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Emergency Department, Hospices and Brazil

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Antonio Pazin-Filho
Internal Medicine Department Ribeirão Preto Medical School University of São Paulo, Brazill

Correspondence: Antonio Pazin-Filho, Full Professor, Emergency Medicine, Internal Medicine Department Ribeirão Preto Medical School, University of São Paulo, Tel +55 11 3091-3116; Email apazin@fmrp.usp.br

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Opinion

Even though the Brazilian Unified Healthcare System (Sistema Único de Saúde – SUS – in Portuguese) started in the 1980s, it is still a development project[1] Emergency Departments (ED) and Family Medicine (FM) are the two main access doors to SUS, but it is still mainly a hospitalocentric system, based on the Flexner model proposed in the EUA in the beginning of the last century.[2] The major hospitals are restricted to cities with more than 200,000 inhabitants and almost 70% of the Brazilian cities has less than 30,000 inhabitants. Only 20% of these smaller cities has a "hospital", represented by charitable hospitals founded in the beginning of the last century, which lack most of technology resources modern medicine uses. This implies remitting patients to hub cities, with huge impact in resources and some processual problems, being remitting the patients back to smaller cities one of the greatest. Primary medicine was essentially preventive in its origins and the coming of FM is trying to revert the problem of dealing with chronic conditions. Only recently, structured clinical pathways to guarantee patient flow, designing tools to social reinsertion of patients after hospital stay becomes more prevalent.

Considering patient flow through the SUS is a cornerstone to face the challenges of the new century.[3,4] One of these problems is the ageing population, with greater incidence of chronic degenerative diseases and, of particular interest for Brazil, a low-income one. Brazilians usually took care of old or debilitating disease patients (DDP) at home a century ago, when the survival was low and the families more structured. Nowadays, the survival of patients with debilitating conditions is longer thanks to the technology at our disposal, but in lower-to-middle-income countries (LMIC) such is the case of Brazil, assigning a family person to be the caretaker of a patient at home means unemployment and reducing the family income even further.

Considering the lack of dedicated hospices in the SUS, the only scape a DDP family has is take the patient to ED, the only access to SUS open 24 hours a day, 7 days a week.[5] Once admitted to ED, the patient social reinsertion is difficult after the immediate demands are taken care. This usually occurs because the patient doesn´t need the high technological treatment concentrated in EDs, but is still highly dependent of care that the family cannot provide. The care provided in the ED is incomplete and inadequate, considering that those facilities goal to guaranteeing survival and that death is still considered a failure, even though an expected event in several circumstances.

This "emergencialization" of chronic degenerative conditions are one of the main reasons of overcrowded EDs across the country, which is not different of what we see in developed countries. European countries receiving migrants in the last decades face the same problem.[6,7]

However, how to treat this "emergencialization" system disease? The diagnosis is clear, but not so the treatment.

There is no clear answer, but one could group the initiatives as related to ED process (Micro) or those related to the system (Macro), keeping in mind that the best scenario is a coordination of both strategies.

Brazil recognize Emergency Medicine (EM) as a specialty only in 2015.[8] Its development is our best hope to restructure EDs around the country and professionalizing care once relegated to recently graduated physicians on duty for complementing their income. A similar situation occurs with Palliative Care Medicine (PCM) in Brazil. Implementing Palliative Care Medicine consultation in ED is a reality in several countries and some recently evidences present good results in expediting patient social reinsertion.[9,10] Emergency Medicine and Critical Care Medicine should interchange experiences with Palliative Care Medicine, but more important than that is guaranteeing the interaction where the patient is, i.e., in the ED. Allocating dedicated hospital wards to Palliative Care seems a solution to some settings and could be part of a route inside the hospital up to the point the patient can go home, depending on their needs.[11] Both strategies can help if add value to patient care, instead of only prolonging their hospital stay.

The macro strategies include dedicated facilities to Palliative Care in several countries. Such is not the case of Brazil, where reinforce the access to SUS still consumes the majority of resources as previous explained. Converting small cities charitable hospitals (less than 50 beds) to Palliative Care centers is a solution proposed by law with a dedicated economic incentive is a possibility. Our group demonstrated that remitting patients to these hospitals is possible in 2015 and other centers are adopting the system with good results. In this pioneering work, we demonstrated that dedicated palliative care centers to care for dependent patients admitted to ED implied in a greater bed turn over increasing 9.3% the number of beds available in general. For specific areas that are systemic bottlenecks such as intensive care, the increase in bed availability reached 50% and in Neurology 66%. The small hospitals also benefited from the strategy since they were able to use the economic incentive to improve their facility and our hospital implemented a training program to their staff. A win-win project that could be a very good solution to LMIC.[12]

Other macro solution to reinforce the healthcare system is telemedicine.[13] Most of the healthcare professionals that work in the small hospitals around referral hospitals could be unprepared for Palliative Care and Emergency Medicine since they did not have this training in graduation or residence. Telemedicine can be a bridge to empower these professionals to take care of the patients remitted to them. Actually, in the previously mentioned project, capacitating the small hospital professionals was one of the main reasons of success.

In summary, EM and PCM should act hand-in-hand, using creative tools to overcome cultural or any other issue to guarantee properly patient care.

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Conflicts of interest

The authors declared no conflicts of interest.

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