HEALTH ORGANIZATION AND ETHICS

J. Heal Ethics Admin
Volume 12 | Number1 (Winter 2026)
www.jheaonline.org
ISSN 2474-2309 | doi:10.22461/jhea.6.7168
https://doi.org/10.22461/jhea.6.7168
Published Feb 03, 2026

THE EROSION OF CARE: LEGAL AND ETHICAL IMPLICATIONS OF EMERGENCY DEPARTMENT CROWDING AND PATIENT BOARDING

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Abstract: *Emergency department (ED) crowding and patient boarding have emerged as critical threats to patient safety, healthcare quality, and provider well-being. Crowding occurs when the demand for emergency services exceeds available resources, leading to prolonged wait times, delayed care, and treatment in non-traditional spaces. Boarding, the retention of admitted patients in the ED due to lack of inpatient capacity, is the most significant driver of ED crowding and is associated with increased morbidity, mortality, adverse events, and staff burnout. Legal implications are substantial: malpractice data reveal significant financial losses, with boarding cases twice as likely to close with indemnity payments and nearly half involving patient death. Regulatory bodies such as The Joint Commission (TJC) and the Centers for Medicare and Medicaid Services (CMS) have proposed measures to mitigate boarding, recognizing its impact on patient outcomes. Ethically, boarding undermines the principles of beneficence, nonmaleficence, autonomy, and justice by delaying treatment, eroding privacy and dignity, and exacerbating health inequities. It also contributes to moral distress and violence against healthcare workers. Addressing this crisis requires systemic, multidisciplinary reforms. Strategies include optimizing weekend discharges, harmonizing elective admissions, creating admission-hold units, expanding staffing, and implementing full capacity protocols. ED-level interventions, such as fast track models, observation units, and telemedicine, can improve throughput, while policy action is needed to mandate maximum boarding times and to restructure reimbursement models that incentivize efficiency. Ultimately, ED crowding and boarding represent an ethically unacceptable and legally dangerous consequence of systemic capacity failures. Comprehensive institutional and policy reforms are essential to safeguard patient welfare, reduce liability, and preserve the ED's role as the healthcare safety net.*

Keywords: *Patient Boarding, Crowding, Hospital Capacity, Length of Stay, Emergency Department, Patient Safety, Medical Malpractice, Legal Liability, Ethical Principles in Healthcare, Beneficence, Nonmaleficence, Patient Autonomy, Clinician Burnout, Moral Injury, Full Capacity Protocol, Discharge Optimization, Health Policy Reform.*

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+To cite this article: Lindsay, A. "The Erosion of Care: Legal and Ethical Implications of Emergency Department Crowding and Patient Boarding". The Journal of Healthcare Ethics & Administration Vol. 12, no. 1 (Winter 2026): 39-46, https://doi.org/10.22461/jhea.6.7168

INTRODUCTION AND BACKGROUND

An alarm sounds, "Code Blue" is announced, staff arrive at the patient's bedside, cardiopulmonary resuscitation (CPR) is in progress. The emergency department team instantly takes action, like a choreographed scene at the ballet; each member knows their role, the next action to take, and the steps to save a life - but this time it didn't work. Despite 24 minutes of Advanced Cardiovascular Life Support (ACLS) and the team's best effort, the patient passed and the team pauses in a moment of silence to honor the life lost before them. The patient's son arrives, and with great strength, the physician shares the news, "I am so sorry, but your Mom has died. We did everything we could."

This was a 75-year-old female with an extensive past medical history on 5 liters of continuous home oxygen who arrived to the emergency department (ED) via emergency medical services (EMS). She waited for a room for almost 2 hours and was then placed in the only available bed, one without telemetry or central monitoring. The ED had no idea she was decompensating until it was too late, until she was gone. With the utmost certainty, the ED regularly practices expert resuscitation medicine to the most critically ill patients, so then why did this patient arrive to the ED talking and exit through the morgue? This is the painful reality of ED crowding, long wait times, and inpatient boarding.

