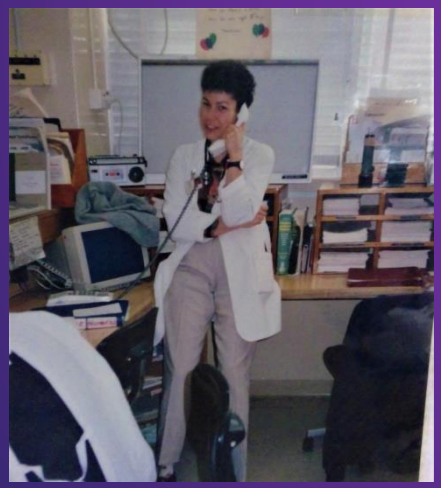
O U T S I D E.....

....looking in

Sue Ieraci Nov 2019

My story

- NSW public hospital medicine since 1983
- FACEM since 1990
- Vancouver, Canada 1990
- HOD 1990s, ACEM Council and VP 1990s
- Medical Regulation
- Health system consultant



2018: Community Emergency Medicine

Disclosure: I do casual work for myemergencydr.com but have no financial interest in the group

Can you do EM outside ED?

- Triage
- Initial assessment and stabilisation
- Specific treatment
- Disposition

- Disaster management
- Policy-making

Casemix: Is there a “true ED patient”?

- Even in major urban EDs, resuscitation makes up less than 10% of cases
- Bread-and-butter of ED work: assessment and risk-evaluation in relatively stable people with acute or acute-on-chronic symptoms

Triage and urgency

- ATS hijacked and distorted by vested interests and risk aversion.
- In the real world, a same-day response is ‘urgent’, and a two-hour response is ‘super-urgent’.
- Very few patients who are initially physiologically unwell will deteriorate significantly within 2 hours – much less 30 mins.
- What is required urgently is medical assessment and alleviation of anxiety, not necessarily emergency treatment.

  There IS a true, major overlap between emergency medicine and general practice, though EM is much more episodic and injury-orientated.

- Chest pain, back pain and hypertension are also managed in general practice every day, with GPs of varying risk-tolerance also making variable percentages of referrals to ED.

What characterises EM expertise?
What is our role as EPs?

- Rapid risk assessment for THAT PRESENTATION
- Definitive diagnosis not always possible – or necessary
- Understand pathophysiology very well
- Understand risk assessment very well

Therefore can :

- come to conjoint risk-management plans with patients
- minimise wastage of scarce resources

EPs have a unique role and skills in:

- seeing both the very unwell and the very stable patient with symptoms, know how to distinguish them.
- Can establish a relationship with a patient very quickly, making quick decisions on the basis of incomplete information

Community emergency medicine allows us to do is to respond urgently to concerns and symptoms without putting all-comers on the ED investigation treadmill.

The institutions we work in can distort our rational risk assessment

- Institution's risk management practices: can be more about risk to the organisation than risk to the patient
- Our short snapshot of time with the patient and relative isolation from the community: can lead us to think that all possibilities must be excluded in a short period of time.

Reality in the community:

- Many benign symptoms get better in time, and
- Diagnoses can be distorted if based on a short part of the course of the condition

Reality in ED: over-testing and over-diagnosis

...and...

- Patients presenting by ambulance may have an unconscious incentive to remain unwell

Risk-Tolerance and Risk Transfer

- In the hospital, referral and admission transfers the risk to the inpatient teams

- In community emergency medicine, emergency physicians can comfortably accept risk, in agreement with patients and families
- This is a valuable service and requires skill

Bringing EP skills to the RACF and UCC

- Backs up on-site nursing staff
- Overcomes the unnecessary transfer policy

-> increase the sense of safety of patients and colleagues
avoid further transferring risk to other services

Avoid over-diagnosis and over-treatment

- Explain the pathophysiology of hypertensive disease as a chronic rather than an acute condition
- Reassurance acts as a better antihypertensive than any drug
- No need for cannulas or bloods or emergency treatment and their complications

Frustrating things about hospital EM

- Bed block
- Time imperatives
- Playing to the KPIs
- Reluctant inpatient teams
- Risk-averse “risk management” system

....not the patients!

Can we separate the EP from the ED?