



Where's the way out? Access block, boarding and hospital overcrowding: a narrative review

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Abstract

Emergency department (ED) overcrowding is a persistent global challenge associated with adverse patient outcomes and system inefficiencies. Boarding and access block, which delay the transfer of admitted patients to inpatient beds, represent its most critical manifestations. While overcrowding has traditionally been attributed to rising demand and ED inefficiencies, growing evidence identifies downstream constraints in hospital capacity and patient flow as major drivers. A non-systematic literature search was conducted using PubMed and Web of Science focusing on studies published between January 1990 and December 2025 related to ED overcrowding, boarding, hospital overcrowding, access block, patient flow, and hospital capacity. The literature was narratively synthesized and organized according to the input–throughput–output framework to examine system-level determinants and interventions and to explore overcrowding as a hospital-wide phenomenon. Interventions targeting input and throughput processes improve local ED performance metrics but often fail to reduce overcrowding when output capacity remains constrained. Conversely, high inpatient-bed occupancy, delayed discharge processes, and inefficient hospital-wide patient flow are frequently associated with access block and boarding. Overall, the literature supports the interpretation of ED overcrowding as a manifestation of hospital-wide dysfunction. High-performing hospitals prioritize patient flow as an institutional focus and adopt a system-level approach, characterized by executive leadership involvement, real-time data monitoring, and shared accountability across departments. Boarding may be better understood as the clinical manifestation of system-level failure in hospital patient flow rather than an ED-specific issue. The way out requires a shift from ED-centered interventions to coordinated, hospital-wide strategies, recognizing that the responsibility for timely and safe patient flow lies with the entire organization.

Keywords Emergency department overcrowding · Access block · Boarding · Hospital overcrowding · Patient flow

Background

Emergency department (ED) overcrowding has been recognized as a critical issue in healthcare systems since the 1980s. Despite growing attention over the past two decades, both in research and policy initiatives, it remains a

widespread and often underestimated crisis affecting public hospitals worldwide [1].

Central to this phenomenon are two interconnected issues: *boarding*, defined as the prolonged stay of admitted patients in the ED due to a lack of available inpatient beds [2], and *access block*, a systemic barrier that prevents the timely transfer of these patients to appropriate wards [3].

Together, these conditions transform the ED into a *de facto* holding area for admitted patients, diverting staff time and attention away from newly arriving emergencies [4].

The clinical consequences of ED overcrowding and boarding are well established. Delays in time-sensitive care, increased risk of medical errors, and worse patient outcomes have been consistently reported, with several studies demonstrating an association with increased mortality. Beyond clinical outcomes, overcrowding also impacts staff well-being, training environments, and overall healthcare costs,

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reflecting a multidimensional burden that extends far beyond the ED itself [5–7].

The causes of ED overcrowding have traditionally been interpreted through the *input–throughput–output* model, which links demand for ED care, internal processes, and downstream hospital capacity [8]. While this framework describes ED-level dynamics, it also provides insight into broader hospital and health system functioning.

Initially, boarding was largely attributed to rising volumes of nonurgent visits and internal inefficiencies within ED operations. However, emerging evidence increasingly points toward more systemic dysfunctions, particularly in the output domain.

Despite multiple interventions targeting triage, workflow redesign, and nonurgent attendances, durable improvements have been limited, suggesting that a key bottleneck lies downstream, in bed allocation, inpatient flow, and discharge processes.

This narrative review examines the role of output-related factors as major drivers of boarding and ED overcrowding, supporting the interpretation of overcrowding as a whole-hospital phenomenon rather than an ED-contained issue. We narratively summarize conceptual and empirical evidence published between 1990 and December 2025, and propose reframing boarding as a manifestation of hospital-wide flow dysfunction. Rethinking this framework may facilitate a shift toward organizational and governance strategies capable of improving patient flow, safety, and overall system performance.