Crowding "occurs when the identified need for emergency services exceeds available resources for patient care in the ED, hospital, or both."[1,2] Crowding is a public health crisis and national challenge that has worsened over the last 3 decades as EDs increasingly become the main entry point for hospitalization and the choice for acute unscheduled care. Crowding is often manifested in the ED as long wait times, an inability to offload ambulance patients, delay in evaluation or treatment, long length of stay, treatment that occurs in spaces outside of a patient room (i.e. waiting room, hallway, conference space), patients leaving without completion of their evaluation or treatment, and the boarding of admitted patients within the ED.[3,4]

The crisis of hospital and ED crowding likely began in the 1980s, when EDs experienced a persistent and substantial increase in the number of patient visits,[5] and was exacerbated significantly during and after the COVID-19 pandemic. In 1986, the United States (U.S.) federal government enacted the Emergency Medical Treatment and Labor Act (EMTALA), requiring hospitals to assess, treat, and stabilize or transfer patients with emergency medical conditions. EDs have since served as the safety net for all patients, regardless of their ability to pay. Under EMTALA, EDs have also found themselves caring for patients with non-emergent medical concerns rather than deferring their care or turning patients away. While EMTALA has undoubtedly improved access to care for those who are under- or uninsured, it has also increased the volume of patients receiving care in the ED, contributing significantly to ED crowding.

Conceptually, ED crowding is caused by a combination of input, throughput, and output factors. Input considers the volume and acuity of patients who seek care in the ED. Over time, there has been an increase in the number of patients with complex chronic disease, resulting in higher patient acuity. These patients often have inadequate outpatient support and/or incomplete treatment of their condition(s). Patients are often sent to the ED for diagnostic testing, particularly when outpatient testing is limited or delayed, or when hospital admission is required. Some may argue that patients seek care in the ED unnecessarily for non-emergent conditions, but research demonstrates that most patients believe that they have a serious medical condition when presenting to an ED. However, some elect to receive care in the ED for convenience due to difficulty with scheduling an outpatient appointment or receiving care in an alternative way.[1,5]

ED throughput, the time patients spend in the ED, also known as length of stay (LOS), has increased over time and was further exacerbated by the COVID-19 pandemic[4]. In addition to a larger volume of patients with significant disease burden and higher acuity, EDs are also seeing a higher number of older patients. These factors necessitate more complex evaluation and treatment plans, resulting in numerous laboratory tests, imaging studies, and medical interventions. Bottlenecks can occur at any step in a patient's ED course, such as a delay in blood collection secondary to workforce shortages or patient factors (e.g. difficult intravenous stick), or the volume of diagnostic tests ordered. Ultimately, the complexity of patient conditions and required diagnostic evaluation has resulted in increased ED care delivery times. [1,5]

Output refers to a patient's disposition via admission to the hospital or discharge from the ED. Boarding - the practice of retaining admitted patients in the ED due to an inability to transfer them to an inpatient or observation unit once their emergency medical care is complete - is the most significant cause of ED crowding[1,3,4]. Increased patient acuity and complexity of medical needs have resulted in prolonged inpatient length of stay, an elevated hospital capacity, and a shortage of inpatient beds, further exacerbating hospital crowding and worsening patient boarding in the ED. Boarding delays definitive inpatient treatment and restricts the ED's ability to evaluate new patients. Consequently, patients may receive inpatient care by clinicians and nurses who are not trained in inpatient medicine. Boarding is associated with

increased patient morbidity and mortality, adverse events such as delayed or missed care and medication errors, higher rates of delirium in elderly patients, lower patient satisfaction scores, longer inpatient/hospital length of stay, increased ambulance diversion time, higher costs for care delivery, reduced revenue, increased rates of staff burnout, and reduced employee engagement and staff satisfaction. [1,3,6,7,8,9]

Boarding has become a widespread and serious challenge to healthcare quality and patient safety nationwide. According to the Society for Critical Care Medicine (SCCM) and the American College of Emergency Physicians (ACEP), ED volumes increased by 30% from 2006-2014, and for critically ill patients, the number of ED visits increased by 80%.[4,10] During the COVID-19 pandemic, ED volumes significantly fell in 2020 for both admitted and discharged patients, and remained low through April of 2021. The number of ED visits then began to increase and is now at or near pre-pandemic levels. However, the proportion of visits from high-acuity patients increased, demonstrating the increase in severity of illness among ED patients and need for admission. [4] In January of 2022, it was found that 40.1% of admitted patients boarded in the ED for more than 4 hours and 6.3% for 24 hours or longer.[11] Hospital crowding, and therefore, inpatient boarding in the ED result in patient harm that may expose healthcare institutions and providers to legal liability, and raise significant ethical concerns regarding patient rights and quality of care.

