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Use or abuse? A qualitative study of physicians' views on use of observation stays at three hospitals in the United States and England

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Abstract

Objective: Accumulating evidence has seen increasing use of observation stays for patients presenting to EDs requiring diagnostic workup or time-limited treatment plans, but critics suggest that this expansion arises from hospitals' concerns to maximize revenue, and shifts costs to patients. Perspectives of physicians making decisions to admit, observe or discharge have been absent from the debate. We examined the views of emergency physicians in the US and England on observation stays, and what influences their decisions to use observation services.

Methods: We undertook in-depth, qualitative interviews with a purposive sample of physicians in three hospitals across the two countries, and analyzed these using an approach based on the constant-comparison method. Limitations include the number of sites, whose characteristics are not generalizable to all institutions, and the reliance on self-reported interview accounts.

Results: Physicians used observation status for the specific presentations for which it is well-evidenced, but acknowledged administrative and financial considerations in their decision making. They also highlighted an important role for observation not described in the literature: as a 'safe space', relatively immune from the administrative gaze, where diagnostic uncertainties, socio-medical problems and medico-legal challenges could be contained.

Conclusions: Observation status increases the options available to admitting physicians in a way that they valued for its potential benefits to patient safety and quality of care, but some of these have been

neglected in the literature to date. Reform to observation status should address these important but previously unacknowledged functions.

Introduction

Background

When emergency physicians need additional time to evaluate patients prior to a decision to admit or discharge them, they may place them in observation—an increasingly utilized hospital-based ambulatory service.[1–6] Used appropriately, observation helps resolve diagnostic uncertainty and instigate time-limited treatment plans while minimizing the potentially adverse consequences of full hospital admission. In the US, research finds that observation not only affords physicians additional time to make an accurate diagnosis, but also represents a cost-effective substitute for short-stay admissions that could save the healthcare system up to $3bn a year.[7–10] Similarly, in England, research finds that observation can reduce unnecessary inpatient admissions, inappropriate emergency department (ED) discharges, and length of stay.[11–15]

However, others are critical of observation stays. In the US, studies have found that observation is used for a much wider range of diagnoses than indicated by the Centers for Medicare and Medicaid Services (CMS), and often for more than 48 hours,[16] with dubious clinical or cost benefit, and potential negative consequences for patients. Observation stays may shift healthcare costs to patients, because they are classified as outpatient care, even though patients can remain overnight in the hospital. As such, patients are liable for a 20% copayment—and for up to 100% of hospital charges for all prescription medications and supplies, and any room and board beyond 48 hours,[17] increasing out-of-pocket expenses for some patients in highly-publicized incidents.[18] Recent Medicare policy changes have sought to simplify classification of observation status;[19] nevertheless, some claim that hospitals are increasing their use of observation stays to reduce inpatient claim denials under the Recovery Audit Contractor (RAC)

program, and avoid financial penalties imposed for high readmission rates by CMS' Hospital Readmissions Reduction Program.[20–22] Yet recent work suggests that the increase in observation stays is not attributable to hospitals' efforts to reduce their readmission rates.[23] One study found that use of observation in the Veterans Administration (VA) is increasing at a similar rate as in Medicare, even though VA hospitals are subject to neither RAC audits nor the Readmissions Reduction Program.[4] This casts doubt as to whether these policies are truly what is driving the increase in the use of observation stays, and raises the question of what is actually behind the increase.

In England, observation stays are also increasingly prevalent, and National Health Service policy may provide an explanation.[24,25] EDs in England are struggling with issues of overcrowding and increased wait times, and observation may be one strategy for addressing these issues by improving the flow of patients through the facility,[26] avoiding breaches of the system's "four-hour standard"—which stipulates that patients should spend no longer than four hours in an ED before being admitted or discharged, with associated financial and reputational costs for hospitals that fail to meet this standard for 95 percent of patients.[27]

Importance

The increasing prominence of administrative, rather than clinical, considerations in discussions of observation status has led some commentators to describe observation as "medical purgatory",[5] and current policy as "madness" designed "to confuse and enrage physicians,"[28] who must navigate the complexities of its rulebook and prioritize billing concerns over patients' needs.[29] The Society of Hospital Medicine, representing hospitalists who are sometimes responsible for classifying patients as inpatients or observation status, recommends the elimination of observation status altogether.[30] There is evidence of the consternation caused by observation status for physicians, asked to make decisions replete with financial, legal and clinical risks for hospital and patient.[5,17,30,31] But to date, no systematic study has examined observation from the decision-making physician's perspective, and the relative influence of

clinical and administrative considerations in these decisions.

