The other millennium bug

To the editor:

Having been in Zimbabwe, I missed this past winter's flu epidemic, but my Canadian Internet newspapers told the familiar story of overwhelmed emergency departments (EDs) as the flu bug invaded the true north, weak and dizzy.

Canada's EDs wage a furious and relentless battle against tetanus, and our diligence is no doubt successful in preventing a handful of cases every year. We are so effective that Health Canada reported only 3 tetanus cases in 1997 and 2 in 1998.[1] On the other hand, influenza, also preventable, strikes millions, sends thousands to emergency departments and kills scores.

The Laboratory Centre for Disease Control publishes graphs that document influenza activity over time.[2] Confirmed cases erupt like stalagmites from the floor of the graph in late December, peak in late January and disappear again in early March. This invidious virus employs the same predictable battle plan year after year and regularly brings our Canadian EDs to their knees, yet we do little but sniffle and groan.

In the January 2000 issue of *CJEM*, Chiasson and Rowe[3] reported that, despite Canada's "free" health care system, half of the people who show up on our doorstep have not had the influenza vaccinations they should have had, and that most of these patients are happy to be vaccinated in the ED.

We have the potential to provide a flu-free winter for many of our patients. It's not just about preventing relentless rhinorrhea, miserable myalgias and economic losses caused by work absence; it's about preventing severe complications, hospitalizations and deaths, which our ED population is more susceptible to. We also have the potential to mollify the annual January ED devastation. And the beauty of flu is that we don't have to demean ourselves with this wimpy vaccination stuff all year long. We gear up for 4 weeks to save countless complications and ED visits.

Emergency medicine has been slow to integrate disease prevention into the care of our (captive) clients. After all, a healthy community begets a healthy ED, which provides us the time, space and resources to beget a healthy community.

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The *real* Third World

To the editor:

Having returned to Canada after 6 months in the real Third World, I found many issues of *CJEM* awaiting my attention. Much to my dismay, the first one I opened contained your editorial[1] regarding the "third world." You use the phrase "third world" to describe what you believe to exist in Canada's health care system. It is quite apparent that, while you are faced with a many problems in the emergency department (ED), you are completely out of touch with the Third World. Permit me to take you to the *real* Third World.

Picture a small hospital set amongst terraced farmlands. It is unlike any of the small hospitals that dot Canada's rural landscape. This facility is functional but lacks many items you or I would consider basic or essential. Supplies are limited, costly and, typically, out of date. Equipment is old and donated, but usually functional. Basics such as electricity and running water are unreliable and cannot be taken for granted. This is not the case in Canada.

Your patients have problems, and there is no denying this fact. Illness is a universal phenomenon, but some people are blessed with more opportunities to lead healthy lives. Others are faced with difficult choices and no opportunities. What do you say to the children who suffer from rickets, intestinal parasites and recurrent infectious disease because basic public health measures are not available? How do you tell a mother that her premature infant is not likely to survive because there are no neonatal intensive care facilities? How do you tell a 32-year-old mother of three that she will die of kidney failure because dialysis is not available? These questions are not relevant in Canada because primary and preventive health care measures are well established. Your ED patients have problems, but they do have access to primary, secondary and tertiary health care. Patients in the real Third World don't.

You complain of the long waits and lack of space for your patients. What would be your response if these patients had to wait for days just to see a physician, let alone a specialist such as you? Walking for days just to find a doctor is

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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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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