Materials and methods

This narrative review synthesizes current evidence on the determinants of boarding and hospital overcrowding, with a particular focus on output factors.

A non-systematic literature search was conducted using PubMed and Web of Science, focusing on studies published between January 1990 and December 2025 related to emergency department overcrowding, boarding, access block, patient flow, hospital capacity, and hospital-level interventions.

Relevant original studies, reviews, and conceptual articles were considered according to their relevance to the aims of the review, particularly those addressing clinical, organizational, or system-level determinants of *boarding* and *hospital overcrowding* in adult emergency department and hospital settings. Studies focused exclusively on special populations or non-hospital settings were not considered. Given the narrative design, study selection prioritized conceptual relevance over exhaustive inclusion. The literature was narratively synthesized and organized according to the *input–throughput–output* framework, with particular

attention to *output* constraints and whole-hospital patient-flow strategies.

Results and discussion

The Asplin model: input–throughput–output

In 2003, Asplin et al. proposed the *input–throughput–output* model, which remains the main conceptual framework for understanding ED overcrowding [8]. The model highlights that overcrowding extends beyond ED processes and reflects broader imbalances between healthcare demand, hospital capacity, and patient flow. This model was designed not only to describe operational dynamics within the ED but also to provide administrators, researchers, and policymakers with a structured framework through which to identify causal pathways and develop targeted interventions.

Input factors

Input factors include all determinants of demand for ED services. While emergency care represents the core mission of the ED, a substantial proportion of visits is related to urgent but unscheduled conditions that are not effectively managed by other components of the healthcare system. Structural barriers such as limited access to primary care, diagnostic delays, and fragmentation of outpatient services frequently redirect patients toward the ED. The ED also serves as a critical safety net for vulnerable populations, including individuals with limited access to primary care or, in some healthcare systems, without insurance coverage. Patient-related characteristics further influence resource utilization and length of stay [9–11]. Population aging, social isolation, and seasonal surges (such as influenza outbreaks) add additional variability to input demand [12].

Throughput factors

Throughput refers to all internal ED processes from triage to final disposition. In the Asplin model, ED length of stay (ED LoS) represents a key operational metric within this domain [13].

Two major phases can be identified: initial triage and clinical assessment. The first phase consists of triage, nursing assessment, and allocation to a treatment area; the second phase consists of medical management, along with diagnostic workup, treatment, and decision-making, and it is often the longer of the two. Throughput time is influenced by team coordination, physical layout, staffing ratios, diagnostic efficiency, access to prior medical information, and timely specialty consultations [14]. Workforce-related variables also play a substantial role. Staffing shortages,

burnout, excessive workload, and high turnover rates are strongly associated with throughput inefficiencies and may exacerbate overcrowding [15, 16]. Importantly, although these factors manifest within the ED, they are often shaped by broader system-level organizational factors [10].

Output factors

Output encompasses all processes occurring after the clinical decision to admit or discharge a patient, including barriers that delay transfer from the ED or impede safe discharge.

Typically, ED patients are either admitted to inpatient wards, discharged home with follow-up, transferred to another facility, or returned to residential care settings. Multiple obstacles may disrupt this pathway. One of the most frequently cited determinants of persistent ED overcrowding is the inability to transfer admitted patients to inpatient beds, resulting in boarding [17, 18].

Discharge processes may also generate output strain. Discharge-related barriers, such as delayed outpatient follow-up or difficulties in arranging safe discharge, may prolong ED LoS or contribute to avoidable admissions. When adequate follow-up cannot be guaranteed, especially in vulnerable populations, clinicians may opt for hospital admission, further occupying inpatient beds. Conversely, patients discharged without adequate continuity of care may return to the ED to complete their diagnostic or therapeutic pathway or because of persistent or worsening symptoms [19]. A similar pattern is observed among individuals who leave the ED before completing their evaluation [20].

