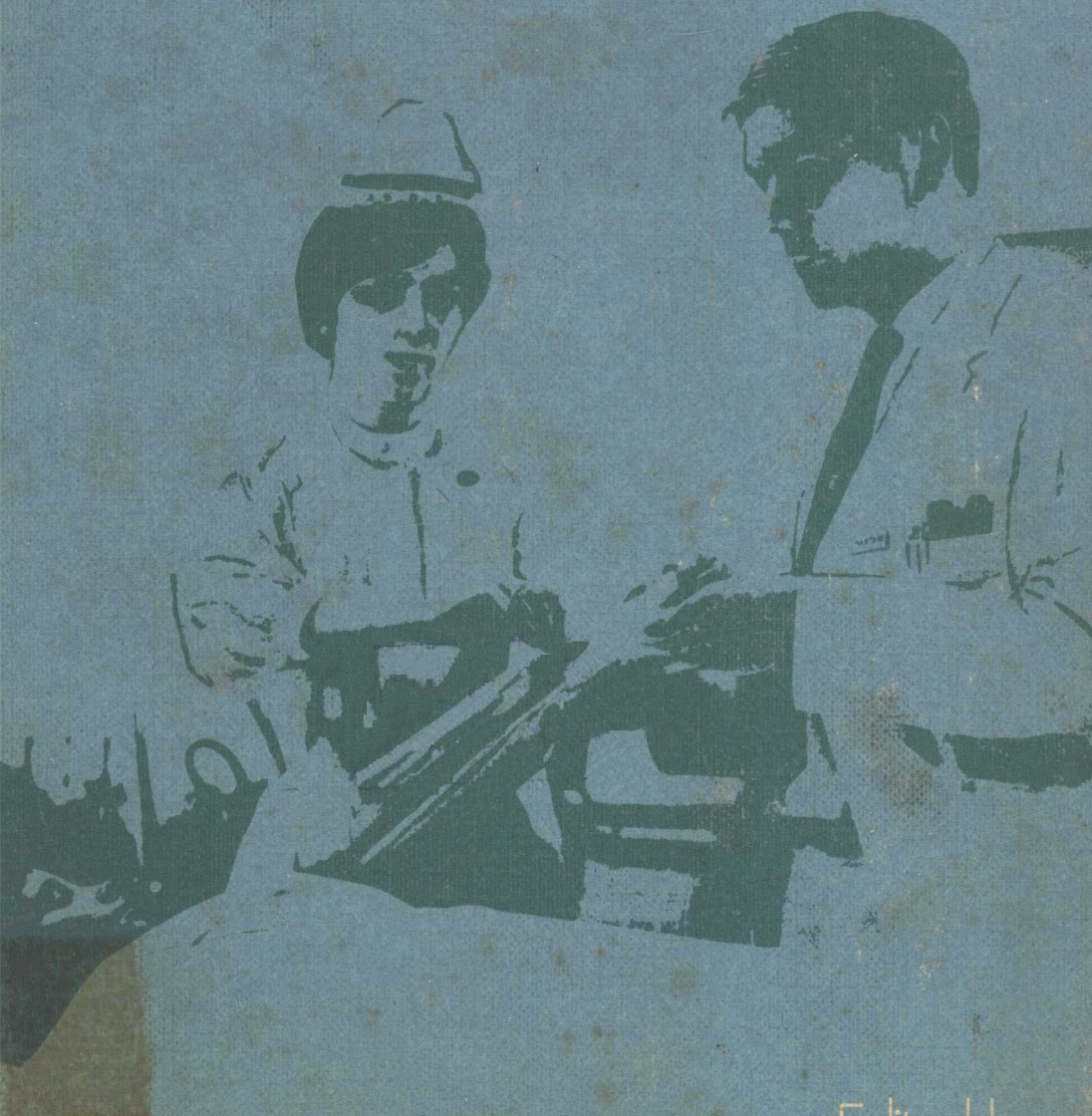
2nd Edition

Emergency-Room Care

By 26 Authors



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Care SECOND EDITION

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Preface to the Second Edition

Emergency departments of general hospitals have assumed positions of increasing importance in the delivery of medical care in this country since the first edition of this book was written. The need to provide increased medical service has resulted in expanded facilities and led in many hospitals to the appointment of a corps of full-time physicians in an effort to meet these requirements. No specific educational program has yet been evolved to provide a background adequate to carrying out satisfactorily the functions of an emergency-room physician. For this reason we believed it important to revise this book, as well as to correct deficiencies present in the first edition and to bring it up to date. Several chapters have been entirely rewritten and a new chapter on drug abuse has been added for obvious reasons.

Albany, New York C. E.

Preface to the First Edition

This manual has been prepared for the use of professional personnel working in the emergency rooms of general hospitals. It may also prove to be of some value to hospital administrators. In it we have attempted to provide a guide to current emergency-room practice, using as a model experience with the care of patients in the emergency room of The Albany Medical Center Hospital. It is believed that this experience is reasonably typical of that in most general hospitals throughout the country, since our institution serves a dual function: as university teaching hospital and as community hospital. Furthermore, the community has no city- or county-supported hospital.

The authors have chosen for the most part to avoid lengthy discussions of alternative methods of management in the belief that by simply giving the particular method preferred in our own institution they will increase the value of the book as a ready reference source. However, we acknowledge a priori that valid differences of opinion may exist.

Much of the material contained in this book has received practical trial by our own house officers. We are grateful for the suggestions offered by these critical young men. We are also grateful to Mr. Fred Belliveau of Little, Brown and Company for the helpful advice he has given in the book's planning and preparation.

Albany, New York C. E.

