Specialists, guidelines and turf battles

To the editor:

I enjoyed reading the July 99 issue of *CJEM*. Thank you for a thought-provoking and diverse spread of articles. I found the discussions[1–9] about guidelines and "turf battles" fascinating and, in many ways, familiar. The Australasian College for Emergency Medicine (ACEM) has faced similar issues and processes.

ACEM produced a policy for the ED sedation procedures in November 1997. Although there was wide consultation during the formulation of the guidelines, including from our anesthetic colleagues, we did not seek endorsement from any other body. Recently, ACEM adopted a position statement regarding the use of focused ultrasound in the ED. Again, we did not seek the endorsement of any other specialty group.

I see a clear link between the way we define our "specialism" and the confidence with which we can make statements about standards. Unless we claim confident ownership of our legitimate turf, we will always be seen as "Jack of all trades and master of none." Why would another specialist body want to endorse our position papers if we are not confident that we own the territory? If we ask for endorsement, aren't we really saying that we want their permission to make our own statement about an area that is really theirs?

So, is there legitimate specialist territory that belongs to us alone? I believe that the definition of our specialty lies in a system of practice rather than a body of knowledge. Sure we know a lot about toxicology and environmental injuries, but so do others. Where we are uniquely specialized is in the reception, triage, assessment and initial management of multiple undifferentiated patients presenting simultaneously, throughout the spectrum of diagnoses and age groups, and with a minimum of background information. This territory is unique to us, and only we understand it well enough to make statements about how practice should occur within it.

Of course we must use knowledge or expertise developed by other specialists. However, we must then translate those principles into rational and realistic guidelines that are appropriate for our setting. When we sedate patients for procedures in the ED we are practising emergency medicine, not anesthesia. In the same way, an anesthetist reading a preoperative ECG is practising anesthetics, not cardiology. When we use focused ultrasound to evaluate the abdomen of a trauma patient we are practising emergency medicine, not radiology (just as we are when we interpret plain x-rays).

In relation to focused ED ultrasound, the answer to the question "why aren't we allowed to use it?" must surely be "you can do anything you like, as long as you are answerable for the consequences." The standards of training and practice must be appropriate for the setting, and the procedure and consequences must be subjected to the same quality control processes that we would apply to the interpretation of plain radiographs or the decision to use thrombolysis in ED.

We need to behave, speak and think with enough confidence in our own specialty that other specialists will understand that we have no need to invade theirs. At the same time, we must approach them with the respect and recognition that we would wish expressed towards ourselves.

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A Canadian approach?

To the editor:

Congratulations on the launch of *CJEM*. This journal represents a landmark achievement in Canadian emergency medicine and is long overdue. It's important for us to realize that the US approach is not the only standard of care, and perhaps not the best one. Finally Canadian emergency physicians will have an alternative to the legally-driven, overly investigation-oriented USA style of practice. *CJEM* will enable us to publish our own standards of care, guided by logic, evi-

https://doi.org/10.1017/S148180350000405X Published online by Cambridge University Press

dence and common sense rather than by the Bar Association, the National Rifle Association, commercial interests and big industry. In addition, *CJEM* is showing us that medical journals don't have to be dry, with a stiff upper lip. An informal approach that is intellectual and, at the same time, humorous, provides the ideal format for learning. Congratulations on a job well done.

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ED ultrasound

To the editor:
I wish to address comments made by Drs. Ducharme and McPhee in the July issue of *CJEM*.[1,2] Their comments on the use of ED ultrasound (ED U/S) seem to reflect common misconceptions about this important diagnostic tool. These doctors suggest that the amount of training required to perform ED U/S is prohibitive and that, to meet the requirements of the Canadian Association of Radiologists, a great deal of EM residency time would have to be reallocated. This might be true if the purpose of such exams was to delineate specific pathologies or disease processes. But ED U/S exams were never intended to be definitive evaluations, which are far too time intensive to be practical in the busy ED setting. On the contrary, ED U/S is meant to provide rapid answers to specific questions, such as: Is there free fluid in the abdomen of this trauma patient? Is there an intrauterine pregnancy in this woman with suspected ectopic? and Does this hypotensive patient have an abdominal aortic aneurysm?

To avoid confusing ED U/S with the comprehensive exams carried out in the radiology suite, I propose that we refer to the former as EMERGENT scans.[3] Emergent scans are performed by **E**mergency physicians, are **M**edically indicated, occur in the **E**mergency department, are **R**apid, **G**oal directed, **E**vidence-based, **N**ot difficult and will decrease **T**ime to diagnosis. Less training time is required to master EMERGENT scans. The Society of Academic Emergency Medicine recommends only 40 hours of didactic teaching and by 150 clinically-indicated examinations.[4] This could easily be accomplished during a 5-year EM residency and might even be possible within the CCFP(EM) curriculum.

Importantly, the recognition of the EMERGENT scan as distinct from the definitive radiology U/S should facilitate a more open dialogue with our radiology colleagues. Perhaps if radiologists realized that EMERGENT scans are not a threat to their incomes, then a more collegial interaction could occur.

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EM training

To the editor:
I am pleased that Dr. Steiner, in the July issue of *CJEM*,[1] responded to our article.[2] He made several interesting points, but I am less than convinced by his arguments. Steiner refers to two clauses in the CCFP Residency Program Accreditation and Certification book that were, in his opinion, taken out of context. This has not been the view of others (from whom Dr. Moore and I have received positive feedback), so I guess interpretation remains a judgement call. In any case, it's clear that the coin does have two sides and that, for now, we'll agree to disagree.

The important issue is to ensure the continuing positive evolution of Canadian emergency medicine. As long as this remains our primary goal, then let the debate continue.

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Esophageal detector devices and children

To the editor:
Rhine and Morrow[1] suggest that the esophageal detector device (EDD) is a useful adjunct for confirming tube placement in adults. It may be less accurate in young children.

The EDD was evaluated in 20 children under 1 year of age undergoing elective surgery.[2] All were intubated and had a second ET tube placed into their esophagus. An observer, blind to tube placement, was then asked to use a modified EDD and aspirate from one of the tubes. Esophageal tube placement was identified correctly in 7 of 10 cases and tracheal tube placement in 8 of 10 cases, giving an overall failure rate of

https://doi.org/10.1017/S148180350000405X Published online by Cambridge University Press