IS THERE AN EMERGENCY?

What happens in the emergency room (ER) is not commonly discussed among medical specialists outside of those staying in the ER. It is therefore good, in my opinion, to see an article tackling the length of stay (LOS) in the ER in this issue – mentioned by the authors as probably the first study reported in local literature. Length of stay in the ER is actually a healthcare quality metric that is monitored in patient care institutions in many countries worldwide.[1-3] Many of the patients managed by their doctors have at some point or another gone to the ER either to get initial treatment before being admitted or to receive added care before they are sent home. How well they are treated in the ER can determine to a large extent the eventual outcome for many important diseases (e.g., stroke,[4] myocardial infarction,[5,6] etc.). For some, an ER visit is an indicator of inadequate disease control (e.g., hypertension[7-9] or bronchial asthma[10]) or a need to modify pharmacologic treatment (e.g., COPD[11]). And for many others (acute abdomen, accidents, disasters, etc.) going to the ER is an important, if not the best means, to access appropriate healthcare for their conditions.

The study reported in the article was retrospective in design and understandably therefore came with limitations. It was also conducted in a large private tertiary medical center in Metro Manila where the patient pool may not be representative of the Philippines in general. But it does provide some initial insights. The authors found that longer length of stay (LOS) was associated with urgent and emergent triage-levels, older age range, out of pocket payment (OOP), and morning and afternoon shifts – although it should be mentioned that the absolute differences of LOS were mostly less than two hours. Whether or not these differences are clinically significant, for example as determinants of clinical outcome and/or healthcare costs, remains a question.

Interestingly, more than 50% of the patients seen in the study were less than 40 years old with more females than males, the latter also a phenomenon among outpatients with more females seeking medical consultation.[12,13] If the catchment area of the hospital is reflective of the predominantly young population of the Philippines then, as the authors suggest, this can just reflect that. But younger people should have less reason to go to the ER. Even trauma (or accidents) which are more common in younger age groups constituted only about 10% in the study cohort, so there may be other explanations worth looking at.

For one, it would have also been interesting to see the relative distribution of LOS by gender and the reasons for their ER consults among the various age groups. Given the greater mortality and morbidity among older males – would a preference to going to the ER to seek medical care rather than following up with their doctors be a possible explanation for this greater mortality? The breakdown of the reasons for their ER visits could have given a better insight on the health seeking behavior among older males as well as across the different age groups and gender.

One might expect that older patients may also have more complicated conditions thus needing more care – and thus longer LOS – but this was not reported. It would also have been noteworthy to see whether costs would have also been higher with longer LOS as this would certainly be of more consequence to a patient who may have to bear at least some of these costs. One could also surmise that more complicated conditions require more diagnostic procedures (which can explain the longer LOS) leading to greater costs. The interaction of LOS with various factors such as older age groups, higher triage level – which can imply more serious disease conditions and OOP would have been very interesting relationships to look into as it could reflect the challenge patients face with our current healthcare system. Therefore, the LOS could have been more meaningful if it could be correlated with clinical impression, reason(s) for consultation, number and/or complexity of diagnostic procedures, time until seen by a physician, etc., as these would give better insights on health seeking behavior and standards of patient care. These are factors that have been identified in other studies looking into determinants of LOS in the ER.[14-18]

This may even have relevance to the (not uncommon) observation among clinicians in private hospitals that those who did not have to pay were more likely to go to the ER. In the study, 70% of those who consulted had a third-party payer (e.g., HMOs) but also tend to have the lower LOS. Knowing the reason for consultation could have helped understand this better as those who do not have to think of payment may also tend to be more predisposed to going to the ER even for non-urgent conditions.

Across all shifts – including the night shift – nearly 40% of cases being seen were non-urgent but it was not possible to correlate this with the type of payor based on the data in the article. For HMO patients, it may even provide an opportunity to get free home medications which are not covered for a visit on an outpatient basis. It may therefore be worth looking into this phenomenon in the local setting where the ER is being used as an outpatient facility – with a bonus of free medications from their third-party payor. It is also possible that with parents working night shifts (e.g., those in the BPO industry) and majority – if not all – of the outpatient clinics closed, they bring their children or even themselves to the ER even for non-urgent conditions. In a future era of truly universal healthcare, this needs to be anticipated as it may lead to overutilization of ER visits and potentially higher costs.

Hopefully, if more data can be reported from this cohort, more notably the conditions for which ER consults were made and their accompanying costs and outcomes, there may be more answers coming. Alternatively, focusing instead on those with prolonged LOS and/or specific conditions could better reveal where the potential problems are.[19-20] More importantly, I think, a similar look into what happens in the ER of public hospitals is needed as the findings may be very different. This way, we can really determine if we have an emergency in our hands.

Joven Jeremius Q. Tanchuco, MD
Editor-in-Chief

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