

Emergency Department Overcrowding: An Action Plan

From the time I began working in emergency departments (EDs) in New York City as a full-time profession in 1980 until I left the city in 1988, I do not recall a *single* shift at any time of day or night, in any of five different EDs, on *any* day or in any week, month, or year, where there were not admissions stacked up knee-deep in the ED. The entire borough of Queens ran at over 100% occupancy every day for more than a year. When holding 30 admitted patients in a ten-bed ED, I once called a nearby ED to attempt transfer of some of our admitted patients. The receiving ED politely declined the transfers, as they were holding more than 50 admitted patients in their ED. We had been averaging 20 admissions held in the ED on each shift for an entire year. In 1987, I had the opportunity to treat a 45-year-old male (a malpractice lawyer, as is usual for such stories) with an acute anterior wall myocardial infarction. He represented the first time in my career I had ever provided the first moments of care to a patient on a blanket on the floor of our ED, having utilized all our stretchers, the hospital's stretchers, and additional stretchers brought in by an outside company.

Interestingly, it simply never occurred to me at that time to demand that some of these admitted patients be moved up to hallways on the inpatient units; after all, there was a lot more hallway space upstairs than in our tiny ED. I, like most involved in emergency medicine (EM), had simply become acclimatized (brainwashed?) to the notion that this, of course, was both unsafe and undoable. It just seemed natural to keep the pa-

tients in the ED, and to become narcotized by our daily Sisyphian drama.

New York and California were particularly active during this period, the mid-'80s, at bringing this issue to the public. Articles in the *New York Times* and major magazines appeared. National news shows featured stories on the "crisis" of ED overcrowding. It made for great story. Similar stories recycled in the mid- to late '90s. Overcrowding didn't reach Suffolk County, where I work now, until four or five years ago. When it did, it was "worthy" of a CNN special report.

What was lacking, however, was any *useful* solution to the problem. Ambulance diversion was tried with little success, given that entire regions were saturated with patients. Directives to cancel elective admissions were issued, but elective admissions were, by that time, a thing of the past. Hospitals in New York were cited for not providing adequate privacy, for not documenting repeatedly on the patient's chart that an inpatient bed was not available, for not calling in additional staff (which didn't exist) to provide needed care, and for not providing the appropriate nursing ratios to intensive care unit (ICU) patients boarding in the ED. The ED nurses began completing the ten-page admission forms for the admitted patients. We were required to go through the motions of attempting transfer, requesting ambulance diversion, and other steps that we knew held little hope of relief. We collected daily stats in New York City on overcrowding. As it got worse, the response was to collect stats every shift. When we would meet to discuss why physicians

weren't discharging patients, why nurses weren't reporting available beds, there would be another round of studying and documenting. Meanwhile, a fair number of patients spent their entire hospitalizations in the hallway of an ED.

From the mid-'80s and through the '90s, another theme came crashing down on our attempts to deal with ED overcrowding—the "unnecessary" or "nonurgent" ED visit. In one fell swoop, this became the cause of ED overcrowding, as well as the cause of the ever-increasing national health care costs. There was now no longer any reason to fix ED overcrowding. Why throw resources at this reprehensible group of people who were just abusing the system? The obvious (though impossible) solution was simply to send all those "unnecessary" visits away. Suddenly we had been transformed into an overstaffed and overpriced walk-in clinic. Studies that showed we were paid half of charges were interpreted to mean we charge twice as much. All of this opened the floodgates to denial of payment for care rendered. Worse, we became the first (and probably last) profession to *actively* conceptually agree, via the American College of Emergency Physicians (ACEP)—Kaiser agreement and prudent layperson laws, that there are some patients we *have* to take care of but should *not* be paid for. The idea that we occasionally take care of real emergencies seemed permanently lost in these discussions. Even recent articles that attempt to legitimize ED overcrowding as a real issue, such as last year's flu epidemic, suggest that, once the flu goes away, then so will overcrowding.² Thankfully, the television show "ER" has served to remind the public that we *are* in the business of saving their lives.

The article, by Drs. Derlet, Richards, and Kravitz in this issue of *Academic Emergency Med-*

*icine*¹ brings us full circle back to the real problem of ED overcrowding—too many sick patients, and too many admitted patients. In this survey of a random sample of EDs in the United States, 91% of the 575 responding ED directors reported overcrowding as a problem. Even granting the obvious limitations of a survey, the results resonate with the experience of many emergency physicians. The respondents' definition of overcrowding was all too familiar—patients in hallways, all ED beds occupied, full waiting rooms, and acutely ill patients waiting for prolonged times to be seen. The top causes of overcrowding, as reported by the respondents, were high patient acuity, hospital bed shortage, high ED patient volume, delays in lab and radiology, and insufficient ED space. The type and location of the hospital mattered little. It came as somewhat of a surprise to me that only 30% reported that overcrowding has “always” been a problem. Half reported that the problem had occurred in the past several years. Importantly, but not surprisingly, the ED directors also reported significant delays in treating sick patients, with a high risk or actual occurrence of bad outcome due to overcrowding.

I would have liked to see several other questions included in this survey. Specifically, if the ED were not to hold admitted patients at all, would they still experience a significant, sustained problem with overcrowding? How often were patients held in the ED in spite of available inpatient beds because of lack of adequate inpatient staff? How often were numbers of ICU patients held in the ED with no dedicated staff to care for them because staff ratios in the ICU needed to be preserved? How often were admitted patients held in the ED in the face of continuing transfers to the inpatient

units for specialty care (in particular, cardiac catheterization and surgery)? How many sites actually have extra staff available as backup when admitted patients fill the ED? How soon, and how often, did the admitting physician see the patient while boarding in the ED? Was emergency care ever compromised solely because of a high volume of low-acuity patients? And, finally, how many nurses have burst into tears during their shift because they were simply overwhelmed by the needs of their patients?

