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Research Article

Emergency Service and Urgency For Patients Admitted To The Hospital And Academic Centre (Hac) In Yopougon (Abidjan District)

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Abstract: This study analyses the gap between emergency medical standards and patients' ideological productions of subjective emergency reality. To achieve the expected results, in addition to the literature review and semi-structured interviews, we used the triangulation and saturation technique that is at the centre of the qualitative survey. This technique allowed us to systematically cross-reference data, whether during the interview (returning to the same question through other channels), from one interview to another, and between different sources (Observation and semi-directive interview). This has allowed us to achieve the following results: First, patient triage protocols allow emergency priorities to be prioritized based on pre-established clinical criteria. Secondly, ideological productions legitimize the position or behaviour of patients from the emergency room to the hospital.

Keywords: Emergency service, Medical standards, Patients, Ideological productions.

1. INTRODUCTION

Medical emergency can be defined as: "The perception of any situation that worsens rapidly, or is likely to worsen, without medical intervention or even with" (J.-P. Carpentier, 2002). To this end, emergency services were created to regulate access to the hospital according to the more or less urgent nature of the problems posed by patients whose care could not be scheduled by the specialist services. Over time, they have been perceived by the population as a remedy capable of quickly resolving many truly urgent or only unforeseen problems, which has led to a large influx of situations that are difficult to classify according to medical nosology (François Danet, Marc Bremond and Dominique Robert, 2006).

Indeed, emergency room management lasts less than two (2) hours for half of the patients, except for those who have stayed in a short-term hospitalization unit (UHCD), which takes longer. These results are based on the national survey conducted among the 52,000 patients who visited the 736 emergency centres in metropolitan France and the French overseas departments on 11 June 2013, six out of ten of whom came to an emergency department at the initiative of the patient or the advice of a relative (Bénédicte Boisguerin and Hélène Valdelievre, 2014). Two thirds of patients arrive at home and most of them go to the emergency room on their own. They are less often transported by fire brigade or ambulance. Emergency use is higher for infants and people 75 years of age or older, with more varied reasons for use than for other age groups. In this context, traumatic injuries continue to be the leading cause of emergency room visits (36% of patients) and account for seven out of ten visits for 10- to 14-year-olds. After a visit to the emergency room, three quarters of the patients return home and 20% are hospitalized (Bénédicte Boisguerin and Hélène Valdelievre, idem). in the same vein, a study conducted in the emergency department of La Pitié-Salpêtrière (Paris) among patients and hospital staff, the authors report on patients' expectations and caregivers' attitudes towards the various diseases and events that led to the emergency room. The reception, the organization of the order of passages, the reactions to users' requests, and the interest for patients from the point of view of other services and the organization of patient transfer are analysed from a sociological perspective (Camus A, Dodier N, 1994). It is in this sense that this study questions the triage protocols that

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allow priorities to be prioritized on the basis of pre-established clinical criteria and the ideological productions that legitimize the position or behaviour of patients in the emergency department.

In view of the above-mentioned theoretical findings, in Côte d'Ivoire, the Yopougon University Hospital is a public industrial and commercial establishment established by Decree No. 89-341 of 5 April 1989. It is divided into three blocks, two of which are dedicated to internal medicine, general surgery, imaging and neurology, while one block is reserved for mother-child couples and includes gynaecology/obstetrics, medical paediatrics, and neonatology and paediatric surgery. Indeed, Yopougon University Hospital offers hospitalization opportunities for patients. In addition, various preventive medicine development actions are also created by this training, which contributes in the District of Abidjan with the University Hospitals of Cocody and Treichville to university and postgraduate medical education, as well as to pharmaceutical, dental and paramedical training. The Yopougon University Hospital also remains a medical research centre (Agobe, 2015).

In addition, the Yopougon University Hospital is responsible for providing emergency care, diagnostic tests, consultations and treatment. However, the emergency service, initially created to treat acute and serious diseases, is nowadays confronted with multiple requirements. This emergency service must not only respond to life-threatening emergencies, but also fill gaps in the health and social services available to treat diseases.

