

The emerging subspecialty of Hallway Medicine

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While we applaud the efforts of some Ontario hospitals to quarantine their entire emergency departments (EDs), the growth in the subspecialty of Hallway Medicine seems irrepressible. It is impossible in a simple review article to adequately describe all the great strides made in the science of Corridorology; yet we feel com-

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pelled to explore the emergence of this fascinating branch of medicine that first introduced the intricacies of physical examination through three layers of clothing.

It is unfortunate that the architects and designers of our medical institutions had the myopic vision to ignore the possibilities of using the hallways for advanced medical care. In an era of cutbacks and cost constraint, can we honestly overlook the efficiencies of using every available space? Certainly it is wasteful to ignore long hallways, alcoves, waiting rooms, and even nursing stations, as repositories for complex patient encounters.

Triage

The word triage comes from the Latin root “*trial*,” which means literally, “to sit and wait for something horrible.”

Deciding which patients fit the complex criteria necessary to qualify for hallway placement is a premiere opportunity to practise the art of medicine. Although one would think that placing patients in the hallway is best initiated only when other resources are stretched to their limits, the true hallway connoisseur will find ample reasons to use corridor space early. For example, witness the following discussion.

Doctor: Could that be melena I smell from the man in the hallway?

Nurse: Yes doctor, I’m sure it is.

Doctor: Oh, I am so glad this patient was not in a room where we may have missed this clue to his underlying presentation.

In fact, olfactory recognition is often one of many subtle indicators to help with triage decisions. The simple rule of Hallway Medicine, “Never remove the shoes,” can be followed logically by the corollary, “All hallway patients require a pedicure” — an add-on service to increase private payment reimbursements. While the neophyte may believe that the patient who requires testing for ethanol level (major criterion) is an ideal candidate for hallway space, the minor criteria of gingivitis, dysentery, mange, delirium or psychomotor agitation may all make for perfect hallway candidacy.

Benefits of hallway placement

Infection control

We know that many ED patients harbour as yet undetermined infectious diseases. Enclosing them in private

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rooms ensures that the highest concentration of spores and airborne particulates are condensed into a small space, increasing the likelihood of you or your nursing staff inadvertently sucking one of these “death morsels” into your airway. Public health experts who study nosocomial infection have long raved about the airflow dynamics of hallways. Airborne pathogens that would otherwise concentrate in enclosed rooms can frolic, free and unencumbered, in ED corridors. Clearly, by placing those patients with the highest infectious risk in our hallways, we encourage the dilution of these floating fomites into the far greater capacity of our inner spaces, thus decreasing everyone’s risk.

Disaster preparedness

One of the greatest challenges posed by a community disaster is finding the space to triage and manage a large number of potentially ill or injured casualties. By continually practising, implementing and perfecting the efficiencies of Hallway Medicine on a daily basis, we can work out the obstacles ahead of time — although, when a real disaster does occur, the parking lot will have to be used, because the hallways will be full.

Visibility

Like an erupting comedone, the question of privacy keeps reemerging. Although “privacy liberals” criticize the lack of confidentiality of the hallway experience, they conveniently ignore the undeniable advantages of increased visibility. Every year, thousands of confused elderly patients, concealed behind ED curtains, clamber over bedrails and hit the floor, with disastrous consequences. But in the high visibility milieu of the corridor, when a patient rears up and attempts to test gravity, there are bicycle couriers, security guards and pizza delivery boys to leap to the rescue. Who could miss a patient on a hallway stretcher who is having a seizure? And who could question the diagnostic advantages of having multiple medical practitioners offer quick glance opinions as they walk past your

“diagnostic dilemma” in the hallway? If two heads are better than one, why stop at two?

Efficiency

Cynics point to Hallway Medicine as a by-product of hospital overcrowding. But isn’t overcrowding just another word for efficiency? When Intel squeezed 4 gigabytes into the same silicon wafer that once housed 20 megabytes, did software experts whine about overcrowding? Of course not! Efficiency and technological advancement run hand in hand. To illustrate, in the 1980s, a decade characterized by waste-

ful excess, EDs typically managed only one patient in a standard 4 × 8 ft ED cubicle. Yet even a simpleton could tell you that two 2 × 6 ft stretchers — and two patients — will easily fit into the same space. And this is only *two-dimensional* innovation. Thinking outside the box and exploiting Japanese initiatives in hotel cubicle design, it is plain to see that an average ED cubicle can accommodate

two stretchers stacked 3 deep, allowing 6 patients to share the same treatment space. By limiting our vision to the obvious, the full potential of Hallway Medicine may never be realized.

Point-of-care testing

Why bring the patient to the hospital when we can take the hospital to the patient? The simple bedside glucose testing of yesteryear has evolved into bedside chemistry, blood gas testing and cardiac marker analysis. Recently, portable ED ultrasound has enabled us to further expand the gamut of medical resources we can deliver to the patient. Call me a dreamer, but I foresee a day when we can examine, test, treat and discharge patients from our hallways and ambulance bays without ever moving them into an area staffed by health care providers.

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Customer satisfaction

As medicine is increasingly recognized as a service industry, we owe it to our patients to keep them happy. Has a hallway patient ever complained of boredom? Or of not be-

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ing carefully monitored? And how better to avoid the discomfort of being placed in a semi-private room with an undesirable partner, or worse yet, the embarrassment of being housed with a patient of another gender? Yes, patient satisfaction and Hallway Medicine are a match made in heaven.

Future challenges

Unfortunately, Hallway Medicine carries certain stigmas that require alteration if we are to continue the deserving growth in this specialty. The first hurdle to overcome is the unthinking disapproval associated with the perceived lower status of hallway placement. Better Hallway Medicine terminology will aid in this conversion. Rather than calling key treatment areas “the Back Hall” or simply “the Waiting Room,” we should assign more fitting and dignified monikers: “Hall of Fame” or “Carnegie Hall” for starters. Perhaps the titles “High Occupancy Rotunda” or “Over Census Antechamber” are more appealing. And who would refuse an opportunity to be treated in the “Over-Beveraged Vestibule?”

Research

Like any emerging field, research is the key to credibility, success and advancement in the field of Hallway Medicine. Fortunately, HM researchers will not be driven by the same financial challenges (i.e., painfully huge pharmaceutical incentives) that have led otherwise talented scientists to address the same monotonous research question over and over and over again (e.g., “Which thrombolytic-glyco-

protein inhibitor-anticoagulant combination will generate the smallest p value without producing an actual survival benefit?”). No, Hallway Medicine researchers will answer important questions like, “When doing a hallway examination, is it best to use the sheet to cover the patient’s head or the doctor’s?” Or, “Is privacy enhanced more by taking a history in pig Latin or by using cellphone text-messaging?” Or, “Can logistic regression techniques be used to derive a valid formula to predict the number of complex waiting room patients an untrained candy striper can monitor at one time?”

Already there is a backlash. Undiscerning critics of Hallway Medicine have pointed to a series of double standards. Why are EDs allowed to have the full use of their hallway resources when other floors are constrained to using only identified patient rooms? Why is it acceptable for the ED to convert their dirty utility room into a procedure room? How can the ED withhold basic human rights and ignore the Amnesty International standards for Turkish prisons when other wards are expected to treat their patients humanely?

Only through the concerted efforts of hospital administrators and their political masters has this burgeoning subspecialty been allowed to flourish. It is the hope of the author that the families and loved ones of those responsible will someday have the opportunity to benefit from the progress we have made in the hallway management of acute illness.

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