

ED pressure: an update from the ‘front lines’

Emergency departments in our teaching hospitals remain under pressure, but the solution does not depend solely on bigger and better emergency departments, according to **Dr Bill Heddle** – we need to understand why they are overflowing, and address the causes. Increased clinical leadership in health care and system planning could hold the keys, although a ‘hard hat’ may be required ...



APPROXIMATELY six months ago, I wrote a brief article for *medicSA* concerning stresses in the emergency departments (EDs) of

our teaching hospitals. Since then the workload has decreased but, as I write, it is the “quiet” time of year before the winter “rush” and, in seasonally adjusted terms, I suspect the situation remains potentially hazardous.

It remains embarrassing to have to take a history from a patient in a very public environment (when they are in an ‘A’ or ‘triage’ bed) and apologise that you cannot decently examine or take a history from them because of the complete absence of any privacy – with no room available for privacy until they leave the emergency department.

The feedback I received after my last article was very interesting, particularly the point (which I had failed to make clearly) that the problem in the EDs is not just due to inadequate resources there, but primarily due to the absence of sufficient capacity within the hospitals to ‘pull’ patients requiring admission and workup, to unload the EDs. For example, patients within hospitals frequently spend extra days in hospital because the imaging procedures requested have to be delayed because of overload of the service.

I am concerned that the perceived solution will be bigger and better emergency departments. Understanding why they are overflowing is very important, and holds the potential solutions to the problem: streamlined management pathways, including

hospital avoidance mechanisms; clearly defined advance directives of patients; and better ability of the inpatient services attached to the EDs to admit and manage well the large patient load. (The increase in recent years has been predominantly in elderly patients with multiple morbidities, the decrease in the last 20 years has been in inpatient bed availability.)

Both organisations were “turned around” by empowering clinicians to be “healer, leader, partner”. The VA became a leader in clinical quality, such that the risk of death for men over 65 in the VA’s care is 40% lower than the US average, and patient satisfaction rose to 12% above the national average. These results followed having doctors play “an integral part in shaping clinical services”. The common aim became

“delivering excellent care efficiently”. Further studies have confirmed that the importance of clinician leadership also applies outside the US.

The studies also indicated that a “command and control” approach to leadership in such a complex system does not work well. I am concerned that in SA the public hospital system is trending in the latter direction, despite efforts to engage clinicians in “leadership”.

It is very disappointing to devote much hard work to refine the system ‘from below’ to find one’s efforts thwarted by decisions from above, and this is not an occasional event but a

frequent occurrence. A good example of this is the secret way the plans for the former Marjorie Jackson Nelson Hospital were released without consultation with the main potential patients and health care workers of the proposed institution. Similarly, many of the excellent proposals of the Menadue Report (the *Generational Health Review*), developed after much consultation with clinicians, appear to have been forgotten.

I suspect the best way forward is for clinicians to take every available opportunity to be involved in health care and system planning, and not be daunted when it seems you are always ▶



The other problem to surface is the inadequate provision for teaching within our system, with the primary goal always appearing to be the rapid, efficient and safe ‘processing’ of patients.

A most interesting article came to my attention recently; the *McKinsey Quarterly* from February 2009 entitled ‘When Clinicians Lead’. The article gives examples of two major US medical providers, specifically Kaiser Permanente (Colorado) and the Veterans Health Administration (VA), both of which were struggling with poor clinical and financial performance.

knocking your head, not against a brick wall (which might just give before your head does), but a solid reinforced concrete wall.

A very useful start to improvement would be for "administrative time" of at least 30% be factored in for all clinicians, such that planning can be continually done to improve our complex health care system to improve quality of care.

A good example I noticed recently was when I asked my residents how they could write an accurate discharge prescription which would also be in the discharge summary. They said they could do it on the 'OACIS' information system and they would then have to print it out, sign it, and fax it to Pharmacy! Why could they not electronically sign it, such that it would immediately go to Pharmacy and be a valid prescription, without the potential for further multiple handling?

Having said all that, the 'front lines' are currently relatively quiet, but I suspect turmoil will rapidly return with the onset of the winter rush, and we will then again see the 'top down' administrators

walking the wards saying, "You need to make beds to decompress the Emergency Department". My first response will be: "Have you read the February 2009 *McKinsey Quarterly*?"

My second would be that we need an army of clinical leaders to cut through the problems. The 'redesigning care' concept to improve how we do things is alive and well in our public hospitals, but probably needs more impetus.

I suspect the solution is in multiple small steps, particularly with all clinicians devoting a little effort to improving the efficiency of the system, remembering that it is health care personnel (and not buildings) that make, not only hospitals, but our health care system.

Dr Bill Heddle is a cardiologist who divides his time between public and private practice. He is an AMA(SA) councillor and past president.

The views in this article are the author's personal views and are not intended to represent those of any organisation in which he holds position/office.

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