*Conference **1***

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How do we experience medicine of the person today? Emergency medicine by telephone: an unusual medical relationship

I am honoured to open this new medical session with you for the 3rd time since 2006. Thank you for the organizing committee's trust in me. I hope to be able to share with you my interest in this very particular practice of medicine, since it is medicine without any equipment, simply a headset and screen.

My current experience as a primary care practitioner began in the 90's. This service was unknown in 1980, created by the SAMU (Emergency Medical Assistance Service) which deployed this service in each département in order to respond to any caller (direct line on 15).

To start with, I suggest that you travel with me, first of all in France to Moulins, a small town of 45,000 inhabitants. We will discover the many facets of this profession, what constitutes good practice, communication techniques and the difficulties we encounter.

To illustrate this, I thought back to several clinical cases ranging from a two-month-old baby to a 91-year-old man.

Then we will take a tour of a few countries abroad to see the medical situation in 2025 when we need medical advice from a doctor or when faced with a real emergency.

Finally, I will talk about how I conceive of this service, which is still at the stage of being developed, about strengthening the technical means at our disposal, and about an assumed humanism almost as though one were on a special mission.

You are going to dive into the centre of a reactor with me, not that of a nuclear power plant, but of an emergency medical telephone exchange, that of life and death on a daily basis, 24 hours a day, 365 days a year.

One of the doctors here today knew well the premises in which I still work. It was about 25 years ago, that Etienne, himself on call in nephrology, came to greet me and see how I was doing. More than once, as a gesture of support, he brought me a few biscuits in a TINTIN box, which he had unearthed in Paris or Brussels!

Those were the good old days, as we often say, the work was reasonable, not too many calls, I took the time to listen, to give advice to all callers ringing with questions, they were happy with my performance, or so it seems to me, and I could continue to chat with Etienne.

I liked this beautiful relational medicine and still do. I could have chosen to describe to you in detail how easy it was at the time to do this new profession of doctor already at a distance from the patient.

But we are in August 2025, the conditions are no longer the same, there are fewer volunteers, and the number of calls has multiplied by at least four.

Plunging in :

Let's imagine that it is a Thursday evening....

It's 7:55 p.m., here I am at the hospital in Moulins, I'm going to start my shift at the centre for 15 from 8 p.m. to 8 a.m. tomorrow morning (emergency number 112, for the whole of Europe).

Around me a very close-knit medical team with experience of all possible situations:

On the line are three permanent dispatching assistants (ARM), who take calls first, asking for name, address and reason for calling before forwarding them to the doctor. At my side, another emergency doctor assists me in the most serious cases.

I log in and prepare myself psychologically for the unknown calls that I will receive and have to deal with.

I've been doing this job for nearly 30 years, and like a marathon runner I've trained, I've channelled my reactions, I've trained myself to listen, I've learned to manage my sleep, I've been able to manage conflict better to achieve the famous "holy grail" of a medical emergency call centre: "signing the contract" with *my* caller.

That *my* is important, because each time it is *my* patient, a stranger that I will have to inform, reassure and sometimes convince of the choice to be made.

This individual conversation will be repeated all night long, and each time I know that I have a human being who wants either advice or a request for consultation and sometimes hospitalization.

I also know that I will not know the sequel to my decision with regard to this stranger: did I do the right thing? Did he understand correctly? (issue with language), will he sleep better? In rare cases I want to keep my file next to the phone, so I can call back after my shift.

I have to be focused, 100% available to ask the right questions.

To my mind, from 8 to 10 p.m. my role is comparable to war medicine: I have to triage very quickly, diagnose how serious it is (what is really urgent, and what may have slipped through the filter of my permanent staff, what will be seen tonight by a doctor, what can wait until the next day or what is in

fact a frivolous call). Between 20 and 30 calls per hour. It's huge, some doctors can't keep up with this pace.
Like Sherlock Holmes, I have to consider very quickly all imaginable and even unimaginable diagnoses, so to this day I still have confidence in my experience acquired over many years.

