Overcrowding for Dummies Redux

A Common Sense Solution for a Complex Problem

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I am always disturbed by reading about ED overcrowding, because the article usually talks about the poor, the uninsured, unnecessary visits to the emergency department, the flu, or how prudent layperson laws have opened the floodgates. I am disturbed for two reasons. First, I don’t believe any of these issues lead directly to the problem of ED overcrowding. (Note that issues related to the poor and the uninsured are most immediately financial issues; if they all paid, I doubt we’d have our knickers in a twist about their presence in the ED.) Second, by talking about ED overcrowding in the same breath with any of these issues invites a shrug of the shoulders and a sympathetic pat on the back for having to deal with unsolvable problems.

How can I say such a thing? Simple, really. If the poor, the uninsured, the unnecessary, and the imprudent come to the ED and they’re not sick, they leave. They may wait, but they eventually get evaluated, treated, and leave. As far as I know, no emergency department is going on diversion because there are too many sore throats sitting in the waiting room. However, if I keep linking them to problems with overcrowding, or even mention them in the same paragraph, I’m not going to solve what can be solved. And I want to fix what I can.

Maybe you work in a different environment, but here’s our little New York secret about overcrowding. Our EDs are full of sick people, not healthy people with “unnecessary” problems. But that’s OK too, because what else are we really here for, after all? Our problem with overcrowding has nothing even to do with sick patients. Our problem with overcrowding has to do with sick patients who have been evaluated, treated, and admitted, and now never leave. We’re filling the tub, but can never open the drain.

The math is so simple. Take a single bed in a 20-bed emergency department. Assume you see 100 patients per day, and 75 of them have “nothing wrong with them,” as some like to speciously claim. Well, then you can see all 75 in that single bed. They are seen, and then leave. You have 19 beds for the other 25 patients. Now, take that same bed. Put an inpatient in it. How many patients can you see?

This is how the math has worked in virtually every ED I’ve worked in. Take 40,000 patients and try to see them in a 20 bed emergency department. Easy. Now try to see them in the same ED when you’re holding 25 admitted patients. A crowd builds. Patients wait for hours to be seen. There’s no place to see them. The physician might be available, and even other staff might be available to help with the new patient, but the place you came to do your good work has been simply taken away from you.

Now let’s look at things selfishly. What’s our business? Emergency medicine. Ambulance patients. The sick, the wounded, the minor stuff. What’s throwing a wrench in our business? Admitted patients. Are admitted patients our business? No. Do we want to continue in our business? Yes. So what can we do?

Well, let’s look at what we have done. Most of our strategies for solutions have revolved around one central theme – decreasing our business. Think about this. Admitted patients aren’t our business. Emergency patients are. But because we have become the Motel 6 for admitted patients, our solutions are to decrease our business.
Overcrowded with admitted patients? Send the ambulances away. Overcrowded with admitted patients? Triage the minor patients away, make them wait, make them suffer – hurt your business (and, of course, hope that you were right about them being "minor"). That's our national strategy. Keep the business away. Let's make it formal, with meetings, memos, national and state positions, with committees coordinating with other committees, trying their best to keep as much business away as possible.

Silly me. I go to work every day and want to do my business. I want the ambulances to come. I want the sore throats and sprains and whoever else feels they need a doctor now to come and see me. The more the merrier. My patients don’t “overcrowd” the ED. I call that “being busy.” That's the business I want.

I have thought long and hard, pondering over why we have adopted this strategy for survival. How does all this make sense? I finally figured it out. It doesn't make sense. It doesn’t work, for one. If someone's having an emergency, they need to come to an emergency department, and not be a roving tourist in the back of an ambulance. It's not in our selfish interest, either.

Step One to solving this overcrowding problem is to understand fully and correct the origin of the problem. The problem is us. We're, in a word, pushovers. How can I say that? Easy. Do you know of any other businesses that routinely let their business be usurped? Surgeons don't allow admitted patients to fill up their operating rooms. You may think that the reason is that a hospital must have an operating room. No. The reason is that surgeons are not pushovers. Ever hold ICU patients in the ED because the staffing wasn’t perfect in the ICU? If so, you were just given a nice lesson in who is and who isn't a pushover.

Why is being a pushover so important? As I said, every hospital really needs an operating room, and it just wouldn't be rational to essentially shut down an operating room for such a silly reason as stacking admitted patients knee deep to the scrub nurse. If you were thinking that, you are correct. However, here's a little pop quiz: is it also important to have a functioning emergency department? If your answer is yes, you are correct. If your answer was “yes, but….” you are a pushover.