Goals of this investigation

In this qualitative study, we interviewed a sample of American and English emergency physicians to uncover the drivers of observation use. We aimed to use cross-national comparison to illuminate commonalities and divergences in practice, highlighting how peculiarities of organization and financing give rise to differing norms and conventions of clinical practice that may or may not be driven primarily by patient need. By comparing the views of practitioners in two very different systems, we sought analytical purchase on the relative importance of drivers that are relatively context-independent (such as clinical need) and those that arise from specific features of the American and English systems.

Methods

We interviewed 24 emergency physicians using an in-depth semi-structured format. Our sample included 10 physicians from a university healthcare system in the US Midwest, and 14 from two hospitals in central and northern England. The study was approved by the University of Iowa IRB. Capitalizing on the professional relationships of emergency physicians on our research team, we contacted potential participants by email and/or telephone, informed them of the study, and invited them to be interviewed. We attempted to elicit a variety of viewpoints and bolster generalizability by recruiting physicians of both sexes and with wide-ranging practice experience. Participants received a $50 Amazon.com gift card as a participation incentive.

We conducted all interviews in person, using a digital audio-recorder to capture data, which were then professionally transcribed. The interview guide contained fixed-response and open-ended questions (see web appendix 1), developed after reviewing the literature and discussion among co-investigators, including American and English emergency physicians. We allowed conversations to evolve naturally. We did not ask every question on the interview guide of every participant, and sometimes changed the

question order and asked additional questions when interesting, unanticipated topics arose.

GPM led analysis, using a blend of inductive and deductive approaches informed by the constant-comparison method.[32] He began by reading and rereading each transcript, then coded data, assisted by NVivo software, combining *a priori* themes derived from the existing literature and included in the topic guide with themes that emerged in the course of reading the transcripts themselves. A process of refinement followed whereby data assigned to each category were re-read, compared with one another, and some categories were merged or further disaggregated. BW read all the transcripts, reviewed the codes developed by GPM to validate their accuracy and adequacy, and discussed discrepancies until reaching consensus.[33] Finally, we explored relationships between codes and constructed a narrative to explain our data, focusing on similarities and differences between the American and English findings.

Results

Twenty-four physicians (five women and 19 men) were interviewed for the study. Their post-residency practice experience ranged from two to 17 years for the 10 US participants (mean eight years), and from one to 15 years for the 14 English participants (mean seven years).

We briefly compare the forms and functions of observation stays in England and the US, and the drivers behind these. Then we consider physicians' views of the advantages and disadvantages of observation status. Despite cynicism about its growth, most participants saw merit in observation status, due in part to the expedited care pathways it offered certain patients. But physicians also emphasized a different role for observation, which aligned neither with policy objectives, nor with conventional criticisms of observation status's 'mission creep': as a 'safe space' for dealing with patients who fell outside clean diagnostic categories, but whose safety required extended medical oversight.

1. Observation stays in comparative perspective

Across all three institutions, physicians described a common set of circumstances behind the rise of

observation status. Developments in medical science, together with the 'bed crunch' and an increasing awareness of the downsides to hospital admission, meant that greater numbers of patients presenting in the ED could and should be treated on ambulatory pathways (Table 1). On a day-to-day basis, though, this manifested as a generalized pressure to reduce utilization of inpatient resources as much as possible, particularly in England, where "we just don't have enough space for inpatients" (England#1).

Alongside this, the distinctive characteristics of the national context also affected the specific form taken by observation. In the US, the application of utilization-management guidelines in payers' policies resulted in a precise definition of observation stays, based on CMS' 'two-midnights rule', and on the specific criteria accepted as necessitating inpatient admission. In the American hospital, a team of 'nurse navigators', inculcated in these criteria, was employed to review physicians' decisions, and revise these 'upward' (if an observation patient's clinical presentation merited inpatient admission) or 'downward' (if an admitted patient's presentation did not), as required. Perhaps in consequence of these organizational arrangements, physicians in the American hospital had few qualms in referring patients for observation rather than as inpatients: "those ambiguous cases we tend to go more towards obs, and we've been taught that it's easier to flip them to inpatient than it is to downgrade them" (US#1).