But first, let's talk about the dysfunction of health coverage throughout France and not just in my small département. It can be summed up by a sharp decrease in the supply of care while the needs are exploding. The causes are multiple, and the deleterious effects varied. The situation can be different depending on whether you are in the public or private sector. I will limit myself to talking about the effects on the continuation of the service provided by 15 in Moulins in the public sector.

In the morning, requests of all kinds converge on this single number, 15. Very often we do not have a solution to give in the following situations: "we don't have a general practitioner anymore, or he is on holiday, or he is sick, we don't have an SOS doctor". So, it all very simply gets funnelled into: "CALL BACK after 8 p.m. you will be able to speak to the duty doctor..." ».

In our job specifications, it is written that we have to deal with between 7 and 8 calls per hour. In twenty years, the situation has deteriorated considerably, but we have to deal with this avalanche of calls so as not to endanger the population.

If we respected this limitation, the "telephone waiting room" would get longer and longer and already in some emergency services the wait can be more than an hour, people get discouraged and hang up and we can miss an important call which hasn't been dealt with.

So, we have to be quick and do our best, we know that at this hour we won't have much time to give advice, to calm the anxiety of a mother simply worried by a fever of rapid onset. The doctor on duty (the one who goes out to the patient) will often be put to the test, we must ask him for a medical examination even if it seems obvious that there is nothing seriously wrong, we must take as little risk as possible.

Over the past year with the competent authorities (ARS, Regional Health Agency) there has been a significant improvement: we have gone from one general practitioner to two doctors from 8 p.m. to 11 p.m.: the workload is more satisfactory, still as much work but the waiting time has clearly decreased.

You're going to ask yourself, "What about the quality of the relationship with our caller in such a short time?"

This time of talking is an exchange which, although short, must be "loving"!! I looked for a synonym for empathy (very fashionable). I immersed myself in Dr. Bonhoeffer's lecture (2023): "Love as a Healing Power". By looking again at a few passages, I am sure that you will understand the nature of my exchanges: it is Heartfulness: the sense of the heart:

- Having access to loving care,
- Have learned to assess whether patients feel heard,
- Focussing our attention on the present moment, creating a dynamism that awakens the vigilance of the other,
- Being the original version of ourselves (being authentic,)

- Setting the tone for a true therapeutic alliance.

Practising general medicine over the phone: a young doctor receives a solid theoretical training, his internships in France have diversified over the years, internships with the general practitioner in his own practice are more numerous, so we hope to encourage vocations in general practice. But the multiplicity of cases when triaging over the telephone requires solid experience. In my opinion, it takes a few years of practice to become a good emergency physician over the phone.

Best practice is quite simple and logical and consists of several stages,

- listening to the caller, letting them express themselves in their own words and taking into account their level of concern
- questioning the caller, in order to have them specify the reasons for their call, its context and their expectations.
- explaining to the caller the hypotheses made about their state of health, the risks involved, the proposed management plan.
- a verification step to ensure that the caller has understood and accepts the proposed management plan (putting it into words).

Our responsibility is total, what power in our hands (our ears), but also what risk we take! This reminds me of a passage from the Gospel according to St. Matthew (Mt 8:5-11) in which Jesus takes up his responsibilities as a doctor, it is he and he alone who intervenes:

> At that time, as Jesus had entered Capernaum, a centurion came to him and pleaded with him, 'Lord, my servant is lying at home, paralyzed, and suffering terribly.' Jesus said to him, 'I will go myself and heal him.'

Who is calling us?

In 95% of cases, it is the patient himself, or his representative, such as the parents of minors or the children of vulnerable elderly people. Our attention is solicited for the remaining 5% by health care professionals, doctors, district nurses or palliative care specialists, or simply a night carer. Each time, we reach a shared decision (noted in the file) depending on whether hospitalization or staying where they are is chosen.

Trends in Demand

In France, we were proud, about twenty years ago, of our French-style medicine, the quality of care in the hospital (in the emergency room), the quality of the response at the 15 Centre, the availability of doctors, the regular appointments and daily home visits, for example.

We have already mentioned the deteriorating functioning of the health system in France, but a good number of countries in Europe are affected, except perhaps Switzerland!!? On the other hand, innovation and creativity are very present, here are some examples:

Educational work to "teach" patients:

- Call 15 before going to the emergency room,
- Remember the duty hours, such as 8 p.m. to midnight or weekends.

