The Interaction Reform and emergency medicine

The Interaction Reform sets new requirements for cooperation in the field of emergency medicine. This is an excellent opportunity to establish emergency medicine as a separate professional specialisation.

Future socio-economic and demographic challenges will necessitate more efficient operations in the Norwegian health and care services. The Interaction Reform (1) sets the course, and the new national healthcare plan (2) provides the guidelines for how the Government wants to ensure effective and adequate care for patients. Whether this will entail any consequences for emergency medicine depends on how this concept is defined.

In the «Regulations for emergency medicine outside hospitals», emergency medicine is defined as qualified medical diagnostics, counselling, treatment and/or monitoring in instances of an acute manifestation or deterioration of a disease or an injury, including mental disorders, where immediate medical assistance may have a decisive effect on life and health (3). In Norway, emergency medicine is mostly perceived as «blue-light medicine» (4), but it is essential to emphasise that this is a broad and extensive field that caters to conditions and diseases of varying gravity. Emergency medicine includes all medical practices in the emergency departments of hospitals and/or in a pre-hospital setting.

In his presentation of the Interaction Reform, former Minister of Health and Care Services Bjarne Håkon Hanssen stated that «there are major advantages to be gained from early detection of diseases...», but he added that very few municipalities had systems that could follow up patients who display early symptoms of serious chronic or long-term illness (1). It is natural to expect that follow-up and better care will be able to reduce an acute deterioration in certain diseases. The Interaction Reform is based on the assumption that many hospitalisations are made unnecessarily. The effect that better follow-up in the primary health services may have on the hospital emergency services remains uncertain.

In Norway, emergency admissions account for 45 % of all admissions to hospitals, with disorders related to internal medicine as the dominant category (2). Most of the patients are admitted via the emergency department. Taken as a whole, there has been an increase in the number of emergency admissions of 3–5 per cent in this country in recent years (3). The data show that the number of admissions caused by acute disorders is increasing among the elderly (over 65) in particular (3). An increase in the proportion of elderly people is foreseen for the years to come, and large groups of diseases that predominate among the elderly will increase by 40–60 per cent in the period until 2030 (4). The need for care services is predicted to increase by at least 60 per cent. The same tendency is noticeable in a number of countries (5). There are indications, however, that this reflects a real increase in the number of people needing emergency services, and not in the rate of admissions/visits per person. We can see an increase which is more directly related to medical conditions than to surgical ones and primarily associated with the older age groups.

A considerable proportion of those who arrive at the emergency department have been referred by the municipal casualty clinic, and only 12 per cent of the referrals are made by the patient's GP (6). One factor that may have a bearing on the decision to hospitalise the patient is how well the referring doctor knows the patient. Those who arrive at the emergency department via the municipal casualty clinics are not generally treated as outpatients there (7). This could obviously be an indication that the emergency departments are not adapted to undertake sufficient examinations and treatment, but it could also indicate that these patients have a similar need for specialist health services as those who arrive at the emergency department directly. By analysing patient data and improving the interaction between the primary health services and the emergency department, those who should be referred directly to the specialist health services could more generally be selected at the pre-hospital stage.

The main intention of the Interaction Reform is to achieve «the right treatment at the right place and the right time». This presupposes that the health personnel that will take care of an acutely ill patient must possess a broad set of necessary skills in emergency medicine, irrespective of organisational forms. The municipal emergency primary health services have a key role as «gatekeeper» between the primary and the specialist health services (8). The review of Norwegian somatic emergency departments undertaken by the Norwegian Board of Health Supervision in 2007 described the competence of the emergency departments as a «risk area» (9). This referred to the risk that the necessary competence may not be present when acutely ill patients arrive, since the least experienced doctors are often assigned to this task.

The Directorate of Health has been commissioned to establish trials of further training (a competence area) in emergency medicine for doctors (10). This will represent a step in the right direction towards being able to define and ensure the future need for the broad set of skills in the field of emergency medicine which is requested. In its «Proposal for a national action plan for municipal emergency primary health services», the National Centre for Emergency Primary Health Care writes that in the future, emergency wards will be «more focused on preparedness, emergency medicine and urgent matters» (11). The emergency departments of hospitals would thus be a suitable arena for competence development in the field of emergency medicine. This could ensure better knowledge and a deeper understanding between the cooperating units within the primary and the specialist health services. Not without reason, Denmark has decided to define emergency medicine as a joint competence area for GPs and hospital doctors.