From Asplin model to the funnel model

Subsequent interpretations of the Asplin model, such as the funnel model, have further emphasized the structural imbalance between growing input and constrained output capacity. In this model, the wide opening of the funnel represents input factors, the central body corresponds to throughput processes, and the narrow neck symbolizes output factors. Under conditions of overcrowding, the metaphor illustrates a structural imbalance: the funnel mouth progressively expands to accommodate increasing demand, while the neck effectively narrows due to processing delays, rising care complexity, and insufficient downstream capacity [4]. As the hospital's primary entry point and the interface between community care and inpatient services, the ED is uniquely exposed to fluctuations and failures in both domains. Consequently, dysfunction in either upstream access to care or downstream bed availability inevitably manifests as ED overcrowding, regardless of how efficiently the department itself is managed.

Access block and the boarding phenomenon Among output factors, a central one is the inability to admit patients who have completed their diagnostic and therapeutic pathway in the ED and require inpatient care. When no bed is available, the emergency physicians are compelled to retain admitted patients within the ED, assuming ongoing clinical responsibility until ward placement becomes possible. This situation directly compromises both the quality of care delivered to boarded patients and the ED's capacity to evaluate and treat newly arriving individuals, thereby fueling a self-perpetuating cycle of overcrowding and workforce strain.

Access block (Exit block)

Access block refers to the condition in which patients requiring hospital admission from the ED are unable to obtain an appropriate inpatient bed within a reasonable timeframe [21, 22]. The term *exit block*, historically used in a similar context, emphasizes the obstruction of patient outflow from the ED, whereas access block adopts a more patient-centered perspective, highlighting the failure to access definitive inpatient care [23].

The definition of a “reasonable timeframe” has been debated. Definitions vary across systems, with time-based thresholds ranging from 4 to 8 h in the UK, Australasia, and Italy [3].

A large Irish university hospital study demonstrated that, for patients requiring admission, the single longest interval (accounting for approximately 60% of total ED length of stay) was the time between bed request and bed allocation [24].

Multiple studies have demonstrated a strong relationship between access block and inpatient bed shortages. Reduced bed availability, combined with delayed acceptance by admitting services, appears to be a primary determinant of prolonged boarding [4, 23]. Periods of high hospital occupancy are consistently linked to increased ED LoS and higher rates of access block [25].

Boarding

Boarding represents the operational manifestation of access block. It describes the practice of holding admitted patients within the ED after completion of their diagnostic evaluation due to insufficient inpatient capacity [2].

This practice reduces ED capacity, diverts staff attention away from new patients, and exposes admitted patients to an environment not designed for ongoing inpatient care [26]. In large EDs, more than 40% of the medical and nursing workload may be devoted to managing admitted patients

awaiting beds, significantly reducing the ability to care for new arrivals [4].

Boarding, therefore, constitutes not merely a logistical inconvenience but a structural distortion of the ED's function, transforming it from a rapid-assessment and stabilization unit into an involuntary holding area [27]. The system-wide consequences of boarding are summarized in Fig. 1.

Quantitative impact of boarding and overcrowding

The magnitude of these effects is evident in quantitative studies. In a cohort of more than 41,000 admitted patients, in-hospital mortality increased from 2.5% among those boarded for less than 2 h to 4.5% among those remaining in the ED for 12 h or longer. Hospital length of stay also increased, from an average of 5.6 days in patients boarded for less than 2 h to 8.7 days in those boarded for at least 24 h [7].

The impact is not confined to patients directly experiencing boarding. In an analysis of more than 466,000 ED encounters across two hospitals, each additional boarded patient was associated with approximately 12–14 extra minutes in the median ED LoS of all admitted patients [26]. A similar spillover effect was observed among patients who were ultimately discharged. In a retrospective study of nearly

180,000 discharged patients, median ED LoS increased by approximately 10% across increasing levels of boarder burden. The greatest effect was observed among medium-acuity patients presenting between 11:00 a.m. and 11:00 p.m., whose median stay was 57 min longer [28].