- Establishment in our department of an S A S (service to provide access to care or ‘Service d’Accès aux Soins’) in order to respond during the day, during the week to all calls by a triage doctor.

Fairly frequent clinical cases

A mother's anguish
Two-month-old baby who falls from the parents' bed (parental oversight): after a thorough neurological interrogation I reassure them (low height of the bed), but I am talking to foreign parents who speak French badly, the mother shows major anxiety, I have to conclude by telling her to go to the paediatric department at the hospital, when monitoring at home would have been enough.

Unbearable
It's 9 p.m., a call from a 24-year-old person: on my file: flu. To my questions, start date: this morning, fever: 38, main signs: sore throat, body aches. No history, no signs of complications. Epidemic period, overload of work for the doctor on duty, so I decide to give him only advice and to offer to consult a doctor tomorrow. His answer is administrative: "But I haven't gone to work, I need a break!"

Unpleasant (at first)
The same evening, a woman who is seven months pregnant, sick only since the morning, with an isolated sore throat, wants to see the doctor on duty. I am once again resorting to advice. Suddenly, the tone brutally changes: "It’s lucky, it's not a life-threatening emergency!" While remaining very calm, I tell her that my work is difficult, that I have to triage and that we always provide an answer adapted to the seriousness of the illness. In this case, her annoyance is short-lived, and we part on good terms.

Violent
Around 3 a.m., the daughter of a 48-year-old woman is in a panic: her mother has fainted and been incontinent of urine, she is currently violent, breaking objects. During the interrogation I learn that she is in alcohol withdrawal. Decision on how to transport her to hospital that often ends up with the fire brigade and the police.

The anguished woman
Around midnight.: Mr. PIL's wife calls because he has chest discomfort: The permanent staff member questions her a little: she is very anxious, says she is 95 years old, her husband 88 years old, cardiology history: previous aortic valve surgery. He immediately passes her on to the doctor given her distress, and he asks to speak directly to the patient. She is surprised and complies. Mr PIL "reassures the doctor", if it were down to him, he would not have called. The doctor's rigorous questioning allows him to confirm the absence of an acute cardiac issue and concludes by asking him to contact his own doctor the next day.
For this emergency doctor manning the 15 service: who is he to believe? The hyper anxious wife or the patient who may be minimizing his clinical signs. These are situations we frequently encounter, and the doctor's experience allows him in some cases to send help even though the patient may believe that there is nothing seriously wrong with them.

The "broken record"

A drunken man calls me at 4 a.m.: "I don't feel well, I want to be hospitalized in order to detox." Faced with the impossibility of finding a place for him in a hurry, I explain to him that it is not possible. He doesn't want to hear it and starts to insult me. Immediately I set up this broken record technique by repeating the same thing as calmly as possible. I can tell you that it works! In the end, the person becomes exhausted and less aggressive, and I am even entitled to a concluding insult, such as: "I've never seen such an idiotic doctor!" In your personal life, think of the broken record technique when you want to end an argument without losing your temper...

More complex cases

Not vigilant enough

It was about 25 years ago, when I was just starting, and this observation shows that sometimes empathy is not enough. It was 3 a.m., a 25-year-old woman wants a gynaecological opinion, she has to undergo treatment in a few days for a suspicious lesion of the cervix (cone biopsy): she is very anxious and, on my file, I had simply added "not very coherent". I reassure her and tell her that she can come to the emergency room if things don't get better. An hour later, I learn that the firemen had intervened because she had attempted suicide (by slightly cutting her veins). Even back then, on call doctors no longer went on home visits; in my time, sending the duty doctor could have defused the situation one-on-one, I could even say heart-to-heart.

This story left an impression on me and a few years later I did an in-depth training on suicide. This may interest you all, we know that proceeding to the act of suicide can be abrupt but often it is premeditated. We talk about a scenario, or a plan, which is very often discovered if we ask the right questions when faced with a state that seems to be a combination of anxiety and depression. We need to dare to ask: "Have you thought about committing suicide?" If the answer is yes, "in what way, taking pills, shooting yourself?" (we know that a gun in the house is a risk factor). What a decision? If the risk is low, think about quickly finding a "safety net": ask a friend or relative to support them. In the event of proven suicidal ideation with a plan of how to do it, emergency hospitalization is required. (In France we have a scale of severity from 0 to 7: the R U D – Risque, Urgence, Dangerosité).

