life-threatening illness or injury is paramount. Yet, 90% of patients accessing emergency services are not critically ill or injured but seek help and advice. In addition to seeking advice, patients may also be anxious, frightened, intoxicated, misusing drugs or have unhealthy lifestyles. They may have psychosocial reaction to physical disease or

vice versa - physical illness such as irritable bowel syndrome, asthma, tension headache can be triggered by psychosocial factors. The effects and interpretation of illness will trigger a different response to the individual depending on their view and experiences. All these factors will have different needs and concerns and it is important to elicit these concerns within a consultation. However, it has been found that nurses working in emergency care disregard the potential for anxiety and the need for support and reassurance in patients who are not severely ill or injured. In addition, where communication skills of junior doctors working in emergency departments have been researched, they are found to use approaches considered to be more physician/illness orientated than patient-centred. By way of similarities of patient presentations in the pre-hospital setting, this could equally be assumed for paramedic practice.

Emergency department

The emergency department occupies a key position in terms of the interface between primary and secondary care [5]. It has a high public profile. Many patients attend without referral, but some are referred by NHS (National Health Service) Direct, minor injury units, general practitioners (GPs), and other medical practitioners. The ED manages patients with a huge variety of medical problems. Many of the patients who attend have painful and/or distressing disorders of recent origin.

Priorities are as follows:

- To make life-saving interventions.
- To provide analgesia.
- To identify relevant issues, investigations, and commence treatment.
- To decide upon need for admission or discharge.

A principal focus of the ED is to provide immediate resuscitation for patients who present with emergency conditions. In terms of sheer numbers, more patients attend with minor conditions and injuries, often presenting quite a challenge for them to be seen and treated in a timely fashion. Different departments have systems to suit their own particular needs, but most have a resuscitation room, an area for patients on trolleys, and an area for ambulant patients with less serious problems or injuries. Paediatric patients are seen in a separate area from adults. In addition, every ED requires facilities for applying casts, exploring and suturing wounds, obtaining X-rays, and examining patients with eye problems.

Prehospital care

Prehospital care by EMS personnel is a delegated medical practice [6]. EMS systems must retain a physician who is legally responsible for clinical and patient care aspects of the system. The medical director, in conjunction with local and state entities, develops and oversees training programs and clinical protocols and authorizes EMS personnel under his or her direction. He or she participates in personnel and equipment selection, directs the quality improvement and quality assurance programs, provides direct input into patient care, and is a liaison between the EMS system and other health care agencies. The medical director is the ultimate authority for all medical direction.

Medical direction may be described as online or offline. Online medical communication provides EMTs with clinical consultation in the field via telephone or radio communication with a physician at a base station. Offline medical communication is a function of the EMS organization. Nonphysician prehospital personnel operate under standing orders and treatment protocols developed by a physician medical director that are appropriate for the provider's level of training. These protocols determine the type and level of care administered at the emergency site. Physicians who provide online medical supervision of paramedics from base hospitals may permit paramedics to deviate from established protocols or to provide treatment not specifically covered in standing orders as long as prehospital providers do not deviate from their given scope of practice. The medical director assumes authority for offline medical direction via policies, procedures, standing orders, and field protocols.

Protocols and standing orders are instruments developed and approved by the medical director to instruct and guide prehospital personnel. As every system is different in its composition, geographic coverage, and capabilities, there is no ideal set of protocols or standing

orders that can be applied broadly. The breadth and depth of the protocols are most dependent on the system's ability to monitor the care given.

Clinical decisions

Clinical decision rules are practical tools intended to assist us in deciding whether a diagnostic test is needed, or what the likelihood is for the presence or absence of a particular disease or condition [7]. They are designed to be simple and provide a practical decision-making guide to differentiate patients who require testing or treatment from those who do not. Clinical decision rules typically include at least three elements from the patient's history, a physical exam, and simple ancillary tests that can guide us at the bedside in the emergency department or in the office. Decision rules are derived using a series of research studies on a specific clinical question. They then must be validated and tested in a different population. Each step in the derivation, validation, and external testing of a decision rule involves specific study designs and statistical analyses. At each stage in the development process, aspects of exactly how the study was conducted (i.e., the patient population tested and specific outcomes) impact how the rule should be interpreted and used in clinical practice. In this chapter, we describe the steps researchers take to derive (generate) and validate (show that it works) clinical decision rules.

Crime victims

Forensic emergency medicine is the application of forensic medical knowledge and appropriate techniques to living patients in the emergency department [8]. Patients with penetrating trauma will seek care in the emergency department; they are usually not victims of happenstance or accident, but of malice and intent at the hands of assailants. This phenomenon reflects a major change in our society's interactional dynamics. Given this new reality of our patient population, physicians must practice medicine-trauma medicine, in particular-in a new way, with attention to details heretofore overlooked. What was once considered confounding clutter that gets in the way of patient care (such as clothing and surface dirt) takes on a whole new significance when recognized for what it really is-evidence.

