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EDITORIAL

Paediatric emergencies: Two ideas for reflection..., two challenges☆

Urgencias pediátricas: dos reflexiones..., dos retos

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An appropriate organisational response to the demand of the population in the area of emergency care is an issue that still needs to be addressed in Spain. The high level of visits to hospital emergency departments (EDs) and other after-hours clinics, in many cases to the point of saturation,[1] are the tip of the iceberg, evidence that there is considerable room for improvement in the operation of the service and the structures responsible for responding to this demand. When we seek to identify the reasons for this situation, a very often mentioned point is inappropriate use of EDs. A number of factors associated with the possible inappropriate use of emergency medicine have been described, including demographic variables such as age, educational attainment and socio-economic level, factors related to healthcare organisation, state of health and contextual circumstances (distance to the hospital, day of the week, time of visit), so-called ''perceived need'' or the culture of immediacy, and the type of demand (higher level of inappropriate use in spontaneous visits).[2] Given the validity of these arguments, and with a view to finding solutions, it seems reasonable that all groups, and therefore professionals, involved in the area of emergency care should reflect on the situation and propose actions for improvement. In this issue of ANALES DE PEDIATRÍA, Rivas García et al.[3] describe a state of affairs that goes beyond ''mere inappropriate use'' of emergency departments. Thus they put forward the concepts of frequent and super-frequent use registered in 5 hospitals in the Autonomous Community of Madrid in the course of a year. Out of the total number of patients, 40% were classified as ''frequent users'' (2–9 visits/year) and 0.60% as ''super-frequent users'' (10 or more visits/year), and these two groups together accounted for over 118 000 visits. A significant feature of the profile of super-frequent patients is that they commonly visit the emergency department during the evening shift for a low-complexity acute condition for which they have not previously consulted their health centre. This last point raises a first idea for reflection. Why does it happen? As the authors point out, it does not follow from their results that the quality of primary care is one of the factors for reducing overuse of EDs. There is, of course, no doubt about the professionalism of primary care paediatricians and their ability to treat this type of patient, and yet the fact that such patients do not consult them beforehand is a very common and widespread phenomenon.[4] In our view, as a first step to the problem, the overall lack of resources in the area of primary care, with particular emphasis on the shortage of paediatricians, and the limited availability and distribution of patient consulting hours in the non-hospital setting – evenings, nights, weekends and public holidays are the times when the saturation of EDs is at its greatest – are two factors for which improvement actions could be taken. Therefore, if we are clear that we must expect and ask users to use healthcare resources rationally by visiting the facility recommended for addressing their concern, we must be able to offer them suitable alternatives to avoid this inap-

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propriate and indiscriminate use of EDs. In addition, turning to more specific issues, good coordination between the various points of care is undoubtedly essential; setting up joint committees with the hospital, making it possible to have single shared medical records, doing shifts and rotations at the hospital to foster knowledge of both healthcare levels, standardising action protocols (''they will give you the same tests at the hospital as at the health centre''), providing greater access to diagnostic tests outside the hospital and establishing clear criteria for referral between the various healthcare levels are also cornerstones of the improvement process.[5] It is certainly a great challenge, a first challenge.

In another study in this same issue, Parra Cotanda et al. contribute their experience on ''Patient experience in emergency departments'',[6] taking this to mean the sum of all the interactions produced by the culture of an organisation that influence the patient's perceptions throughout the health care process. This concept goes beyond what is conventionally referred to as ''satisfaction'', linked almost exclusively to finding out whether patients' expectations regarding their treatment and healthcare have been fulfilled. Moreover, what undoubtedly makes this manuscript more interesting is that the perception of the patients' ''experience'' is related by the actual protagonists, the children and adolescents (aged 8–18 years) themselves, through pre-validated questionnaires. This initiative is clearly in line with the concept of family-centred care, which is particularly important in a setting like emergency care, where rapport between professionals and patients and/or their caregivers is essential to decision-making. This sensitivity to making sure the user experience is appropriate can be extrapolated, in my view, to most EDs, and this is certainly the result of changes in the healthcare model of those EDs. Clearly, EDs are undergoing organisational changes, albeit more slowly than we would wish, whether these are driven by necessity or by conviction for improvement, in the sense of equipping them with specialists in paediatric emergency medicine exclusively or primarily dedicated to this activity, which undoubtedly results in more motivated and better qualified professionals, and consequently in a clear improvement in health care delivery. It is difficult to understand the fact that emergency care, which is a recognised speciality in many countries and therefore has its own body of doctrine, is currently carried out to a greater or lesser degree by other specialists, excellent in their own field, more or less sporadically, ''motivated'' solely by employment obligation or extra pay. Parents who attend a cardiology or endocrinology clinic, for example, expect to find a specialist there to offer a response to their consultation. It seems logical to suppose that when these same parents attend an ED, they have similar expectations, and we must therefore fulfill them.[7] And this point also gives rise to a second idea for reflection. If the objective is for the experience of patients and their families to attain the level that we all want and that our patients, young or older, deserve, it is essential to provide EDs with the best possible resources, and to structure them like any other service, taking account of their special nature in providing uninterrupted care 365 days per year, and thus achieve an organisational model that makes it possible to tackle this type of care in a way appropriate for both professionals and users. This requires gradually introducing the concept of professionalising the workforce and evolving from the traditional notion of ''doing shifts'' as a sporadic job to ''working in the emergency department'' as a basic activity, with the enormous advantages this entails for all concerned. We face another challenge here, the second challenge, and in this case, moreover, the will of the healthcare authorities to promote this evolution is indispensable. If they do so, they will be living up to the saying that ''emergency care is a major part of the hospital's image and must be looked after''. Now is a good time to put it into practice.

Beyond specific reflections and challenges, the problems of paediatric emergency care that I referred to at the beginning of this editorial are a complex subject, raising very specific issues and requiring a manifold approach. All of us who are involved in the process must and do have something to say and do about it.

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