At the hospital level, a 10% increase in hospital occupancy was associated with an approximately 18-min increase in ED LoS among admitted patients and it appeared to increase extensively when hospital occupancy exceeded a threshold of 90% [18]. Patients experiencing access block also remained in hospital, on average, 0.8 days longer than those transferred without delay to an inpatient bed [22]. Together, these findings illustrate how boarding generates cumulative clinical and operational effects across the entire emergency and inpatient system [10].

Interventions targeting input and throughput Historically, strategies aimed at reducing ED overcrowding have primarily focused on input and throughput domains. Early policy efforts largely assumed that regulating demand or improving internal efficiency would substantially mitigate overcrowding.

Interventions on input factors

Early interventions focused on input factors, including public education, improving primary care, and redirecting non-urgent attendances [1, 29]. However, accumulating evidence has challenged the assumption that presentations for non-urgent complaints are the principal driver of overcrowding. Their overall effect appears modest and context-dependent, especially when boarding remains unresolved [1]. More recent reviews further confirm that while input-focused interventions may improve appropriateness of ED use in specific subgroups, their overall effect on overcrowding remains limited and inconsistent across settings [30].

Interventions on throughput factors

Throughput interventions target internal ED processes and have been widely implemented due to their direct controllability. Strategies such as process redesign, streaming models, early senior assessment, fast-track pathways, nurse-initiated protocols, expanded nursing roles, and advanced practice providers consistently improve operational metrics, including waiting times, rates of patients leaving without being seen (LWBS) and ED LoS. However, despite these local gains, their impact on overall overcrowding remains limited [1, 30–32].

In the Italian context, the development of *Short-Stay Observation Units* (OBI) represents a structured throughput strategy. Designed for patients with moderate complexity or diagnostic uncertainty, OBI allows for extended evaluation

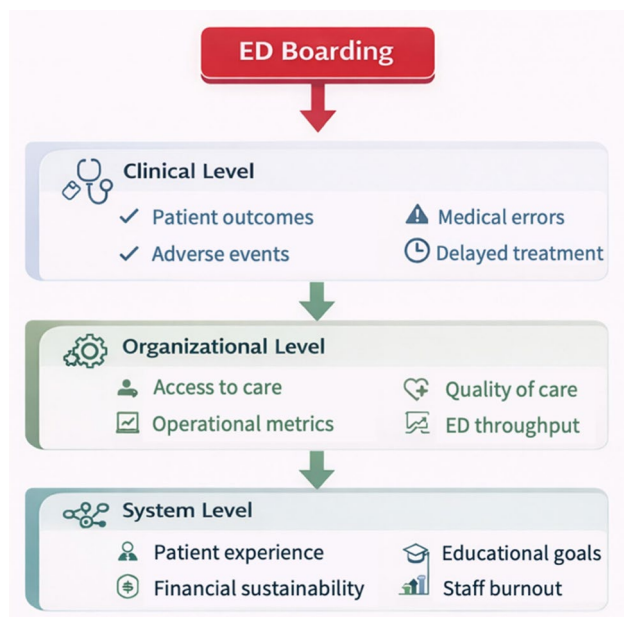


Fig. 1 System-wide consequences of ED boarding. Boarding in the ED affects multiple domains of healthcare performance. At the clinical level, it is associated with delayed treatment, medical errors, adverse events, and worse patient outcomes. At the organizational level, boarding compromises access to care, quality of care, operational performance, and ED throughput. At the system level, it also impacts patient experience, medical education, staff burnout, and the financial sustainability of healthcare systems

and stabilization under ED supervision. Studies suggest that this model can reduce unnecessary admissions, potentially alleviating downstream demand on inpatient beds [33]. Point-of-care testing and other diagnostic acceleration tools demonstrate benefit primarily when laboratory turnaround time is the true rate-limiting step; otherwise, their effect on global overcrowding metrics remains limited [10, 32].