In England, the bulk of the caseload seen as appropriate for observation was similar to that in the US, with two exceptions. First, English physicians tended to refer larger numbers of relatively short-stay patients for observation. The four-hour standard in England—whereby 95 percent of patients must be transferred within four hours of attendance—meant that observation stays were used for patients requiring diagnostics that were difficult to administer within a four-hour window, who in the US would have remained in the ED (Table 1). If asked to say what minimum duration of stay indicated observation, English physicians unanimously stated four hours, whereas American physicians largely gave answers in the six-to-eight-hour range, likely driven by Medicare reimbursement policies for observation stay, which stipulate a minimum of eight hours. Second, there was less inclination to move or re-designate

patients whose stay was longer than anticipated as inpatients, in the absence of the financial consequences for the hospital or the patient that applied in the US. Financial risks to the patient simply did not apply in the English system: there was no prospect of being billed for appropriate or inappropriate use of observation or inpatient facilities in a system that remains free at the point of use. That is not to say, however, that English physicians' decision making was purely clinical. Though still a single-payer system, hospitals in England are reimbursed by activity, not capitation, and some aspects of the English system have been remodeled in a way that resembles the American managed care model.[34] Accordingly, the drivers in the two systems had more in common than received comparisons of the American and English systems might suggest,[35] particularly in relation to the time spent on administrative and financial systems. Efforts to maximize reimbursement were noticeable in England as in the US, exemplified in one participant's description of "an army of people [employed by the hospital] called clinical coders who just troll through anybody's hospital encounter and look for things they can code to earn income" (England#6). English physicians acknowledged that they had to be cognizant of such concerns, and of the four-hour standard, in their practice (Table 1), even if they had repercussions only for the system's finances, not their patients'.

2. Emergency physicians' views of observation stays

Reflecting the perceived importance of billing criteria (US) and waiting-time standards (England) in its rise, participants expressed ambivalent views about observation stays. In both countries, there was some cynicism about its expansion. In the US, it was seen to have increased the bureaucratic burden, both in terms of auditors whose primary concern was determining an administrative categorization with limited clinical significance, and for ED doctors themselves:

> "There are always more issues that are far more pressing and time-sensitive than what level of care this patient needs to be assigned. Does this patient need to be shocked or not: that's the decisions that I'm under." (US#7).

In England, observation status was similarly contaminated by its association with the four-hour standard. In both countries, physicians gave examples of how these issues sometimes influenced clinical decision-making:

> "[Hospital administrators] would see that, for instance, there are no acute medical beds in the moment, but there is five empty beds on [observation unit]. They would then actually say, 'OK, could the patient not go into the bed?'" (England#8)

> "It doesn't affect me at all and it doesn't really affect the care that the patient receives. It could affect their bill. Whether their outpatient prescriptions are covered and those sorts of things. […] It's a nuisance." (US#4)

Such influences had no direct impact on the safety of care received by patients, however, and participants were clear that the clinical need of the patient always took precedence in their decision-making. Accordingly, we found no outright hostility to observation status.

Indeed, many participants saw observation stays in a more positive light than the literature would suggest,[17,30,31] and felt that it made important contributions to high-quality care. Broadly, these could be split into two categories, following a distinction first made by sociologist Robert Merton:[36] the *manifest* functions of observation status—the deliberate, declared objectives of policymakers and administrators—and its *latent* functions—activities that may be just as important and just as prevalent, but which are not formally recognized in official policy, regulation or organization. This typology is similar to other frameworks, such as Hollnagel's distinction between 'work as imagined' and 'work as done',[37] the sometimes-loose relationship between the 'formal' and 'informal' organization,[38] and the disjunctures often observed between the 'blunt end' and the 'sharp end' of healthcare delivery.[39]

3. The manifest functions of observation

The manifest functions of observation status were the clearly defined diagnostic and treatment pathways, with clear evidence bases, guidance and protocols, which could usually be delivered within 24 hours

without recourse to inpatient admission.[19] In such cases, physicians were clear that observation presented a 'win-win' for system and patient, avoiding unnecessary admissions and offering patients speedy resolutions:

> "A classic example is chest pain where we really just need to rule out acute coronary syndrome, and we can do that with a series of EKGs, blood tests and maybe another provocative test. [...] It's a useful thing and I think that's the right thing for a lot of patients." (US#2)

