Emergency department overcrowding: peering through the holes in the safety net

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I know it when I see it.

— Supreme Court Justice Potter Stewart describing the difficulty of defining "hard-core pornography" in the case of Jacobellis v. Ohio (1964)

In this issue of CJEM, Ospina and colleagues provide an important addition to the emergency medicine literature on the indicators of overcrowding in Canadian emergency departments (EDs).[1] Their efforts to define overcrowding and derive scientific tools to measure and correct it are admirable. Nonetheless, I was struck by their statement that "A more consistent approach that focuses on standardized indicators of events occurring in the ED would help distinguish between the causes, characteristics and outcomes of overcrowding."

We can likely agree on the harm of ED overcrowding — errors in care, delays in treatment, patient dissatisfaction and staff burnout and turnover. ED overcrowding is a challenge that urgently needs a solution. Yet like many labyrinthine problems, taking the wrong path is unlikely to determine a way out.

In my view, we must be particularly careful not to confuse improving overcrowding measures with improving emergency care, as these do not necessarily go hand in hand.

Once the indicators most able to identify overcrowding are established, the next step may be to identify metrics that best reflect those indicators. What if improving overcrowding metrics has minimal or no effect on health care outcomes? One could envision scenarios in which, for example, increasing the number of staffed acute care beds or improving emergency physician satisfaction had no effect on patient health. Or similarly, as appears to have happened in the United Kingdom, decreasing the ED length of stay by rapidly admitting more complex patients to inpatient beds or "medical assessment" wards may have no effect or even detrimental ones on cost and expeditious patient care; and while some busy EDs have improved their time to physician assessment by staffing a physician at the triage desk, it remains uncertain whether this consistently improves patient flow, treatment or even satisfaction. Moreover, it is unclear whether this is a cost-effective use of physician resources.

The United States automobile industry is still learning the bitter lessons of process improvement, despite sophisticated management tools such as Six Sigma, Lean and reengineering. Blind adherence to process improvement, without careful evaluation of the resulting customer impact, can produce a faster assembly line cranking out cars nobody wants to buy. Similarly, teaching students to improve standardized test scores does not necessarily improve the life skills that education aspires to teach. Health care, like car manufacturing or education, demands a clear vision of the desired endpoints before reflexively tinkering with the processes.

Not everything that counts can be counted, and not everything that can be counted counts.

— Albert Einstein, 1879–1955

One of the problems of isolating process measurement in a disconnected manner from system improvement is the potential for accelerating a process without actually improving or managing a problem. For example, when the US Joint Commission on Accreditation of Healthcare Organizations began enforcing measurement of the time to antibiotic administration in pneumonia, some emergency physicians "gamed" the system by giving antibiotics before patients were diagnosed, "just in case." Similarly, taking blood cultures became an expected and

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measured standard, despite minimal scientific support.

In the future, we will be increasingly evaluated by our ability to improve quantifiable parameters of emergency care. Whether you want it or not, pay-for-performance in medicine is coming soon to a hospital near you. Administrators, elected officials and the public are all eager to have a rational approach to the allocation of our limited health care resources. Both ED budgets and reimbursement will soon be tied to outcome measures in the United States, and in Canada as well.

"Who gets to determine the outcomes?" is a seminal question in the pay-for-performance debate. In general, physicians have failed to provide leadership in this regard. As a profession, we have neglected to provide the transparency and measures required for judgment of our performance. In this age of communication and data accessibility, we have sadly failed to consistently provide either on health care outcomes.

Those who speak most of progress measure it by quantity and not by quality.

— George Santayana, 1863–1952
(*Winds of Doctrine: Studies in Contemporary Opinion*; 1913)

"If you can't measure it, you can't manage it" is a truism that has become a mantra in many organizations. Unfortunately, in a complex system such as an ED, where causality and consequence cannot be predicted with accuracy, it is clearly not enough to measure and manage. Leadership demands that we agree on the desired result. Thus it is critical for us, as emergency care providers, to define and measure the outcomes that *we* identify as meaningful. Without our input, administrators will be forced to implement metrics that they consider significant, or worse yet, metrics that are simply easy to obtain, and we will only be left to dispute their value.

I recall one of the first experiences I had with a patient complaint letter. It was written to the chief of the medical staff and I was summoned to his office. I was simply asked whether I had given the patient the best medical care possible. Not whether the patient had been satisfied, or treated quickly, or had a right to be upset. Can we, in the setting of ED overcrowding and limited resources, continue to give the best care possible?

It is no measure of health to be well adjusted to a profoundly sick society.

— Krishnamurti, 1895–1986

Returning to an educational analogy is worthwhile. We can test students relentlessly, measure the improvements in their test scores, improve teacher–student ratios and tutor the outliers. But does improving these metrics provide lasting value for each child? Only when we clearly define an outcome that is valuable at the individual level, and measure it, can we improve the system.

What is it that is valuable to an ED patient, or to our society as a whole? Speed is valuable, but not if it compromises quality care. Patient satisfaction is valuable, but not if it means unnecessary use of medications or procedures. Comprehensive care is valuable, but not if it means costly, unnecessary testing with little change in outcomes. In a nutshell, we have to be meticulous in defining what is valuable to patients, care providers and society before we leap into change.

The doctor who makes a friend of his patients. . . the schoolteacher who opens a child's eyes to a new world of books and poetry — such people do nothing that can be measured in marketplaces.

— John Mortimer, 1923–
(*Where There's a Will: Thoughts on the Good Life*; 2003)

We can't measure the success of a health care system in patients per hour, minutes per admission or on a scale of 1 to 10. The magnum opus of some cultures took centuries to complete. Imagine the grandeur of our health system if we toiled with equal dedication.

While we should continue to support efforts to research and manage ED overcrowding, we should not allow ourselves to become complacent to the agenda. Our influence in setting priorities to monitor and approach solutions is critical. We must not become habituated to either ED overcrowding or the measurement of ED processes without insight into genuine meaningful goals. Our focus should be on better care for our patients and on a better work environment, in that order.

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References

1. Ospina MB, Bond K, Schull M, et al. Key indicators of overcrowding in Canadian emergency departments: a Delphi study. Can J Emerg Med 2007;9:339-46.

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