Emergency-Room Care

Contents

Introduction

CHARLES ECKERT

Public demand for care in emergency departments of general hospitals has increased tremendously in recent years. A number of factors are responsible for this; among these are: the shortage of physicians in family practice, increased awareness on the part of the public of the possibility of obtaining medical care in emergency rooms when a family physician is not available, and a population increase with no lag in the accident rate.

Many patients presenting in the emergency room have problems of chronic disease or trivial illness. The former, after careful screening to exclude urgent problems, should be given an early appointment in the outpatient department, while the latter should be given appropriate medical advice and sent home. Surprisingly, despite an increase in the above categories, the number of patients requiring immediate admission to the hospital also continues to rise. In many hospitals this has resulted in a shortage of beds available for elective admission. In teaching hospitals this disproportion can have deleterious effects on the educational program. It can also have a harmful effect on public relations.

The increased number of patients to be seen may make it impossible to render adequate service without the expansion of both personnel and physical facilities. A lag periodically occurs between the increased demand for service and ability to provide it. In the case of the emergency room, such a lag is likely to be disastrous because of

reduced efficiency of patient care and subsequent criticism by the public of the institution as a whole. Perhaps in no other area of hospital operation is the interface between the hospital and the public so thin. Prolonged waiting, delays in obtaining roentgenograms, or the impression that another patient has been improperly treated is likely to create a poor image. Realizing that the voluntary hospitals in this country up to the present time have been largely dependent upon the goodwill of the public for many phases of their funding, we feel it is particularly important for hospital administration to interpret correctly the changing trends in order to reduce the periodic "lag phases" to a minimum.

In hospitals that are departmentalized, the increase in nonsurgical cases seen in the emergency room has brought about a reorganization with involvement of all departments in the responsibility for the full operation of the emergency room. Insofar as possible, this has been coordinated with the outpatient department for the study of those patients needing investigation that can be conducted on an ambulatory basis. It is to be emphasized that no patient who comes to the emergency room seeking medical attention is referred to either the outpatient department or his private physician without a careful screening examination in the emergency room, including studies deemed necessary on an emergency basis.

The distinction between private, semiprivate, and ward patients is rapidly disappearing with increased government involvement in medical care. We maintain a panel of staff members from all departments who are willing to care for those eligible patients who request a private physician but do not have one who is a member of our staff. Patients eligible for private medical care who do not wish a private physician are assigned to the member of the staff currently consulting on the teaching service in the specialty in which the patient falls. They are thereafter treated as teaching patients, with the staff physician having final responsibility for their care, a situation in no way different from the management of other patients in the teaching environment.

Although the increased utilization of emergency-room facilities is due to a great extent to the increase in patients with medical illness, there has been a constant rise in surgical patients as well. The frequency of serious accident cases, involving multiple organ systems in particular, is greater with each passing year. The trend toward specialization in surgical practice creates a situation in which the patient with multiple injuries is likely to have multiple physicians, each car-

ing for his special area of interest without assuming overall responsibility for the patient. The priorities for definitive treatment are determined by the comparative threat to the patient's life, and as such should be well defined. Our solution to this problem is to assign patients with multiple injuries to the general surgical service or to a private practitioner of general surgery, as the case may be. Either assumes responsibility for requesting consultations, assigning priorities, and for the overall care of the patient. With this system problems seldom arise. In this manual, reference to the securing of consultation with representative specialists has been intentionally omitted for the most part, but the reader will understand that in each instance consultation is obtained as necessary. The securing of multiple consultations, unless they are immediately available, which is seldom the case, sometimes causes undue delays in the initiation of treatment or disposition of the patient. These delays are avoidable by the assumption of responsibility for decision on the part of the senior resident staff physician or the physician in charge of the emergency room.

On occasion, patients are seen in the emergency room who have been transferred from the emergency rooms of other hospitals. When this is done, proper notification of the transfer should be given. It is also essential that a record accompany the patient, containing pertinent information concerning the previously obtained history and physical examination, laboratory reports, and any medication or other treatment which may have been given. If roentgenograms were obtained, the actual films should accompany the patient with the understanding that they will be returned as soon as they are no longer of use.

A final word is necessary concerning the advice and instruction given to patients by the emergency-room physician. Complete explanations in nontechnical language, preferably in words of one syllable, should be given. The physician should never assume, on the basis of a patient's education, work in a scientific field allied to medicine, or seeming comprehension, that any detail will be logical and obvious to him. It is in just such patients that the possibility of misinterpretation or illogical behavior is greatest. All instructions should be clearly explained and set down on paper as well, and in readable script. A copy of the instructions should be placed in the record.

Planning and Operation of the Emergency Room 1

JOHN H. CARTER

Two great mistakes are made in the organization and management of emergency rooms. The first is attempting to do too little, and the second is attempting to do too much. To chart a safe middle path it is important that fundamental decisions be made early to define the scope of activities of a given emergency room. These decisions will depend to some extent on the size and type of hospital involved, the available hospital personnel, the type of community (metropolitan, urban, or rural), other available medical facilities, and medical personnel in the community. To avoid doing too little, an emergency room must be capable of managing at all times such true emergencies as cardiac arrest, airway obstruction, crush injuries of the chest, life-threatening external blood loss, shock, and so forth. The greater problem for emergency rooms today is to avoid trying to do too much. Strict regulations *prohibiting* the use of the emergency room for minor elective surgical procedures, or for emergency surgical procedures which require general anesthesia, or for elective medical, pediatric, or psychiatric work will do much to alleviate the problem. The most effective way to avoid overuse of the emergency room is to provide outpatient clinics elsewhere in the hospital to handle the increasing number of patients presenting themselves in emergency rooms throughout the nation who, in fact, are not true emergencies but come to hospital emergency rooms for lack of other medical facilities.