> "There are quite clear pathways that they come under. Where it comes with head injury and CT scanning, patients who have possible cervical spine injury, they require a period of observation. There's a wait for them because we often have to wait for the reporting of the scans." (England#4)

In all three hospitals, conversely, participants stressed the need to avoid using observation stays as a catch-all for patients without differential diagnoses: "[without] an explicit diagnosis and an intended course of care, […] they become what is jokingly referred to as clinical indecision units" (US#7), leaving patients "in limbo" (England#2). But used judiciously, observation offered a functional and efficient route to effective care for patients with particular, well-defined indications—albeit with the potential for greater out-of-pocket cost for American patients.

4. The latent function of observation

However, not all patients could be readily assigned to these diagnostic categories and corresponding care pathways. Participants noted that much of their caseload was characterized by uncertainty, of a kind that was unlikely to be resolved satisfactorily within the ED. While some patients were 'no brainers' for inpatient admission or swift discharge, others were in a 'gray area' that required careful risk assessment and management. Here observation served a second—equally important, but unintended or 'latent'—function.[36]

Thus while explicitly rejecting the use of observation for deferring decisions without an explicit care plan, participants also described a particular group of patients for whom there was a legitimate role for observation even in the absence of a clear pathway. These included patients whose pathologies were yet to 'declare', but who did not meet inpatient admission criteria, or for whom conservative management seemed most appropriate:

> "Certain patients may have no known medical problems but are having abdominal pains and you want to watch them to see if that develops into anything worse—appendicitis. Maybe in that younger population who you could avoid having to send them to a CAT scan, because that's a lot of radiation and you've got a 14-year-old female: you really don't want to radiate her ovaries at 14. So maybe you just want to watch that patient for 12 hours." (US#10)

> "We just sometimes need longer with these patients to see which way their disease is progressing and therefore we're stratifying them rather than just a very definitive very black-and-white decision of admission or home. It gives us a third way and it keeps patients safe." (England#13)

They also included patients for whom discharge would pose significant risks in the short or long term, for reasons ranging from the medical to the social:

> "The people that we really don't know what to do with, and they're symptom-based, like just pain. […] Failure to thrive, I think, is a valid diagnosis to put somebody in the hospital for at least 24 hours to figure out what they are going to do." (US#3)

> "I look at their social circumstances, and that's becoming more of a prevalent problem with our geriatric population who just don't have an adequate social network to look after them. Even if medically they don't need to come in for whatever reason, their social setup is not good enough, they will often bounce back within 24 or 48 hours anyway."

(England#1)

In practice, 'medical' and 'social' reasons for observation overlapped significantly. Two patients with similar clinical presentations might necessitate very different courses of action, depending on factors such as their home circumstances, ability to self-manage, and access to primary care:

> "There's some things that could be safely treated as an outpatient if the stars align and the patient has good care at home. […] On paper you can make an outpatient treatment plan, but say the person doesn't want to get their antibiotics, or doesn't have a primary-care doctor to follow up with, or has been noncompliant with their medications for the 10 last times you've seen them. That in my mind makes that person a high-risk patient for outpatient treatment failure, so that's somebody that I will obs, and again it's more for those social reasons, which the hospital hates." (US#1)

> "Particularly for the kids, and honestly for all groups, it depends a lot on the rest of the situation. If [...] the parents are there with the kid—and this is a value-judgment call—but they seem like engaged parents who are comfortable taking the kid home, who would watch the kid closely, and would have good transportation to get back to the emergency department if something happens with the kid, then a lot of times we'll send those people home. Conversely, if it's a situation where the place that they would be going to isn't a good environment, either kids or adults, […] then those patients we would admit to be observed." (US#2)

> "An 89-year-old patient who comes in, has been living on their own, and they just generally are not feeling right in themselves. It could be a mixture of medical problems. When you go deeper into their social and functional aspect of their things, you might find out that they've been living alone for a long while and they're struggling. […] These are the ones that we typically need some more time where other members of the team can

observe and have a more detailed chat." (England#7)

Finally, in the US in particular, medico-legal considerations also permeated physicians' decision making—specifically the fear of being held liable for missing a rare but dangerous pathology. Such concerns were also present, though less prevalent, in the English participants' testimony. Table 2 provides further examples across the continuum of medical, social and legal reasons for using observation offered by physicians in both countries.

