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 readmission 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.

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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.

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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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More recent evidence suggests that the problem is no longer episodic but constant. As such, hospitals have effectively curtailed their ability to deliver emergency services to meet cost-containment goals. Hospitals now have an obligation to advise the public and the provincial authorities of the actual level of service that they can provide.

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3. Kollek D. Overwhelmed in emergency: examining ER status at Hamilton Civic Hospital. *Ont Med Rev* 1990;57:11-3.
4. Canadian Association of Emergency Physicians, National Emergency Nurses Affiliation. Joint position statement on emergency department overcrowding [position statement]. *CJEM* 2001; 3(2):82-4. Available: www.caep.ca/002.policies/002-01.guidelines/overcrowding.htm (accessed 2002 July 17).

[The author of the review article responds:]

In his response to my article,[1] Daniel Kollek has identified the essential legal issue with which we are now faced: whether it is reasonable and ethical to hold a physician (or hospital) liable in negligence for failing to treat or for inadequately treating an individual in need of emergency care due to patient overcrowding, lack of personnel or equipment, or both. By the "reasonable person" standard, the answer may be "no"; however, it remains to be seen what the judicial response will be.

Since the Fleuelling case,[2,3] a second action has commenced in Ontario relating to the issue of emergency department overcrowding. In the Mitchell case,[4] a girl of 10 months died after a 5-hour wait in a hospital emergency department. The family has commenced an action against the hospital and the emergency department staff. In a separate action against the Government of Ontario, the family alleges that negligent actions and decision-making by servants of the government, including decisions to reduce health care funding, contributed to the overcrowding and the resultant delay in treatment. The Ontario government failed on a recent motion to strike out the statement of claim as disclosing no reasonable cause of action, and the litigation can proceed.[4]

Kollek has identified an obligation on the part of hospitals to advise the public and the government of the actual levels of emergency services that they can provide. Such disclosure may serve to emphasize the severity of the health care situation and may reduce public reliance on the services provided by emergency departments and staff. Although the court has identified a duty for hospitals to advise the public of emergency department closures and reductions in staffing, I would hesitate to conclude that a declaration by a hospital that it is no longer performing up to the accepted standard of care would protect it and its staff from legal ramifications, especially considering the recent trend in litigation.

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Decriminalizing nonmedical drug use

Robert Remis' commentary[1] questions the potential effectiveness of safe injection sites for secondary prevention because of the chaotic lives of many injection drug users. But Remis fails to mention that much of that chaos comes from users' struggles to obtain money to pay for their drugs and evade criminal prosecution.

As a family doctor with a longstanding interest in HIV, my practice has in recent years increasingly come to encompass hepatitis C, injection and other drug use, prescription drug abuse, harm reduction, Aboriginal and mental health, advocacy for access to the nonmedical determinants of health and liaison with prison health services.

I would suggest a far bolder approach than Remis advocates to minimize nonmedical drug use and its enormously (and increasingly) costly personal and societal consequences.

Government should confine its role to what it can do. It is surely by now beyond dispute that if an individual wants to use a particular drug he or she will do so. Drug price, poverty, the law, warnings and the risk of violence are clearly ineffectual deterrents. People make their own choices and have to live with the consequences. The important thing is that they comprehend the facts needed to help them decide so that the consequences are minimized. To achieve this (as with liquor and Al Capone), government must take over the supply and distribution of drugs from the gangs. The gangs' profit motivation ensures the constant recruitment and initiation of new users.

Decriminalization without regulation could do more harm than good. I suggest that the right to obtain, possess and use each drug — from marijuana through "party drugs" to injection drugs — should be subject to licensure. High quality, accurate primary preventive education for the specific drug concerned would be targeted precisely at each licence applicant. A government monopoly and affordable drugs would go a long way toward ensuring that safe and supervised legal injection sites would be accepted by users.

After an initial period of enforcement, this would result in a significant shift in human resources from police, legal and correctional service vocations to research and preventive work in the fields of health and the nonmedical determinants of health.