Taken together, these findings highlight a fundamental limitation of ED-centered interventions: efficiency improvements within ED may not generate durable reductions in overcrowding when substantial downstream output constraints remain unresolved.

From microcosm to macrocosm: beyond the ED The *input–throughput–output* model provides a framework for interpreting patient flow both within the ED and across the wider healthcare system, with *access block* and *boarding* representing the critical interface between these levels. Although overcrowding results from factors across all three domains, many influential determinants, particularly those related to output, remain beyond the direct control of the ED [34].

A consistent finding across the literature is the mismatch between the most frequently identified determinants of ED overcrowding and the interventions most frequently implemented. While output constraints appear to account for a substantial proportion of the structural drivers, most strategies have historically focused on input and throughput processes. This misalignment may explain why improvements in triage, streaming, or internal ED workflow do not necessarily translate into sustained reductions in overcrowding when inpatient bed allocation and discharge processes remain constrained [10, 35, 36]. Nevertheless, high-quality evidence on sustainable macro-level solutions remains limited, underscoring the need for further research and managerial engagement.

ED as the epicenter of systemic failure

ED overcrowding is increasingly recognized as the surface expression of a broader phenomenon: hospital overcrowding. The ED may therefore act as a sentinel of hospital-wide flow dysfunction, where downstream capacity constraints become clinically visible through *access block* and *boarding* [35]. The interaction between ED and hospital-wide patient flow is illustrated in Fig. 2.

Some authors have described access block as a “theory of everything” in emergency medicine, emphasizing its pervasive and integrative nature [3]. A persistent obstacle to systemic understanding has been the enduring myth of inappropriate ED use. Available evidence suggests that low-acuity patients may contribute less substantially to overall resource consumption and sustained overcrowding than is commonly assumed. Although their impact varies across

settings and periods of demand, they generally account for a small proportion of admissions and exert less influence on the ED’s ability to manage critically ill patients in many large EDs. The continued focus on “inappropriate attenders” may divert attention from the structural determinants of overcrowding [37].

More broadly, prolonged ED stays may also arise from organizational bottlenecks across the acute-care pathway, rather than from ED processes alone. In a root-cause analysis of patients with an ED LoS exceeding 6 h, 78% of the identified causes were organizational, and 95% of these were outside the direct control of the ED. Frequent causes included delays in admission or interhospital transfer, radiological waiting and reporting times, and sequential specialist consultations [34].

Among these organizational constraints, boarding of admitted patients has been consistently identified as one of the principal contributors to sustained overcrowding [38]. Its effects propagate across the acute-care system, increasing ambulance holding times, delaying diagnostic assessment and definitive treatment, and disrupting transfers to inpatient wards and intensive care units [3].

Interventions targeting output factors

Interventions targeting output factors may provide critical leverage points for meaningful and sustained improvement [10, 30].

A first group of interventions focuses on optimizing the dynamic use of existing capacity through coordinated bed management. This usually involves structured patient-flow systems led by dedicated roles (e.g., bed managers or patient flow managers) with the authority to coordinate admissions and balance elective and emergency demand. When supported by effective hospital-level decision-making power, such models can improve bed allocation, anticipate bottlenecks, and better synchronize urgent admissions with discharge processes. In this way, the benefit derives not from an absolute increase in the number of inpatient beds, but from improved management of bed resources, with a reduction in organizational inefficiencies that sustain chronically high occupancy levels [39].