In response to this poor situation of patient care in the emergency department, initiatives have been taken. It is with this in mind that, in a press release dated 13 December 2017, Yao Etienne, Director General of the Yopougon University Hospital, informed the population of the closure of the emergency service of the Yopougon University Hospital from Thursday 14 to Saturday 23 December 2017. The main reason given was the completion of the rehabilitation work during this period. To this end, the General Directorate of the Yopougon University Hospital asked users to turn to the Cocody and Treichville University Hospitals instead.

Consequently, in the face of chronic overcrowding, the emergency department's policies are oriented towards restricting reception to the core of serious pathologies. Triage protocols allow priorities to be prioritized based on pre-established clinical criteria. But behind the normative sorting model, there is an otherwise complex reality, susceptible to adaptations and arrangements, derogating from the rigour of official norms to open up to the particularity of the situations encountered (Valérie WOLFF, 2016). How are the different perceptions of the actors (Treators and patients) articulated and interpenetrated to give meaning to the urgency of the hospital? To this end, this study analyses the gap between emergency medical rules and the subjective reality of patients that gives meaning to urgency in the hospital. This includes defining the typologies of medical emergencies, describing emergency reception and treatment, and identifying patients' perceptions of urgency.

2. Theoretical And Methodological Approach

In this study, Reynaud Jean Daniel's theory of social regulation (1997 and 1999) linked its unique place and importance to help us treat patient triage protocols, thus allowing us to prioritize on the basis of pre-established clinical criteria of urgency. In other words, the theory of social regulation (TRS) makes it possible to understand the typologies of medical emergencies, emergency reception and treatment and to identify the ideological productions of emergency actors.

Methodologically, the study is based on an essentially qualitative approach. It took place from March 10, 2019 to March 27, 2019 at Yopougon University Hospital, with 37 individuals, including 5 healthcare providers. With them, semi-structured interviews were organised to understand the functioning of the emergency medical authority and 32 patients, with whom we also had semi-structured interviews to identify the ideological productions that guide their behaviour or determine their concerns in the emergency department. The eligibility criteria of the respondents are based on their status as care providers on the one hand and their status as patients on the other. In addition, we conducted direct observation. This allowed us to assess the reception process and the treatment of the emergency from an observation grid. The observation grid therefore concerned the physical structure of this emergency space; as well as the functioning of social relationships resulting from this structuring of roles between care providers and patients. The various themes thus identified were made intelligible on the basis of the analysis of thematic content (Krippendorff [1], 2003). This approach has resulted in the following results:

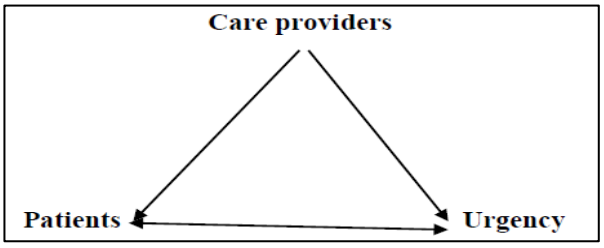
3. RESULTS

1. Emergency Reception and Treatment

In emergency departments, the mission of the staff who receive patients is therefore to sort according to pre-established clinical criteria and to set priorities. But apart from the formalized elements, the practices relating to the reception and care of patients are also played out in the concrete reality on the ground. Behind the official prescriptive model is an otherwise complex

[1] The most common method for studying interviews or qualitative observations. It consists of transcribing qualitative data, providing an analytical grid, coding the information collected and processing it. The analysis describes the survey material and examines its meaning

reality, subject to adaptations, arrangements and adjustments, departing from the rigour of official norms, to open up to the particularity of complex cases and the variety of situations. The diversity of problems encountered and the exceptional difficulties presented by patients can upset established norms and lead the professional to redefine the meaning of urgency (Valérie WOLFF, op cit). The increase in the number of patients in emergency departments also reflects new behaviours of patients seeking a service and the safety of unscheduled consultations for care that is not always of an emergency nature (Valérie WOLFF, op cit). The relationship between medical personnel and patients who have come by themselves or transported by firefighters or EMS paramedics can be translated into the following triangular relationship:



