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, 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). 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 PEDIATRIA, Rivas García et al. 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. 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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appropriate and indiscriminate use of EDs. In addition, turning
to more specific issues, good coordination between the vari-
ous 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. 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 emer-
gency departments”,4 taking this to mean the sum of all
the interactions produced by the culture of an organisa-
tion 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 ful-
filled. Moreover, what undoubtedly makes this manuscript
more interesting is that the perception of the patients’
"experience" is related by the actual protagonists, the chil-
dren 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 particu-
larly 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 activ-
ity, which undoubtedly results in more motivated and better
qualified professionals, and consequently in a clear improve-
ment 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 spo-
radically, "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 sim-
lar expectations, and we must therefore fulfill them. 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 tradi-
tional 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 pro-
 mote 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 begin-
ning 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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