A second core domain is discharge optimization, including early discharge strategies, proactive discharge planning, and strengthening weekend discharges [40]. Delays in discharge are often driven by organizational rather than clinical factors, and targeted interventions are frequently associated with reduced inpatient occupancy and increased bed availability for ED admissions. In addition, discharge lounges (dedicated areas for patients who have been discharged but are awaiting transportation) may facilitate earlier bed release. These structures have been linked to reduced transfer delays, shorter overall hospital length of stay, and, in

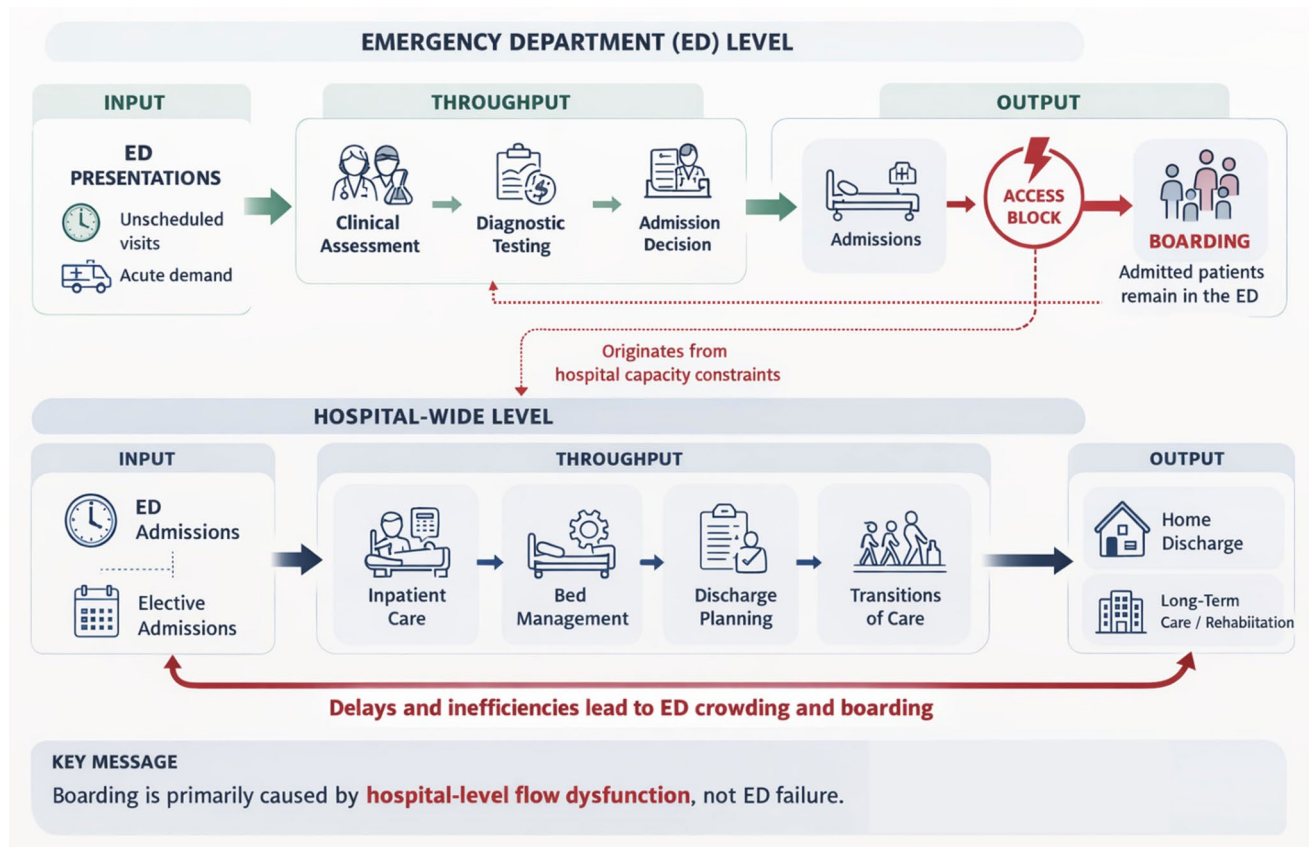


Fig. 2 Conceptual model of ED boarding as a manifestation of hospital-wide flow dysfunction. Patient flow in the ED follows an *input–throughput–output* model. When inpatient beds are unavailable, admitted patients remain in the ED, resulting in access block and boarding. At the hospital level, both emergency and elective admis-

sions compete for limited hospital capacity and depend on efficient inpatient care, bed management, and discharge processes. Delays in hospital throughput generate upstream pressure that manifests as boarding in the ED. In turn, the accumulation of boarded patients further slows ED throughput and contributes to ED overcrowding

some contexts, cost savings without increased readmissions. However, the limited available evidence indicates wide variation in discharge lounge design across sites and offers little generalizable insight regarding their performance [41].

