EDITORIAL

An overview of strategic differences for internal medicine care in Dutch Emergency Departments

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Internists in the Netherlands are shedding more light on the organisation of Emergency Departments (EDs) in order to improve its structure and thus, quality of care. Cases presenting to the ED have become more complex, and the number of elderly patients presenting to EDs is increasing.[1,2] These factors contribute significantly to ED overcrowding, which has a considerable impact on quality of care.[3] There is certainly a need to restructure the acute care system in Eds, however, to date, it is still a matter of discussion on how to achieve this, since there is significant disagreement between hospitals and healthcare insurers.[4]

In the current issue of NJM, Kremers et al. are the first to describe a nationwide detailed overview of the organisation and structure of different EDs.[5] The first step is simply wanting to re-organise where needed, especially with respect to care of internal medicine patients. These patients pose a significant challenge for Emergency Physicians (EP) given their complex medical background with multi-morbidity and polypharmacy; it requires more time to perform a diagnostic work-up than other similar presentations. Since our population is expanding and growing older, this will lead to more crowding and longer wait times in the ED, especially if the required knowledge and expertise is lacking or absent.

The study by Kremer et al., highlights the important finding that ED staffing (consisting of residents, EPs, medical specialists) is considerably different between EDs in the Netherlands, and this has an impact on workflow.[6] They also show that the presence of acute care specialists in EDs improves the quality of care and patient flow. This topic remains a matter of debate, since it may be difficult to pursue a uniform organisational structure for all EDs, where specialists are present at all times. Nevertheless, having the right expertise and knowledge present will definitely improve our healthcare services. Therefore, we should evaluate and improve the role of internists in the current structure of EDs more carefully. One solution, for example, could be the presence of an internist in the ED to review cases, especially in EDs where there are no EPs present.

Investigating the current structure of EDs in the Netherlands, and obtaining more details as to when and where medical specialists (mainly internists) are needed and how we can implement this, increases and improves collaboration with the EPs, residents, and medical specialists. This would be the first step to a more uniform organisational structure nationwide, and is crucial to improving our current acute healthcare system. In the future, we should start by implementing the presence of an (acute) internist in EDs, especially during 'office' hours, to be able to compare the quality of care and workflow with our current knowledge.

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