Getting Better at Being Worse

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Although we know people in general (and physicians in particular) are unreliable estimators of quantitative patient risks,[1-5] it is not broadly understood that they are rather good at accurately ranking and managing risks.[2,6-8] Studies of "situated cognition" have shown that human performance on real-world tasks is generally good even if performance on formally similar tasks under laboratory conditions is not.[9] Thus, when forced to distribute a scarce resource (eg, ICU or inpatient beds) among a group of deserving patients, skilled clinicians are consistently able to allocate the resource to those who need or can benefit from it more and to do so in such a way that those denied that resource get other interventions that decrease their risk. For example, when the coronary care unit is full, potential admissions are screened more carefully so that individuals selected to remain on the floor or in the emergency department (ED) are at lower risk than those transferred to a higher level of care[10]; when the hospital is full, patients selected to board in the hallways have better outcomes than those assigned to regular beds[11]; when the ICU is full, a few less seriously ill patients are identified as "bumpable," potentially transferable to the ward should a new patient with greater need present.[12]

The Scheuermeyer et al[13] report in this issue of *Annals* clearly demonstrates this ability. To cope with crowding, the authors devised ways to manage some chest pain patients in the waiting room when there were no staffed, monitored beds available in the ED. They were able to adapt to a severe resource constraint in a way that allowed them to meet their clinical goals while keeping risk as low as reasonably practicable, given their straitened circumstances.

Although we usually think of adaptability as an individual, in-the-heat-of-the-action phenomenon, this report and others[14] show that organizations can exhibit a similar sort of adaptability; they can come up with creative ways to largely meet organizational goals while moderating the concomitant increases in risk.

We appreciate this capability, but it has a dark side.[15] Success in coping with a problem can mask it or be misinterpreted to imply that it is inconsequential or has been resolved. And, because no one gets credit for preventing things that haven't happened, success often leads to a drift toward failure,[16] especially under economic and workload pressures.[17,18] Although the adaptive performance of the emergency physicians reported by Scheuermeyer et al[13] is admirable, there is a danger that the wrong lessons are being learned from their success.

First, it seems misguided to attribute success to the use of a "validated triage tool" and a "rigorous triage process," rather than judgment and expertise. Virtually all these patients would be level 2 in the Canadian Triage and Acuity Scale; thus, the success of the triage process likely depended more on bringing to bear the experience, tacit knowledge, intuition, judgment, and expertise of skilled nurses and physicians to dynamically resolve resource and goal conflicts in real time, in context. The rationalist thinking that currently dominates medicine makes us uncomfortable with words such as *expertise*, *intuition*, or *judgment*[19]; they sound too much like magic. But, the rigor in the triage process that contributed to success was most probably not in tools, algorithms, decision support, or "validity" but rather in engaging experts' situated judgments promptly and consistently. It involved *phronēsis*—knowing how to act effectively in a particular context—rather than *sophia*—knowing how to reason logically about the world. If any magical thinking were involved, it is in the inference that following the model of technical rationality was the key to success.[20]

Second, the idea that because nothing went wrong, everything is all right is both seductive and dangerous. Organizations flirt with the boundaries of danger all the time; it's one way they discover where those boundaries are. But repeated exposure to potential hazards without obvious adverse consequences leads to a numbing of the sense that a boundary has been crossed. This has been called the "normalization of deviance" and was popularized in studies of the *Challenger* disaster.[15,21,22] Normalization of deviance is a slippery slope; experience with boundary crossing leads people and organizations to embrace substandard practices as normal. At first there is a reluctance to cross the boundary, but repeated trespasses without visible consequences lead to the conclusion that boundary crossing is acceptable. Ultimately, boundary crossing becomes viewed as the *normal* way of working. When the new, deviant pattern mitigates a resource problem or serves some other goal, it is likely to persist even when the initiating conditions have abated.[23] Thus, organizations come to behave in

ways that are more risky than they realize or would desire.[24-26] Accidents in such a system are not aberrant events, but rather the normal outcomes of the system's structure.[27,28]