***(Source:** Agobe, 2019)*

The triangular relationship we have just shown below reflects that urgency is the point of action between providers and patients. The central issue of the nature of the relationship between medical personnel and patients is based on the caregiver-patient relationship (Agobe *et al.*, 2015). Let us remember that in the relationship between medical personnel and patients, relying on a person who holds such power as "the power to heal" immediately leads health specialists into a deeply asymmetric relationship. This healing power is fundamentally based on knowledge that the patient does not have. It is technical, theoretical and scientific knowledge based on validation criteria. Indeed, this medical power immediately establishes a rupture between health specialists and patients, which contributes to creating this characteristic rupture in the medical relationship (Agobe *et al.*, op cit).

Consequently, medical knowledge accentuates this rupture insofar as it intervenes in the context of the suffering body: pain, illness and death are all attributes that affect the body, and which give rise to a feeling of marginalization, all the more so since patients almost always reside in obedience to the recommendations of health specialists. This is what D.M. testifies in these expressions: "*Coming in an emergency or being admitted to the emergency service shows that the individual is at risk of losing his or her life. The suffering endured by the individual for this purpose is terrible. The wish of any patient in an emergency situation is that he or she be cared for as quickly as possible to get out of this suffering. Unfortunately, it is not easy for the patient to receive care so early. Because the doctor's view of what the patient describes as suffering is not often perceived as suffering by the doctor. In my opinion, there is then a breach of the definition of emergency with regard to emergency medical standards and the popular reality of emergency."* In addition, the suffering patient relies entirely on the care providers, which implies that he/she is bound to him/her by total trust. Doctors have the technical knowledge. *The patient must comply with the prescriptions of his doctor. In medical emergencies, most patients are unconscious and therefore unable to appreciate the emergency protocol. It is the parents or carers of patients who are very often concerned about the state of suffering of their loved ones. Sometimes people complain about the slowness of the emergency system or the lack of drugs on site in the emergency department. But this has no impact on the emergency protocol. Because, coming in an emergency or being accompanied in an emergency shows that you are at risk of death, so rapid intervention is desirable. As a result, health care providers are trained and aware of the degrees of urgency. In this case, it would not be possible to rely on them with great humility,* About G.P., parent of a patient. When analysing these remarks, it must be mentioned that suffering does not allow the patient to develop harmful behaviours. On the contrary, suffering constitutes a complete submission of the patient to recover health. It is in this sense that B.N. adds value: *"The patients who come to us are mostly obedient, but if, at times, we observe somewhat unpleasant behaviours related to their impatience or doubts they have about getting out of it or seeing their loved ones recover. These doubts are not scientifically based because, the care providers work according to a predefined or pre-established protocol. However, it would also be necessary to understand the concern of patients with the very aging technical chart often not adapted to the new emergency realities. In all cases, health care providers objectively practice according to scientific standards of urgency, whether in triage of patients or in the administration of care."* This shows that health care providers pre-establish an emergency typology in accordance with emergency medical standards. To this end, the management of patients in emergency departments follows a process of prioritizing the triage of patients admitted to the emergency department of the yopougon University Hospital.

2. Patients' Perceptions of Urgency.

The difficulties encountered by patients before being admitted to emergency care are of various kinds. Some patients report difficulties in being treated immediately. To this end, S A declares: "*The reception in the emergency service is slow. Patients receive care only upon presentation of medical prescriptions. However, in my opinion, the urgency would mean that there is a risk of losing one's life. Then the State should equip the emergency technical panel. This would minimize the number of deaths in large numbers. Some patients lose their lives in emergencies because of a*

lack of medication on the one hand, but also because of the slowness of health care providers to receive patients. It can be seen that healthcare providers are often demotivated because the technical platform is very old. All these problems are the anchor point for the suffering of patients admitted to the emergency department of the Yopougon University Hospital." Indeed, it is not often obvious that some patients construct an acceptability relationship with their state of emergency. The state of emergency is sometimes experienced by them as a relationship of disruption to life, but rather the state of emergency as a situation of powerlessness and deconstruction of production relationships with its socio-cultural environment (Agobe *et al.*, 2015). It is in this vein of idea, as T.Y. testifies in these words: "*Being admitted to the emergency service is a time of trauma. This painful situation experienced by the patient during his or her emergency stay leaves psychological after-effects throughout the individual's life. We could get out of an emergency and no longer be productive*" For his part, G.K. qualifies: *"the emergency as a time of distress, trauma. The passage of the individual to the emergency room following a traffic accident, for example, is a difficult period.*

