VIEWPOINTS

Hiercorchical organization of hospital emergency departments: a necesary condition for ongoing improvement

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Last October 9, 2014 saw the publication in the Official Gazette of the Generalitat de Catalunya (DOGC) the order[1] that incorporated the resolution adopted by the Board of Directors of the Institut Català de la Salut (ICS) which set out the nature of services by physicians from different specialties, provided certain conditions were met that we will detail later, which ended a long history of doubts and discussions on how to recognize an obvious reality: that professionals who perform their work in emergency departments (EDs) have the same responsibilities as any other department professional and the head of this team of doctors fulfills at least the same functions as any department head, besides those of the coordinator. The reality is that in public hospitals, regardless of the autonomous communities to which they belong, the regulations prevented such recognition, until the publication of this order.

Coordinators and heads of emergency departments in Spain

AAlthough we have no official data, in 2000 the work of Montero et al.[2] was published, containing the results of a mail survey in 1997 of 340 EDs, with a response rate of 56% (190 EDs). This paper shows that 92% of EDs have a specific head and in 52.3% of cases this was the coordinator. Only 29.3% were heads of department. On the other hand, of the 190 hospitals surveyed, 63.7% claimed to have a sufficient staffing to carry out emergency care, although paradoxically higher level hospitals were the most deficient. The profile of these professionals was in 56% of cases a general practitioner (GP) and in 21% a specialist in Family medicine. As for the professional profile of the head of EDs, in 31% of cases this was a GP and in 29.9% a specialist in internal medicine, in 17.2% a specialist in intensive care and in 12.6% it was a specialist in Community and Family Medicine, and in the remaining 9.2% other specialties. O the 190 hospitals surveyed only 35 were and are reference hospitals.

The results of a recent survey (2012) commissioned by the Catalan Society of Emergency Medicine[3] continue to show a situation that is far from optimal. Of the 82 hospitals in Catalonia that have EDs active 24 hours a day, 79 (96%) responded and participated in the survey. Of these, 55 are public use (70%) and 24 private use (30%). The participants' responses indicate that in 69.6% of cases they are organized as a department and 53.2% have a department head, compared to 29.1%, which have a coordinator. Similarly, only 63.3% of those responsible for the ED considered that it had sufficient professional staff, but this is a subjective assessment that does not respond to any standard. Regarding the specialty of ED professionals, family and community medicine (24%) was the majority, followed by internal medicine (16.6%), orthopedic surgery (11%) and pediatrics (9.7%), while 11.3% do not have a specialist qualification.

The emergency departments of the Institut Català de la Salut

The ICS, publicly owned, manages 8 hospitals and 280 primary care teams in Catalonia. The 8 hospitals, 6 of which are university teaching hospitals, are located in the four Catalan provinces and can be categorized into high-tech tertiary

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RECEIVED: 17-11-2004. **ACCEPTED:** 19-11-2014.
CONFLICT OF INTEREST: The authors declare no conflict of interest in relation with the present article.

(Valld'Hebron Hospital in Barcelona, Hospital de Bellvitge in L'Hospitalet de Llobregat and Hospital Germans Trias in Pujol in Badalona), regional reference (Hospital Doctor Josep Trueta in Girona, Arnau de Vilanova Hospital in Lleida, Hospital Joan XXIII in Tarragona) and two nearby hospitals, one of medium size with intensive care (Hospital Verge de la Cinta in Tortosa) and another of smaller size but which serves about 200,000 inhabitants (Regional Hospital of Vilamoura). Overall, in 2013, about 696,568 emergencies were attended, representing about 20% of hospital emergencies in Catalonia, with a distribution that can be seen in Figure 1. It should be noted that in the case of the Hospital Universitario Vall d'Hebron, which attends most emergencies, organizational complexity increases: there are three buildings, with three entrances to different EDs: trauma, maternal and child emergencies, and general emergencies. The staff of physicians who are directly responsible for the EDs varies depending on hospitals, between 14 and 22 professionals. So when we talk about the ICS and its EDs, we are referring to the largest provider of health services in Catalonia, with reference hospitals and EDs of high organizational complexity and a high volume of emergency visits.

