Note of the editors: This is a BOWMAN-generated English translation of the officially indexed Spanish-language article, which should be cited as Emergencias 2026;38:321-322. In this translated version, the editors have supervised the process; however, it cannot be ruled out that some errors resulting from the artificial intelligence translation process may have gone unnoticed.

EDITORIAL

Time spent in the emergency department prior to hospitalization: a wait that kills?

Estancia en urgencias previa a la hospitalización: ¿una espera que mata?

Pere Llorens

The overcrowding of emergency departments (EDs) and the retention of patients awaiting admission represent a global structural crisis that directly compromises quality and patient safety.[1,2] However, emergency physicians face a pressing paradox: while everyday clinical experience suggests a clear deterioration in prognosis among patients retained in the ED, large epidemiological studies addressing this issue show apparently neutral or discordant results. The 3 studies published in this issue of EMERGENCIAS[3-5] address this contradiction from complementary perspectives—meta-analytic, observational, and clinical modelling—providing an essential conceptual framework for redefining the problem.

The rigorous updated meta-analysis by Di Paolo *et al.*[3], which synthesises data from 22 studies and more than 9.3 million patients, concludes that there is no statistically significant overall association between emergency department length of stay (EDLOS) and in-hospital mortality (OR, 1.02; 95% CI, 0.85-1.23). This study stands out for its methodological thoroughness and its stratification across multiple time cut-offs. Nevertheless, its key lesson is that measuring the crude total time from ED admission to transfer to an inpatient ward is insufficient. As the authors themselves acknowledge, the extreme heterogeneity of the literature and the inability to distinguish time devoted to medical care from the time elapsed between the decision to admit and the patient's departure from the ED (boarding time) dilute both the problem and the conclusions. Combining systems with differing bed availability under the same metric masks 2 phenomena with opposite effects: whereas time devoted to active medical care in the ED could have a protective effect—by ensuring continuous assessment and early stabilisation of acutely ill patients—it is the passive wait for a bed or the need to remain overnight in the ED that truly compromises safety. Although this dichotomy currently represents a reasonable hypothesis that must be confirmed by future studies or specific meta-analyses isolating the 2 phases, it is clear that the ED clock does not measure a homogeneous variable, but rather 2 radically different clinical realities.

Along the same line of epidemiological nuance, Fernández-Cisnal *et al.*[4] analysed the MIMIC-IV cohort from a Boston hospital with low overcrowding and a low overnight-stay rate. Their primary analysis found no association between remaining overnight in the ED after the decision to hospitalise had been made and in-hospital mortality (OR, 1.21; 95% CI, 0.56-2.60). The strength of this study lies in its meticulous temporal categorisation, separating the time until the medical decision from the waiting time for a bed, as well as in its control of immortal time bias through a landmark analysis (OR, 1.64; 95% CI, 0.75-3.59). However, its key weakness is the limited representativeness of the cohort: at a centre where overnight stays are the exception, beds are preferentially allocated to the sickest patients, while more stable cases remain in the ED. This is demonstrated by their sensitivity analysis without requiring a formal admission order, in which remaining overnight showed an implausible "protective" effect (OR, 0.68; 95% CI, 0.48-0.97) resulting from clinical selection bias. Therefore, these findings cannot be extrapolated to systems with systemic overcrowding such as that in Spain.

However, we all know that prolonged delays do not occur in a vacuum, but rather in frequently "inadequate" ED spaces. In a recent prospective multicentre study involving 165 EDs in the United Kingdom,[6] almost 1 in 5 patients received care in "escalation" areas, predominantly corridors and non-clinical locations. This routine practice deprives patients of privacy, causes sleep deprivation, and seriously compromises clinical safety and appropriate monitoring, adding a non-protective effect in these patients with prolonged EDLOS.

To overcome the limitations of observational epidemiology, Carballo *et al.*[7] contribute a disruptive tool in this issue of EMERGENCIAS: the 24-hour Limit calculator. By applying the attributable fraction among exposed patients, this tool converts the relative risks described in the literature into an absolute and quantifiable population impact. Applied to a real cohort of 8,439 patients aged 75 years or older, the model estimated that reducing stays longer than 24 hours would prevent 124 deaths annually in the baseline scenario (RR, 1.3) and up to 239 deaths in scenarios of greater vulnerability (RR, 1.8). The model's major strength is that it converts abstract estimates into a tangible metric

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for healthcare managers and policymakers. Its limitation lies in its theoretical nature based on aggregated data, which calls for caution when assuming direct individual causality.

These findings acquire their true significance when contrasted with previous evidence from Spain. Fernández Castro *et al.*[8] demonstrated at a tertiary-care hospital that 61.4% of total ED time is consumed by administrative and placement processes and that admission to an outlying bed is an independent predictor of mortality. Likewise, the multicentre EDEN-18 study[8] showed that prolonged stays among older patients significantly increase the risk of subsequent hospitalisation lasting > 7 days and mortality. We should remember the maxim: "Older patients are not the cause of ED overcrowding, but its most vulnerable victims".[9,10]

As emergency physicians, we must adopt a firm and original position: length of stay does not kill because of a mathematical biological constant, but rather when organisational inertia transforms an area intended for acute diagnosis and treatment, such as the ED, into a holding area for unstructured care.[11-13] The neutrality of meta-analyses is not a licence for inaction; it reflects the inability of "classical" epidemiology to measure the iatrogenic effects of ED overcrowding. Retaining a frail geriatric patient on a stretcher in an unsuitable area for more than 24 hours increases adverse events. The "wait that kills" is the euphemism we use to disguise the failure of hospital flow.

If EDs know with remarkable mathematical precision the daily flow of patients presenting for care and the proportion who will require admission remains extraordinarily stable, the number of inpatient beds required each day is known in advance. Except in genuinely exceptional circumstances or unforeseeable disasters, demand for admission from the ED is fully predictable. The ethical and organisational question that hospital administrators must answer is not whether waiting kills, but why hospitals continue to refuse to adapt bed capacity to a demand they know hours in advance.

In this scenario, the solution is not to resign ourselves to managing overcrowding. As Millán Soria *et al.*[14] demonstrate, the need for hospital admission can be predicted to a large extent in real time from the moment of triage using artificial intelligence and machine learning. If technology allows bed demand to be anticipated hours in advance, persistent boarding time ceases to be merely a logistical problem and becomes a failure of commitment to patient safety. Bed management must no longer remain hospitals' unfinished business.[15-17] Limiting ED stays to less than 24 hours should become a mandatory ethical and quality-of-care standard.

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