LEGAL AND LIABILITY IMPLICATIONS

The breakdown in patient safety and quality of care caused by admitted patients boarding in the ED creates significant legal and financial risks for healthcare organizations and providers.

Malpractice Exposure and Financial Severity

Candello, a division of the Risk Management Foundation of the Harvard Medical Institutions Incorporated, analyzed medical professional liability (MPL) cases asserted between 2014-2023 and found 314 open and closed cases associated with ED boarding resulting in approximately $119.9 million in financial losses.[12] Additionally, cases involving ED boarding had a 110% higher probability of closing with an indemnity payment compared to cases without this factor.[12]

Candello further evaluated ED boarding cases by injury severity and found that 44% of cases involved death and 25% involved high injury severity. Major allegations within ED boarding claims were diagnosis-related (41%) or treatment-related (35%). For cases in which death occurred, Candello assessed co-occurring contributing factors and found that allegations mainly were related to clinical judgment including patient assessment issues, selection and management of therapy, communication among providers, patient monitoring, and failure or delay in obtaining a consult or referral. [12]

Safety and liability risks can occur at any point during a patient's time in the ED. Candello created a framework to more closely evaluate risk and identified 7 steps in a patient's journey: recognition and arrival; initial assessment; ongoing monitoring; diagnostics, including orders, tests, and interpretation; consultant management; discharge planning; and post-discharge adherence. Through the analysis of malpractice claims, they found that the ongoing monitoring step posed the highest risk to boarded patients. Furthermore, failure to connect symptoms with test results and an evolving condition was also common, particularly when there was a communication breakdown between the ED and other medical professionals outside of the ED.[13]

Regulatory Standards and Enforcement

Regulatory bodies recognize the severity of the ED boarding problem and the increased risk to patients. The Joint Commission (TJC), a not-for-profit organization that accredits U.S. healthcare organizations and programs, recommends that boarding times be limited to less than 4 hours, as boarding beyond this is a serious patient safety concern[11,12,14]. Effective January 2026, TJC requires hospitals to measure and "set goals for mitigating and managing the boarding of patients who come through the emergency department". TJC will also require healthcare leaders to review patient flow data and metrics to assess whether goals were achieved and to take action if they were not.[15]

The Centers for Medicare and Medicaid Services (CMS) is also starting to regulate ED boarding. CMS has proposed new quality measures to improve access and timeliness of emergency care, including: percentage of patients who left the ED without being seen, average (median) time patients spend in the ED, and average (median) admit decision time to departure time for admitted patients. CMS has identified that long LOS and long wait times may signify that an ED is overcrowded or understaffed, resulting in treatment delays, patient suffering, and disagreeable treatment environments.

Additionally, CMS recognizes that ED boarding is associated with adverse patient outcomes, among other quality metrics, and that addressing ED patient throughput will improve LOS and patient safety, allowing for higher quality care.[16] ACEP notes that CMS will track the proportion of 4 specific metrics, which include wait times that exceed 1 hour, patients who leave without being seen, boarding time of more than 4 hours, and time from arrival to ED departure greater than 8 hours. [17]

CMS also oversees and ensures EMTALA compliance. It investigates EMTALA complaints to ensure hospitals have not violated its conditions and have provided an adequate medical screening exam. Previously, it has been claimed that ED crowding may violate EMTALA by preventing a timely medical screening exam and patient evaluation.[18] There have also been occasions in which patients file EMTALA complaints in an effort to build a malpractice suit against a provider and/or healthcare institution. However, legal precedent has shown that actions filed against hospitals alleging EMTALA violations secondary to ED crowding have generally been dismissed[18].