A seemingly banal malaise

A 60-year-old woman is in a department store with a friend, she feels unwell without loss of consciousness with pallor and abdominal pain on the left. Her friend calls 15: The emergency doctor questions her briefly and to be on the safe side asks if her husband will be able to take her to the emergency room a little later. A doctor friend who was notified immediately afterwards by phone learns that in the morning she had fallen in her bathtub and that she had had a bit of pain in her side. Thinking of possible internal bleeding, she was urgently taken to the hospital: it was indeed a splenic rupture with intracapsular bleeding, an emergency embolization stopped the bleeding.

Know how to listen, take your time:

It's a man who calls me on behalf of his wife at 6 a.m.: she has just returned from Clermont Ferrand (a university hospital 90 km from Moulins), where she had her third cycle of chemotherapy (leukaemia). Just two days later, she had a fever of 40°C. She is weak, not sweating, I understand their concern, because we immediately think of aplasia and perhaps septicaemia. The dialogue is good, he asks me a lot of questions, having a blood pressure device at home, I ask him to take her blood pressure in order to exclude septic shock. I get the impression he is a little lost, I have to wait a few minutes, I don't rush him. "Take your time." Finally, I reassure them and tell them that I do

not think anything indicates extreme urgency. Not wanting her to go to the emergency room in Moulins, I advise him to call the help-line at the university hospital at 8 a.m.

It's a relatively frequent situation, I'm confronted with a serious illness from the start, it is a priority. Despite the waiting calls: I have to find the right tone, the right words and I feel very quickly when I establish a climate of trust. Thus, by lowering his level of anxiety (on the emotional side), I lead my interlocutor to regain his ability to think (on the reasoning side). In such cases, this special time of listening will result in him sticking to the decision we have made, which will in fact have been a shared decision.
The next day I made sure to call him back, he told me that it had ended well: at 8 a.m. her temperature was still 40° and he immediately called the department at the university hospital: the doctor asked for her to be urgently transferred.
Faced with the unavailability of ambulances, he decided to take her himself in his car! When blood cultures were taken, it turned out to be a bacteraemia causing the temperature.

Refusal to go to hospital, the difficulties in extreme old age

Mr C., 91 years old, lives with his wife at home.

One Saturday at 4 p.m. his daughter calls (she lives 100 km away): "My father has been confused since yesterday, he's recently fallen twice, and my exhausted mother is very worried about tonight. He even drove to his lake, and he came back completely lost. Can you hospitalize him?"

I ask if anyone has power of attorney for him (no) and if he will agree. His daughter replies that already this morning she called 15: an ambulance had come, and he had categorically refused to get into the ambulance and had signed a waiver.

We are in a delicate situation, I could call the patient, but we have to look for a solution with his daughter. It's psycho-geriatric case that is not a priori life-threatening, but I'm also thinking of a subdural hematoma to be excluded. Despite the insistence of his daughter I already know that it will be almost impossible to bring him in ... forcibly.

For two reasons: he is not under power of attorney, and it is a question of transport: even the firemen (there are 3 per vehicle) will refuse transport under duress without a medical certificate (these are cases of imminent danger in a violent subject for himself or for others).

Having asked her daughter to go to her parents' house, I call her back a little later, and then, to my surprise, I learn that her sister (who also lives 100 km away) does not agree and does not want their father to be hospitalized. We are in the presence of a family disagreement, and I invite the family to contact their usual doctor the next day.

Two days later I contact the girl again who tells me that in the meantime he has fallen again, an ambulance took him away and he only stayed a few hours in the emergency room. I then understand that the wife wants him to enter a retirement home, which he categorically refuses to do.