The overall picture painted by these findings is one of acutely ill patients arriving at the ED, their treatment delayed, and then once treated, never leaving, leading to an ever-growing population of sick patients spending their most critical hours and days in an area not designed to provide such a service. It is important not to confuse the issue of overcrowding with the issue of the ED as a safety net. Rich and poor alike routinely lack access to an appropriate inpatient bed. Their hospitalization occurs without space, specialist, or service.

Why do admitted patients remain in the ED? It is indeed a strange acquiescence on our part to embrace the notion that, when hospitals have no inpatient beds, the patient will naturally have to remain in the hallway of an ED. (Even stranger is how they remain in the ED when there *are* inpatient beds.) This logic, one should note, is differentially applied. Obstetrical patients don't remain in EDs; they are moved to the obstetrical suite, regardless of occupancy. It is illogical that this does not occur in other areas of the hospital, which has far greater square footage than the ED. The suggestion of hoarding patients in the operating room would be met with ridicule, for obvious reasons. Why is it not obvious that the critical ability

of the ED to function as an ED cannot similarly be subverted? Should the door-to-needle time be dependent upon the inpatient physician who won't discharge his or her patient, the nurse who doesn't report the empty bed to admitting, or the housekeeper who won't clean the room?

Hospitals are peculiarly misshapen institutions. Most were built and organized in an era of elective admissions, and prior to many advanced procedures such as cardiac bypass. The bulk of business, being elective, could proceed without difficulty within the context of a 9-to-5 Monday-through-Friday schedule. It was perfectly appropriate in this context to reduce staff on evenings and weekends. Hospitals generally enjoyed an excess of ICU beds. How things have changed! Most admissions are now unscheduled, and the acuity level and need for ICU beds have soared. Unfortunately, this has occurred without a significant change in the weekday organizational philosophy and structure of the hospital.

At the same time, ED volumes and acuity have soared. This is only part of the story, however. As the volume has increased, so has the sophistication of the workup. The patient previously admitted for abdominal pain now undergoes extensive testing and imaging in the ED. I frequently tell my patients, frustrated by the hours spent in the ED, that we are accomplishing in eight hours what used to be accomplished in three days of hospitalization. In any event, the bottom line is more patients, sicker patients, and a far greater portion of their inpatient workup occurring in the ED. No surprise, then, with more patients staying longer, that we're overcrowded.

Dr. Derlet's group has documented once again the desperate circumstances existing in today's EDs across the country. They do not attempt to define what can

be done about it, but it cannot escape our attention that clear action is needed. The findings in this article differ little from the personal experience of many of us—that the very function of the ED is being usurped. There are many financial and organizational reasons for this. Given the modern-day political climate, few areas of medicine have been left untouched by changes in health care policy and financing. As such, vociferous demands for financial redress, although important, are unlikely to achieve more than modest success at best. However, organizational mandates can have direct and immediate impact on our practice environment. Recall the impact of the unfounded mandate of COBRA—no one should now be denied an evaluation of his or her problem when presenting to an ED.

Overcrowding is an issue that should be given the highest priority within our EM organizations. We need a plan of action. I would respectfully argue for several interrelated activities that we, as a profession, should pursue.

First, we need an aggressive, meticulous program of research that details the problems with and results of overcrowding. Overcrowding needs to be the next “buffered lidocaine” of EM—researched, studied, and documented to the point of exhaustion. (As a corollary, I would respectfully submit that further

studies on the “unnecessary” ED visit are actively counterproductive.) Why are we having the problem? How much has to do with volume? With acuity? With admitted “holds” in the ED? With staffing? With space? What harm is really done, to whom, and how much?

Second, having identified through repeated research the reasons for and consequences of overcrowding, we need to implement policies and programs that address the issues identified through research, and study their effectiveness. For instance, would a larger ED “fix” the problem? (Currently, if we expanded our ED by 30 beds, we would simply hold 50 admissions instead of 20.) Does ambulance diversion work? How is care delivered in the ED hallway compared with an inpatient hallway? How is overall length of stay affected by ED holds vs moving the patient to an inpatient unit?

Third, we need to voice not only the problems (we’ve done that), but the solutions as well. We cannot, within our own ranks, continue to accept admitted patients remaining in the ED as the “solution” to overcrowding. The “story” of ED overcrowding is a dramatic and newsworthy one, and I suspect we have become a bit too enamored with being the tragic, heroic figure for our own good. Given the complexity of the issue, our expertise is needed to define

some of the solutions. The news media and legislative branches cannot do it for us, without our direction.

Finally, our representatives, through the Society for Academic Emergency Medicine, ACEP, and other EM organizations, need to work with the Health Care Financing Administration, with our state health departments, and, in particular, with the Joint Commission on the Accreditation of Healthcare Organizations, to mandate the immediate transfer of patients, once admitted, to an inpatient area, regardless of bed availability. We must make it clear that, first, this is the hospital’s problem to solve, not the ED’s; and second, that our EDs cannot otherwise function. We are many things to many people. But we must first and foremost be an emergency department, and the only “crowd” we should have there are *our* patients.—PETER VICCELLIO, MD (aviccellio@epo.hsc.sunysb.edu), *Department of Emergency Medicine, School of Medicine, SUNY at Stony Brook, Stony Brook, NY*

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