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Emergency physicians should be knowledgeable about GHB and the precursors GBL, and 1,4-BD. The patient who presents to the Emergency Department with toxicity from these agents is likely have a nonspecific comatose state, and management should be focused on airway control. Rapid recovery from unconsciousness is considered the hallmark of GHB toxicity.

#### References

1. Tunnicliff G. Sites of action of gamma-hydroxybutyrate (ghb)-a neuroactive drug with abuse potential. *Clin Tox* 1997; 35:581-590.
2. Kam PCA, Yoong FFY. Gamma-hydroxybutyric acid: an emerging recreational drug. *Anaesthesia* 1998; 53:1195-1198.
3. Takahara J, Yunoki S, Yakushiji W et al. Stimulatory effects of gamma-hydroxybutyric acid on growth hormone and prolactin release in humans. *J Clin Endocrinol Metab* 1977; 44:1014-1017.
4. Craig K, Gomez HF, McManus JL, Bania TC. Severe gamma-hydroxybutyrate withdrawal: a case report and literature review. *J Emerg Med* 2000; 18:65-70.
5. Anon. GHB added to the list of schedule I controlled substances. DEA Press Release March 13, 2000. <http://www.usdoj.gov/dea/pubs/pressrel/pr031300.htm>.
6. Lammers GJ, Arends J, Declercq, Ferrari MD, Schouwink G, Troost J. Gammahydroxybutyrate and narcolepsy: a double-blind placebo-controlled study. *Sleep* 1993; 16:216-220.
7. Sanguineti VR, Angelo A, Frank MR. Ghb: a home brew. *Am J Drug Alc Abu* 1997; 23:637-642.
8. Chin RL, Sporer KA, Cullison B, Dyer JE, Wu TD. Clinical course of  $\gamma$ -hydroxybutyrate overdose. *Annals of Emergency Medicine* 1998; 31:716-722
9. Ingels M, Rangan C, Bellezzo J, Clark RF. Coma and respiratory depression following the ingestion of ghb and its precursors: three cases. *J Emerg Med* 2000; 19:47-50
10. Anon. FDA warns about products containing gamma butyrolactone or gbl and asks companies to issue a recall. FDA Talk Paper January 21, 1999.
11. Toil LL, Hurlbut KM (Eds): POISONDEX® System. MICROMEDEX®, Inc., Englewood, Colorado Volume 106 expiration 12/31/2000.
12. Ferrara SD, Tedeschi L, Frison G, Rossi A. Fatality due to gamma-hydroxybutyric acid (ghb) and heroin intoxication. *J For Sci* 1995; 40:501-504.
13. Couper FJ, Logan BK. Determination of  $\gamma$ -hydroxybutyrate (ghb) in biological specimens by gas chromatography-mass spectrometry. *J Anal Tox* 2000; 24:1-7.

#### MEETING REMINDER:

American Academy of Emergency Medicine  
Annual Scientific Meeting  
February 22 - 25, 2001  
Orlando, Florida For Detail: [www.aem.org](http://www.aem.org)

## The Call for Academic Departments of Emergency Medicine Throughout the University of California

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### Introduction

The ten University of California (UC)-affiliated teaching hospitals suffer from a collective lack of influence in the academic hierarchy of their five parent medical schools. This is in stark contrast to the vital position of emergency medicine (EM) in California healthcare, and to the nationwide trend of prominence of emergency academics. Nationwide, there are 57 academic Departments of EM, including the Universities of Michigan and Pennsylvania, Johns Hopkins, Vanderbilt and Ohio State. UC must recognize the central importance of EM to the state's medical students. Academic department status will enable UC emergency departments (EDs) to fulfill their destiny as premier sites of clinical care, teaching and research.

### Current Scope of Influence of the Specialty of Emergency Medicine

The five University hospitals and their five affiliated county and city facilities see more than 600,000 patients per year, (personal communication from medical directors) and comprise 6% of the California ED census. However, the import goes far beyond patient volume. All five campuses have affiliated Level I trauma centers, which care for 18,000 critically injured patients per year. The UC campuses at San Diego, Irvine, Los Angeles, San Francisco, and Davis support seven accredited emergency medicine residencies. Four of the five university hospitals support EM residencies. These programs now train more than 200 EM residents, two-thirds of the state's complement.

EM programs provide clinical rotations for medical students at all affiliated hospitals, to assure that all UC students receive instruction in this vital field. More than 6% of UC medical students train in EM (compared to 4% nationwide). This is testimony to the quality education that UC medical students receive.

The ten hospitals engage in substantial EM research. This research effort has been hampered by lack of faculty resources, grant funding, and time to pursue independent investigation. Nevertheless, EM faculty publish in some of the most prestigious journals, including *JAMA*, *NEJM*, and the *Annals of Emergency Medicine*.

The ten UC-affiliated EDs lead such important initiatives as the reduction of child and elder abuse, domestic and gun violence, and injury prevention. They also work to define the statewide response to earthquakes and bio/chemical terrorism. They are active in surveillance for established and emerging infectious diseases such as AIDS, tuberculosis and influenza. They provide radio control and education to more than 1000 paramedics, who deliver patients to UC, community and public hospitals. They staff the state's poison centers, which field hundreds of thousands of calls yearly.

