

The emergency department is no place to be told you have cancer

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■ Cite as: *CMAJ* 2024 May 13;196:E626-7. doi: 10.1503/cmaj.240612

See related article at www.cmaj.ca/lookup/doi/10.1503/cmaj.240095

This issue of *CMAJ* features Brenner and colleagues¹ projections for cancer diagnoses in Canada in 2024. Despite overall declines in cancer incidence and mortality, population growth and aging will drive an increase in the absolute number of people receiving a diagnosis of cancer this year. This is a daunting prospect, considering that many people with worrisome signs or symptoms of cancer already face circuitous and frustrating paths to obtain a diagnosis and start treatment. Receiving a diagnosis of cancer in an emergency department is becoming routine in Canada, which highlights the failure of health care systems to support adequate primary care-initiated pathways for diagnosis of suspected cancer. One in 5 people in Canada do not have a regular primary care provider and, even among those who do, many report poor access to primary care.² Moreover, wait times for diagnostic imaging vary widely, and some patients wait months for diagnostic imaging for suspected cancer.³ We discuss how expanding access to streamlined paths for cancer diagnosis is critical to ensure the gains that have been achieved in cancer screening and treatment are not lost amid inefficiencies in health care systems.

Between 2012 and 2017, 26.1% of patients with cancer in Ontario received their diagnosis as part of an emergent presentation requiring urgent hospital admission as a consequence of an emergency department visit.⁴ As emergency physicians, we perceive that this proportion has increased substantially in the pandemic recovery period. People who have an emergency department visit associated with their cancer diagnosis are often older, do not have access to primary care, come from minority backgrounds, or have lower socioeconomic status than those who do not have an emergency department visit associated with their cancer diagnosis.⁵ They also have worse cancer-related outcomes, such as higher stage at diagnosis and worse overall survival.⁶

Patients with symptoms of suspected cancer, such as unexplained weight loss or a palpable mass, are seen in the emergency department because it is one of the few places where urgent diagnostic imaging or other tests can be arranged. Although access to testing may be expedited, an

emergency department is an unfortunate place to be told “you may have cancer.” One important reason is that emergency departments are now routinely overcrowded, with patients receiving care in spaces like waiting rooms, hallways, and utility closets. In a qualitative study of patients who found out they had gastrointestinal cancer during an emergency department visit, patients overwhelmingly reported the lack of privacy as distressing and inappropriate.⁷ Patients also leave the emergency department with uncertainty about follow-up and treatment plans, let alone prognosis.

Another reason that emergency departments are a terrible place to receive a cancer diagnosis is that most of them do not routinely have processes in place to confirm a cancer diagnosis, such as arranging and following up on biopsies or ordering other diagnostic tests that are often necessary for referral to a cancer specialist.⁸

Single-entry referral models for patients with suspected cancer may be a potential solution to facilitate further testing and improve access to specialist follow-up. When specialist referrals are made using a single point of entry and a coordinated approach to triage, the time from referral to consultation decreases, and patient and provider satisfaction is higher than before implementation of the single-entry model.⁹ Given the projected increase in cancer diagnoses and use of emergency departments to facilitate diagnostic testing, all emergency departments should have access to a single, streamlined, and uniform process for any patient with a new suspected diagnosis of cancer.

To address increasing medical complexity and the large proportion of patients without family physicians, hospitals are also piloting navigation programs after discharge from emergency departments to ensure that follow-up care for patients with complex medical conditions occurs as planned.^{10,11} These have been adapted from the broadly implemented navigation programs for patients with cancer,¹² whereby phone calls and email communication between the clinician-navigator and patient may mitigate some patient uncertainty and distress after receiving a new or suspected cancer diagnosis in the emergency department.

Patients may not need an emergency department visit at all if access to outpatient clinics that streamline the diagnosis of suspected cancer is increased. In Ontario, several diagnostic assessment program (DAP) clinics are available for the work-up of certain cancers, such as lung, colorectal, and breast cancer.¹³ A person with a suspicious lung mass on chest radiography can be referred, and the DAP clinic will arrange for further imaging, biopsy, and management, as needed. Studies of patients with lung cancer in Ontario have shown that people assessed through DAP clinics had earlier treatment and improved survival.^{14,15} Expanding access to diagnostic clinics for suspected cancers and increasing their regional availability may help ensure timely work-up and management.

Brenner and colleagues¹¹ projections serve as a reminder that successes in prevention, screening, and treatment of cancer lead to a decline in the incidence of cancer and associated mortality. Continued efforts to increase awareness of early cancer symptoms, reduce barriers to cancer screening, and increase capacity for its early diagnosis in primary care and hospitals are critical. To lose the gains made in cancer outcomes to the overcrowding, fragmentation, and inefficiencies of health care systems would be a tragic shame.

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Competing interests: Keerat Grewal reports funding from the Canadian Institutes of Health Research and the Canadian Association of Emergency Physicians. Catherine Varner's competing interests can be found at www.cmaj.ca/staff.

