

The influence of ambulance offload time on 30-day risks of death and re-presentation for patients with chest pain

TO THE EDITOR: We applaud the authors for comparing ambulance offload times with mortality and re-presentation rates for patients presenting with chest pain.¹ However, the model employed by the authors fails to account for the independent impacts of access block and emergency department (ED) overcrowding on poor outcomes and thus risks overemphasising the influence of ramping.

There is clear evidence that ED overcrowding and access block are associated with worse patient outcomes, including increased mortality, re-presentation rates and ambulance offload times.²⁻⁵ This could explain many of the study's findings: ramping is the symptom, ED overcrowding and access block are the disease.

Secondly, there are fundamental differences between tertiles 1 and 3 that have not been addressed. The patients in tertile 1 are more likely to have been offloaded straight into the waiting room, a common procedure in most EDs, whereas patients in tertile 3 would not, potentially due to poor mobility, dementia, or being assessed as requiring significant cardiorespiratory monitoring. For this reason, patients in tertile 1 would be expected to have better outcomes than those in tertile 3.

The article adjusts for the presence of eight comorbid conditions but not their

severity. Furthermore, the incidence of each individual comorbid condition was marginally higher in tertile 3, and although individually not statistically significant, the cumulative impact of multiple comorbid conditions would be higher in tertile 3, which could confound the results.

The study's use of the Charlson index is limited, as it only uses the identified eight comorbid conditions. The Charlson index also includes dementia, hemiplegia, heart failure, liver disease, and cancer; these are not measured in the study and would all contribute to offload delays and worsened outcomes.

Lastly, without including patients presenting via private transport with chest pain, and in the absence of any measures of ED overcrowding and access block, the analysis of patients presenting with chest pain remains incomplete.

That ED overcrowding and access block, evidenced by ambulance offload delays, is associated with worsened outcomes is well known. Unfortunately, focusing on the symptom of ambulance ramping, rather than the disease of ED overcrowding and access block, risks leading to ill-informed policy decisions and ineffective solutions.

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