The role of the UC hospitals as a safety net cannot be overemphasized. They provide primary and tertiary care for the state's underserved and immigrant population, as well as caring for the mentally ill. There is nowhere in the state where its citizens can go at all times, and be guaranteed access to health care. Federal law and medical ethics dictate that the ED must evaluate all patients regardless of ability to pay. The huge burden of uncompensated care already strains the safety net. The further diversion of EM resources by the UC hospitals makes fulfilling the complex mission of teaching, research, and patient care next to impossible.

The solution to this problem is to increase academic and administrative control for EM at the five campuses through the formation of academic departments.

#### *Statewide Crisis of Emergency Care*

There is a crisis of emergency care in California. A recent survey of ED Directors reported that all 21 university or county-owned facilities (including all 10 UC-affiliated hospitals) reported significant problems with overcrowding. (1) The result is increasing time of ambulance diversion because care in the ED is dangerous. There are very long waits (at times, some 2-8 hours in UC EDs, and greater than 12 hours in city or county EDs). Patients stay for 1-3 days at times for lack of inpatient beds, and this makes treatment of new patients impossible.

The facilities and equipment for the UC hospital EDs are inadequate, designed and procured some 20-30 years ago. Except for the UCLA hospital under construction, the UC ED patient care space has not been increased for more than 15 years, while patient volumes have increased 15% in the past decade. The ED is often the last area to benefit from upgrades in technology and equipment.

Ancillary support is lacking as well, as fiscal constraints reduce staffing to levels incompatible with optimum care. Qualified nurses are in short supply, and hospitals have not responded to calls for appropriate ED staffing. There are shortages of clerks, technicians, case managers and social workers. Residents are used as an unwitting substitute. At some UC hospitals, STAT laboratory and x-ray results return more than three hours later. Angiography, CT scanning and ultrasound, critical to the care of acutely ill and injured patients, is often unavailable after hours. At these times, emergency patients most need these services. The UC hospitals have been largely unresponsive to requests to enhance these services.

It is common practice in UC hospitals to divert EM revenue for ECG and x-ray interpretation to cardiology or radiology, despite HCFA rules allowing the physician whose interpretation affects patient care to bill. EPs must be appropriately compensated for this work. The academic hierarchy at the UC hospitals has refused to remedy this injustice.

The current fiscal arrangements at the UC hospitals mandate taxation from the subordinate hospital ED to a parent academic department. This financial obligation, which provides no benefit to emergency patients, accounts for 5-35% of patient care revenue, depending on campus.

#### **Advantages of Academic Department Status**

Establishment of Academic Departments of EM in the UC medical schools would eliminate the diversion of EM revenue. It would require that the medical schools devote resources to EM, as they do to the other departments. The inherent academic respect and validation would promote recruitment and retention of higher caliber faculty. A survey of medical schools which already established academic departments of EM showed extramural grant funding increased 33%, while participation on medical school committees increased by 40%. There were substantial improvements in academic attributes mutually beneficial to the institution and to EM. (2)

Control over finances would allow faculty protected time to devote to a research career. In other specialties, faculty typically work 20% clinical service, and devote the rest to research and teaching. The FTE positions that make this possible are not available to EM. Of the more than 125 EM faculty in the UC system, none have state-supported FTE positions. Research and grants benefit UC as much as they do EM, and should clearly be fostered.

Finally, department status would also position EM faculty as decision-makers within the hospital and medical school. They would have equal influence with other chairs over policy decisions and resource allocations that affect emergency patients.

#### *Barriers to Academic Department Status*

Leaders in EM understand the urgent need for academic department status. Derlet (3) and Kazzi (4) have openly called for this progression. The Macy Report on the Role of Emergency Medicine in the Future of American Medical Care, called for universal department status for EM throughout the nation's medical schools in 1994. (5) However, the current UC medical school deans are reluctant to establish new departments, fearing repercussions from existing chairs. Furthermore, the deans rely on revenue from EM to subsidize divisions and departments. This is in contrast to the forward thinking of medical school deans in the three private medical schools in California. Two have had academic departments for 16 (Loma Linda University) and 30 years (University of Southern California). While some of the UC medical school deans are sympathetic to the need for department status, none have been willing to lead the necessary conversion process.

#### **Configuration of the Optimum Academic Department of Emergency Medicine**

An academic department of EM would receive proportional resources from the dean, and conversely, the diversion of funds generated by EM to other uses would cease. The distribution of tenure-track FTE positions must be proportional to other departments. There must be an EM residency on each of the UC campuses. The Department of EM must have control of personnel in and around the ED, including emergency nursing, technicians and security staff. The department must also control STAT laboratory and emergency imaging. These services must be in

concert with the acuity and volume of patient care, and be available at all times.