A further output strategy involves smoothing elective admissions, as elective admissions clustered on specific weekdays can saturate inpatient wards and reduce surge capacity for unscheduled ED demand. Literature also describes potential benefits from creating medical assessment units and short-stay units managed by inpatient services, which can physically and functionally separate patients awaiting admission from critical ED flows and act as a “decompression buffer” for urgent admissions [42, 43].

Finally, broader macro-level initiatives, including enhanced transitional care pathways and home-based care models (e.g., hospital-at-home), aim to support timely discharge once patients are stabilized, thereby increasing effective output capacity.

Evidence suggests that delays in discharge and inefficient inpatient flow, more than bed scarcity alone, are key

determinants of access block and boarding. Accordingly, interventions that enhance hospital-wide coordination and prioritize patient flow across the entire admission–discharge continuum may have a substantial impact [44].

The continuous flow model

Recent developments in the debate on *output* interventions have clarified that the core issue is not merely the static availability of inpatient beds, but the hospital’s capacity to maintain a continuous and dynamic flow of admitted patients. In this perspective, models of continuous flow or proactive flow (including structured Full Capacity Protocols) have been proposed as strategies to redistribute admitted patients from the ED to inpatient areas even during periods of bed saturation [45].

The underlying rationale is that boarding is not a neutral waiting condition, but a clinically and organizationally hazardous state associated with treatment delays, worse outcomes, and increased mortality. Concentrating admitted

patients within the ED amplifies these risks while simultaneously impairing its function and pre-hospital emergency system responsiveness. Continuous flow models therefore seek to distribute operational strain across the hospital, rather than allowing it to accumulate disproportionately within the ED [46].

By reallocating responsibility for admitted patients to inpatient services, even in high-occupancy conditions, the hospital acknowledges boarding as a system-wide risk rather than an ED-contained inconvenience [47].

However, as critically emphasized in the literature, no intervention is universally effective, and effectiveness remains context-dependent: one size does not fit all [48]. Even output interventions, though potentially high-impact, require adaptive design and strong hospital governance.

Hospital-wide interventions

In recent years, a growing body of literature has shifted attention from isolated interventions targeting specific phases toward hospital-wide strategies.

Increasing acute-care bed capacity and staffing is one of the most direct ways to reduce access block, but in practice this depends on resource allocation and policy priorities, a challenge that hospital management continuously faces while attempting to balance competing healthcare demands. Consequently, healthcare funders and policymakers must be persuaded that boarding represents a critical system-level issue that deserves prioritization in resource allocation alongside other areas of healthcare [49].

Although many hospitals acknowledge boarding as a major driver of overcrowding, no single intervention has consistently demonstrated superiority across settings. Instead, studies have identified four recurring organizational domains associated with better performance: direct executive leadership involvement, coordinated hospital-level

strategies, data-driven management, and clear accountability mechanisms.

High-performing centers typically rely on real-time data monitoring, transparent dashboards, and rapid feedback loops to frontline staff, while framing ED overcrowding as an institutional priority with shared accountability across departments. By contrast, lower-performing institutions tend to depend on retrospective reporting and lack structured accountability processes.

Active engagement of executive leadership (through clear goal setting, resource allocation, and direct oversight of patient flow processes) has emerged as a critical determinant of success, together with improved coordination across departments involved in acute-care pathways and the development of multidisciplinary strategies addressing bottlenecks along the entire admission–discharge continuum [50]. The main interventions proposed in the literature to address ED overcrowding across the *input-throughput-output* framework and through *hospital-wide* strategies are summarized in Table 1.