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Investing in streamlined care for patients experiencing early pregnancy loss in Canada would reduce substantial suffering

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■ Cite as: *CMAJ* 2024 October 15;196:E1171-2. doi: 10.1503/cmaj.241402

See related article at www.cmaj.ca/lookup/doi/10.1503/cmaj.231489.

In this issue of *CMAJ*, Mehra and colleagues¹ review the diagnosis and management of early pregnancy loss, commonly referred to as miscarriage, which affects 1 in 5 pregnancies in Canada. The symptoms of early pregnancy loss, such as vaginal bleeding and pain, often begin mildly and increase over a period of days to several weeks. Patients have reported appalling experiences of seeking care for such symptoms in Canada's health systems. At least 1 Canadian jurisdiction has recognized the care gap and developed standards of care for early pregnancy loss in 2019,² yet not much has changed. Canada's health care systems need to ensure streamlined access to urgent and follow-up care for all pregnant people experiencing symptoms of early loss.

Most people with vaginal spotting, bleeding, or substantial pain early in their pregnancy seek urgent medical care with their family physician, in a walk-in clinic, or in an emergency department, given that they have not yet met their obstetrical care provider and hospital labour and delivery units do not see patients before the 20th week of gestation. A 2020 study of all documented pregnancies in Ontario over a 15-year period found that 4 in 5 people with threatened or spontaneous pregnancy loss visited an emergency department.³ Although the emergency department is the safest and most expeditious place for a pregnant person to be treated for massive uterine hemorrhage or a suspected ruptured ectopic pregnancy, pregnant patients who are not critically ill often receive suboptimal care in emergency settings.⁴ They have longer-than-average lengths of stay, sitting in chairs in non-private locations, and describe being made to feel as though they are “wasting the emergency department providers' time,” given space constraints and relative stability compared with sicker patients.^{4,5} Continuity of care is also a concern, with many discharged without a follow-up plan or physician responsible for ongoing care, which contributes to high rates of return visits and puts patients at risk of preventable complications, such as ruptured ectopic pregnancy and massive hemorrhage.^{4,5}

The psychological toll of a bad experience in the emergency department during early pregnancy loss is also high, especially

when access to timely follow-up care is limited or absent. A narrative review of the psychological effects of early pregnancy loss reported that 4–6 weeks after a loss, 8%–20% of people were above a symptom threshold consistent with moderate depression, as were 18%–32% for anxiety, and 25%–29% for post-traumatic stress disorder; the time needed for psychological recovery to baseline was a full year.⁶ Because the physical and psychological sequelae of early pregnancy loss may also affect one's occupation, personal relationships, and parenting, societal consequences are immense; they are also under-recognized.⁷

Considerable evidence, accumulated over more than a decade, has shown that patients with early pregnancy loss are better off if they can bypass the emergency department; in response, early pregnancy assessment clinics that do not require a referral have been established in some health care systems, such as in the United Kingdom and the Netherlands.^{8,9} Such clinics operate on an urgent assessment model and, in program evaluations, have been shown to offer higher quality and more cost-effective care than previous, less-streamlined care.⁸ The national health system in the UK has established 200 early pregnancy assessment clinics, and the care provided has been shown to have a positive effect on physical and psychological well-being.⁹

Recognizing the care gap and the solution, Health Quality Ontario introduced a quality standard for early pregnancy complications and loss in 2019, and suggested 8 care- and system-related recommendations.² One states that all patients with symptoms of pregnancy loss should have access to early pregnancy assessment services, at least in the form of follow-up with a provider with expertise in the management of early pregnancy complications after an emergency department or primary care visit. Five years on, little if any progress has been made toward achieving this goal. Early pregnancy assessment services remain a pipe dream for many, especially in rural Canada.

Health policy-makers should seize the current momentum in health care innovations to champion a patient population with an ambulatory-sensitive condition that has well-defined standards of

care and a proven, cost-effective alternative environment to overcrowded emergency departments. Evidence from early pregnancy assessment clinics in other health systems would support expanding Canada's limited number of such clinics, increasing operating hours, and allowing attendance without a referral to mitigate substandard physical and psychological care of pregnant people undergoing a common event that can — without quick access to care and good follow-up — result in unnecessary suffering.

Although expansion of early pregnancy assessment clinics would improve the care of most patients experiencing miscarriages, patients for whom medical management has failed or who prefer surgical management may still experience additional delays or be unable to access surgical care. Some hospitals are unable to accommodate these patients in elective operating room schedules, and rely on resources of abortion clinics to provide surgical management. Even if patients are added to urgent surgical wait-lists, they are often still waiting when they spontaneously pass a recognizable fetus at home or in the waiting room of an emergency department, while experiencing heavy bleeding and pain.¹⁰ As provinces fund new outpatient surgical models of care, they should consider urgent gynecologic procedures as well, as these surgical centres may be ideal environments to coordinate these urgently needed, low-risk procedures. Failing to do so would be a giant misstep.