We are receiving more and more calls of this kind, behind a medical pretext we can see that for months a solution has not been found and that calling 15 is a way of "forcing" emergency treatment. In the most complicated cases, such as in Alzheimer's disease, an unscheduled arrival at

the emergency room quickly becomes a disaster for the department and especially for the patient (left for hours on a stretcher, sometimes with physical or chemical restraint if agitated).

In the case of Mr C., his doctor organised a videoconference one morning with the emergency services and the geriatric department. Direct admission to geriatrics (without going through the emergency room) turned out to be the right solution.

A unique level of care
It was in Dijon, Marie Claude Vincent, a psychiatrist, who gave a conference in the Netherlands in 2022, told me this anecdote: "I was at a friend's house for an end-of-year meal with another friend, a 65-year-old doctor, who had just eaten well and drunk two or three glasses of wine while she was in a difficult emotional state (her mother approaching the end of her life). She went to the toilet, when she came out felt unwell, we sat her down and she lost consciousness for a few minutes, her eyes rolled back. The 15 service sent out firemen and they asked for an emergency doctor to be sent out from the SAMU. The young doctor from the SAMU seemed to me quite impressed that there was a doctor on site and that the unwell patient was also a doctor. She did not want to take the risk of putting the patient in a sitting position in the lift and asked for the fire truck with the large ladder. So, the patient was carried through the window on a special stretcher... In retrospect I felt that the firemen were happy enough to get some practice evacuating a person through the window!"

A short tour abroad

We give here examples of emergency care in other countries, which have been reported to us by friends, without presuming it applies to the country as a whole or knowing how the health systems of these countries work.

In the USA
In the state of Kansas, a friend tells me about a fairly simple case: At the end of the afternoon, the doctors' offices are closed, a man is having a panic attack at home. Faced with the distressing situation, my friend calls 911, they suggest going to the emergency room or sending an ambulance (in France we reserve ambulances for more serious cases). On arrival, after a few hours of waiting, a psychological evaluation guides him to a free service (988 Crisis): An appointment is made the next day with a psychologist.

In Quebec
911 for serious emergencies. 811 for simple cases. In clinics and medical centres, there is no charge. On the other hand, in the city, if you find a doctor directly, you have to pay. In Quebec, a service provided by primary care nurses (SNNs) has been developed, they have been trained in minor emergencies ("bobology") and only call on a doctor if it is serious. (*in France too, nurses specialize in many fields (IPA – infirmier en pratique avancée or advanced nurse practitioner), with a Bac + 5 qualification they are able to practise either in private practice in clinics and do home visits, or in specialized hospital consultations).*

In England
Kathy was kind enough to describe their organization to me:

Non-emergency calls: 111. First: a secretary or a nurse has a standard questionnaire that the caller must answer. The answers make it possible to direct either to the emergency room or to a doctor for a consultation by phone or in person.
Urgent calls = 999 again standard questionnaires, starting with “is the patient breathing?” Kathy once recalled, “No matter how much I said I was a doctor, they persisted in asking their useless questions...”

In Burundi
A small East African country with 13 million inhabitants, located between Rwanda, Tanzania and the Republic of Congo. This year in Moulins, I met a Burundian woman married to a Frenchman, and we talked about her country's health system. Like many countries on our planet there is no social coverage, calling someone for a health problem is complicated. Outside of hospitals, there are doctors' surgeries operating in the evenings and weekends, which are very expensive. Family solidarity makes it possible to avoid hospitalization, especially among the elderly.

Three anecdotes:
If you call in the fire brigade, they have no training in first aid and only manage fires.
For those who have the means, you can call on the "Flying Doctors" who will medevac a sick person by plane, to Kenya for example.
There are no complaints to the hospital or the doctors because in all the cities there is a "head of the ten houses" by district, by street, he is a designated wise man who is responsible for settling many neighbourhood conflicts such as in healthcare.

In the Czech Republic
Thanks to Petr, who I contacted twice, here is the current situation: telephone calls are centralised by the single number 155, an ambulance is often sent in case of emergency. For less serious cases, general practitioners no longer want to be on call, so patients come directly to the hospital's emergency room with a lot of waiting and some abuse of the system. But who responds in this 155 centre ? They are experienced nurses, the doctor is rarely called upon. Petr confessed to me that he had never used 155!

