Inside the emergency department

Clare A Skinner

Emergency departments are under pressure. Chronic staff shortages, access block and other problems are increasingly affecting the ability of medical and nursing staff to treat patients

On 23 September 2007, *The Age* (Melbourne) reported a leaked letter to the Victorian Health Minister from Dr Andrew Buck, an emergency registrar, who described compromised patient care in the overcrowded and understaffed emergency department (ED) at Monash Medical Centre in Melbourne.[1]

News of a miscarriage in its ED waiting room on 25 September shifted the focus to Royal North Shore Hospital in Sydney, initiating scores of complaints in the media from patients and clinicians about treatment provided in New South Wales public hospitals.[2] A fatal cardiac arrest occurred in the waiting room of the Canberra Hospital ED on 5 October. Meanwhile, an identical event occurred in the Royal Perth Hospital ED.[3] These events patently demonstrate that pressures facing these departments are shared nationwide, and that chronic staff shortages and access block are increasingly affecting the ability of medical and nursing staff to treat critically ill patients in a timely manner.[4]

The effects of overcrowding and overwork on patient outcomes have been well described. A study in 2006 found that presentation to the ED during periods of high bed occupancy was associated with higher mortality at 10 days, translating to an estimated additional 13 deaths per year.[5] Numerous studies have described the association between clinician's fatigue and stress with adverse outcomes for patients. The wellbeing of doctors and their clinical practice are affected by making mistakes and the increasing public scrutiny of health care.[6] The qualitative effects of working in chronically stressful ED environments on workforce morale and retention have been less well examined. Despite evidence that overcrowding and overwork harm both patients and clinical staff, few measures have been introduced to combat the pressures or to address the issues at a system level.

Recent media criticism and public scrutiny has caused me, along with many of my colleagues, to reflect on my choice to practise and train in emergency medicine. I have worked in several EDs during the past 6 years: large and small, rural and metropolitan. I can honestly say that there is no other clinical job that provides the exhilaration and satisfaction of a good day spent working in the ED. Unfortunately, a bad day in the ED can leave you very flat indeed.

There are so many reasons why emergency medicine appeals to me as a specialty. Above all, it is always interesting. We deal with all sorts of people and all sorts of problems, often finding ourselves in the thick of human tragedy or triumph. We are the medical jacks-of-all-trades, which means that we have something to offer when faced with any kind of clinical problem, often providing a bridge between other disciplines. We are "safe hands" in the hospital, possessing resuscitation skills to save the lives of critically ill patients, and medical and procedural skills to initiate early treatment. We work with our minds, our hands and our hearts to a degree not shared by any other single specialty. We have the ability to do enormous good for our patients and their families.

Emergency departments have a special quality. The nature of the work makes multidisciplinary teamwork a necessity. Nurses, doctors, allied health professionals and clinical support staff work, and socialise, together more closely in an ED than in most other departments. Emergency medicine attracts competent, quick-thinking and personable clinicians, who not only care for their patients, but look after each other too. An ED nurse told me recently that the only thing that kept her coming to work each day in the face of public criticism was that she loves her colleagues and did not want to let them down. I share her sentiment and her pride.

Despite the many positive features, emergency medicine is struggling to attract and retain clinical staff. Obvious disincentives include shift work, which continues into consultant life; limited access to private billing, resulting in low pay compared with other specialties; and the lengthy and difficult training program. Work intensity has increased, with more patients presenting for treatment, and admitted patients staying longer in the ED while waiting for an inpatient bed to become available. This includes many agitated psychiatric patients. Staff who feel that they are unable to provide timely and high-quality care to their patients become burnt out and take time out from the discipline, entrenching chronic workforce shortages and creating further stress for those left behind. Emergency medicine is very exposed at the "front-end" of the hospital system, and has therefore become overtly political, subjecting staff to regular media attack and reactive, knee-jerk policy implementation. As our doors are always open, EDs are increasingly caring for those who have nowhere else to turn — the homeless and indigent — who present with uncontrolled chronic, often preventable, conditions and have limited or no access to appropriate outpatient treatment or social supports.

It is difficult for ED practitioners to feel valued in the current climate. Negative media reports have given patients and families implicit permission to criticise and even abuse clinical staff. There have been verbal and physical assaults against ED doctors and nurses after the recent publicity, and colleagues report that they increasingly feel emotionally and physically frightened at work. Reliance on locum and overseas-trained staff to fill medical and nursing vacancies has increased. Not only is there resentment of the pay differential, but reliance on casual staff potentially affects teamwork and delivery of patient care. Clinicians also feel undervalued by colleagues in other hospital-based disciplines who do not recognise or respect their unique skill set. It is commonplace for a junior doctor from an inpatient team to speak down to an emergency consultant or advanced trainee. While the "ED versus the world" mentality that ensues may enhance clinical teamwork, it can too easily slide into "ED versus ED" as stress levels increase, damaging workplace cohesion and the quality of patient care.

Emergency medicine is at a crossroads. It is vital that steps be taken to improve workforce recruitment and retention, and to better manage escalating workloads. These measures must deal with education and training needs, industrial conditions, availability of hospital beds, and provision of appropriate primary, community and outpatient care. Staff-to-patient ratios recommended by the Austral-

ian Medical Workforce Advisory Committee in 2003 should be adopted.[7] Emergency clinicians should be valued and supported in providing the best possible care for their patients.

Competing interests

None identified.

Author details

Clare A Skinner, MB BS, MPH, BA(Hons), Registrar
Emergency Department, Royal North Shore Hospital, Sydney, NSW.
Correspondence: clares1@med.usyd.edu.au

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