Urban legends

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I work in the Kelowna General Hospital Emergency Department — a busy place with high acuity and a volume of nearly 50 000 patients per year. Until recently we've avoided the big city problems of hallway stretchers and ambulance lineups. This has, unfortunately, begun to change.

I have just returned from a meeting with our hospital administrators. They believe one key solution to ED overcrowding is to use the media to convince potential patients that they are not sick enough to come to hospital, and that they should stay home or go to walk-in clinics. Many administrators share a common and unshakeable belief that there exists a vast pool of patients who come to EDs unnecessarily, tying up valuable resources and costing the medical system enormous amounts of money. I'm not sure where these patients are, and I've concluded they are an urban legend along the lines of the Roswell flying saucer crash and the babysitter who took LSD and roasted . . . . well, you know the rest.

Unfortunately, this urban legend isn't circulating harmlessly around schoolyards like the ones I heard when I was growing up. Instead, it is propagated by otherwise-credible people and considered by the media, hospital administrators, ambulance personnel, nurses and many doctors to be fact. Sadly, there are even emergency physicians who have bought into this myth. When I was a resident, I remember an attending telling me that a patient registering in the ED for a prescription renewal "cost the system $300." I suspect this figure was derived by dividing the annual cost of running the department by the census.

This urban legend has also made its way into the medical literature. A paper[1] published in the *Canadian Medical Association Journal* 6 years ago assumed a priori that when patients use EDs rather than walk-in clinics, this constitutes an "inefficient use of expensive hospital resources." Had the authors chosen science over folklore, they would have learned that ED care is generally very cost effective[2,3] because the costs of running an ED are mostly fixed costs (it is staffed and operated on a 24 × 365 basis) and the incremental costs for additional non-urgent patients are minimal.

Alarmingly, hospital administrators seem to believe that our hallway stretchers are filled with patients who have hangnails, pinkeye and yeast infections, and that diverting low-acuity patients elsewhere will solve the ED overcrowding problem. They couldn't be more wrong. Our stretchers, hallways and waiting rooms are full of sick people who need hospital care. This reality is stated clearly in the joint CAEP/NENA Position Statement on ED overcrowding.[4] Focusing on "non-urgent" patients merely diverts attention from the true cause of ED overcrowding: a growing and aging population who have diminishing access to a shrinking pool of acute care beds. It also leads us to view patients as burdens to the system rather than human beings who need care.

No doubt there are patients who "abuse" the ED — just as there are those who abuse family physicians, mediclinics and the Workers' Compensation Board. These patients are not our problem. We need to dispel urban legends by educating health professionals, the media and the general public about the true causes of ED overcrowding. And we must never lose sight of the reason we work in the ED: to help those who need us.

Competing interests: None declared.

References

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