



Unacceptable emergency wait times

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It has been a long time coming, but finally a report has been presented by a public authority who understands the unacceptable backlogs in our nation's EDs. Kudos to Ontario's Auditor General, Jim McCarter, for his annual report,¹ which nailed the diagnosis.

McCarter highlighted 3 domains that are not meeting system expectations and patient needs: access to alternate level of care (ALC) facilities for patients ready for discharge from acute care, availability of home care, and wait times for the seriously ill in EDs. Not surprisingly, the ED problems are inextricably linked to the long-standing failure of our system to resolve the shortcomings in the other 2 domains:

The public suspects that the main underlying cause of [ED] overcrowding and long waits is the inappropriate use of [EDs] by walk-in patients with minor medical ailments [O]ur research concluded that the lack of available in-patient beds requiring admitted patients to be housed in the [ED] may well have the greater impact. This is influenced by hospital beds occupied by patients awaiting alternate care in a community-based setting.¹

McCarter reported that, in 1 year, more than 50 000 patients in Ontario were kept in hospital longer than necessary—and “admitted” ED patients remained for days in the ED, occupying treatment areas needed for arriving patients. Further, while seriously ill patients in EDs experienced unacceptable delays, those with less urgent problems were attended to within Ontario's target wait times. The report concluded that reducing wait times for seriously ill ED patients by improving access to hospital and ALC beds should be the priority in addressing ED challenges. Others though, including the Health Council of Canada in its analysis of the Commonwealth Fund study,²⁻⁴ state that the main cause of ED backlogs is patients with minor problems whose FPs are not available. They recommend that FPs should work more hours in their offices.^{2,3}

Patients choose EDs for nonurgent problems for various reasons, including—but not limited to—the availability of their FPs. But the number of patients presenting to EDs with minor problems has not decreased despite walk-in clinics and extended office hours offered by many FPs. Further research needs to probe this issue more deeply than the Commonwealth Fund study did.

Recent FP shortages have made finding FPs and getting timely appointments difficult for some. But Canadian FPs currently work, on average, more than 50 hours a week of scheduled office time; 70% of them provide 20 further

hours per week of additional services, including ED shifts.⁵ Are the Health Council of Canada and others suggesting that these physicians further increase their office time or give up their ED duties? Following such advice might not only ensure total burnout of an already strained FP work force but could also be an excellent strategy to deplete the ED work force—further exacerbating the ED crisis.

Many attempts have been made to explain to government that the main challenges facing our EDs are related to capacity to care for seriously ill patients. Commissioned reports^{6,7} have had their recommendations on the need for better home care and ALC services ignored or cherry picked, resulting in isolated strategies rather than comprehensive approaches. Those responsible must heed the evidence and address the spectrum of ED problems we are facing.

Acute care hospital inpatient units and EDs must be staffed with enough skilled nurses and physicians to face daily volume and unexpected surges. Hospitals that have marginalized the role of FPs need to revisit their policies to ensure this valuable cadre of caregivers is appropriately used and recognized. Governments must address shortages of ALC beds and ensure ALC facilities and staff are prepared to provide the levels of care that will enable hospitals to discharge patients promptly. Increases are needed in the numbers and skills of home care and nursing home workers so that fewer people are sent to the ED.

To support appropriate ED use, FPs need to provide patients with timely appointments and a comprehensive scope of services. They should work on teams with other health professionals in their offices or nearby, and include ED and hospital care in their commitment to providing continuity for patients. Practices should maintain patient records electronically, use advanced access booking, and offer extended coverage shared among team members. Family medicine residency programs need to ensure graduates have the knowledge and skills to provide these levels of care for rural or urban communities.

Many factors contribute to ED backlogs, but the volume of less urgent cases is not the main problem. Until patients have better access to ALC facilities and home care, ED wait times will remain unacceptable. 🌻

References

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