The organization of hospitals is regulated by Order No. 621 of 18 November 1985 issued on 4 December of the same year. Later in 1987, 1990 and 1992 partial modifications were made. Therefore, although the ICS is an institution in Catalonia and Spain, the regulatory framework, as in other communities regarding their public centers, is obsolete. Only thus can we explain that the EDs of Spanish public hospitals are not hierarchical. But that does not just affect public hospitals, but also others who, by extension, have fragile organizational structures in the ED, with frequent changes of responsibility, with the difficulty that implies for their doctors to develop a career or to consolidate a care model. These organizational structures are unattractive to attract professionals, who prefer to be integrated in a structured and hierarchical department. That may also explain in part why some doctors who work in the ED do as an access platform to another department or as a transitional stage in their careers.

And what is the critical point that prevents establishing hierarchical EDs? The structure of the department is linked to the existence of the specialty. This is the impediment to normalizing a situation which, obviously, is nonsensical and satisfies neither those responsible for the ED, nor its professionals or the hospital managers, aware of the weakness of the position of coordinator of EDs unless that management itself explicitly reinforces it, or the ability of the ED professional acting as the person responsible for managing a team of professionals without having any intermediary (section head or chief physician) in whom to delegate part of the functions and, in turn, relate to department heads with a higher position and professional recognition.

Modification of the Order

The original text (translated into Spanish by the author) states: "The Institut Català de la Salut can create hierarchical care services when the care activity is that of their own medical specialty." So far the link specialty- hierarchical department. The modification is then introduced after the prece-

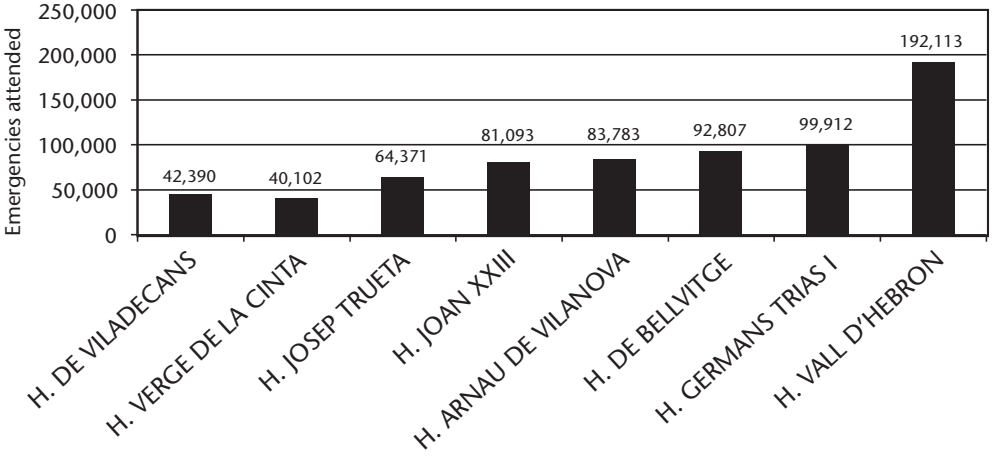

Figure 1. Number of emergencies treated by the emergency services of the 8 hospitals of the Institut Català de Salut in 2013.

ding sentence is added: "One can also create hierarchical departments where care activity is developed through a stable organizational structure with clear care objectives, teaching, research and specific management and appropriate to the service and the care activity undertaken by at least 8 staff physicians with specialties related to the care objectives and able to work permanently in the newly created department."

Notably, the ED is not mentioned in any case. The number 8 is solely to avoid using this Order to form unnecessary microstructures.

On the steps taken which led to approval by the Board of Directors of ICS, with representation of the Ministries of Health and Economics, professionals, local authorities and trade unions and which is the highest decision making body of the organization since its establishment in 2007, it is important to highlight the role of human resources management and legal counsellors of the institution in articulating a text aimed at real change and not a partial solution. Similarly, the president of the Board of Directors and the Managing Director of ICS have played a key role in responding to a technical analysis of the problem and have listened to the professionals involved.

