tient-controlled sedation using propofol in doses of greater than 25 mg/min would undoubtedly be a short, unpublished study.

I do, however, agree with Dr. Ducharme's comments that mini-dose titration of propofol (20 mg every 45–60 seconds) for sedation during cardioversion minimizes the incidence of apnea and hypotension and allows for rapid emergence for the procedure. In obese patients I have found that positioning the patient in the right lateral decubitus position (recovery position) prior to cardioversion has several advantages.

1. The anterior-posterior placement of the paddles in the obese patient provides a more direct route of energy through the heart and in my experience is associated with a high success rate.

2. Airway obstruction is less likely to occur in the recovery vs. the supine position (as there is a tendency for obstruction to occur as a result of the tongue falling back when the patient is in the supine position).

3. Airway assistance and manoeuvres (jaw thrust, chin lift, positive pressure ventilation) are essentially never required in the recovery position when propofol is titrated properly.

4. Having the patient position himself in the recovery position prior to the procedure saves the staff from manually turning the unconscious patient on his side at the end of the cardioversion.

5. Obstructed respiratory efforts in the supine position generate positive intra-abdominal and negative intra-thoracic pressures, which increases the likelihood of gastric regurgitation and or aspiration.

6. The recovery position is preferable to the supine position for suctioning should regurgitation occur.

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Reference
1. Ducharme J. Propofol in the emergency department: another interpretation of the evidence [commentary]. CJEM 2001;3(4):311-2.

[The author responds:]

I thank Dr. Sullivan for his comments, and am encouraged by his endorsement of mini-dose titration of propofol. I need to correct him in his misunderstanding of my comments about patient-controlled sedation. I did not suggest, nor would I, that infusions of propofol in the order of 16–33 mg/min be used. The study quoted[1] showed that patients giving themselves such doses every minute by pushing on a button could not sedate themselves to the point of deep sedation (i.e., loss of protective reflexes). This study was quoted to demonstrate the safety of the mini-dose approach and was not meant to encourage ongoing infusions.

I am otherwise heartened by this positive input from Anesthesia, and encourage all emergency departments who are hoping to initiate safe procedural sedation policies to work with their anesthesia and emergency colleagues to establish standardized practices.

Jim Ducharme, MD
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1. Smith AF, Thorpe SJ, Cook LB. Patient-controlled sedation using propofol: randomized, double-blind dose refinement. Eur J Anaesthesiol 1999;15: 18-22.

Paediatric CTAS

To the editor:

Our centre is one of the busiest urban pediatric emergency departments (EDs) in North America, with more than 65 000 visits annually. We implemented the Canadian Paediatric Triage and Acuity Scale (PaedCTAS) 5 months ago [since published as a supplement to the October 2001 issue[1] of *CJEM*] and we are generally pleased with it; it has been quite easy to use. However, from the time it was discussed at meetings of the Canadian Paediatric Society and Canadian Association of Emergency Physicians, we have had concerns about the infection category. Our experience is proving that these concerns are real.

Lumping all children "*aged 3 to 36 months with fever*" in the Level III triage category is unrealistic. Febrile children in this age group represent the most frequent reason for consultation at our centre, and most have relatively benign viral illnesses. If we apply the PaedCTAS consistently, these patients disproportionately expand the Level III triage category, forcing potentially sicker patients with asthma, possible appendicitis or moderate allergic reactions (who should be seen earlier) to wait longer than necessary.

In general EDs with less pediatric experience it may be acceptable to lump all of these children into Level III, but in centres with pediatric triage expertise it is important to redefine this category based on other established criteria, so that some patients can be moved into higher or lower triage levels. Our triage nurses now do this informally without benefit of objective criteria, by placing selected Level III patients ahead of others who arrived earlier. Utility and relevance are critical characteristics of a triage tool and, at least in the infection category, we feel that the PaedCTAS has failed.

