EMERGENCY MEDICINE NEWS
THE NEWS MAGAZINE FOR THE EMERGENCY PROFESSIONAL

Emergency Medicine News:Volume 25(5)May 2003p 25

ED Overcrowding: Right Diagnosis, Wrong Etiology, No Treatment [Readers' Voices: Editorial: August 2000]

Viccellio, Peter MD

There's been a lot of hoopla about the phenomenon of emergency department overcrowding in recent years. This has been an issue worthy of *Time* magazine, CNN, and Nightline. Do we know the solution? Are we on message? Or have we done ourselves harm?

Emergency departments are overcrowded because of the large number of patients seen in the ED who could better be seen elsewhere.

Wrong! Count the times you left work thinking, Gee if only those acne cases hadn't come in, it would have been an easy day. Sore throats are not what grind our system to a halt. Admissions are. Admissions fill our examining rooms and hallways. Treatment of heart attacks is not delayed because of sore throats. Treatment of sore throats is delayed because patients with heart attacks may spend a substantial portion of their hospitalizations in our hallways. Any delay in the treatment of the next heart attack entering the emergency department is due almost solely to the previous heart attacks, pneumonias, and traumas already admitted but still remaining in the emergency department and consuming staff time, space, and resources.…

hen the emergency department is truly overloaded and cannot provide care to more patients, the hospital can divert ambulances to other area hospitals.

Wrong! If our emergency department is full, so are the other area emergency departments. In some areas, there is no other emergency department for miles. In some regions, entire hospital systems run at more than 100 percent occupancy for months on end. If you're full and they're empty down the street, they must have a pretty scary ED.…

Admitted patients held in the emergency department cannot be moved to the inpatient service until a bed is available.

Wrong! There's far more square footage and hallway space on the inpatient units than in the ED. Don't like the hallways? Use conference rooms, waiting rooms, sun rooms. Put the patients on the wards where the appropriate nurses and physicians providing inpatient care exist. Spread out the overcrowding problem. Let multiple units absorb a small part of the larger crisis. If the patient is to be stuck in a hallway for lack of beds, why should he care which hallway he is stuck in? Who doesn't believe that beds would be found more quickly for these patients if they were moved onto the units? Every objection to placing patients in hallways on floors pending a bed also applies, in spades, to the ED.

Can't do it? There is no JCAHO policy that gives the ED hallway special status. We're not Stonehenge. Bring in your local structural engineer to demonstrate the surprisingly observable fact that the ED is not built out of rubber bands that can stretch to provide never-ending space. They also might be able to point out the similar amenities available in any hallway, regardless of location.…

We should quit discussing solutions that don't work because they impede the implementation of solutions that can work. The solution to ED overcrowding is to get rid of the crowd. Admit them, and put them on an inpatient unit. Get JCAHO to mandate it. Clearly, nothing else has, will, or can work.