Other indications for ED bedside U/S include life-threatening conditions such as cardiac tamponade, ectopic pregnancy and suspected abdominal aortic aneurysm. As a busy emergency physician, I don't have the time to perform detailed abdominal or pelvic scans, nor do I want to! Because EPs have specific and limited needs, it is inappropriate to apply the same U/S training standards to emergency physicians and radiologists. Many studies show that, to address the above conditions, we do not need 3 months of training and 500 examinations, as stipulated by the American Institute of Ultrasound Medicine! Even the American College of Emergency Physicians' proposed 40-hour curriculum and 150 examinations is more than we require for *focused* U/S in the ED.[4] Some US emergency physicians who perform detailed bedside U/S see only 2 patients per hour or work in departments with an abundance of house staff. How many Canadians can say the same? Fifteen minutes is the most time I want to spend scanning.

Can EPs and radiologists collaborate to provide timely focused bedside scans? This might be ideal; however, in our tertiary care trauma centre, the responsibility for ED U/S has been delegated to the radiology residents on call, who are also responsible for all other after hours imaging procedures. As you can imagine, FAST is not always as fast as one would wish. In addition, when these residents are called to the ED to perform bedside U/S, other imaging studies and their interpretations are delayed, which impacts negatively on ED patient flow. Moreover, there is constant turnover of the junior residents who provide this service. Do they have experience with 500 scans prior to performing and interpreting ED scans? This would be less of a recurring problem if a stable complement of EPs gained U/S experience over time.

Why are radiologists not supportive of such an arrangement? Are they concerned that once EPs master the focused U/S, we will go on to do detailed scans and decrease the number of radiology referrals? Perhaps they fear that emergency physicians would do the easy scans and refer only the difficult ones. Not likely. I don't want to be a radiologist! I am only interested in a few selected life-threatening conditions. Turf wars should not distract us from good patient care.

Finally, let it be said, "no department has ownership of a technology."[5] That is true, whether we are talking about a laryngoscope, a slit lamp or an ultrasound.

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Emergency department ultrasound — practical and political

Ron Matthews, MD

Practically speaking, bedside ultrasound is well within the scope of emergency physicians (EPs) and is gaining acceptance. The literature supports the use of limited, goal-directed ultrasound in the diagnosis of many emergent conditions. EPs should use ultrasound as a tool to answer specific questions (e.g., Is there blood in the belly?); they should not surf the body for clues. ED ultrasound offers rapid evaluation of potentially life-threatening conditions and the opportunity for serial examinations in selected cases.

Politically speaking, we have a problem for which we, alas, are not blameless. Cardiology, gynecology, surgery and particularly radiology have an interest in what we do. We have surged ahead enthusiastically without the requisite preparation. Our approach is like suturing a wound before administering the anesthetic. Introducing ultrasound covertly by organizing emergency physician in-services will,

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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.

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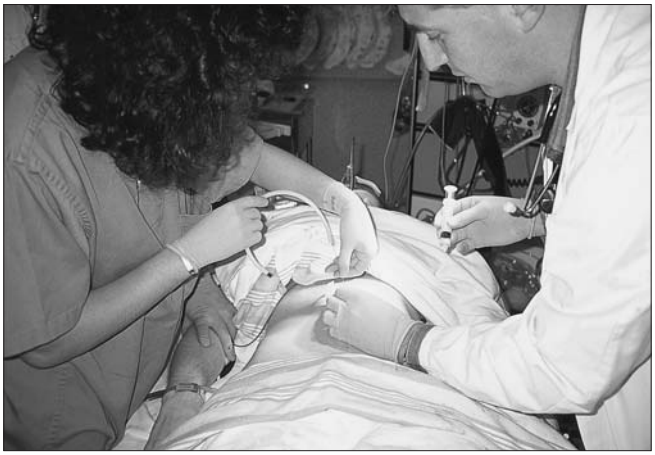
The ultrasound controversy

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. . .

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