In Switzerland
I am ending these journeys in Switzerland, and that is quite right and proper since you are hosting us. Your regulatory system is interesting, and I would like you to talk about it in your small groups: it is a question of delegating tasks. One of my young patients (in the 80s/90s) has been living in Switzerland since 2007 in the canton of Vaux. He created his ambulance company, and it was he who introduced me to what the 144 is (equivalent to our 15) Here is how it works: a large building in Lausanne brings together the 144, a medical centre for doctors, the Smur (vehicles with emergency doctor) the fire brigade, the police. It covers the cantons of Vaux (850,000 inhabitants) and Neuchâtel (190,000 inhabitants).
All medical requests arrive through 144. Either ambulance drivers or nurses (all trained to be experts in emergency response) answer. They can send help or pass the call to the doctor who will give advice or send a duty doctor.
The big difference with France is the high level of training of ambulance drivers: 4800 to 5000 hours in 4 years since they can then insert a venous line themselves, treat acute pulmonary oedema with furosemide, deliver analgesia or become experts themselves at 144. I haven't yet been able to visit Lausanne (the 144), so I can't tell you if humanism reigns in these premises.

Finally, do you know the oldest emergency doctor in Europe? I got back in touch with him at the beginning of the year to ask him to tell me about his memories. For a very long time, during his shifts, he would go to the patient's home to do an electrocardiogram.
When he retired from the association of cardiologists, he became, like me, an emergency doctor. His finest story: he was 95 years old, he was explaining to an unconcerned patient that his chest pains merited an urgent examination. The patient listened to him and was treated for a heart attack. With his sense of humour, he told me that on the phone he was careful not to tell him his age.

He lives in Neuchâtel, and you will have guessed that it is our friend Jean Claude Jornod who sends you all his friendly greetings.

In conclusion

A little spirituality!

By presenting to you all these very different clinical situations, I would like to share with you my feelings, I could even say my deepest self. Every time I pick up my phone, I know I want to live in the moment. I am in direct contact with a person. With my experience I think I can manage to love him better. Quite simply, I have in the long run shed my annoyance, my negative judgments. I would have to achieve a complete detachment from my prejudices by offering this time to listen that many expect, although, as you have seen, some abuse our system. Humanism, empathy, competence must be brought together during each call, from the most banal to the most complex.

Medically speaking, I found help in a prayer that I have made my own for the last two years: it was St. Teresa of Avila (Spanish Carmelite 1515 – 1582) who led an extraordinary life in order to reform the Carmelites by speaking of prayer: her whole life was one of prayer and of action. She also quoted this prayer that I say when I have finished a complex interaction: "Lord, are you pleased with me?" This question, which is addressed directly to God, is quite different from: "Am I pleased with myself?"

Mission field

The magnitude of the task is immense, the longevity of our elderly, medical shortages, worsening insecurity, increased demand, stress on all levels. We are sorely lacking in manpower, in volunteer doctors, and I will agree to be on the mission field a few more years (like Etienne in the Jura or in Dijon).

I see it as a call from God, I want to stay on the medical ship, well aware that on some shifts, we are in the middle of a medical shipwreck (epidemics of influenza, of gastroenteritis).

It is especially in the middle of the night that I appeal to my Lord when, on the 20th call, I grumble and curse the patient inwardly, judging that he is calling me for almost nothing. My suffering is very real and I must accept it.

Just as for Médecine de la Personne, I am appealing to doctors younger than me (including young retirees), I am not very successful because they often have good reasons to decline and have found other ways of investing their time.

I leave the last word to a night carer in a retirement home who told me:

"There was a 98-year-old lady who was a little disorientated but who still managed to make herself understood. At 8 p.m. before leaving, the nurse noticing respiratory discomfort had written: "Watch out for acute pulmonary oedema tonight". At 11 p.m. I found her to be worse and called 15. The duty doctor arrived and confirmed pulmonary oedema with impaired consciousness, he called the 15 service back and asked for a medical team (SAMU). When the emergency doctor arrived, he found that in fact it was just that her breathing was very noisy. After a few stimuli this lady came out of her torpor saying: "I WANT TO STAY HERE".