EDITORIAL

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# Emergency Medicine–SR*


Last September, I wrote about the increasing number of patients spending hours or days—entire hospitalizations in some cases—in EDs, receiving inpatient care while waiting for beds upstairs to become available. I compared the handoff of medical and nursing care for such patients to a relay race where one runner hands the baton to another but doesn't let go completely for another two or three laps. But what happens when no one is available to accept the baton? Should the emergency physician keep running? And if so, for how long?

Current solutions to the lack of inpatient beds include observation units adjacent to or outside the ED and "virtual" observation beds in the ED or elsewhere. These beds are designed for patients who require short-duration "post-ED" care. The lack of sufficient numbers of traditional inpatient providers relies on emergency physicians, hospitalists, physician assistants and nurse practitioners to staff these and other "non teaching" inpatient services. In many cases, hospitalist services are not consistently staffed during off-hours and holidays. At academic centers, an additional gap in care providers has resulted from reductions in residents' clinical hours and the number of patients they are permitted to care for, stranding many more patients in EDs.

One issue that must be resolved quickly is the confusion caused by differing rules for short-stay units. Such units generally operate under strict state-mandated limits on lengths of stay and reimbursement, and they vary from state to state. Obviously, creating and mandating uniform nationwide definitions and standards is something only CMS can do.

Dealing with the human resources component of short-term "post-ED" hospital care may be more difficult. There aren't enough hospitalists, PAs, and NPs currently to provide the needed care, and there won't be for many years. But hospitalists need not come from only a single specialty, and family practice and emergency medicine can also contribute to the pool. Emergency physicians may be best suited to care for patients in short-term care units. But all providers must be available 24/7, and should probably be required to undergo some additional training. If emergency physicians are not permitted to use the designation "hospitalists," perhaps "Emergency Medicine–Slow Release" might best describe their activities.

Forty years ago, emergency medicine was created out of a critical need for high-quality care for the increasing number of patients coming to ERs—a need that other specialties were unable to meet or uninterested in addressing at the time. By all accounts, EM's response to that need has been spectacularly successful, changing the course and history of medicine. Now, the acute need has shifted downstream, after the initial phase of emergency care has been completed. Once again, other specialties have not responded fully to the need, and once again, emergency medicine should rise to the challenge by increasing its scope of practice and training.

To those who feel that current patient care must suffer to obtain necessary resources for high-quality future patient care, and to those who place medical education or their own schedules ahead of patient care, the words of Richard Fariña, 1960s singer/song writer and member of the famed "Cornell School" of writers, seem particularly relevant: "No use crying, talking to a stranger, naming the sorrow you've seen/Too many bad times, too many sad times/Nobody knows what you mean/But if somehow you could pack up your sorrows and give them all to me/You would lose them, I know how to use them/Give them all to me." **EM**

*Slow release.