ETHICAL AND MORAL CONSEQUENCES OF ED CROWDING

ED crowding and boarding directly conflict with the fundamental principles of healthcare ethics: beneficence, nonmaleficence, respect for patient autonomy, and justice. [5]

Violations of Beneficence and Nonmaleficence

Beneficence is the ethical principle that obligates a physician to act in the patient's best interest by preventing or reducing harm and promoting patient welfare. Nonmaleficence, on the other hand, obligates the physician to "do no harm" and to keep patients safe. [5] The duties of beneficence and nonmaleficence are severely compromised by ED crowding and inpatient boarding. Crowding is associated with significant delays in care, which impede beneficial treatment and increase potential for harm. Prolonged length of stay in the ED has been associated with increased risk for adverse events. Boarding patients are less likely to have a medical order completed on time or not completed, and they are more likely to have a missed home medication, ED treatment, or laboratory check. [3,19] Those who are admitted during crowded periods tend to have poorer outcomes, longer hospital stays, and higher mortality rates. [5]

Compromise of Autonomy, Privacy, and Dignity

ED crowding often forces healthcare providers to care for patients outside of a treatment room, such as in a waiting room, hallway, conference room, results waiting area, or other shared space with more than one patient. This results in a lack of privacy and may compromise the patient encounter due to incomplete information offered by the patient or inadequate physical exam, harming the physician-patient relationship and inhibiting effective treatment regimens. Ultimately, this practice deprives patients of the dignity and privacy they deserve when receiving care. [5]

Challenges to Distributive Justice

Emergency departments in the U.S. serve as a safety net for patients to receive care regardless of socioeconomic status or background. Patients who are economically challenged or uninsured may rely on the ED for medical care due to a lack of access otherwise. ED crowding may result in prolonged wait times and ambulance diversion, further exacerbating inequities and healthcare disparities, and ultimately affecting patient outcomes. [5,20]

Moral Distress and Burnout

ED crowding, inpatient boarding, and long wait times jeopardize provider wellness and safety, resulting in moral injury and burnout. According to a survey by the American Academy of Emergency Medicine (AAEM), 98.5% of respondents reported that ED boarding has impacted their job satisfaction, and 86.7% noted that boarding has resulted in moral injury and burnout.[9] Emergency clinicians and nurses experience moral injury when they are unable to provide efficient, high-quality care to a patient secondary to systemic barriers and constraints, such as those that exist with ED crowding[5]. Studies have shown that ED crowding increases burnout and staff turnover, decreases productivity, and increases distraction, potentially resulting in medical errors. [5,7] Additionally, long wait times and ED crowding are associated with increased violence against healthcare workers. One study found that more than half of survey respondents experienced violence because of boarding, and approximately 80% witnessed violence towards a coworker. [9]

STRATEGIES TO MITIGATE CROWDING AND IMPROVE BOARDING

ED crowding and patient boarding represent an ethically unacceptable and legally dangerous consequence of systemic capacity failures, resulting in increased risk to patient safety and considerable moral challenge to healthcare workers. To address this crisis, solutions must be institutional and multidisciplinary.

Administrative and Operational Reform

Health system or hospital leadership must recognize that crowding is a hospital problem, not an ED problem; it cannot be solved by ED interventions alone. System-wide and institutional actions are imperative, and dynamic bed allocation strategies must be considered. Hospitals should implement a crowding-assessment tool or capacity- monitoring program and analyze subsequent data to identify institution-specific causes of crowding, potential solutions, and methods of prevention[1,9]. The following solutions should be considered: optimize patient discharges, harmonize elective admissions, create a dedicated admission-hold unit, increase resources, and implement a full capacity protocol.

Hospitals can improve capacity by increasing the number of weekend discharges. It is estimated that the number of discharges that occur on the weekend is almost 50% less than during the week. Inpatient LOS has been found to be 1.22 days shorter for medical patients discharged home on Saturday in comparison to Monday, and LOS is approximately 2 days longer for surgical patients. Montefiore Medical Center (MCC) implemented a weekend discharge protocol, and reducing boarding from an average of 30 patients to almost zero. Increasing weekend discharges can also decrease overall LOS and increase revenue.[2]

Another consideration is to harmonize elective admissions. Inpatient services must balance unexpected admissions (i.e., patients admitted from the ED or transferred from another facility) with expected admissions and delayed discharges. Hospitals should therefore restructure scheduled surgical cases to prevent bottlenecks early in the week and more evenly distribute expected admissions by time and destination. [2,9,12,21] Optimizing expected admissions has been shown to decrease LOS, shorten wait times, lessen ambulance diversion, and increase the number of patients seen[2].

