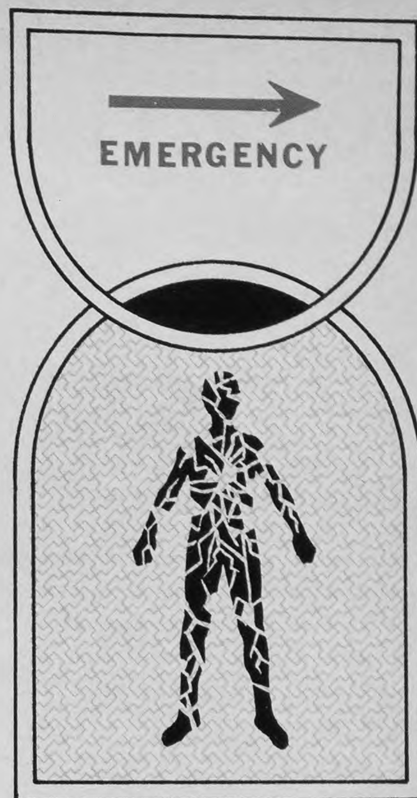

In Defense of the Emergency Room

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A recent position statement in *The Journal of Family Practice* on "The Emergency Room Rip-off" by Dr. Len Hughes Andrus (J Fam Pract 2:147, 1975) uses the terms "inappropriate," "inadequate," "fragmented," "depersonalized," (lack of) "continuity," and (lack of) "comprehensive approach" in relation to emergency care. In my view, there is nothing "inappropriate" or "inadequate" or (un) "comprehensive" in responding to patients suffering from such urgent problems as myocardial infarction, broken bones, laceration, bleeding ulcer, gunshot wound, subdural hematoma, septic abortion, pulmonary embolization, spontaneous pneumothorax, tension pneumothorax, pelvic inflammatory disease, drug overdose, epidemic meningitis, congestive heart failure, pulmonary edema, severe cellulitis, and other emergent conditions. The care of these problems does involve "fragmentation" since the majority of these patients are transferred to the care of the appropriate medical staff member for treatment, resolution and long-term follow-up by specialty or, alternatively, by the physician of the patient's choice. We find in the Emergency Room that we are not knowledgeable enough to render the specialized care demanded by these problems, and further, by becoming involved in inhospital care, we only dilute our time and capabilities from the hordes of people who are knocking down the Emergency Room door to be treated.

There is a great difference between "primary care" and care after-the-fact. Dr. Andrus does not seem to recognize that in spite of the primary care he so romantically espouses, people do become ill, sustain injuries, and even die. Furthermore, after so brazenly daring to do so outside of office hours, patients (failed primary care) have the right to be able to receive rapid and responsive after-the-fact care, and at the time of onset. Not after haranguing some answering service looking for Dr. Houdini who magically evaporates at 5 PM each day, all day Saturday and Sunday, and Wednesday afternoons, leaving absolutely no trace of his presence until office hours again provoke his Christ-like reappearance.

The adage of there being no idea so profound as one whose time has come can easily explain the rapid surge in Emergency Room patronage. Emergency Rooms and their personnel are providing the public with what it is demanding from the medical profession, and not unjustly so. We do see patients with chronic diseases, once, and when their chronic disease is identified, they are referred most positively for continuing care with a private physician. We do see many patients who are strangers. However, not knowing a patient or having just met is not synonymous with "depersonalization." Empathy for and responsiveness to a patient's medical needs is the highest form of personalization.

In the instances where Emergency Rooms are the portal of entry for patients with unmet medical needs, emergency care physicians feel bound by training, experience, and a sense of honor to gain effective and pertinent care for as long as it is required. The only "rip-off" by Emergency Rooms is of the unreal facade of the present fallacy that family practice is all-sufficient.

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