Viewpoint

'I'm as Mad as Hell, and I'm Not Going to Take This Anymore!'

By Peter Viccellio, MD

Emergency departments are in a crisis! says the Institute of Medicine report on the status of emergency medicine. How's this for proof? "A survey of one day's hospital activity … showed 22 of 57 voluntary and municipal hospitals to be over 100 percent occupancy, with the remainder at greater than 90 percent occupancy. [A] total of 379 patients were compelled to remain in the emergency department overnight for lack of available inpatient beds."

Dr. Peter Viccellio

Wow! We have a crisis! Problem is, I wrote this for the New York ACEP newsletter in *1987*. In 1989, the *New York Post* ran an article entitled "Dying for a Hospital Bed," and considered the system doomed.

At www.hospitalovercrowding.com, you can read multiple news articles dating back to 1987, all declaring the system to be defunct. In a crisis. Something must be done.

This long history would suggest that the strategy of "somebody must do something" isn't exactly, well, working. Another "what's wrong" document, like the IOM report, needs a companion. What we need is a "what would be right" document. We need a road map. To construct the proper road map, we must entirely empty our minds of the current practice of emergency medicine, which historically has evolved from an underfunded, underresourced, unwelcome stepchild of the hospital to what now is the epicenter of medicine, at least in the view of a third of the United States who stopped by to say hello this year. If "the emergency department" were a new idea, what would it look like? Look at what needs to be accomplished, and build the road map from there. In short, we need to replace our now chronic sense of *urgency* with an acute sense of *direction*. To fix a system, one should first decide what the system needs to do.

Interestingly, where we've failed to fill this void, others have stepped in with great vigor. The neurologists, the cardiologists, the infectious disease specialists, the traumatologists, and the pulmonologists have no difficulty speaking on behalf of *our* patients. Get the CT and have it read in 20 minutes. On any patient with chest pain, get an EKG in 10 minutes. Treat that pneumonia within four hours. Treat that sepsis within three hours. And there you have it. That's what an emergency department should look like. It's not the structure. It's the function.

They make demands not just on us but on themselves as well. They certainly have to come in during off hours far more than they used to as a result of their own efforts (and I commend them for their good spirit in doing so). Good for them. They skipped the "why we can't" part, and created a road map for what the patient needs, not what they need or what we need. They haven't said, "We should try." They said, "Do it. Go figure it out, but do it. Success is the only option."

How do we respond? Debate the need for thrombolytics, the utility of blood cultures, the influence of the pharmaceutical industry on guidelines (cf. Nero fiddles, AD 64). We debate the leaves and get lost in the forest. The point is, it's dangerous to let people sit in the waiting room for hours on end. It's dangerous to have every staff member working at absolute maximum speed to barely, just barely, meet the needs of some but not all who come for help. Finally, someone else has said not only that this is not acceptable, but has gone further to define what is acceptable. We have a dog in this hunt, so it might actually be time to toss out our own road map, and say "Do it."

How big does an ED need to be? How many staff? What equipment? What backup? Should doctors and nurses be spending time writing, typing, calling, pushing, seeking, and retrieving? Or (perish the thought!) would their time be better spent being doctors and nurses with these other tasks offloaded to support personnel? These questions can't really be answered until you define the task at hand. These are questions of far more interest to the 120 million people who visited emergency departments last year. I can imagine that they'd like us to say something useful on their behalf.

So let's start. Here's the premise: The system should be designed to meet the needs of the patient population. Period. I'll throw out some specific numbers for you to disagree with, but as you disagree, go ask your patients (and other physicians, for that matter) what *they* think. Think of these numbers as something we (the institution) would be

Continued on page 6

Continuing Medical Education in *EMN*

In this and every issue, *Emergency Medicine News* offers two CME activities: 1) InFocus, the clinical evidence-based column written each month by James R. Roberts, MD, and 2) Learning to Live with the LLSA, a review of the American Board of Emergency Medicine's Lifelong Learning Self-Assessment reading list by Daniel K. Mullin, MD.

Target Audience Statements: The InFocus CME activity in *Emergency Medicine News* is intended for emergency physicians with an interest in the diagnosis and treatment of various disease processes commonly seen in emergency departments, with special emphasis on evidence-based medicine. The Learning to Live with the LLSA CME activity in *Emergency Medicine News* is intended for emergency physicians with an interest in studying for the annual American Board of Emergency Medicine's Lifelong Learning and Self-Assessment examination.

Accreditation Statement: Lippincott Continuing Medical Education Institute, Inc., is accredited by the Accreditation Council for Continuing Medical Education to provide medical education to physicians.

InFocus Credit Designation Statement: Lippincott Continuing Medical Education Institute, Inc., designates this educational activity for a maximum of 1 *AMA PRA Category 1 Credit.*™ Physicians should only claim credit commensurate with the extent of their participation in the activities.