Given health systems' current focus on health care innovations that seek to provide the right care, at the right time, by the right provider, in the right location, prioritization of patients experiencing early pregnancy loss would seem deserving of attention, given their risk for enduring physical and psychological effects related

to existing models of care. It is time to invest in early pregnancy assessment clinics that are better equipped to provide a more tailored, patient-centred experience and greater understanding of early pregnancy complications and loss than can be found in an overcrowded emergency department.

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“Social admissions” to hospital are not personal failures but policy ones

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■ Cite as: *CMAJ* 2024 May 6;196:597-8. doi: 10.1503/cmaj.240577

See related article at www.cmaj.ca/lookup/doi/10.1503/cmaj.231430

In research published in this issue of *CMAJ*, Mah and colleagues summarize clinicians’ experiences of providing care for patients whose presenting illness is not acute and for whom admission to hospital is not warranted, and yet complex health needs and a background of inadequate social supports mean they cannot safely be discharged.¹ The article’s authors use the term “social admissions.” Yet, the pervasive, pejorative term often used is “failure to cope,” which implicitly blames the person for their circumstances.

In an era when hospitals routinely exceed 100% occupancy, “socially admitted” patients are seen as a problem by clinicians, hospitals, and governments.¹ Providers perceive that such patients receive suboptimal care, yet they experience frustration that hospitals have become the place where all roads lead for an increasing number of people who cannot manage in the community. However, patients are not to blame for the fact that home care is inadequate, long-term care is unavailable for a patient who really needs it, or lack of access to secure housing means managing a chronic condition in the community is impossible. We discuss how reframing this problem as a policy failure and applying evidence-based upstream policy investments could help to address it.

Many hospital quality committees use the percentage of patients admitted to hospital who no longer need acute care (they occupy 10%–20% of hospital beds in many parts of the country) as a quality indicator, and “alternate level of care throughput ratio” is now a priority metric for Ontario Health’s 2024/25 Quality Improvement Plan.^{2,3} The urgent need to open up hospital beds and mitigate emergency department crowding has led some governments to tell patients who are occupying an alternate level of care bed that they will be transferred to a long-term care bed many kilometres from where they live; if they do not wish to go, they will be charged for the hospital bed.⁴ Without other options available and amid unprecedented crowding, emergency department providers are also discharging patients to situations they know are likely harmful and hazardous. In almost all cases, clinicians and not the policy-makers are tasked with telling patients they need to go to a location that is unsafe, undesirable, or both.

Punitive policies like these cause distress to patients, families, and providers and have not restored hospital occupancy to manageable levels. These policies are also at odds with most health care workers’ deep commitment in wanting to do better for patients who are otherwise let down by the broader health and social care systems.¹

Nonpunitive approaches are better for patients and decrease hospital admissions and costs.⁵ One approach is to embed personnel and programs that address the complex care needs of patients at risk of needing “social admission” within emergency departments.

Emergency department pilot programs of peer support workers are underway, whereby people with previous or current lived experiences of marginalization, such as homelessness, mental illness, or substance use, help patients with similar lived experiences establish trust with the clinical team and navigate social supports within the community and avoid hospital admission. Recent literature on peer support workers in hospital-based settings shows that they provide critical support for patients accessing social supports and harm-reduction services.⁶

Geriatric emergency medicine nurses and multidisciplinary geriatric teams are increasingly commonly embedded in Canadian emergency departments and help manage and coordinate the care of frail older adults with declines in function or cognition. These initiatives reduce admissions and decrease repeat visits in a cost-effective manner.⁷ However, they are not a replacement for community-based supports, such as adequate home care or access to long-term care.⁷

Hospitals are also expanding health care teams to include community health workers to help vulnerable people connect with health and social services. Often lay people living in the same community, community health workers tailor supports to the physical and mental health needs of the individual and assist with tasks such as helping with access to income supports, or accompany people to medical appointments. This shift aligns with the long-standing evidence of health and social care being shaped by conditions outside clinical settings.^{8,9}

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A review from the World Health Organization concluded that community health workers extend health care services to vulnerable populations, meet health needs in a culturally appropriate manner, improve access to services, address inequities in health status, and improve health-system performance and efficiency.¹⁰ However, these gains are contingent on community health workers being integrated through public policy measures that include linkages to planning for health human resources and data sharing, and processes for addressing the myriad of governance, legal, and financing issues that arise when building strong community health worker programs.¹⁰

Canada's health systems are fragmented, uncoordinated, and underresourced, and its social safety nets are frayed. Despite the promise of the programs described herein, they do not address the social determinants of health that can drive presentations to emergency departments. To restore human dignity in health care — to properly address the barriers experienced by patients and the moral distress of health providers — structural factors causing health disparities must be confronted as policy failures, not personal ones.

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Competing interests: www.cmaj.ca/staff (Varner and Laupacis). Andrew Boozary serves on the board of Inner City Health Associates.

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