Proposal for continuous improvement in emergency departments of the Institut Català de Salut

However, this process must be contextualized in a proposal for continuous improvement of EDs, where hierarchical structuring is a necessary condition to solidify the possible changes proposed. For example, the work we are currently doing in the ICS, with the participation of all professionals involved, has several essential points. As regards the ED, they are as follows:

1. Hierarchy as a tool to propose and develop a model of care, promote careers, capture talent and consolidate improvements.

2. Organization from triage[5]. Although all EDs covered by ICS have the same triage system, its incorporation into already established structures and still very dependent on other specialties generates dysfunctions which should be corrected.

3. Own ED units. Among them the most important is the observation unit[6], in all its forms, essential for adequate emergency care.

4. Alternatives to conventional hospitalization (UAHC) Units. Among the different UAHC, all short-stay units (ECU)[7,8] of the ICS depend on the ED. The rest of UAHC must have a special relationship with EDs and in turn should be used so that "drainage" is guaranteed, to address one of the critical and major causes of ED overcrowding[9].

5. Teaching and research programs. Although improvement in this regard in recent years is undeniable[10], we can not leave teaching[11] or research to the private initiative of ED professionals.

But we are not just addressing the problem of urgent care from the perspective of EDs. We understand that urgent attention is a transversal and interdisciplinary process that does not start at the time the patient visits the ED, but before. For that reason, we are working continuously to improve, following the model of management by processes[12], establishing the initial limit of the process when any citizen initiates a demand for urgent attention at any point in the system, so that includes community health and primary care. This year, we had the participation of 80 different professionals, who have worked on the critical points with a view to excellence, proposing over a hundred of improvement actions that affect all levels involved (administrative, orderlies, auxiliary nursing technicians, nurses, doctors and managers) and other figures in the system (emergency coordination center, other specialties etc.). Among the proposals there is a plan of clinical quality and safety specifically for EDs. Given the number of emergencies attended in the ED, one priority is clinical safety, so this must be one of the issues requiring greater attention[13,14].

Looking ahead

Given that this problem affects not only Catalonia, this proposed change opens the possibility that other regions can follow suit. That would place us at the level of the more advanced countries[15-17]. This question, which depends on the health authorities of each community, is not a minor issue and deserves respect and reflection. In this regard, the Spanish Society of Emergency Medicine (SEMES) has already expressed the same ideas through its president[18].

Secondly, it is conceivable that in the near future the coveted recognition of the specialty of emergency will occur[19]. If so, for years to come in the ED, professionals from different specialties will continue to work together, so this proposal would also respond to this situation.

Finally, we need to make a few comments on what the role of a head of department should be and what the organizational structure of hospital services in which key processes are performed

should be, such as the urgent care process. The figure of the head of service has evolved from purely clinical leadership (in care, teaching and research) to the current reality, a need for leadership in management of both professionals and material resources. In this line, periodic evaluation is mandatory, so that, in organizations that have a statutory work regime, heads of department with a life tenure are no longer needed. This has already been introduced in ICS hospitals in 2014 and previously in other hospitals with different regimes20. Now it may seem paradoxical that we propose the creation of a vertical organization when we are talking of a transverse process in which other specialties are involved. On this point we would like to point out two issues. On the one hand, we believe that the head of the emergency department must continue his/her coordinating role, since their hierarchical relationship must place him/her above the heads of other specialties whose staff are involved in emergency care. Although hierarchical organizational structures may be more appropriate, as in a clinical management unit (UGC)20, this would be a later step. First we have to overcome a delay of more than twenty years in establishing ED hierarchy. Once this new situation is achieved and the changes are consolidated, those professionals responsible for the ED will be in the same condition as other department heads to accept new challenges.

Therefore, in conclusion, we feel that this is a necessary change, a prerequisite for improving EDs and for other changes that will undoubtedly arise in the near future.

Acknowledgements

To all those who have made possible a change of this nature, especially to all members of the Board of Directors of ICS and its president Dr. Carles Constante, Dr. Pere Soley, managing director of ICS, Eladi Medina, head of the legal counsellors and the other executive committee members of ICS: Pol Perez, Josep Maria Gimenez, Clara Parés and Ramon Ortiz.

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