

## Non-Urgent Patients Are Not a Primary Cause of Emergency Department Overcrowding

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It has long been the conventional wisdom that overcrowding in emergency departments (EDs) is caused by inappropriate ED use by people who should instead take their injuries and illnesses to their doctors' offices during regular business hours.<sup>1</sup> It is often further assumed that many offenders are poor, undocumented, or uninsured people taking advantage of the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires most EDs to provide at least a medical screening examination to all people who present to the ED with an ostensible medical emergency, and to stabilize those who do in fact have an emergency, without regard to ability to pay.<sup>2</sup>

In recent years, these theories have increasingly been debunked. First, the rise in ED use dramatically outstripped increases in both hospital stays and physician visits for many years pre-dating EMTALA's enactment in 1986.<sup>3</sup> Second, non-urgent use appears to have been driven in recent years primarily by patients with private health insurance and Medicare.<sup>4</sup> Third, declining hospital inpatient capacity often prevents acutely ill ED patients who need to be admitted to the hospital from quickly obtaining a bed, meaning that they need to remain in the ED for longer periods, using ED staff time and space which could otherwise be used for other patients.<sup>5</sup>

A study recently published in the *Annals of Emergency Medicine* adds to this growing body of evidence. Michael J. Schull et al. evaluated the effect of "low-complexity" patients on the time it took for "medium- and high-complexity" patients to make their way through the ED.<sup>6</sup> To do this, they used data from the Canadian National Ambulatory Care Reporting System to evaluate all the ED visits that took place in Ontario between

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<sup>1</sup> See, e.g., U.S. GENERAL ACCOUNTING OFFICE, *EMERGENCY DEPARTMENTS: UNEVENLY AFFECTED BY GROWTH AND CHANGE IN PATIENT USE* 4 – 5 (1993), <http://161.203.16.4/d36t11/148331.pdf> (finding that ED administrators believed that the primary cause of ED crowding was the use of the ED by people with non-urgent problems, even though those people had other sources of care in the community).

<sup>2</sup> See 42 U.S.C. §§ 1395dd(a), (b)(1)(A) (West 2002). All hospitals that accept Medicare as payment are included under the statute.

<sup>3</sup> Kevin F. O'Grady, et al., *The Impact of Cost Sharing on Emergency Department Use*, 313 *NEW ENGLAND J. MED.* 484 (August 22, 1985).

<sup>4</sup> Peter Cunningham & Jessica May, *Insured Americans Drive Surge in Emergency Department Visits*, ISSUE BRIEF NO. 70 (2003), <http://www.hschange.org/CONTENT/613/613.pdf>.

<sup>5</sup> Robert Wanerman, *The EMTALA Paradox*, 40 *ANN. EMERGENCY MED.* 464 – 69 (Nov. 2002) (citing American Hospital Ass'n, *Emergency Departments - An Essential Access Point to Care*, TRENDWATCH (March 2001)); AMERICAN HOSPITAL ASS'N (AHA), *CRACKS IN THE FOUNDATION: AVERTING A CRISIS IN AMERICA'S HOSPITALS* 4 (August 2002); Robert W. Derlet, *Overcrowding in Emergency Departments: Increased Demand and Decreased Capacity*, 39 *ANN. EMERGENCY MEDICINE* 430, 431 (April 2002).

<sup>6</sup> Michael J. Schull et al., *The Effect of Low-Complexity Patients on Emergency Department Waiting Times*, *ANN. EMERGENCY MED.*, doi:10.1016/j.annemergmed.2006.06.027 (2006). "Low-complexity" cases were distinguished from "medium-complexity" and high-complexity" cases based on triage acuity, arrival by other than ambulance, and discharge to home. *Id.*

April 1, 2002 and March 31, 2003.<sup>7</sup> More than four million visits to 110 EDs were included in the final analysis.<sup>8</sup>

The authors found that, on average, 16 new low-complexity patients presented for treatment in an eight-hour interval.<sup>9</sup> These patients together raised the mean ED length of stay for medium- and high-complexity patients by 8.6 minutes (where the mean total ED length of stay for that group was 4.5 hours), and the time it took to see a physician by 3.4 minutes (where the mean total time to first physician contact for that group was 1.2 hours).<sup>10</sup> While these results are statistically significant, the authors found them clinically insignificant; in other words, they likely had little if any impact on the treatment outcomes for the medium- and high-complexity patients.<sup>11</sup> They accordingly concluded that attempts to divert low-complexity patients from EDs “are unlikely to produce meaningful improvements in waiting times for sicker patients.”<sup>12</sup>

This study further underscores the disconnection between the conventional wisdom regarding ED overcrowding and the actual causes. It is easy to blame EMTALA for ED overcrowding. Hospitals and other health care providers may see the statute as burdening them with mandatory charity care for potentially anyone who sets foot in their ED. Additionally, those most helped by the statute – poorly-insured, uninsured, and/or minority populations – tend to be less powerful in this society and accordingly may be easier to scapegoat. Yet the present approach of seeking to divert patients with non-urgent conditions from the ED will likely do little to solve the problem of ED overcrowding. A more complex solution will likely be required.

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<sup>7</sup> *Id.*

<sup>8</sup> *Id.*

<sup>9</sup> *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*