Traditionally, emergency physicians and nurses have been trained in the provision of emergency medical care without regard for forensic issues. In the process of providing patient care, critical evidence can be lost, discarded, or inadvertently washed away. Victims then lose access to information that can be of critical significance when criminal or civil proceedings arise secondary to their injuries.

Emergency physicians and nurses, by design and default, evaluate and treat people with gunshot and stab wounds and victims of physical assault, sexual abuse and assault, domestic violence, and motor vehicle crashes. All of these patients have injuries or conditions that have criminal or civil forensic medical implications and the prospect or specter of courtroom sequelae. A patient's emergency medical evaluation must be detailed and the documentation comprehensive. Comprehensive documentation ideally contains three components: narrative, diagrammatic, and photographic. The failure to document clinical findings comprehensively may have far-ranging consequences for a patient, an accused suspect, and, potentially, the treating physician.

The forensically untrained emergency physician or nurse may easily overlook and inadvertently destroy evidence, both gross and trace, in the course of providing patient care. The emergency care provider may misinterpret physical injuries and evidence, and form an inaccurate opinion as to their cause. Such opinions, when recorded in the patient's emergency department chart, may pose a considerable problem for the patient, the court, and the emergency physician if circumstances progress to legal proceedings.

Responsibility of the physicians

The duty of care is a physician's obligation to provide treatment according to an accepted standard of care [9]. This obligation usually exists in the context of a physician-patient relationship but can extend beyond it in some circumstances. The physician-patient relationship clearly arises when a patient requests treatment and the physician agrees to provide it. However, creation of this relationship does not necessarily require mutual assent. An unconscious patient presenting to the ED is presumed to request care and the physician assessing such a patient is bound by a duty of care. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires ED physicians to assess and stabilize patients coming to the ED before transferring or discharging them. Such an assessment presumably creates the requisite physician-patient relationship.

When caring for a patient, a physician is obligated to provide treatment with the knowledge, skill, and care ordinarily used by reasonably well-qualified physicians practicing in similar circumstances. In some jurisdictions, these similar circumstances include the peculiarities of the locality in which the physician practices. This locality rule was developed to protect the rural practitioner who was sometimes deemed to have less access to the amenities of urban practices or education centers. However, the locality rule is being replaced by a national standard of care in recognition of improved information exchange, ease of transportation, and the more widespread use of sophisticated equipment and technology.

Establishing the standard of care in a given case requires the testimony of medical experts in most circumstances, unless the breach alleged is sufficiently egregious to be self-evident to the lay jury member—for example, amputating the wrong limb or leaving surgical implements in the operative field. A physician specializing in a given field will be held to the standard of other specialists in the same field, rather than to the standard of nonspecialists.

To be eligible to receive federal funds such as Medicare and Medicaid, hospitals with an emergency department must offer emergency and stabilizing treatment services to the public without bias or discrimination [10]. The Emergency Medical Treatment and Active Labor Act is a comprehensive federal law that obligates hospitals offering emergency services to do so without consideration of a patient's ability to pay. It's important to note that this obligation does not apply to inpatients or non-emergent conditions. The absence of bias in the delivery of care should not be misunderstood to suggest all hospitals must provide all medical services, but rather the services they choose to offer must be delivered without bias to the individual patient.

A hospital and its entire staff owe a duty of care to patients admitted for treatment [11]. Following an emergency call, the ambulance service has a duty to respond and provide care. Accident and Emergency (A&E) departments have a duty of care to treat anyone who presents themselves and are liable for negligence if they send them away untreated. Hospitals without an A&E facility will display signs stating the location of the nearest A&E department. This ensures that the hospital could not be held negligent if a patient presented and required emergency treatment as the hospital or its staff had never assumed a duty of care. Once a patient is handed over, a duty of care is created between the patient and the practitioner and this cannot be terminated unless the patient no longer requires the care or the carer is replaced by another equally qualified, competent person. It is therefore extremely important that practitioners are aware of their local policies, professional standards and their scope of practice to avoid becoming liable for litigation by putting a patient at risk, delivering ineffective care or breaching their duty of care.

Conclusion

Emergency implies urgent medical care of people who have a direct life threatening to their life, body or body parts or in which where they could come to the life threatening situations in a short time with a goal of maximally shortening the time from the occurrence of an emergency to the beginning treatment, or to refer to further treatment. One analysis of emergency medical services showed that the ratio between urgent medical cases and those who are not is 20% : 80% in favor of cases that are not urgent, and as a result of the usual opinion that the emergency medical service is doing everything: examination of the throat, rinse of the ears and blood pressure control, etc. With the elimination of non-urgent conditions, the emergency medical team has deprive coming-out for necessary intervention, thus reducing the chance of healing and surviving those who need medical help at that moment.

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