Learning to Live with the LLSA Credit Designation Statement: Lippincott Continuing Medical Education Institute, Inc., designates this educational activity for a maximum of 1 *AMA PRA Category 1 Credit.*™ Physicians should only claim credit commensurate with the extent of their participation in the activities.

InFocus CME begins on p. 19

LLSA CME begins on p. 34

EMERGENCY MEDICINE NEWS

VOL XXIX, No. 1

Published monthly by Lippincott Williams & Wilkins.
Editor: Lisa Hoffman
Art Director: Kathleen Giarrano
Associate Director of Production: Barbara Nakahara
Desktop Manager: Peter Castro
Manager of Circulation: Deborah Benward
Editorial Assistant: Erin Bascom
Circulation Associate: Fred Rella
Group Editor: Serena Stockwell
Executive Director of Continuing Education: Jay Magrann

Publisher: Ken Senerth
Vice President, Executive Publisher: Ray Thibodeau
Director of Advertising Sales: Mike Guire
Manager of Advertising Sales: Martha McGarity

Advertising Representatives:
Breuning Nagle Associates
58 Pine Street
New Canaan, CT 06840
James L. Nagle
(203)801-0055
(203)801-0011 (fax)
nagle@BreuningNagle.com
James F. Breuning
(609)397-5522
(203)801-0011 (fax)
breuning@BreuningNagle.com

Classified Advertising:
Melissa Moody
351 W. Camden St.
Baltimore, MD 21201
(800)269-4339
(410)528-4452 (fax)

BPA INTERNATIONAL

Emergency Medicine News (ISSN 1054-0725) is published monthly by Lippincott Williams & Wilkins at 16522 Hunters Green Parkway, Hagerstown, MD 21740. Editorial, business, and production offices located at 333 Seventh Ave., 19th Fl., New York, NY 10001; (646)674-6544; fax: (646)674-6500; emn@LWW.com. Printed in the USA.

Periodical postage rates paid at Hagerstown, MD, and at additional mailing offices. Physicians who are registered with AMA/AOA as having a primary or secondary specialty related to emergency medicine, as well as SEMPA members (within the U.S.), are eligible for a free subscription. To place an order, cancel a subscription, change your address, or for other subscription services, please call (800)430-5450, fax to (800)383-1781, or send an e-mail to emn@dmddata.com. (Please remember to include your current mailing address and specialty.)
POSTMASTER: Send address changes to: Emergency Medicine News, 2340 River Rd., Ste 408, Des Plaines, IL 60019-9883.

Mad as Hell

Continued from page 4

required to meet at least 90 percent of the time.

Patients with chest pain should get an EKG, and have it interpreted by a physician within 10 minutes of hitting the ED door, and the doctor should be at the bedside within 15 minutes. A CT should be done and read in 20 minutes for suspected strokes. Someone with abdominal pain shouldn't wait more than 30 minutes to be seen. If that patient is over 50 or has hypertension, 10 minutes. A pregnant woman with pain shouldn't wait more than 10 minutes. Patients over 65 shouldn't wait more than 15 minutes to see a doctor for *any* truncal complaint.

Crucial lab results should be back in less than 30 minutes. STAT films should be done in five minutes. Type-specific uncrossmatched blood should be available in five minutes. There should be sufficient nursing staff so that each acutely critical patient has his own nurse, based on the 90th percentile volume. Ambulance diversion should occur no more than 15 minutes a decade. Door-to-admit to leaving-the-ED time should be less than four hours 90 percent of the time. How about this one? *No one* should wait more than one hour to be seen. You can add 50 more ideas to the list.

Once you define it, you can measure it. Things you can measure have a tendency to become important. Performance measures also are susceptible to modeling, with actually meaningful projection of space and staffing needs. (I recently did nursing staffing calculations for our department using five models out there. The answers: We need 67 or 85 or 92 or 98 or 128 nurses. In short, the answer is, "We don't know.") With the system described in terms of performance measures, you can now begin to answer the question, "How do we fix it?" because you now have a sense of what the specific mission is. (By the way, we ought to actually *have* an answer, just in case someone actually asks.)

Such a model would directly imply that you need sufficient redundancy to adequately meet the needs of your patients on a day-to-day basis, rather than the current model of "how little do we need to get by?" It would directly imply that ED crowding is incompatible with the mission. (It would also imply that "crowding" is defined by the patient not getting what he needs if that failure is due to lack of space.) It also changes the measure from something meaningless (percent of time on diversion or number of patients who waited more than 100 hours to be seen) to something everyone can see is palpably important.

Problems such as overcrowding now have a framework, a measurable impact. It's much simpler to measure. If we can't deliver to our patients what needs to be delivered in the timeframe it needs to be delivered because of lack of space, we're too crowded, and something needs fixing. Sometimes the fix and the responsibility for performance will lie with us (which is probably precisely what most readers of this musing will object to). Sometimes it will be beyond us. But it reorients the world to what needs to happen, and allows one to describe the system needed to accomplish this.