What was evident was that observation offered an important 'safe space' for such patients, who lacked positive diagnoses and fell short of criteria for inpatient admission, but whom physicians could not in good conscience discharge. Whereas, in the US institution, utilization-management guidelines were applied fastidiously for inpatient admissions with nurse navigators and auditors screening each admission, use of observation was monitored less forensically (Table 2). Thus while access to inpatient status was governed by the inflexible application of *tightly-specified administrative categories*, observation stays allowed ED doctors to deal safely with *indeterminate clinical realities*:

> "We don't have well-validated clinical decision rules for everything, or even most things, that come to the emergency department. So in the absence of one of those, then it becomes very Gestalt-driven and it's going to be determined by a number of factors, including the patient's social situation." (US#7)

> "Some of that is intuition, just looking at someone and saying, 'Hey, I know that on paper this person looks like they're uncomplicated but they look sicker than they are, or their health literacy is really low, or they have a terrible social situation', and you're not going to discharge this person expeditiously." (US#1)

Given this misalignment of bureaucratic and clinical worlds, however, there was a sense that the safe space provided by observation was also an endangered space. The latent function of observation stays currently operated outside the line of sight of administrators and auditors, but this was not

guaranteed. Participants in the US hospital noted that as salaried physicians in a major tertiary medical center, they were protected from pressures to which peers in other institutions might be subject: for providers "working in a different type of institution where their own personal compensation is more closely tied with reimbursements they get for patient care, […]people practicing in that environment would probably be much more attuned to all of these things" (US#2); "from discussions with other people I know, they are getting increasing degrees of pressure to be discharging patients" (US#7).

Limitations

Two limitations of our study in particular should be noted. First, its generalizability may be limited given its reliance on participants from three institutions, including only one in the US—and one where emergency physicians were salaried employees, which may result in different incentive structures and practices from hospitals with self-employed providers. Second, our reliance on interview-based accounts of practice may give rise to certain forms of bias in the data collected, most notably social-acceptability bias—which may limit participants' acknowledgement of, for example, the influence of administrative concerns on their individual clinical decisions.

Discussion

Our interviews indicate differences as well as similarities in the development and realization of observation status, reflecting the importance of nationally-specific policy in determining eligibility, form and function. In particular, observation seemed to be a broader category in England, resulting from the four-hour standard (increasing the number of shorter-stay observation patients) and the absence of the two-midnights rule (increasing the number of longer-stay patients). Nevertheless, in the main, physicians on both sides of the Atlantic described a similar set of patients as candidates for observation, and while they expressed resentment at the bureaucratic burden it imposed, they saw it as a useful option for these patients, in contrast with the intimations of the limited literature on physicians' views of observation

status.[17,30,31]

These included patients with clearly indicated diagnostic or treatment pathways, for whom observation stays could offer advantages for patients and system—albeit with the potential for greater out-of-pocket cost for American patients. These patients followed clear, agreed ambulatory protocols: the manifest function of observation status. They also included a very different group of patients—but these were not patients who were 'dumped' in observation in order to avoid inpatient claim denials or financial penalties.[20–22] On the contrary, these were patients whose clinical presentations did not fit administrative categories for inpatient admission, but who in the judgment of physicians in both countries could not safely be discharged, for medical, social or legal reasons—or a complex combination of interacting medical and social needs that are poorly reflected in reimbursement models and single disease-oriented treatment protocols in both countries. In participants' views, these were legitimate patients for observation; that such use of observation status was noted in both countries suggests that this is a patient group with distinctive needs rather than a byproduct of the way either jurisdiction organizes healthcare. But use of observation in this way ran counter to the pressures that had led to its expansion, particularly in the US.[1,7–10] Thus while observation stays were in part the product of evermore exacting criteria for inpatient admissions, they were also used to allow safe practice when those administrative categories failed to reflect uncertain clinical realities.

