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The Future of Emergency Medicine: Through the Front Door and Beyond the Emergency

Department

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1. Introduction

Emergency Medicine (EM) is a unique specialty, which is extremely dynamic and progressive. The practice of EM very much reflects the community or city where it is located. The patient and staff profile are usually representative of the area and community. The spectrum of diagnoses too is closely linked to the incidence and prevalence of diseases in that community. Not forgetting that the culture of the institution or department where EM care is delivered does go hand in hand with local practices (culturally driven). All these makes EM very adaptable, exciting and challenging at the same time [1]. Despite being a very young specialty since its recognition in 1979 (or even later in countries that formally adopted EM much later on), [2] EM practices have continued to be very progressive and continue to evolve with the times. The recent Covid 19 pandemic illustrated how adaptable and nimble EM practice has to be in order to quickly manage, ring-fence and provide the necessary frontline care [3].

2. The Beginning and The Evolution

At its onset, the practice of EM was tinged with some territorial issues. This stemmed from the fact that as more structured and formal training became established and more Emergency Physicians (EP) attained qualifications, a larger variety of diagnoses and cases could be managed upfront. [1, 2] For example:

a. EPs would manage Paroxysmal Supraventricular Tachycardia in

the Emergency Department, observe for recurrence and then discharge the patients with outpatient Cardiology follow up as needed. The same goes for mild heart failure and a few other Cardiology diagnoses, which does not require admission.

b. EPs begin to manage serious diagnoses like Acute Pulmonary Edema, providing the definitive airway and admitting the patient to the Coronary Care Unit, without having the Cardiology doctor coming down to the ED

c. More and more acute, simple fractures were managed with manipulation and reduction followed by immobilization in the ED, after which patient would be discharged with Orthopaedic follow up

d. Uncomplicated foreign bodies in the eye, ear, nose and throat could also be managed by EPs instead of calling upon Ophthalmologists or ENT (Ear, Nose and Throat Specialty) doctors

These examples serve to illustrate the “territorial issues” where EPs now manage many acute diagnoses across many disciplines and specialties. Whilst it was initially viewed more negatively, today this has positioned EM at a central core; coordinating, unifying and collegially working with the other specialties, utilizing bilateral or multilateral clinical pathways and protocols for standardization and streamlining of patient management. EM is well positioned to lead Inter-Professional Collaborative Practice (IPCP), especially in large institutions and Academic Medical Centres. It

is standard practice today to have EPs lead in Acute Stroke Teams and Multiple Trauma Team, working together with other appropriate specialties. [3, 4] This is also why EP are well placed in many communities of practice. The practice of EM has also now evolved to enable EPs to lead in Disaster and Mass-Casualty management and incidents, Toxicology and poisoning management and even Hazardous Materials (HazMat) management. Even Geriatric care, Palliative care and End of Life discussions have now been thrust forward, making it necessary for EPs to take on an expanded role in leading such discussions, up front [5, 6].

In Medical Education, EM has also led the way with its many hands-on, immersive training. Teams based education is also a forte for EM, especially due to the unique nature of the practice. In many countries, EM represent one of the disciplines that is the “early adopter” of technology. The Covid 19 pandemic provided the “push” for this and many innovative technologies have now become the norm in EDs. Algorithmic pathways, Artificial Intelligence (AI) and Technology Enhanced Learning (TEL) are all now more widely used in EM for clinical decision support, triage, administrative support, predictive analytics and also diagnostic imaging. In many countries today, EM actively lead in the provision of tele-consult. All these augurs well for the specialty as it moves into the future [7].

Beyond the ED, EM has footprints both upstream and downstream. In the area of Prehospital Medicine and EMS, many EPs are leading these organizations and providing medical oversight. Public health education and public health management also has inputs and contributions from EM. EPs are working in partnership with primary healthcare providers as well as step-down community care facilities to ensure the continuum of care delivery is more seamless, prior, as well as after the ED consultation and management. EM has been leading discussions and making inroads into the issue of bed-block, ED crowding and even surge management. Technology and AI is fast becoming the enabler. EPs across that world are also actively involved in advocacy work, politics, education, research, machine learning, global disaster response and many other new and evolving areas [8].

The mindset of EPs and mental model of the practice of EM has enabled this rapid and progressive development., beyond the ED. The future of EM looks exciting, but remains challenging. Much will also depend on the future generations of EPs as the baton is handed over to them.

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