Overcrowding in America's Emergency Departments: Inpatient Wards Replace Emergency Care

Overcrowding of emergency departments (EDs) has reemerged as a crisis after first hitting national attention more than a decade ago. In many places of the country it never went away. Now it is even more widespread and in some places accepted as the standard of care.

Overcrowding in EDs results from boarding inpatients already admitted to the hospital in the ED for hours to several days. These patients are kept in ED beds, on stretchers placed in hallways, or in "observation" areas, with little if any regard for privacy, dignity, or personal hygiene. One result is that there is often no room left to receive new patients who need emergent evaluation or treatment. Hospitals ask ambulances to divert incoming patients to another facility. The ability of the hospital to provide emergency care to its community and serve its role in the emergency medical services (EMS) system is lost. Recent public hearings in at least two states have elicited testimony of serious breaches in the quality of care delivered, both to patients kept as inpatients and to those who wait to be seen.[1,2]

What could be the cause of such behavior? In the past the "overcrowding problem" has found several whipping boys. In the late '80s it was the AIDS epidemic, in the '90s the flu,[3] and always, of course, the poor who didn't need to go to the ED anyway but had nowhere else to go.[4] When patient care, public health, and emergency readiness are all in jeopardy, it would be wise to follow the dollar for an explanation.

In the mid '80s, Eric Muñoz and colleagues analyzed "The financial effects of emergency department-generated admissions under prospective payment systems" (PPS)[5] and noted that hospitals with large ED admission populations, particularly Medicare, could be at a significant financial disadvantage. Emergency patients who generated the greatest loss included those in diagnosis-related group (DRG) 127 (heart failure and shock), DRG 88 [chronic obstructive pulmonary disease (COPD)], DRG 148 (major small- and large-bowel procedures, >70 years of age), and DRG 14 (specific cerebrovascular disorders except transient ischemic attack). In a series of papers,[6–8] Muñoz et al. confirmed that the "ER identifier" (an admission from the ED) was an independent and negative financial indicator since, for most DRGs, a patient admitted from the ED has higher charges than a patient with the same diagnosis admitted as an elective, and the payment is the same.

The authors theorized that one way for hospitals to reduce such expenditures would be to "prohibit, and hence redirect, admission of all or some of these financially risky patients to the hospital (in other words, to 'dump')."[5] Direct dumping is prohibited under EMTALA statutes. But EDs full of inpatient boarders asking ambulances and emergency medical technicians to find another hospital to receive the next patient, is commonplace across America. In most cities, when one hospital is requesting ambulance diversion, all others in the area are as well. If not, ambulances would descend on the one open hospital with all the emergency patients, the resulting emergency admissions, and the financial consequence.

The advent of managed competition has exacerbated this situation. To cut costs, beds and staff were downsized so hospitals could operate at near 100% occupancy. Without any margin for fluctuations in volume of admissions, there are too few empty (or empty but staffed) beds to accommodate all patients when the day begins. A common scenario is that the scheduled (more profitable) admissions are accommodated first, with the emergencies left in the ED to backfill any empty inpatient beds when the electives are done.

Both DRGs and managed competition were introduced to control costs and place business-like efficiency methods in our nation's hospitals. It is not surprising that the losers are the patients with the least profitable illness. Nor is it surprising that the least profitable are the most sick and injured, admitted from the ED. Strokes, congestive heart failure with shock, and exacerbations of COPD usually present through the emergency door.

What can be done?

There is little hope for any quick fix by waiting for a change in financial policies and their associated behavior to turn this ship around. But some basic steps can be taken. Our job, as emergency physicians, is not to fix the health care system; it is to deliver high-quality emergency care.

First is acknowledgment by emergency medicine through study and in writing that this practice is widespread and detrimental to patients. Derlet et al., in this issue of *Academic Emergency Medicine*, demonstrate that overcrowding in EDs is a national problem, occurring on a regular basis across America, and that serious quality issues are present.[9]

Second is acceptance of re-

sponsibility on our part. We must stop pretending that "the ED is the only infinitely expansible part of the hospital" (Adams JA, personal communication, 2000), which allows this to happen. An ED designed with monitors by each bed because of the unpredictable needs of incoming patients does not mean it is automatically an intensive care unit or telemetry inpatient unit. The willingness of emergency physicians to cope with just about anything is not a virtue if this situation is the result. Many of our colleagues who have experienced inpatient boarding in EDs for many years are giving up, and are turning their heads to this everyday practice in their hospitals. Meanwhile, medical students and residents believe that what they witness as current practice in our teaching hospitals is the way it should be. Karma dictates that we ourselves will be boarded in the ED when our time of emergent illness or injury occurs if we don't do something now.

Third is recognition that we are driven by profit/loss in health planning and delivery today, and EDs are seen as a necessary evil or perhaps more charitably as a "loss leader" in the marketplace. In a publication by the Association of American Medical Colleges, changes in teaching and nonteaching hospitals were analyzed over the past few years. There is seemingly no problem finding capital to expand revenue-enhancing product lines such as PET and MRI imaging or cardiac services in hospitals across America. This is in sharp contrast to the decline in hospitals offering emergency care such as Level 1 trauma.[10] We must acknowledge the faceless economic forces that perpetuate inpatient boarders to get at the root cause of our situation today. The overcrowding of our EDs with inpatients is evidence of the fundamental failure of our current economic incentives in health care.

Last but foremost, we must return to basic principles and demand that the practice of boarding inpatients in the ED cease. Emergency departments are designed and intended to serve incoming patients with emergent medical needs who have a right to expect our immediate and undivided attention. We fail in our primary responsibility when we have no capacity to treat the next patient or when we drop out of the EMS system and ask for ambulance diversion. What is the ED for? When I served as a resident in New York City teaching hospitals in the '70s, patients were never kept in the ED after admission. They went to solariums or treatment rooms in the inpatient areas at times of peak occupancy, which was often. If they needed an intensive care unit (which were usually always full), the inpatient attendings made the triage decision and found a bed. The ED served its primary function and did not pretend to be the Band-Aid for the inpatient services. Sadly, this is no longer the case either where I trained,[11] or at the university hospitals in New York State where I practice today. It has been a big step backward for emergency care. But let's give our inpatient colleagues and hospital administrators more credit and assume they can do their jobs. Because we must insist that we do ours. No one else will.

Emergency medicine needs to respond to the practice of boarding inpatients in the ED with a clear voice: it must stop. Emergency medicine, state health departments, and the Joint Commission on Accreditation of Healthcare Organizations must demand that inpatients be cared for on inpatient floors so EDs can be EDs again. Studies, publications, and public action are all needed. There is no advocacy group for ED patients other than us. Patients deserve timely and high-quality emergency care. We must not fail our patients or our communities. That is our mission. This is our watch.—MARK C. HENRY, MD (mhenry@epo.hsc.sunysb.edu), *Department of Emergency Medicine, State University of New York at Stony Brook, Stony Brook, NY*

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