without doubt, lead to failure. First we must lay the groundwork and prepare our plan. Most questions will come from radiology and can be anticipated. Other departments (e.g., surgery, gynecology) may lend support. The medical executive and senior management should be on board.

The goal is to build a solid base of support and open the lines of communication. The plan must be fully developed and promoted. A good machine should be purchased and a network of other groups supporting ED ultrasound should be encouraged. Documentation must allow for peer review and feedback. Continuous quality improvement (CQI) is essential to the success of an ultrasound program. EP credentialing should be encouraged.

In sum, ED ultrasound is the right thing to do. Political hurdles should be anticipated and overcome by openness, planning, networking and a rigorous CQI process.

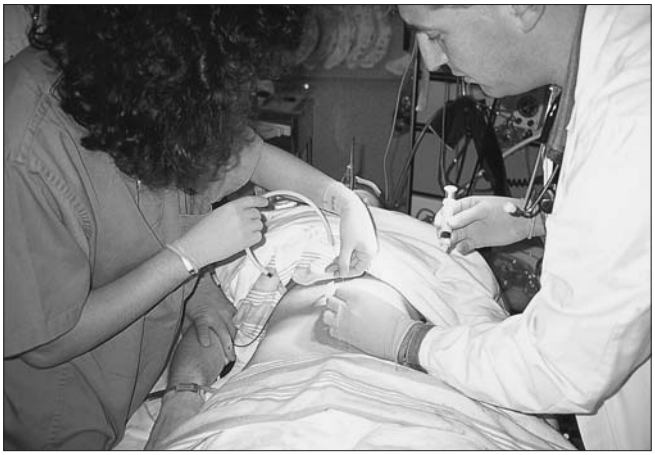
Correspondence to: rmatt@bc.sympatico.ca

The ultrasound controversy

Bruce Campana, MD

Ah, the ultrasound controversy. Every emergency department (ED) that I'm aware of goes through this struggle. The radiology department resists the introduction of ultrasound (U/S) because, and I don't want to oversimplify a complex issue, *they are worried they will lose money*.

The reasons they give are usually couched in a cornucopia of blather, such as, "emergency physicians can't garner enough expertise in their brief training to use the U/S machine properly." Sure. I can't use a stethoscope as well as a cardiologist, nor read plain films as well as a radiologist, nor interpret electrocardiograms as well as a cardiologist; yet somehow we emerg docs are able to make life and death decisions every day using these modalities. How about if we just get good enough with ultrasound to use it for emergency applications, like everything else we do? We'll leave the fancy stuff for the radiologists.



DPL: still the most sensitive test for intra-abdominal injury

The fact is, having immediately available ultrasound is just plain good patient care. Knowing I can confirm an intrauterine pregnancy at 03:00 in a pregnant woman with a vaginal bleed is great. Showing the overweight 50-year-old female the shadow of her gallstones in the middle of the night is great. Using the U/S to place a central line in a patient in shock is great. In the first two cases, I'll get a formal ultrasound later anyway. In the last case, I wouldn't call for an emergency ultrasound because I wouldn't be able to get one. I'd just get whining.

That's what this is really about — whining. The radiologists are whining because they're worried they're going to lose money. Then they whine when we ask them to perform the service. They simply don't provide the service as often as needed or as quickly as needed, and frequently complain when asked. Are they really surprised that we want to bypass them? In the business world, they would be laughed out of town.

Rest assured, the use of ultrasound by emergency physicians is inevitable. Just as there are antediluvian surgeons and internists who call us "casualty officers," there will be resistance. The radiologists' concerns are based on fear and ignorance. Once they realize that their incomes haven't changed and that they're getting fewer 02:00 calls, they'll start whining when we don't do ultrasounds in the ED.

Next, I think we should start doing laser keratoplasties. . .

Correspondence to: campana@hotmail.com

Department of Emergency Medicine, King Faisal Specialist Hospital & Research Center, Riyadh, Saudi Arabia

https://doi.org/10.1017/S1481803500003870 Published online by Cambridge University Press