The Department must participate in contract negotiations that affect reimbursement for EM, including capitation rates. The Department must develop its own budget and business initiatives. The Department must maintain control over ambulance diversion, in order to ensure the safety and optimum care of patients already in the ED. With the seismic retrofitting of the state's hospitals by 2008, the Department must have a central role in the design and construction of new facilities for emergency care.

Required faculty functions for the Department include a Chair, Vice-chair, Clinical Director, Research Director, Residency Director and assistant, Emergency Medical Services Director, Poison Center Director (if the site supports an accredited Poison Center), Pediatric Emergency Physician and Medical Student Director. Faculty should work no more than 20 clinical hours per week to afford time for academic work. The Department must be staffed with sufficient faculty to provide optimum care, comply with documentation requirements, and provide clinical teaching and supervision.

The Department must be eligible for laboratory space. Administrative and academic space must also be available. Equipment purchases must be the purview of the Department, including digital radiography, ultrasound, ED-specific information systems, and physiological monitoring.

### Conclusion

Despite playing a critical role in caring for California's citizens, providing outstanding education to UC students and residents, and publishing substantial original research, EM in the UC medical schools continues to suffer second-class citizenship. Inability to influence policy and finance critically impairs the ability to improve all aspects of patient care, research and education. Only with ascension to department status, can UC EM take its rightful place among the nation's premier programs. The outstanding tradition of the University of California demands no less.

### References

1. Richards JR, Navarro ML, Derlet RW: "Survey of Directors of Emergency Departments in California on Overcrowding." *Western Journal of Medicine*, 172:385-8, 2000.
2. Gallagher EJ, Henneman PL: "Change in Academic Attributes Associated with Establishment of Departments of Emergency Medicine. Task Force on the Development of Emergency Medicine at Academic Medical Centers." *Academic Emergency Medicine*, 5:1091-5, 1998.
3. Derlet RW: "Organization of Emergency Medicine at Medical Schools: Compelling Reasons for Departmental Status." *Academic Emergency Medicine*, 7:1145-6, 2000.
4. Kazzi AA: "Give Emergency Medicine True Departmental Control." *Western Journal of Medicine*, 172:388, 2000.
5. Bowles LT, Sirica CM: "Final Recommendations." In *The Role of Emergency Medicine in the Future of American Medical Care*. The Josiah Macy, Jr. Foundation, New York, 1995, p. 56.

### *A Great Triumph for Emergency Medicine California Leads Again in a Landmark Step Towards Unity*

A. Antoine Kazzi, MD, CAL/AAEM President

In order to address our 358 California AAEM members' educational needs, the CAL/AAEM and AAEM presidents submitted an educational proposal to CAL/ACEP in September 2000. In a landmark decision by its board of directors and its education committee, CAL/ACEP approved this proposal. The CAL/AAEM and AAEM boards later endorsed the agreement. The terms carry an outstanding value as a member benefit for AAEM, CAL/AAEM and CAL/ACEP. However, the most important value of this agreement is in its historical significance for the future of EM. It carries a clear and strong message calling for the unity of the specialty and its EM organizations and adds incredible momentum to efforts in that direction.

With an overwhelming majority, the CAL/ACEP Education committee voted to join CAL/AAEM in inviting all AAEM members (nationally) to attend the June CAL/ACEP 4-day Annual Scientific Assembly for a nominal fee of \$100. For AAEM members who maintain an ACEP membership, the fee is further reduced to \$50.

In return, AAEM invites all CAL/ACEP members to its 4-day February AAEM Scientific Assembly for the same discounted 100\$ rate. AAEM also invites all CAL/ACEP members to its September 2-5, 2001, EuSEM-AAEM First Mediterranean EM Congress in Stresa, Italy, for the same discounted registration (\$250) fee required from all AAEM members.

CAL/AAEM and CAL/ACEP have also agreed to hold together a landmark "California Business Forum" on controversial practice issues during the CAL/ACEP Scientific Assembly. Watch for details. This will be a most exciting event.

The goal is to continue this on a yearly basis. Certainly, AAEM-CAL/ACEP dual members retain their baseline free registration with their own organizations. Next year, AAEM will be on the West Coast (San Francisco or Las Vegas). Non-members would ordinarily be charged \$250 for the CAL/ACEP Assembly, \$300 for the AAEM Scientific Assembly, and \$350 for the First Mediterranean EM Congress.

The AAEM Scientific Assembly is on February 22-25, 2001, at the Disney's Coronado Springs Resort, in Orlando, Florida. CAL/ACEP members who wish to take advantage of the discounted rates or of the pre-Assembly courses should promptly check the AAEM website at [www.aaem.org](http://www.aaem.org) where one can register on-line.

Such a strategy is a win-win for all our members, providing them with additional benefits and educational opportunities of the highest quality. Join us in all these annual events and let us celebrate Emergency Medicine and unity in our specialty. Congratulations to EM, CAL/AAEM, CAL/ACEP and AAEM.

*Dr. Kazzi is a member of the Board of Directors of both AAEM and Cal/AAEM, and Associate Associate Chief of EM at UC Irvine*