

hyperbaric oxygenation. *Intensive Care Med* 2002;28(5): 559-63.

Waiting Room medicine

To the Editor: Winnipeg newspapers have recently picked up the battlecry that the current emergency care system does not work. It is now unacceptable and dangerous that patients wait hours to be seen and treated. In response, the Manitoba government has decided to do a 1-week audit of selected emergency charts to see what the problem is. It seems they have forgotten to talk to the frontline workers, who might have an idea about what the major issues are.

The primary issue, which has been documented extensively in the emergency medicine and health services literature, is outflow block and the resulting lack of available stretchers. The simple fact is, most emergency stretchers are filled with patients already admitted to other services and waiting for an inpatient bed.

As the government has promised the public, the days of *Hallway Medicine* are over. Fantastic! Let's move ahead into the new world of *Waiting Room Medicine*.

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Repeat of Jan.

Role of SARS screening clinic in the ED

To the Editor: Dr. Marcus Ong recently described an emergency physician's perspective on the "War on SARS" in Singapore.¹ Fortunately, the strategy and tactics detailed were effective at that time. We know from the recent appearance of sporadic cases in Guangdong, China, that SARS has returned.²

The SARS crisis has had one positive outcome: it highlighted many of the unique challenges emergency departments (EDs) face in dealing with contagious diseases. In addition, the economic costs of the SARS outbreak demonstrate the need to upgrade EDs to a comprehensive and national standard, as described in the recent CAEP position statement.³

Overcrowding is a key factor that increases the risk of infectious disease transmission in EDs. Overcrowding is increasingly common in urban EDs, where large numbers of patients, some with potentially lethal infectious illnesses, squeeze together in waiting rooms and on stretchers in hallways, exposing ED staff and other patients and increasing the risk of initiating a new infectious outbreak.

Previous ED infection control guidelines are not adequate.⁴⁻⁶ Significant ED retrofitting and redesign is necessary to address future infectious disease threats.⁷ These proved useful in the Singapore and Hong Kong outbreaks. We strongly propose establishing "SARS screening clinics" or "fever clinics" such as those developed in Hong Kong and Singapore¹ during the 2003 SARS outbreak. These units segregate and manage suspicious patients with fever, contact history, SARS or influenza-like symptoms, using a biohazard model that protects staff and patients.

Fever units should apply a universal and high level of protection by making use of redesigned triage areas, nega-

tively pressurized consultation and resuscitation rooms and full personal protection — especially when ED staff are performing high-risk procedures. Efficiency of screening is enhanced by designating senior physicians, protective equipment and resources to the clinic, and the chance of cross infection within the department is also reduced.

Also important is a reliable follow-up system to prevent "missed" cases from falling through the cracks.⁸ We cannot afford to lose a single staff member in the battle or to miss a single patient in the community.

We have adopted these principles and run such a "fever clinic" in our department. Realizing the threat of future infectious agents or bioterror events anywhere in the world, we think this is the right strategy to be instituted in other EDs. Because air travel makes these concerns global rather than local, cooperation between different departments, hospitals, nations and countries is critical.

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