not uncommon in the Third World — that is, if a doctor is available at all. More often than not, a lay medical practitioner is a patient's only contact with the health care system. Your patients are able to see well trained generalists and specialists. Patients in the real Third World are not as fortunate.

I applaud your effort to make a point regarding the intolerable waits imposed on patients due to the ongoing health care crisis. Like you, I have the same problems accepting referrals from rural and remote centres. Finding an inpatient bed for a sick patient, even one in my own ED, is rarely easy. Unlike you, however, not for an instant do I consider our health care system to be comparable to the Third World. Perhaps it's all a matter of perspective, but I would welcome the opportunity to change your definition of the Third World.

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Reference

1. Innes G. Welcome to the Third World [editorial]. CJEM 2000;2(1):6,60.

The Third World?

To the editor:

The editorial, Welcome to the Third World,[1] about bed access block and emergency department (ED) treatment delays, presents a graphic picture of the impact that hospital overcrowding has on our service delivery and job satisfaction — not only in Canada but throughout the western world.

Bed management and bed access block are whole-of-hospital problems, but they affect primarily the ED. And while many creative strategies have been implemented, the problem continues to worsen. It seems paradoxical that the hospitals with the greatest number of innovative strategies for bed management are often those with the worst bed access block. Perhaps this reflects the fact that ED staff (who actually feel the effects of access block) turn themselves inside out to devise ways of enhancing patient flow. I believe there are 2 key aspects to approaching the problem: gaining control and influencing bed use behaviour.

Gaining control is crucial because our sense of helplessness is a prime cause of job dissatisfaction. But what can we do? In Australia, we have established benchmarks for time-to-treatment and waiting time for a ward bed, with incentives and disincentives to encourage compliance. In addition, we use an ambulance diversion system, which redistributes workload by diverting non-life-threatening cases to other institutions. Another way of gaining control is to establish a "no beds in the corridor" policy that is rigidly enforced. When ED treatment spaces are full, we must stem the inflow or force our inpatient bed managers to reorganize their resources to compensate. The inevitable consequence of this strategy is that, at some point, further ambulances cannot be unloaded — not an ideal situation. While these strategies will not immediately improve bed access, they do allow us to exert some control over conditions in our workplace.

Gaining control will make ED life more liveable, but influencing bed use behaviour has the potential to improve access. How many inpatient physicians have changed their admitting practices or bed use behaviour because of access block in the ED? Why would they, when it is us who feel most of the pain? An occasional inpatient colleague expresses sympathy about the fact that emergency clinicians feel frustrated and defeated by our working conditions, but there is no motivation for them to change their behaviour unless the bed block actually impacts on *their* feelings and working conditions.

The key is to shift some of the effects of bed access block to the inpatient wards. When we are having a bad day, everyone should have a bad day, then everyone will have reasons to adapt their behaviour to the new requirements. This may require a system of incentives or disincentives (e.g., over-census beds on the wards), and these must be strong enough motivators to change behaviour.

In negotiating for these strategies, we must match argument for argument. If the argument is that over-census beds on the wards are dangerous for patients, then the answer is that they are more dangerous in ED, where the patients are sicker and more unstable. If the argument is that there simply are not enough ward beds, then the answer is to conduct an audit of the bed use of individual inpatient clinicians.

The "third world" analogy may be a good one, but perhaps not for the reasons given in the editorial. Third World economies can become developing economies, and developing economies can become world powers. Let's not scare away our potential trainees and future colleagues, who should have the chance to share the experiences that led all of us to choose emergency medicine. Let's show them that we can take control of our environment and share the patient care load across the health care system. Let's not be defeated by bed access block.

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1. Innes G. Welcome to the Third World [editorial]. CJEM 2000;2(1):6,60