The Interaction Reform gives rise to some challenges and consequences that are difficult to foresee, even though certain frameworks have been outlined. The challenges consist in defining the required interfaces between the various units involved in a course of treatment.

«By establishing emergency medicine as a separate professional specialisation, the required competence is rendered clear, which will make it simpler to define the responsibilities and distribution of tasks within the chain of emergency medical services»

The purpose of the Interaction Reform is not to instruct the primary health services to provide specialist treatment, but to accentuate and enhance cooperation. In this context, it is essential to ensure a necessary and clear distribution of responsibilities between the services, as well as adequate competence in all sections to cater to the tasks assigned to them. By establishing emergency medicine as a separate professional specialisation, the required competence is rendered clear, which will make it simpler to define the responsibilities and distribution of tasks within the chain of emergency medical services.

Oddvar Uleberg
oddvar.uleberg@stolav.no
Lars Petter Bjørnsen
Department of emergency medicine research and development
St. Olav's Hospital

Oddvar Uleberg (b. 1974) is Acting Head of Department, Chief Consultant and Specialist in Anaesthesiology.
Conflicts of interest: None declared.

Lars Petter Bjørnsen (b. 1975) is a former Chief Medical Officer. He is a Consultant and Specialist in Emergency Medicine from the US, and Chair of the Norwegian Society for Emergency Medicine (NORSEM).
Conflicts of interest: None declared.

References

1. Stoltenberg J, Hanssen BH. Rett behandling til rett tid. Arbeiderpartiet.no 20.6.2009. http://arbeiderpartiet.no/Aktuelt/Kommentarer/Rett-behandling-til-rett-tid. (28.11.2011).
2. Lokalsykehusenes akuttfunksjoner i en samlet behandlingskjede. Sluttrapport fra arbeidsgruppe 19.3.2007. Oslo: Helse- og omsorgsdepartementet, 2007.
3. SAMDATA Nøkkeltall for spesialisthelsetjenesten 1.9.2008. Trondheim: SINTEF, 2008.
4. Scenario 2030 – sykdomsutviklingen for eldre fram til 2030. IK-2696. Nasjonalt Geriatriprogram, 6–99. Oslo: Statens helsetilsyn, 1999.
5. Acute medical admissions – a critical appraisal of the literature. NZHTA Report 6/1998. Chistchurch, N.Z.: New Zealand Health Technology Assessment (NZHTA) – the Clearing House for Health Outcomes and Health Technology Assessment, 1998.
6. Eikeland G, Garåsen H, Jacobsen G. Finnes det alternativer til øyeblikkelig hjelp-innleggelser? Tidsskr Nor Lægeforen 2005; 125: 2355–7.
7. Diagnostiske og logistiske variabler innhentet fra Akuttdatabasen (Versjon 1.5.5. Copyright © Helse Vest IKT) ved Akuttmottaket på St. Olavs Hospital (interne data). Trondheim: St. Olavs hospital, 2011.
8. Zakariassen E. Akuttmedisinske henvendelser til AMK-sentraler i Norge – epidemiologi, hvem varsles og hvem rykker ut. Scandinavian Update Magazine 2010; 3: 54–7.
9. Helsetilsynet. «MENS VI VENTER ...» – forsvarlig pasientbehandling i akuttmottakene? Oppsummering av landsomfattende tilsyn i 2007 med forsvarlighet og kvalitet i akuttmottak i somatisk spesialisthelsetjeneste. Rapport. Oslo: Helsetilsynet, 2008. www.helsetilsynet.no/upload/Publikasjoner/rapporter2008/helsetilsynetrapport2_2008.pdf (28.11.2011).
10. St.meld. nr. 16 (2010–2011). Nasjonal helse- og omsorgsplan (2011–2015).
11. ... er hjelpa nærmast! Forslag til Nasjonal handlingsplan for legevakt. Rapport nr. 1. Bergen: UNIFOB HELSE, Nasjonalt kompetansesenter for legevaktmedisin, 2009.

Received 23 November 2011, approved 28 November 2011. Medical editor: Anne Kveim Lie.