Neal Flomenbaum, MD
EDITOR-IN-CHIEF

The "Twilight Zone"?

In 1979, when emergency medicine became a recognized medical specialty, life seemed a lot simpler: Patients who came to emergency departments were evaluated, treated, and afterwards either discharged with appropriate follow-up or admitted to an inpatient unit. There were many more hospital beds available then, and there also seemed to be many more physicians available to care for patients in nonhospital settings, at all hours.

Nowadays, when patients require admission they often remain in the emergency department for extended periods until beds become available. In most hospitals, the responsibility for the ongoing care is transferred to the inpatient provider while the ED nurses respond to the physician orders and deliver that care. Although the ED care is typically excellent up to that time and the care on the inpatient service will also be excellent, until the patient can be transported to an available bed upstairs, we may all be "traveling through another dimension," as the late Rod Serling used to say.

The point here is that the transition in care from ED to inpatient unit has become increasingly troubling throughout this country in recent years as a result of insufficient inpatient beds and the increasing utilization of EDs. Transfers of patient care from one setting or service to another and from one provider to another are known as *handoffs* and have been identified by JCAHO and others as high-risk situations. Although gradually transitioning from ED to inpatient care over a period of hours—sometimes days—may seemingly offer some safety benefits for the patient, it brings with it a series of problems never envisioned by the founding fathers and mothers of emergency medicine: Imagine a relay race where one runner hands the baton to another but doesn't let go completely for another two or three laps.

The questions of who is responsible for an admitted patient's care in the ED and who is responsible for carrying it out are just the beginning. When the situation was sporadic or seasonal, no one paid much attention to it and everyone did whatever was necessary to ensure the best care for a patient, regardless of location or service. But when overwhelming numbers of such patients in the ED began to compete for attention with newly arriving emergent patients, many began to seriously consider how best to organize the care. In some hospitals, appropriately staffed "holding areas" provide at least a partial solution. In others, the ED staff remains completely responsible for the care until a patient is transported to an inpatient bed, a solution that typically requires emergency physicians and nurses to provide types of care not ordinarily included in their scopes of practice or formal training. Still another solution requires an inpatient service to assume responsibility for such patients from the time of admission, which advances patient evaluations and treatments, but often requires inpatient physicians to be in two places at the same time.

Obviously, none of these solutions is ideal, and the variations from hospital to hospital add confusion to the problem. Nor is there any hope that this is just a passing phenomenon. In teaching hospitals, strict resident working hours are now accompanied by caps on the number of patients permitted per resident, and perhaps soon, the number of new admissions permitted per resident on admitting days. Add hospital closings and insufficient numbers of ICU and isolation beds to this, and the dimensions of the problem become apparent.

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Historically, emergency medicine has solved many difficult patient care problems. Now is the time for all of us, together with our colleagues from internal medicine and other specialties, to figure out on a national level what is best for patients and how best to achieve it. □