REUE | Editorial

It worked then — and it works now!

¡Y funcionaba! ¡y funciona!

Ricardo Juárez González

Everyone in the hospital knew him as Dr. Efraín. He invented triage:[1] "Here's a patient with a headache," advanced triage:[2] "I've put an appendicitis case in a bed, call the surgeons," and reverse triage:[3] "This isn't for here, go to your health center." His coworkers all learned from his skills—and it worked!

The emergency department was a burrow—literally. You accessed it via a single-lane ramp going downhill. Cars and the few ambulances that came in had to back out, and somehow, there were no traffic jams. The door stayed locked at night; visitors had to ring a bell—and it worked!

It was located in a semi-basement, with natural light only in one office. There was a treatment and casting room, a tiny pediatrics space, a six-bed observation room, and a small resuscitation area with *"el machaca"*, grandfather of the so-called Lucas.[4] There was also a hallway that led nowhere, once used to house patients from a nearby village who all came in after a wedding with food poisoning. Since then, it had been named after that village. The burrow flooded from time to time, and on those days, we worked in rubber boots—and it worked!

We wrote clinical notes on carbon-copy paper and sometimes replied directly on the referral slip (P10). "Appendicitis?" asked the terse colleague who sent the patient. "No!" we'd write on that same P10 and send it back… and it worked!

Every patient with chest pain got a 12-lead ECG, making sure the suction cups were in place and didn't fall off. Sometimes they'd swap leads just to test us. A chest X-ray and a CPK—if nothing was found, the patient was discharged with aspirin. There wasn't much else we could do—and it worked.

On duty, there was one attending, 1 resident, 2 nurses, 1 aide, and 2 orderlies. We handled around 25,000 patients a year, across all specialties. We never stopped. Simple lab tests and plain X-rays—results never reported, same as today. A few ultrasounds, reluctantly done—but it worked!

How did we do it? With the traits of a good hunting dog: strength, courage, perseverance, intuition—the clinical eye—and spirit. We shared everything, read everything, treated everything. Drive, enthusiasm, hard work, and self-learning. In one word: heart. We had heart!

History-taking was fundamental: What's wrong with the patient? How did it start? How long has it been? I wonder—do we still take good histories today? Physical exams were thorough; we devoured Noguer y Molins.[5] "Better to put your finger in than your foot in your mouth," they used to say. Do we still examine our patients?

We only admitted patients if they came directly from a department head's private office, with a handwritten referral on fine letter paper: "Dear Ricardo, please admit this patient to my department. A hug." The patient brought it personally, suitcase ready. Do we, emergency doctors, still admit patients ourselves?

We did everything there—"To the OR, quick!" Yes, there was an operating room in the emergency department, and surgical procedures were performed there. We placed subclavian lines, intubated, inserted intracavitary pacemakers, did peritoneal lavages, and even attempted Sengstaken-Blakemore balloons—attempted, on purpose.

No CT scans, no MRI, and no bedside ultrasound.[9] "If only we had a scanner…" we used to tell the surgeon with an acute abdomen case. "Don't worry," he'd say, "I'll do it myself—with my own eyes." The 1980s—what nostalgia. Why do I feel that back in the '80s, everything worked?

Yes—but only halfway.

Currently, clearly, times have changed. Based on those experiences and all that daily work, with the training and technology available today—even if we still find it insufficient, hence our insistence on the Emergency Medicine specialty[6]—I'd say we've succeeded. People trust us. Sadly for them, we never lack patients. We're in fashion.

But here's the million-dollar question before we die of success: Does it work? Yes—but halfway. Not "on fumes," as we used to say, but at full throttle—and still halfway.

Why doesn't it work perfectly? Because an emergency can never work perfectly.

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Emergency means uncertainty and chaos, by definition. It's here and now, not there and later. Not "I'll check it tomorrow" or "Let's wait for renal function and tell him to drink 2 liters."