Consequently, the latent function of observation as a 'safe space' for managing clinical and social uncertainty seemed precarious, given the evermore intensive focus on healthcare resource use with a view to cost containment. ED physicians acknowledged that not all hospitals were willing to overlook this use of observation status, given the likelihood of incurring costs that payers would not cover, and recognized that they were sheltered from the consequences of their decisions in a way that colleagues paid on a fee-for-service basis were not—with the potential, as others have noted,[29] for clinical decision-making to be influenced by financial incentives. Our findings also suggest that the potential of

observation stays for cost containment may be limited: while for one group of patients it was indeed used to expedite care and reduce unnecessary inpatient resource use, for the other it merely brought patients out of the immediate gaze of administrators and insurers. This raises the possibility that observation stays in the US may be subject to the same scrutiny, and tighter stipulation of eligibility criteria, as inpatient care. But we would caution against this: it was evident from our interviews that emergency physicians did not take decisions to observe lightly, and that if forced to discharge, there was real potential for adverse outcomes in the short term, and increased resource use in the long term. Recent thinking in safety science has noted the place of adaptability in response to clinical uncertainty,[37,40,41] and the pragmatic use of observation status by the physicians in this study might be seen as exemplifying such mindful, professional flexibility. Any rush to further formalize use of observation status may thus be ill-advised—and seeking to expand observation status to account for the breadth of purposes to which it is put in practice may have just as many unintended consequences as efforts to tighten eligibility and 'legislate out' such uses. For patients with uncertain disease trajectories, or suboptimal home environments, the latitude that currently exists has clinical benefits that could easily be undermined. Baugh and Schuur note: "not all observation care is the same; payment reforms should protect patients from excessive out-of-pocket expenses and reward the efficient care delivered in observation units, which prevents prolonged hospitalizations. Public outcry about observation abuses has led to governmental attention, but reforms may threaten all observation care."[18] Our study suggests that a neglected, third function of observation—beyond its roots in protocols for specific conditions, and its use to protect revenue from inpatient utilization audits—also has clinical and organizational value that should be recognized.

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Table 1: Physician views of the antecedents of observation care

Generic factors	US-specific factors	England-specific factors
"For me as an older physician, it's a little different because back in the 70s in the US, you would admit somebody for a week for their physical. And they would get their stress test, and a colonoscopy, and they'd hang out. We don't do any of that anymore." (US#5) "The cost of a bed, proportionally, to the cost of getting other tests done, has risen in a disproportionate way. So a CT scan before, we used to have one CT scan to do everybody and length of scan for CT head used to take you an hour to do. Now, a CT head takes under ten minutes to get done with three scanners working around the clock. So the proportionate cost of that has fallen considerably." (England#10) "It's not benign just putting someone in the hospital because the hospital, let's face it, is where all the sick patients are. So you get admitted, you get put in for something that really didn't need it and then you get pneumonia." (US#10) "PE is an example. I would have never have dreamed about sending a pulmonary embolism home in the 90s, ever. Now, it's like OK, you got a shot of Lovenox, they're stable, we started them on Coumadin. They can follow up tomorrow with their doctor. Perfect." (US#3) "The most recent one that's come up is patients with pulmonary embolism, that is a group of probably 50% of them or maybe 30% that we can now manage as outpatient so they don't need to come in. We used to admit all of them." (England#1)	"It all comes down to pay structure and what you can bill for, what Medicare, more importantly, will pay for. So just recently we've gone through a big overhaul of needing to meet certain objective requirements to be an inpatient. At least in my experience, in the past, when I started training, there wasn't that available, or there wasn't that purpose. It would simply be the physical would decide one way or another. And now, with more regulatory bodies, the payers who are doing this, we really do have more restrictions on what we need to see." (US#9) "We have a nurse navigator in the department, and they're pretty well-versed with Milliman criteria. And they will assist us in establishing should this be an observation patient or an inpatient. […] Often we get talked to about, oh, this patient came in as an inpatient but they didn't meet criteria for that, so we're not going to get paid for that form an insurance company's standpoint. So they push trying to make sure we make the correct decision up front." (US#5) "If you're confused, I think they bump it up to this external auditing company. And they actually sometimes will do it in real time. You'll sometimes get phone calls while the patient is still in the emergency department saying, 'Hey, you made this patient obs'. Usually it's, 'You made this patient inpatient, this patient should be obs'." (US#1)	"[They] have been created more to deal with the patients that potentially will be discharged after an extended period of observation or extended period of waiting for tests. I don't think that the idea was to avoid breaches [of the four-hour standard] in the first place, but with any kind of new intervention that we bring, there is always going to be somebody who is looking at an opportunistic way of saying, 'Actually, we've got a few beds there. The clock stops when they get there, let's do it'." (England#3) "We have a clinical decision unit which is run by the emergency department; it's specifically for people who are awaiting a decision that will take them beyond the four-hour target but we're not clearly expecting them to be admitted." (England#12) "Hospital management does tend to get involved, especially considering the bed pressures and the whole winter season coming in, and the whole bed management of the entire location. In [this area] they do tend to get interested in the decision making and they tend to have interest in using the beds, observation beds at times for the patients who are awaiting a medical bed, so they tend to ask for that." (England#7)

