Just three things...

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As I was preparing to begin a leadership role in the Department of Emergency Medicine in a tertiary hospital in Atlantic Canada, I was asked by a colleague to name just three things that I thought would improve emergency medicine (EM) and the emergency department (ED) significantly? Wow. Just three things? How could I possibly distill the complexity of emergency care, the multiple teams, the many interactions, the multiple committees, groups, papers, the hundreds of protocols, and the significant problems we face...into just three things?

I am not sure that it is possible, but after much thought, I propose that the following three principles, if followed, would take us a long way toward a place where EM could regain much of its lost functionality.

I believe that if we had

1. The space and resources to allow us to do our jobs;
2. The appropriate skillset and ongoing education to maintain our skills; and
3. More empathy for our patients and our colleagues

that emergency care would flourish.

Fantasy or achievable reality? Why spend hours chasing the un-catchable, climbing the unassailable?

However, I believe that, while almost universally problematic, each of these principles can be achieved. What we need are leaders, within and outside EM, to make some brave decisions to begin the process.

Every system needs flexibility, a pressure valve, capacity to deal with surges. Unfortunately, in the modern hospital system, it seems that the flex-zone is often to be found at, or

just inside the front door. While perhaps this is reasonable in the setting of a restaurant, where potential diners wait for a table to open up, it is certainly not appropriate in a system where those arriving have undifferentiated problems, have had minimal to no assessment of their condition, and where no treatment has been initiated. Yet, those patients who have a clear diagnosis, have been receiving treatment for several days, if not weeks, and who are stable, somehow take priority over those with the much higher uncertainty and risk at the front door. It would be like allowing diners to stay at the table even though they had finished their meal, paid their bill, and were now just waiting for the movie to start, while other stomachs rumbled in the foyer! We can of course improve our efficiency within the foyer, providing menus and taking orders, but diners really want a table. So how to improve this universal problem? Move the flex-zone. Open up more tables or decrease the table bookings during busy periods. In the hospital? Boarded patients in the ED account for less than 2% of hospital beds [1], yet in that high-flow, high-risk setting, the loss of even a few open beds cripples the ability of emergency teams to do their job. So why concentrate that flex-zone in the ED, backing up into the waiting room and the ambulance bay, putting the highest risk patients in danger? Why not spread out the surge capacity throughout the facility, placing one extra patient in each inpatient unit, gently moving patients with less risk to an alternative space [2], or even arrange for them to go home earlier? I have no idea! It makes little sense to me. Someone must see great logic in it though, as it is common practice in most hospitals.

Space is not everything though, and there is a danger that we in EM focus on crowding as the cause of all poor care and undesirable outcomes. What about our skills? Are we adequately trained for the job of modern emergency practice? With increasing complexity of disease, advanced procedures and perhaps at times less access to immediate specialty support, can we honestly look at the minimum

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standards for privileges to work in an ED and say they are OK? This is political; however, I have no political interest in this topic. I do however have a strong interest in ensuring that the patients in our departments are cared for by team members with appropriate skills. I will not stray beyond the physician training lane, and I fully respect the varied paths we have all taken to reach where we are as emergency physicians. However, can we not agree on what it means to be an emergency physician? What is a reasonable approach to residency training? What should be required for ongoing skills maintenance and quality assurance, maybe even quality improvement? The Collaborative Working Group (CWG) on the Future of Emergency Medicine in Canada [3] made a united call for increased residency training positions in EM and a recognition that EM certification was desirable, although there was no consensus on a common training pathway, even in the future, to attain that status. Worse, this call has not been embraced by workforce planners or health authorities when setting minimal recruitment standards. Why not? Money and politics, I must conclude. Do we believe we have a specialized skillset over and above general practice or not? If we do, why can we not agree to require that level of training for those whose hands patients put their lives into? Now, I am not so naïve to think that a certain number of hours or years training or a particular certificate actually proves competence—a clear reason why we are moving towards competency-based residency assessments. Yet unless we set some standards of certification in EM and provide a reasonable timeframe for current and future emergency physicians to attain those standards, we will continue to have too many cases where we will lament “if only he had been trained in advanced airway skills” or “if only she had been aware of that condition.”

Finally, empathy. Where does it come from? What is it worth? Well, for some it may be their natural state, for others a learned behaviour [4]. For all of us it is an essential component of that ideal person we need to try to emulate to provide optimal emergency care. Empathy for our patients. Empathy for our colleagues. Empathy for our team, and for other teams we interact with. When we cease to care, patients

loose out. They sense it. And most likely the “care” they get is below par. Sure, the prescription might be reasonable, but was the explanation, the reassurance, the consideration of the patient’s fears? And with our colleagues and teams? The culture of criticism that often accompanies loss of empathy, often labelled ‘burnout,’ spreads quickly, destroying trust, impairing improvements in care, eating away at the soul of the group. And yet, acts of empathy (deliberate acts) are like seeds that can flourish and grow to replenish the barren emotional desert we so often find ourselves working in. A ‘thank you.’ A ‘how are you?’ A silence or even a positive comment when criticism and gossip is being passed around. Deleting the passive aggressive, or even aggressive email. Slowly, positive acts and truly caring for each other can transform a culture and re-engage burned out, tired team members, creating the environment for better performance, better care, a better patient experience and happier teams in the emergency department.

So, perhaps I am dreaming. However, it must be worth giving these three things a shot, right? I mean, it can’t hurt? It’s just three things...

Compliance with ethical standards

Conflict of interest The author declares no conflict of interest.

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