Institutions should also consider creating an admission-hold unit. Developing an admission-hold unit will allow admitted patients from the ED to leave the physical space and board in a location that is standardized for their care. This unit can be a redesigned conference room or repurposed treatment area. It should be staffed with nurses and other personnel trained in inpatient medicine, thereby optimizing the care of a 'boarded' patient. Once capacity improves and patients are moved to their treatment beds, this unit can close or be converted to another care space, such as a discharge unit.

Increasing resources and investments in ED and inpatient staffing should also be evaluated. Staffing models must reflect expected patient volume in every hospital department. [5,9] Boarding is consistently more severe in the winter months[11]. It also tends to occur with increasing severity at the beginning of the week, with mean estimated boarding times of 3.7 hours on Monday evening and 7.2 hours Tuesday morning, according to one study[22]. Administrators should prepare for anticipated crowding by increasing staffing proportionally.

Lastly, and perhaps most importantly, hospitals must develop a full capacity protocol. When capacity reaches a predetermined level, hospitals should use a protocol to handle excess admissions and reduce inpatient boarding in the ED. Each institution should determine the best approach for its hospital design, patient flow, staffing, and available space. For some, that may be an admission hold unit as described above. For others, it may mean evenly redistributing boarding patients among all inpatient units until a definitive bed becomes available. [2,21] For a full capacity protocol to be successful, hospital leadership must secure buy-in from all staff and departments; there must be clear criteria for when the protocol will take effect and for real-time monitoring. Concerns must be addressed, as this would likely be a significant culture change for some institutions. However, it is important to note that patients generally prefer to board in inpatient hallways rather than in the ED[2].

Emergency Department Interventions

Many EDs across the country have implemented strategies to improve patient throughput and the quality of care provided to patients among widespread capacity issues and inpatient boarding. Common approaches include implementing a fast track model, establishing ED-based observation units, and scheduling a physician in triage during high-volume hours[3,5]. Additionally, fixed-interval reevaluation pathways should be developed to assess for signs of decompensation. Another consideration, particularly for community hospitals, is to expand telemedicine. Telehealth consultations may reduce the time

from patient arrival to treatment and definitive disposition; they may also potentially mitigate transfer needs or time on diversion. From an ethical standpoint, actions should be taken to better protect patient privacy and autonomy. EDs need to consider the implementation of protocols that safeguard sensitive conversations between a provider and their patient.

Policy and Regulatory Action

The implementation and development of new crowding and boarding metrics by TJC and CMS is a step in the right direction. However, policymakers must do more. CMS can impose mandated maximum boarding times. Reimbursement models that promote inefficient high-occupancy rates and incentivize cost-cutting behaviors must be restructured[7,9]. Legislation should be enacted to increase financial support for outpatient clinics and incentivize primary care providers to offer alternatives to the ED for non-emergent care. And, telehealth reimbursement must be optimized and solidified.

CONCLUSION

The challenge of ED crowding and inpatient boarding has escalated into an ethically unacceptable and legally dangerous consequence of systemic capacity failures. This public health crisis undermines the core mission of healthcare, leading to tragic outcomes for patients and severe moral distress for providers. Legally, ED boarding presents a serious liability risk as evidenced by malpractice data showing approximately $119.9 million in financial losses over 9 years, and an association with death in 44% of analyzed cases. Furthermore, the practice conflicts directly with the fundamental principles of healthcare ethics—beneficence, nonmaleficence, respect for autonomy, and justice—by causing delayed or missed care, adverse events, a loss of patient dignity and privacy, and increased health inequities. To effectively mitigate the risk and restore the integrity of emergency care, solutions must be institutional, multidisciplinary, and focused on systemic change. While regulatory bodies like TJC and CMS are taking steps to require measurement and goal-setting for boarding, long-term success requires implementing system-wide administrative reforms, such as optimizing weekend discharges, smoothing elective admissions, and creating and enforcing full capacity protocols across the hospital. Ultimately, achieving higher quality, safer, and more timely care demands fundamental policy action, including mandating maximum boarding times and restructuring reimbursement models that currently incentivize inefficient occupancy rates. Only through these comprehensive reforms can we safeguard patient welfare and ensure that the crucial safety-net function of the ED is preserved.

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