Reflections of a triage physician

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RÉSUMÉ : Dans trop de milieux, les médecins d'urgence sont perçus comme des gestionnaires de traumatismes, des médecins de triage ou d'éternels internes. Cette image déplorable reflète un manque de compréhension de notre identité, de notre formation et de nos fonctions. Les médecins d'urgence ne se conforment pas à la conception traditionnelle des soins aux patients qui consistent à traiter un patient à la fois toutes les demi-heures, les patients étant à peu près tous également malades. Face à ce niveau d'incompréhension, il n'est pas surprenant que nous soyons attaqués par des gens qui n'arrivent même pas à nous définir.

Si nous parvenons à savoir ce que nos patients, nos collègues et les administrateurs pensent vraiment de nous, nous serons en mesure d'établir un inventaire de besoins, un outil d'élaboration d'un programme qui nous permettra d'entreprendre la lourde tâche d'éduquer notre entourage sur ce que nous sommes et ce que nous faisons. La crédibilité professionnelle est essentielle si nous voulons définir des normes cliniques et des programmes de recherche qui nous soient propres. Si, dans l'esprit des autres, nous sommes d'éternels internes ou des «médecins de triage», nous allons, au pire, voir disparaître la médecine d'urgence telle que nous la connaissons, et au mieux, perdre le pouvoir de lui donner sa véritable identité. La question cruciale est la suivante : Les médecins d'urgence réussiront-ils à établir leur identité propre ou seront-ils condamnés à demeurer confondus parmi les marginaux?

I recently cared for a man with stab wounds to his back. He was hemodynamically stable, so, after an appropriate work-up including local wound exploration, irrigation and repair, he was held for observation. The surgeon attended later that morning but, instead of expressing gratitude for extra hours of uninterrupted sleep, she attacked the on-call radiologist with a (figurative) Prussian bayonet and demanded an abdominal CT — immediately! Sunday morning! The radiologist acted with uncharacteristic alacrity, the technician was called in, and the CT was done. All worked out well in the end.

However, without intending to demean me or emergency physicians in general, the surgeon referred to me several times in her consult note as the *triage physician*. Since she doesn't come from the UK or some anglicized remnant of the British Empire that employs weird terminology like *casualty officer*, it is clear that, in her mind, I was a *triage physician* — a glamorized perpetual intern. If we, as a group, suffer this dismal image within the profession, I wonder how the public views us and who they imagine they'll see when they race to their local ED in need of emergent care?

I believe that a *CJEM* patient survey is in order. A proper researcher should, of course, design the survey, but I'd like to suggest some questions to facilitate the process.

Question 1

Emergency departments are staffed by: a) family doctors; b) surgeons; c) anyone willing to work there; d) interns or other doctors who have yet to obtain gainful employment.

Question 2

If you stopped breathing during an asthma attack, who would intubate you and save your life? a) an anesthetist called out of the operating room; b) an internist called in from home; c) someone in a short white coat with a copy of *On Call* in his or her pocket; d) an emergency physician.

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Question 3

How many patients can an emergency physician manage at the same time? a) one, like other doctors; b) three per shift, like the doctors on *ER*; c) a dozen simultaneously and 100 per day, so we can earn half what a radiologist does; d) none (emergency physicians don't actually look after people; they refer them to real doctors).

Question 4

You leave your favourite bar and, for no good reason, some guy climbs out of a Volvo and clubs you with a bat — opening an ugly 7-cm burst laceration on your face. Then he steals your health insurance card and the last $9 from your wallet. In the ED, your wound is repaired by: a) a plastic surgeon with a big heart; b) an ENT surgeon looking for *good cases*; c) the unit clerk, who just discovered the surgical stapler and thinks it's cool; d) the emergency physician — for free!

So how do people view emergency physicians and what do they expect from us? For some reason our identity remains nebulous. Patients don't know who staffs EDs and what skills those doctors possess. Members of provincial colleges are comfortable with family medicine clinics and operating rooms, but they're confused by the chaotic environment of the ED. This confusion, whether it arises on the part of the solvent-abusing ED "regular" or the president of the provincial medical college, creates damaging assumptions and unrealistic expectations.

It's no surprise that we are increasingly victimized by others who cannot even define us. An acquaintance illustrated this for me by explaining how people inside the Ontario Medical Association and the College of Physicians and Surgeons of Canada deal with EM issues.

"They begin by believing they can solve the *crisis* in our emergency departments," he explained, "but after a quick dose of reality, they give up. Emergency physicians don't fit into their models, so they ignore what you are and what you do. When it comes to the big decisions, they force you to conform to *their* models, which involve one doctor treating one patient every half-hour, with every patient being equally ill. God forbid if your care doesn't fit that kind of static expectation."

If we can determine what our patients, colleagues and administrators think of us, we can understand where to focus our energy. To clarify, I do not see this information as a blueprint for emergency physician change. I see it, rather, as a needs inventory, a curriculum development tool with which we can begin the onerous task of educating those around us about who we are and what we do.

Will emergency physicians ultimately establish a defined identity or will we remain lost within the marginalia of societal impressions and bureaucratic dogma? For our own protection we must invite our neighbours, colleagues and overseers into our world and make them understand why we need their help in sorting out our role in Canadian health care. If in the minds of others we remain perpetual interns or triage physicians, we will, at worst, lose emergency medicine as we know it, and at best, lose the power to make it what it should become. Without a doubt, that future would be a sad one.

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