found that patients discharged on Fridays were significantly more likely to experience an event (hazard ratio 1.04, 95% confidence interval 1.02–1.05).

Maybe I'm overlooking something, but a hazard ratio of 1.04 does not look very important, although the huge number of patients makes it significant. The hazard is the slope of the survival curve: a measure of how rapidly subjects are readmitted (or die). If the hazard ratio is 2.0, then the rate of readmition or death in one discharge-day group is twice the rate in the other group. If the hazard ratio is 1.02 to 1.05, readmission or death is 1.02 to 1.05 times more likely on Fridays than on Wednesdays. Although this is not nothing, neither is it as dramatic an issue as the title suggests.

Axel Ellrodt
American Hospital
Paris, France

Reference

1. Van Walraven C, Bell C. Risk of death or readmission among people discharged from hospital on Fridays. *CMAJ* 2002;166(13):1672-3.

[One of the authors responds:]

Axel Ellrodt is correct when he points out the small absolute differences in adjusted 30-day death or urgent readmission. Overall, the event rate was 7.1%. A 4% relative increase brings the event rate up to 7.2%. This is a small increase. The table in our study shows that day of discharge has a weaker association with outcome than the other factors we studied.[1]

We believe that the importance of our findings will stem from an exploration of why such differences exist. We believe that further study is required to determine if the care of patients discharged on a Friday systematically differs from that of patients discharged on other days and, if so, whether this explains the difference in outcomes. We hope this will shed more light on why bad things happen to some patients and identify interventions to improve patient outcomes.

Carl van Walraven
Physician and Scientist
Ottawa Health Research Institute
Ottawa, Ont.

Reference

1. Van Walraven C, Bell C. Risk of death or readmission among people discharged from hospital on Fridays. *CMAJ* 2002;166(13):1672-3.

Emergency department overcrowding

As an emergency physician who has worked for many years in an urban tertiary care centre, I absolutely support the notion raised by Jane Upfold in her commentary[1] that it is unethical for an emergency department to go on critical-care bypass and refuse a critically ill patient. In the same issue, Anne Walker clearly outlines the duty of both the hospital and the physician to provide emergency care.[2]

In 1990, I published a review of 4 years of critical-care bypass statistics. The most striking finding was the more than 8-fold increase in overwhelmed status over the previous 4 years. The 3 most frequent reasons for the department "going on bypass" were insufficient nursing staff, no beds and no cardiac monitors. Often, 2 of these reasons were combined.

One decade later, the Canadian Association of Emergency Physicians and the National Emergency Nurses Affiliation published a position statement on emergency department overcrowding. It stated that overcrowding is a cause of inadequate patient care, prolonged delays in the treatment of pain and ambulance diversions. Overcrowding was again caused by, in part, a lack of beds for admitted patients and a shortage of nursing staff, in addition to a shortage of physician staff. According to the position paper, "the cause of ED overcrowding generally lies outside the ED. Efforts to maximize ED efficiency are important, but overcrowding is a symptom of system failure."[4]

It is unreasonable and unethical to hold physicians liable for not delivering adequate care to patients they never get to see (because they are diverted to another site), that they see too late (because of patient backlog or space) or that they see without the staff or diagnostic and therapeutic tools required to assess and treat in a timely fashion. Hospital cutbacks have created an environment where emergency physicians cannot reliably deliver the standard of care that is legally and ethically expected of them.

Walker noted that the "Ontario Court of Justice confirmed that, if a hospital wishes to discontinue or curtail its emergency services, it has a duty to take reasonable steps to notify the public of these changes." A 10-year paper trail of documentation indicates that the hospitals are aware of the problem.

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