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Once Upon a Time in the Emergency Department: A Cautionary Tale

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Once upon a time, in a not-so-far-away land, a man went to the hospital to get better. Instead, he caught an infection, and he died.

The time was March 7, 2003; the land was Toronto; and the infection was severe acute respiratory syndrome (SARS). The man went on to become the first person to die from SARS that was contracted in hospital in North America.

In February 2003, a woman who had recently returned home to Toronto from a trip to Hong Kong began to exhibit signs and symptoms of a febrile respiratory illness; she died at home 9 days later. Her son, who lived with her in Toronto, began to develop similar symptoms and presented to a Toronto emergency department (ED) where he was diagnosed with pneumonia and admitted. In an all-too-familiar story, there was no inpatient bed, and the woman's son stayed overnight in the ED.

A second man, the subject of this cautionary tale, presented to the same ED with atrial fibrillation and also spent the night in the ED. He had the misfortune of being placed on the adjacent stretcher to the first man, who was later diagnosed with a new and severe respiratory infection, SARS. Both men died from their respiratory infections,[1] but not before the second man infected his wife, who also died. The man and his wife directly or indirectly led to the infection of 44 other people. A third patient, who also spent that fateful night in the ED adjacent to the first man, subsequently died of SARS after causing the infection of a total of 31 people (2 of whom died) and initiating an outbreak in a second hospital.[2]

Seventy-eight people were infected, 5 of whom died, all as a result of 1 admitted patient spending the night in the ED instead of an inpatient unit.

Across North America, as you read this, literally thousands of patients are spending hours or days in EDs because of the lack of access to inpatient beds. How many are unknowingly being exposed to patients with communicable diseases for whom the ED is ill equipped to provide appropriate respiratory isolation? How many are being cared for by overextended ED nurses who are not able to come close to the nursing ratios required to provide appropriate care? We may never know. Yet this practice continues to this day, even in the very Toronto hospitals that were the epicenter of the SARS outbreak in North America.

ED crowding has reached the point at which it now represents a major North American public health crisis. The crux of the problem is not the volume of patients with splinters or stubbed toes or the sniffles who seek care in our EDs; it is a lack of access to appropriate inpatient beds for our seriously ill patients who require admission to the hospital.

For those of us who work in acute care hospitals, it is a familiar refrain. Inpatient beds are full. Some of these patients could be cared for in non–acute care settings: rehabilitation hospitals, long-term-care homes, even at home. But the resources to provide care in these settings are insufficient to meet the needs of our aging and increasingly ill population, so these patients continue to occupy acute care beds while patients who truly need access to this resource stay in the ED.

It may sound somewhat counterintuitive to state that the ED is no place for really sick patients. We pride ourselves in our abilities in caring for the sickest of the sick, patients with trauma, acute coronary syndromes, life-threatening infections, broken bones—the list goes on. And as specialists, emergency physicians and nurses excel at providing this care to some of the most fragile patients anywhere. But we are not experts at providing ongoing, inpatient care. We are not, by and large, trained to do this; our processes and environment are not designed to facilitate this; and our staffing is not funded to support this. Every minute that an ED nurse spends drawing daily blood tests and providing medications for a "boarded" inpatient is a minute he or she is not spending providing care for a new ED patient. Every ED stretcher that is occupied by a patient awaiting an inpatient bed is a stretcher that is not available for the next patient waiting on an ambulance stretcher or in the waiting room.

We know that ED crowding compromises the care we provide to our patients. It delays critical therapies such as thrombolysis[3]; it results in ambulance diversion or delays in offloading ambulance patients in many areas[4]; it has a negative impact on the education of our trainees.[5] And in the example from the early days of SARS, it can facilitate the transmission of life-threatening infections. So why do we continue to accept the status quo with a shrug?

Inpatient units and ICUs have well-established nursing ratios designed to promote safe and high quality patient care. Medicine units typically mandate a maximum 5- or 6-to-1 ratio of patients to nurses; ICUs establish rules for which patients require 1-to-1 care versus those who can be "doubled." If the available nursing staff is unable to care for additional patients within these predetermined ratios, no further patients are admitted to that unit, period.

Are we able to maintain similar nursing ratios in the ED? Not by a long shot. When one takes into consideration the patients on our stretchers, in our waiting rooms, and on ambulance stretchers waiting to be transferred to an ED stretcher, most EDs do not come close to providing comparable ratios of nurses to patients based on their acuity and needs. Why is this acceptable quality of care in the ED if it is not acceptable on an inpatient unit? Our patients deserve and expect better.