Table 2: Observation as a safe space for patients with unresolved medical, social and legal issues

Medical considerations: diagnostic uncertainty	Socio-medical considerations: personal and familial circumstances and patient safety	Medico-legal considerations: liability and risk of litigation
"We don't necessarily have a diagnosis. This is someone who's sick but we're not quite sure from what. One of the first determinations is, are they safe to go home? Would they be able to care for themselves? [...] If we try to put someone in as a full admission to the hospital and they don't meet enough criteria, then they'll go in an obs status patient. If their vital signs look okay, the patient looks fairly decent, but you just have that overall determination they are not safe to go home then they'll probably go in as an obs patient. Which pretty much just provides tincture of time. We can watch for a while and see what evolves. [...] It adds to the care of any patient is it just gives you time to make decision. Not that physicians are necessarily indecisive but sometimes you just need to watch and see if the patient declares themselves one way or another." (US#8) "If I'm obsing someone, I think they need the hospital. I think they need hospital – not for very long, but I think they need the hospital. I guess if they wouldn't let me admit those patients at all, I'd probably do more obsing in the ER. That's what I do occasionally if our hospital is really full." (US#1) "You may be doing very little with them but you've got the added benefit of the disease process hasn't progressed or it's become clearer that it's abdominal pain and now it's gone to their right side and therefore it's an appendix. But that's just been a progression of time rather than you are a different clinician making a different decision in your slower manner of process." (England#13)	"We do see, occasionally, 55-year-old men who are there with their teenage children and their wife, who says, 'I don't want a doctor. I haven't been to a doctor in 20 years'. You think: 'There's no great follow-up plan here. If I send this guy home, he's probably not going to see anybody unless he comes back for heart failure. This is maybe my chance to intervene, especially if he has risk factors with his undiagnosed hypercholesterolemia and hypertensions. If I put him in the hospital for 12 hours, even if he's not having a heart attack right now, I've probably impacted his long-term risk'." (US#4) "I'm much more inclined to send somebody home that is well insured, has good follow up, reliable to take the medicines that I give them. Then opposed to the person that we never met before, seems a little bit socially less inclined toward behaving with any kind of order. So those are the people that are going to get in trouble because they are not going to seek follow up, they're not going to take their medicines, they are going to wait until they are sicker, and then they are going to come back in and start all over." (US#3) "I also factor in the kind of the family unit, purely because the child cannot look after themselves very often. So, is the reason they've attended something they're particularly worried about? Are the parents going to cope with whatever I expect of them at home? And also, I do tend to factor in the time of day and the geography. If they've traveled 45-minutes from one of the outer villages to get to the hospital, I've got to be honest, that does make me have a think about kicking them out quickly if it's a significant transit time to get back to us. It's just about safety netting." (England#6)	"You're seeing them one moment at a time on their continuum of care. So are they getting better, or are they going to get worse? We don't know. And how much time do you need to decide that? And that's where it becomes difficult. So I think people will stay longer in the emergency departments because we need to be sure that they're not going to get worse. And that gets into liability reform, all of those things, because I don't want to send somebody home who's going to get worse and have a bad outcome for them and their family, and then even from a lawsuit standpoint. You don't want that coming back at you." (US#5) "I will admit that the medical-legal environment in which I'm practicing is going to impact my decision too. If I'm working in somewhere like where I trained, which was […] one of the highest, most litigious counties in the United States, then I would be far more inclined to observe somebody for fear of missing something rare. Then compare to if I'm working in a place where the malpractice environment is very favorable and as long as I have done a reasonable job of excluding pathology and I don't have to worry about being sued for a one-in-a-million miss, then I'm much more comfortable not observing patients. " (US#7) "It's in the back of everyone's mind. I think that something bad happens and you'll get sued. I think it's difficult to get that out of your mind in first-world medicine. Even in South Africa where I trained, it's becoming more and more prevalent. It is just something that's there. It's certainly not as big of an issue as in the US, but it's increasing. It's becoming more and more prevalent." (England#1)