In addition, the results of this study indicate that, overall, the intention of healthcare providers to provide information to patients or patients' relatives about the triage protocol in the emergency department is negligible. It should be noted that there is almost total heterogeneity in the way healthcare providers view the ED in their medical practice, and the way patients or patients' relatives experience it on a daily basis. This is reflected in the analysis of the different discourses on emergency service at Yopougon University Hospital. Patients' and their families' opinion of the services provided by the emergency department of the Yopougon University Hospital is positive overall. As a result, the reluctance of some patients or their relatives to give their opinions on the quality and perceptions of the emergency department is linked to ethical and symbolic considerations. It is with this in mind that Y.F. says in these few words: "My education does not allow me to make value judgments about a doctor or anyone who works to provide me with therapeutic solutions or to get me out of a difficult situation"

4. DISCUSSION OF THE RESULTS

The discourse of healthcare providers on triage of patients in emergency departments has shown a prevalence of technical vocabulary, with a breakdown in the relationship with the patient and a perception of the body conceived in its plural dimension (Agobe *et al.*, 2015).

This study, undertaken on the emergency service and the emergency department in patients, provides an objective perspective on the question of the scientific reality of emergency and the subjective reality that legitimizes patients' behaviour in emergency departments. Indeed, the sociological analyses presented here make it possible to reflect the normative framework that regulates in particular the profession of care providers in the emergency service and popular knowledge about the emergency. First of all, healthcare providers are subject to compliance with ethical rules, because of their status as professionals working in the field of public health. In this respect, it is important to highlight the impact of this compliance aspect in the process of identifying and triaging patients admitted to the emergency department.

Second, patients in the relationship between providers and patients rely on a person who has such power as: "the power to heal", immediately leads providers into a deeply asymmetric relationship. This healing power is fundamentally based on knowledge that the patient does not have. It is scientific knowledge based on validation criteria or standards. Indeed, this medical power immediately establishes a rupture between health specialists and patients, which contributes to creating this characteristic rupture of the medical relationship on this aspect, the results of our work are in line with those of Agobe et al (idem) In addition, the present study makes it possible to examine a prioritization of the patient triage protocol in the emergency department of the Yopougon University Hospital. This protocol contributes to the development of the relationship between patients and providers in the emergency department. To this end, the results of this study are consistent with those of Camus A, Dodier N, (1994). For these authors, the reception, the organization of the order of passages, the reactions to users' requests, and the interest for patients from the point of view of other services and the organization of patient transfer must be analyzed with a sociological perspective. It is in this sense that this study questions the triage protocols that allow priorities to be prioritized on the basis of pre-established clinical or scientific criteria that legitimize the position of healthcare providers on the one hand, and ideological productions that legitimize the subjective reality of emergency department patients on the other hand. Finally, it is mentioned that the criteria of eligibility or choice of patients in emergency departments are the anchor points for patients' impatience in the emergency department.

5. CONCLUSION

This study is a contribution to the sociology of the therapeutic itinerary. It highlights the gap between emergency medical standards and patients' ideological productions of subjective emergency reality. It was purely qualitative with appropriate investigative tools. This has enabled us to arrive at the results according to which, the process of triage of patients in emergency rooms makes it possible to prioritize emergency rooms on the basis of pre-established clinical criteria on the one hand, and on the other hand, ideological productions legitimize the position or behaviour of

patients from the emergency room to the hospital. In addition, this study examines a medical value-based patient triage hierarchy that structures the fabric of relationships between providers and patients.

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