A number of solutions have been proposed and implemented, some quite successfully. Dr. Peter Viccellio of Stony Brook Hospital in Long Island, NY, has championed the "full-capacity protocol",[6] which is based on the concept that selected patients who require admission but for whom no inpatient beds are available should be distributed throughout the hospital rather than all being held in the ED. Admittedly, such an approach is not the answer for all admitted patients; those requiring respiratory isolation, for instance, represent as much of a risk on a ward hallway as they do in an ED hallway. However, at least this serves to reduce the number of admitted patients in the ED so that staff is better able to provide care to those "boarded" patients for whom ward hallway placement is inappropriate.

Dr. Viccellio has demonstrated the positive effects on patient care as a result of implementing this protocol: shorter lengths of stay and the virtual disappearance of ambulance diversion in the area. The majority of these patients spent less than 1 hour in the hallway of the appropriate inpatient unit before moving into a bed; more than a quarter of the patients went directly to a room.[7]

But as successful as initiatives such as the full-capacity protocol may be, they are stopgap measures that do not address the underlying, systemic problems that result in ED crowding. What is needed is a paradigm shift in the way we look at access to emergency care in North America. Can it be done? It can, and it has been.

In the early 1990s, England was facing the same challenges that we continue to face in North American EDs. The National Health Service established an ambitious goal: that patients, on average, would spend less than 4 hours in an ED, regardless of whether they were admitted, discharged, or transferred. At the outset of their program of reform in early 2002, this target was being achieved only 77% of the time. By 2004, more than 96% of ED patients in England spent less than 4 hours in the ED regardless of disposition.[8] To achieve this remarkable degree of success, changes were required at all levels of the system, from the community and the emergency medical services system to ED processes themselves, through to the inpatient units and post–acute care system and back to the community.

It is worth highlighting that EDs themselves must play a key role in this reform. We cannot expect the world around us to change without taking a critical look at our own inefficient process and making improvements in our own backyard. Expanded roles of nurses and allied health professionals in the ED and the use of ED nurse practitioners are just 2 examples of initiatives that significantly contributed to the success story in England.[8]

But the first step, as is true of so many challenges in life, is accepting that we have a problem. Without a recognition at the highest levels of government and health care administration that the current realities of emergency care are simply unacceptable, and without the desire and commitment to change, we and our patients are stuck with the status quo.

We have watched the media turn its attention to the issue of ED crowding off and on for the last several years; yet despite growing public awareness, there seems little public or political will to address the issue meaningfully. Paradoxically, there is a risk that such sustained coverage of the problem, absent any solutions, will only serve to desensitize the public and lead them to the conclusion that nothing can be done. We know better.

Those of us who work in EDs across North America see the impact of crowding on our patients each day. No one is in a better position to effect change than we are. As individuals, we do not need lobbying skills or political connections or more statistics. We each have something far more powerful: our patients' stories.

Until we can help this paradigm shift to occur, the ability to provide high quality, safe care to our ED patients will remain a fairytale, and for many patients, the story will not have a happy ending.

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IMPORTANT NOTICE TO CURRENT AND FORMER ABEM DIPLOMATES REGARDING EMERGENCY MEDICINE CERTIFICATION

The Emergency Medicine Continuous Certification (EMCC) program replaced the former recertification process starting January 1, 2004. All diplomates who want to maintain their certification with ABEM beyond their current certification expiration date must participate fully in the EMCC program. EMCC has four components that are briefly described below. A full description of EMCC is available on the ABEM website www.abem.org

Component One - Professional Standing

- Participants in the EMCC process must continuously hold a current, active, valid, unrestricted, and unqualified license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada and in each jurisdiction in which they practice.
- Physicians may hold one or more additional licenses to practice medicine. Each additional license must be unencumbered.
- Participants in the EMCC program must report to ABEM all licenses they currently hold, and all licenses previously held that do not meet the ABEM "Policy on Medical Licensure" if they expired, were not renewed, were revoked or suspended on or after January 1, 2004.

Component Two – Lifelong Learning and Self Assessment (LLSA)

- A list of 20 readings based on the EM Model is posted on the ABEM website each year.
- 40-item LLSA tests are developed based on the annual readings.
- A new LLSA test is posted on the ABEM website in April of each year.
- Each LLSA test remains online for three years. Successful completion of 8 tests is required in a 10-year certification period.

Component Three – Assessment of Cognitive Expertise

- The Continuous Certification Examination (ConCert) is a comprehensive examination based on the LLSA readings and *The Model of the Clinical Practice of Emergency Medicine* (EM Model).
- ConCert will typically occur in the tenth year of each diplomate's EMCC cycle.
- ConCert is a half-day examination, administered at computer-based testing centers around the country.

Component Four – Assessment of Practice Performance (APP)

- The Board is discussing specific options that will be developed over the next several years.
- Activities will be focused on practice improvement.
- Activities will offer diplomates a choice of ways to meet requirements.
- Activities will not require that diplomates be clinically active in EM and will be available to diplomates engaged in clinical EM, teaching, research, or administration.

ABEM provides options for former diplomates to regain certification. Contact ABEM for details.

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