What's important? Think of the common theme in the following list of problems. A nursing home won't accept a patient on off hours or weekends. A patient can't be discharged because a CT hasn't been read. A patient stays an extra day because of limited availability of stress testing. Several hours of delay occur in cleaning rooms or giving report. There are fewer discharges on weekends than on weekdays. Patients wait in the ED to be registered in spite of an available empty bed. The common theme? These problems are symptoms of a system designed to cater to the desires of the staff rather than the needs of the patient.

For the old man with the leaking AAA who walks in the door of your ED, every one of these things on the list is, quite simply, a direct threat to his life. A direct threat. Our system currently weighs the convenience of the nursing home, the CT reader, the stress tester, and the housekeeper as more importance than the old guy with the AAA. Otherwise, he just wouldn't wait (which he doesn't, when he is Someone Who Knows Someone; that's when we see which priorities are truly important).

We've never done this before. We've never enumerated the patients' needs and how long they should take to meet. For that matter, we probably won't because, quite frankly, we view it as impossible or as a burden to be suffered alone. We've been in the underbelly of

the beast for too long. Our view of our own world is simply too dysfunctional. It's unfortunate that others outside our specialty have to step up to bat on behalf of our patients.

We've focused for 20 years on what's wrong. We need to describe what "right" should look like. Empty your mind of anything you currently know about emergency departments. Quit thinking of them as "pits." Victory is *not* reducing ambulance diversion from 40 percent to 25 percent or decreasing waiting times from seven hours to three. The road map I propose describes a very different world from the one in which we currently live. It describes emergency care *as the patient should receive it*. It allows for clear questions, vigorous debate, and clear answers. It provides a framework for what we should do, a framework desperately lacking in emergency medicine.

A pipe dream? Here's what it could look like. I come to work in the morning. Today is different because today I'm not going to page, write, push patients, take messages, wait for calls, seek out results, or find missing stock. Neither is the nurse. The place is brimming with activity, pulsing with technology, the best tracking systems, a STAT lab, an ultrasound machine in every area, adjacent CT, MRI, and stress testing. Telemedicine is available for immediate consultation if needed. Tracking systems alert the appropriate personnel if there are backups in radiology, admissions, etc. In fact, we're so well stocked, staffed, and resourced that someone mistakes us for a new ambulatory surgery center or cardiac cath lab.

Adequate attention has been given to stocking, to care maps and order sets, to streamlining the consult and admit process. A patient with a suspected stroke enters the ED. He moves directly from triage to a bed, with registration occurring in parallel with his care. Within minutes, I'm at his bedside. As I evaluate the patient, my activities are recorded by a scribe. "Initiate stroke protocol" is *all* I have to say to initiate an action map for labs, EKG, and CT to be obtained and read and the neurologist to be paged. Any additional orders are entered by the scribe, and I sign the orders.

Results will be brought to my attention as they return; I won't hunt for them. The nurse's scribe records all of the nurse's activities as well, and records the nursing assessment. I move from patient to patient, able to be thorough and yet move quickly. Doctors and nurses, oddly, are spending 100 percent of their time being doctors and nurses. What has dramatically expanded is adding far less expensive support personnel. (Do the math: Add one doctor or 12 scribes.) Absolutely every action which does not directly *need* a physician or nurse is shifted to support staff, which conservatively gives 25 percent to 40 percent of physician/nurse time back to the bedside of the patient. When we have done what we need to do with the patient, the patient leaves, either discharged or admitted. Period. Consultative services are held to the same performance standards as the ED, and their responses are timely. The neurologist has arrived. Because of the carefully crafted, smoothly flowing system, I now have enough time to argue the utility of thrombolytics in stroke, thus achieving a door-to-debate time of less than 30 minutes.

This is an ED designed to save lives, the front door of an institution determined to do the same. To provide a service to the individual and the community. This is an ED (and hospital) where *everyone* is a Very Important Person who deserves, if we can give them the chance, to continue their Very Important Life, and not to toss it away in the waiting room or ED hallway because we can only hope for an ED built on compromise and capitulation. Why demand any less?

Virtually every person in this country will at a most dramatic and critical point in his life need us. Every person. Those people, their doctors, the regulators, and the administrators also believe that attention should be prompt and thorough, the environment safe, and the resources adequate. They want it to happen when a patient has a heart attack or a finger lac. A clear road map might help them recognize it when they see it. Of course, having the space to see the patient becomes the starting point, not the finish line.

Somebody, somewhere, needs to stick his head out the window and shout, "I'm as mad as hell, and I'm not going to take this anymore." Just like the patients in our waiting rooms. Except the ones too sick to shout.

Dr. Viccellio is a professor of emergency medicine and the vice chairman and clinical director of the department of emergency medicine at the State University of New York at Stony Brook.