The positive way in which waiting room management is described in the article may be a consequence of recent experience. Some months before the intervention, this ED experienced a series of waiting room deaths.[29,30] A cluster of such events rends the social fabric of organizational life and work by challenging its belief in its own efficacy and drawing attention, in ways that can no longer be casually dismissed, to its failure in managing hazards. Consequently, a great deal of effort gets invested in restoring both internal and external beliefs of capability and control. The celebrated deaths of 2005 led to several interventions, and those activities must be seen as successful for work to go on normally. The organization adopted an overcapacity protocol, which has been pronounced a success,[30] at about the same time as the waiting room intervention was implemented. These interventions increase performance pressure more than they expand resources to meet demand, a pattern fairly typical of assertions of the adequacy of control aimed at reassuring internal and external audiences.[31]

In addition, the internal audiences in a complex organization such as an ED are heterogeneous and likely hold different views about value and the risks of the waiting room intervention. If the physicians already had excess capacity (which seems unlikely), then investing that excess in waiting room care might be reasonable; but if they were already near saturation, it raises the question of who does the work forgone by prioritizing the waiting room patients? Nurses may tend to think that they are left "holding the bag" in this situation, and that might play into common nursing framings of work around assignments, ratios, and not overextending oneself past one's competency. Did nurses go out into the waiting room too, or did those patients forgo nursing care altogether? The point here is, given severe resource constraints, conflicting goals, and heterogeneous work groups, it is likely that the intervention affected different groups differently and that there are a variety of views about it beyond the single voice expressed here.

Finally, this article suggests a sad sort of organizational codependency, in which the ED compensates for deficiencies in the larger organization by subordinating its own needs and priorities. There is a deep irony in taking pride in being good at dealing with things you don't deal with well. (See Lund[32] for more on how to accomplish this nifty trick.) The irony is that as long as the ED can somehow cope, using good luck and short-term "patches," the longer the organization can delude itself that everything is all right,[33] that its ability to respond to the extraordinary is adequate, even as that ability is being frittered away dealing with the ordinary.

The first published report on crowding may have appeared in 1974[34]; the American College of Emergency Physicians' first position statement on crowding was published in 1990.[35] Twenty years later, we are close to having an entire generation of emergency physicians who have never experienced an ED that does not routinely manage patients by double bunking or by stashing them in aisles, hallways, waiting rooms, offices, closets, and other nominally nonstandard spaces. As temporary expedients become permanent routines, our creativity in devising short-term workarounds has led not to long-term success, but rather to an unsustainable vicious cycle that can only end tragically. If we do not change course, we will end up exactly where we are headed. Today, the waiting room; tomorrow, the parking lot?

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IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Perinephric abscess presenting as rash. This perinephric abscess extended beyond the perinephric region into the psoas muscle and subcutaneous tissues. The abscess required surgical drainage and 2 weeks of intravenous antibiotics. *Escherichia coli* grew from urine and wound cultures. The patient improved without permanent sequela and the infection was attributed to neurogenic bladder dysfunction.

A perinephric abscess is a localized collection of purulent material between the kidney capsule and the Gerota fascia and is often the result of untreated urinary tract infection, intranephric renal abscess, recurrent pyelonephritis, obstruction, or hematogenous spread. Common etiologic organisms are *E coli*, *Proteus*, and *Staphylococcus aureus*. Onset of symptoms is insidious, and the majority of patients report pain for more than 14 days.[1] Symptoms are usually suggestive of pyelonephritis and include fever, dysuria, and flank pain. Physical findings may include costovertebral angle tenderness. Rarely, a palpable flank mass or rash is present. The mainstay of treatment is percutaneous drainage and intravenous antibiotics.[2]

A useful clinical feature of perinephric abscess is that patients are typically symptomatic for greater than 1 week; in contrast, patients with acute pyelonephritis are frequently hospitalized within 5 days of symptom onset. This insidious presentation may delay the diagnosis and treatment of a perinephric abscess.

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