Interventions proposed in the literature can be grouped according to the *input-throughput-output* model. While input- and throughput-focused strategies mainly improve operational efficiency within the ED, sustained reductions in overcrowding are often associated with interventions targeting hospital output capacity and coordinated hospital-wide patient flow.

Prospective evidence supports this integrated approach. A multimodal hospital-wide intervention implemented in a large Australian tertiary hospital was associated with significant improvements in overcrowding and boarding indicators, reduced ED occupancy, and improved timeliness metrics, without deterioration in quality outcomes such as early returns or rates of LWBS [51].

Future strategies should combine demand management with real-time, hospital-wide flow coordination. Potential

Table 1 Reported interventions to address ED overcrowding within the *input–throughput–output* framework

Domain	Intervention	Overall effect
<i>Input factors</i>	Public education campaigns; strengthening primary care access; redirection of non-urgent attendances	Limited and <i>context-dependent impact</i> on ED overcrowding
<i>Throughput factors</i>	Lean process redesign; patient streaming or split-flow models; rapid assessment zones; reverse triage; physician-in-triage; fast-track pathways; observation units; nurse-initiated protocols; point-of-care testing	<i>Improve ED operational efficiency</i> but rarely resolve overcrowding when <i>output</i> constraints persist
<i>Output factors</i>	Centralized bed management; discharge optimization; early discharge planning; weekend discharges; discharge lounges; elective admission smoothing; medical assessment units; short-stay inpatient units; transitional care pathways; hospital-at-home programs	<i>Potentially high impact</i> through improved inpatient flow and bed availability
<i>Hospital-wide strategies</i>	Increased acute care bed capacity; executive leadership engagement; hospital-wide flow coordination; real-time operational dashboards; multidisciplinary governance	<i>Among the most promising approaches</i> for sustainable reduction of boarding and overcrowding

areas for innovation include predictive analytics to anticipate demand and bed availability, dynamically updated operational dashboards, centralized patient-flow command structures, and regional sharing of inpatient capacity. These approaches should be integrated with targeted demand-management initiatives and improved access to alternatives to hospitalization, including same-day emergency care, virtual wards, and hospital-at-home pathways, particularly for patient groups in whom avoidable ED attendance can be safely reduced.

Although further evidence is needed, these findings support coordinated, leadership-driven, and accountable hospital-wide strategies as a promising avenue for sustainable improvement.

Conclusions

ED *overcrowding* has long been framed as an operational problem of the ED itself. However, the evidence reviewed here suggests that some of its most persistent determinants may lie downstream, particularly in the inability of hospitals to provide timely inpatient placement and maintain effective patient flow. In this perspective, *boarding* is not merely a transfer delay, but a critical failure in the system's ability to provide timely and appropriate care, with direct implications for patient safety and outcomes.

This interpretation broadens accountability beyond the ED alone. Sustainable improvement is more likely when patient flow is managed through integrated bed coordination, discharge optimization, elective-demand smoothing, real-time operational governance, and executive leadership engagement. Although no single intervention is universally effective and local context remains crucial, the literature increasingly supports *hospital-wide* strategies over isolated ED-based solutions.

Ultimately, ED *overcrowding* may be best understood not as the disease itself, but as the visible symptom of broader hospital dysfunction, with *boarding* representing one of its clearest clinical manifestations.

Addressing this challenge requires a shift from an ED-centered narrative to a *whole-hospital* strategy, recognizing that responsibility for timely and safe patient flow lies with the entire organization.

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Declarations

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval and consent to participate Not applicable.

Consent for publication Not applicable.

Human and animal rights statement and informed consent This article does not contain any studies with human participants or animals performed by any of the authors. Informed consent is therefore not applicable.

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