In this chaos and uncertainty, with hundreds of thousands of patients daily, should we replace modern methods with the old ones? Absolutely not. A good history, a thorough exam, and that sixth sense—that "little angel" whispering, "Be careful," what my father (also a doctor) called the clinical eye—must never be lost. Along with the classics, let's embrace the modern:

Triage.[7] A magnificent tool—use it to prioritize and locate patients, not to diagnose them like Efraín did in the '80s. Re-triage when needed, stay flexible, double staff at peak hours. "Emergency services apply the bioethical principle of justice through triage," says SEMES. Enough said.

Electronic Health Record (EHR). A wonderful pantry of information—images, labs, ECGs, functional test reports. Amazing! But here's the problem: to find information, someone must have written it first. So, write in the EHR. No copy-paste, no spelling errors, no made-up acronyms. If you want a well-stocked pantry, you have to fill it.

Modern diagnostic tools. Brilliant! No CT then? In that case, there was no pulmonary embolism—most were found postmortem by pathologists or, worse, by the coroner. Endoscopy for GI bleeds through natural orifices, MRI for some strokes, catheterization for ischemic heart disease, non-invasive ventilation (NIV)[8] for those ineligible for intubation—how many lives has it saved? And the ultimate breakthrough: interventional radiology. Who's afraid?

Bedside Ultrasound,[9] our current star. Very useful, but—pick up the pace! "Can you help me guide a lumbar puncture?" "Never done one." "Well then!"

New laboratory markers. Wonderful tools[10,11]—D-dimer, high-sensitivity troponins, BNP, procalcitonin, proadrenomedullin, suPAR, lactate, tryptase, urinary protobilinogen, new drug screens... But a piece of advice from the old school: if you don't know how to interpret them, don't order them. You'll just end up making a mess my friend.

Lastly, the design of the emergency departments themselves.[12] So important, yet so rarely consulted—at least not with those responsible—before the blueprints are drawn. Consultation rooms should never be lacking: neither fast-track nor slow ones, in cubicles like racehorses' stalls, with more or less equipment depending on the specialty. But yes, always staffed by us, the emergency physicians. And we need many of them—many consultation rooms. Intermediate care areas, the famous recliners; very versatile indeed.

Observation rooms,[13-15] where patients can be placed in beds from the very beginning if necessary—especially now, when we care for so many elderly patients. All should be properly monitored, a fundamental element of these rooms. And if possible, always in the same bed—no need to move the patient forty times.

Short-stay units[16] within the emergency department—so useful for avoiding unnecessary hospital admissions. We must help manage the hospital. The emergency department always helps whoever needs it... like the Red Cross.

Imaging rooms,[17] units that should belong to the emergency department per se, including their own staff. And when they are unoccupied? Good question—well, we can rent them out to the external department responsible for that budget.

And one very important matter for the management of the emergency department: hospital admissions should be handled by Emergency Physicians, within a maximum time frame for effective completion. Things might have gone very differently during the SARS-CoV-2 pandemic if this had been the case in all Spanish hospitals.

And now, the future—with the practical application of EHR data, clinical pathways,[18] digitization, big data, and AI in Emergency Medicine. All aimed at automating processes and developing alert systems to support expert decision-making. Automated triage will help organize the waiting line (yes, you read that right) of those awaiting classification, though it must always be validated by a professional.[19]

Real-time data processing will generate alerts through scientifically robust AI algorithms, ensuring safer decisions. For example, early detection of "suspected" unknown HIV carriers,[20] sepsis code identification[21], or drug use in minors[22]. These and many other advances are already being tested. And they work!

But are we ready to face this great change? In my opinion, yes—but the industry and the system are not. They fail to adapt to the volatility of these tools and to the constant evolution of new technologies.

What is useful today, after so much effort to implement and learn, will be obsolete tomorrow—not in a couple of years. And neither researchers, administrators, nor the industry—eager to capitalize on their investment—are prepared for that.

And do you want to know what we emergency physicians do? We do not forget what we've learned, because experience tells us that's what truly matters. And we never lose sight of the patient—the one who continues to surprise us every single day. And it works!

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