Invited Commentary

What would Osler do?

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This month's issue of *CJEM* includes a debate on the propriety and unintended consequences of assessing patients in the waiting room when there is nowhere else to see them. Innes[1] argues passionately in favour of doing so as a professional and ethical duty, and to maintain the moral authority necessary to advocate for change in other parts of the healthcare system. Pauls[1] argues against it, partly on the assumption that you can always find a patient to reassess in order to clear a spot, and because he believes that a waiting room assessment is of substandard quality and risky in terms of accuracy. While I agree with Pauls that we should do everything we can to optimize flow and avoid waiting room assessments, I agree with Innes that there are times when you've exhausted those options and face a decision: Will you go to the waiting room to continue providing care, or won't you? In this commentary, I will address that critical point in time.

Whether there is an expectation to do waiting room assessments varies by department and among individual physicians. Just as most emergency departments (EDs) have normalized hallway care and invested heavily in the infrastructure and staffing needed to support it, some EDs have normalized waiting room care and have attempted to provide the necessary equipment, privacy, and coverage for orders (my own ED included). Heading out to the waiting room without those supports in place can result in significant peer pressure from both nurse and physician colleagues to desist. I have seen ED waiting rooms overflowing with misery, only to go inside and find doctors chatting because "there is no one to see."

Underlying the two positions are a few assumptions worth examining. One of the assumptions, which is stated in the first paragraph of the introduction to the debate, is that boarded patients and external systemic issues related to ED output are the major causes of crowding to the point of gridlock. But is it true that we are powerless to improve flow until the boarding problem is solved?

In Ontario, where I practise, the government's strategy to address ED crowding and access block since 2008 has had as its centrepiece a pay-for-results program.[2] It provides CAD $90 million in annual incentives to the 74 busiest EDs in the province based on performance across 6 metrics of waiting and length of stay. The assumption at the outset was that incentives to more rapidly move the 10% of ED patients who are admitted would also speed the care of the other 90% who are ultimately discharged. Overall, to my surprise and to that of many involved in designing and implementing the program, it didn't work out that way. In aggregate the program had a disappointing impact on admitted patient flow (the initial target of an 8-hour stay at the 90th percentile seems a naive fantasy, in retrospect) and a better than expected improvement in discharged patient flow (exceeding the 8-hour target on length of stay for complex discharged patients and meeting the 4-hour target on uncomplicated patients). The clear lesson is that, when we put our minds to throughput, we can do a lot more to improve flow, despite a boarded patient problem than we thought we could.

Then there is the assumption that if we see patients in the waiting room, "it only seems to take the pressure off others in the system, rather than inspiring them to work harder."[1] An extension of this belief I've often heard articulated is that good service, especially when provided to lower acuity patients, only encourages abuse of the ED and results in higher patient volumes. Taking this point to an absurd extreme, we should provide poor service to

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discourage unnecessary ED visits and to support our advocacy for better support from our hospitals and governments. What greater act of cynical negligence can there be than to sacrifice our patients in the hope that others will be moved to help, or in the hope that patients will be deterred from coming and adding to the crowding? And yet, we have too many instances of well-publicized crises and tragedies that were successfully managed politically (that is, the storm passed) without systemic change.

Pauls is partly right; we should advocate for change, we should do our best to hold our colleagues in hospital administration and other departments accountable, we should maximize throughput to try to prevent gridlock, and we should prioritize reassessments and discharges over new assessments whenever possible. But when we reach the point of gridlock and there is nowhere else to go, and you are unsure about going to the waiting room to provide care, ask yourself: What would William Osler do? Osler famously said, "Listen to your patient, he is telling you the diagnosis." But I think his principle can be extended here; if we listen, the patient will tell us the right thing to do.

In 30 years of answering patient complaints in my urban academic ED, I heard regular concerns about waiting too long for care, an occasional one about the discomfort and indignity of spending an extended time in a hallway waiting for a room, and only extremely rare complaints about having an initial assessment in a hall, waiting room, or other non-traditional space without adequate privacy. Patients understand that the compromises of rapid assessment zones and whispered chats in waiting rooms represent our efforts to deal with the circumstances thrust upon us without adding to their waits. When I consider how I would feel explaining my actions in a newspaper report or in a courtroom, I am much more comfortable defending care that takes place in a compromised area than having staff sitting and pausing until rooms become available while patients suffer and wait. If we listen to our patients, I believe their message will overwhelmingly be to see them wherever you can, as quickly as you can, and to do the best you can for them when you get there.

Keywords: Quality improvement; length of stay; Emergency Service, Hospital; ethics

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REFERENCES

1. Innes G, Pauls M, Campbell SG, Atkinson P. *CJEM* Debate Series: #HallwayMedicine – Our responsibility to assess patients is not limited to those in beds; emergency physicians must assess patients in the hallway and the waiting room when traditional bed spaces are unavailable. *CJEM* 2019; 21(5):580–586.
2. Ovens H. ED overcrowding: the Ontario approach. *Acad Emerg Med* 2011;18:1242–5.

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