I feel like I’m at an AA meeting. “Hi, my name is Pete, and I’ve been a pushover for 20 years.” And this is true. I have. I’ve participated in those ambulance diversion meetings, and the triage-the-patient-to-walk-in meetings. I’m in therapy now. Hear me roar.

Step Two. Simplify the message. We have behaved like Andy Warhol addicts, looking for our 15 minutes of fame. In front of the camera, however, we’re not satisfied to be heroes. We must be tragic heroes. We continue to talk about the flu, the uninsured, the safety net, COBRA and EMTALA, and all the other tragic-heroic things we put up with and want the world to fix. This strategy is counterproductive, and will never lead to solving overcrowding. Here's a clue – if your solution requires that all the ills of society be cured, and adequately funded as well, you probably will meet with less than stellar success. So my point is simple. Don't even bring it up. I would use my 15 minutes of fame for the following Overcrowding for Dummies simple message:
The hospital (not the ED) is overcrowded with admitted patients. Someone foolishly decided that all the extra patients should be kept in the emergency department. This is wrong. The time for an immediate change in strategy is upon us. We can’t function as an emergency department with no beds, no monitors, and no space. These patients must leave the ED. They must not remain in the ED, because we have a mission, and that mission is to provide emergency care. We cannot fulfill that mission without space and staff. We cannot fulfill that mission when our ED is filled with admitted patients. We cannot and will not send away ambulances. We cannot and will not discourage sick people from seeking care when they feel they need it. That is our mission. If we have a zillion ED patients, we’re not overcrowded; we’re just doing our business. That’s our crowd. We’ll take care of it.

We need you to take care of your crowd, in your space, with your staff. The admitted patient needs care that only an inpatient unit can provide. The care is not only a matter of more or less; the care is different, and we cannot provide the type of care they receive elsewhere in the hospital. We don’t have the space, if we do, we don’t have the staff, if we do, we don’t have the right expertise for inpatient care. We’re not intensivists, pulmonologists, cardiologists. Our nurses aren’t ICU nurses or ortho nurses or cardiac nurses. Our expertise is in the first two hours of everything, and that’s what we pay attention to. We have to look forward at who’s coming in and who’s crashing right now, or look backward and baby-sit the admitted patients; we can’t do both, and we think you ought to really know that. How the hospital inpatient units choose to deal with the problem of excess admissions is up to the inpatient units. It is not our job to suggest or direct solutions, other than to insist that the patients cannot possibly remain in the ED. And by the way – this is what your patients want. They don’t want to sit in a crowded, noisy, chaotic, brightly lit ED all night where they go virtually unnoticed. Don’t believe me. Go ask them – they’ll beg to leave.
“We provide critical and essential services. What we do is important. Very important. The public knows. The ambulance needs to bring the patient. We need to treat the MI, the stroke, or whatever else the patient has. We need to be able to do it, and do it right now. This minute. The nature of our work dictates that some days are slow, some are really busy. That’s our business. That’s OK. Virtually every person in the country will, at one time or another, need emergency care. We should be there for them. Right now, we’re not. And every time any of us go on ambulance diversion, we’re trying to not be there for them. That’s just not right.

Raise hell. Get those admitted patients out of here. We have a job to do.

The end.

PS: In 2001, we implemented what we call the “full capacity protocol” at my institution (see www.hospitalovercrowding.com). When we have no more room to see patients arriving at the ED, then appropriate admitted patients get moved upstairs to other hallways. Most patients who are not ICU or step-down unit patients qualify for this protocol. First, it allows us to continue to function as an ED. Implementation of this protocol reduced the average LOS for such patients from 6.2 days to 5.4 days. This represents gargantuan bucks to the hospital. Our patient satisfaction scores increased so much that we received a national award. Over 95% of patients preferred the inpatient hallway to an ED hallway. The nursing ratios became optimal for the greatest number of patients, both ED and inpatient units, enhancing patient safety. The right doctor and the right nurse (and the right social worker and discharge planner) are at the bedside of the patient. Patients are discharged earlier from the hospital, rooms are cleaned faster, and beds are ready quicker. Our pneumonia, sepsis, and heart attack patients get treated quicker. We did this as an institution, to solve the problem the institution, not just the ED, was facing. We can now be honest and truly say that every patient who enters our institution is as important as any other, and that, when there are problems, we will work together as a institution to find a solution.