The Canadian Emergency Department Triage and Acuity Scale (CTAS)[2] has become a mandatory triage tool in our provincial EDs. Pediatric centres need an appropriate triage acuity scale to help us gather reliable information and define our acuity, resource level and performance. Before recommending the PaedCTAS as a national stan-

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dard, its reliability and validity must be demonstrated.

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1. Warren D, Jarvis A, Leblanc L, and the National Triage Task Force members. Canadian Paediatric Triage and Acuity Scale: implementation guidelines for emergency departments. CJEM 2001;3 (4 Suppl):S1-27.
2. Beveridge R, Clarke B, Janes L, Savage N, Thompson J, Dodd G, et al. Canadian Emergency Department Triage and Acuity Scale: implementation guidelines. CJEM 1999;1(3 Suppl):S1-24.

The trainee in difficulty

To the editor:

I congratulate Robert McGraw and Sarita Verma on their excellent review[1] of "The trainee in difficulty" in the July 2001 issue of *CJEM*. The editorial comments by Tim Allen were also timely and helpful.[2] Several key suggestions have been made that will help us all in our efforts to make the teaching environment in our emergency departments as effective as it can be.

Medical school enrollment is expanding nationally. Emergency medicine is increasingly becoming a core element of many medical school curricula. Our EDs are taking on a greater role as the setting where medical students gain their exposure to clinical medicine. We therefore clearly have an expanding role in not only teaching but in identifying the student in difficulty. Our role is one of both identification and, at times, remediation of students when they fail to meet the standards set.

The ED has several features that make it a setting particularly well suited to teaching and evaluation. I am very concerned though that with the national trend to overcrowding, delays in patient care and resource availability that is often less than ideal, the conditions for optimal teaching are eroding. We muct continue to apply pressure wherever and whenever we can to develop solutions when our departments are blocked and understaffed. We must do this as patient advocates and as educators.

With respect to identifying students in difficulty, feedback loops and early reporting of students whose performance falls short of what we expect are key requirements in our role. A further way in which we can improve our vigilance and consistency is the suggestion that students be encouraged to ask for feedback at an appropriate time at the end of each clinical shift. This critical step can become an expectation whenever staff physicians work with medical students. If shift evaluation forms are used, students can provide these at the same time. This can be an ideal time for assessment and feedback while the events of the shift remain fresh in the minds of both students and staff.

Thank you again to the authors of these articles. Their insights can be helpful to us all and can improve the way we evaluate medical students. Their suggestions can improve our contribution as teachers and will help us to develop a unique approach to medical undergraduate education in which we can all take pride.

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Associate Head
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1. McGraw R, Verma S. The trainee in difficulty. CJEM 2001;3(3):205-8.
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Alternate funding plans

To the editor:

Dr. Marshall is right that physicians should exercise caution and good judgement when assessing new payment plans.[1] However, the problems he ascribes to the Ontario Alternate Funding Agreement (AFA) are misleading. We would like to clarify several points:

The Ontario plan pays a lump annual sum, based on volume (other factors to modify workload are being developed), to emergency groups that sign on. This lump sum replaces fee-for-service (FFS) billings and is intended to exceed the amounts achieved through FFS, although the premium varies. There are no clauses requiring groups to divide this sum into a "salary," and each group is free to create its own distribution scheme. Thus, incentives for productivity, differentials based on training, experience, or for unsocial shifts are all a matter of discretion to the group members. This includes voting rights definitions within the group.

There are neither standards nor external monitoring of individual or group productivity.

There is no evidence from the 65 Ontario emergency departments (EDs) that have taken the AFA that productivity has been adversely affected.

FFS provides no funds for overhead. Under the AFA an individual physician's overhead is lowered as she or he does not need to submit FFS billings, while the group costs for shadow billing are at least partly offset by the AFA.

The AFA covers all non-scheduled visits to the ED. The plan was set up with the conversion of all FFS billings from the ED into the AFA pool, including the billings for patients seen by physicians other than the emergency physician on duty. It is up to the group to identify these funds and distribute them accordingly. Thus, any clawback for fees submitted by local family physicians indicates the lack of a local

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