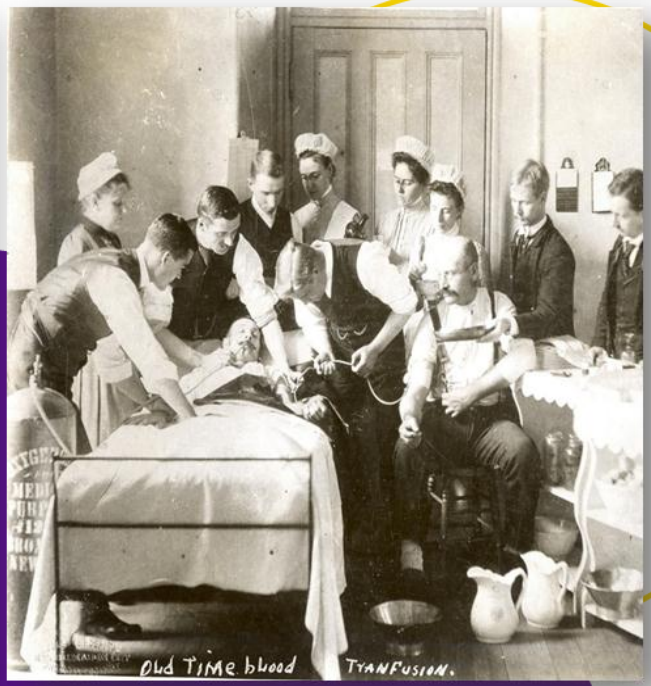
EPAT 3rd International Emergency Medicine Gold Award
May 20, 2017 (11:40AM—12:00PM)

NYU School of Medicine
NYU LANGONE MEDICAL CENTER



Drugs and Poisoning in the World

Lewis R. Goldfrank, MD
Herbert W. Adams Professor of Emergency Medicine
Ronald O. Perelman Department of Emergency Medicine
New York University School of Medicine
Medical Director, New York City Poison Center

Sculptor: Frederic Auguste Bartholdi
Designer: Alexandre Gustave Eiffel

"Give me your tired, your poor, your huddled masses yearning to breathe free, the wretched refuse of your teeming shore. Send these, the homeless, tempest-tossed to me. I lift my lamp beside the golden door."

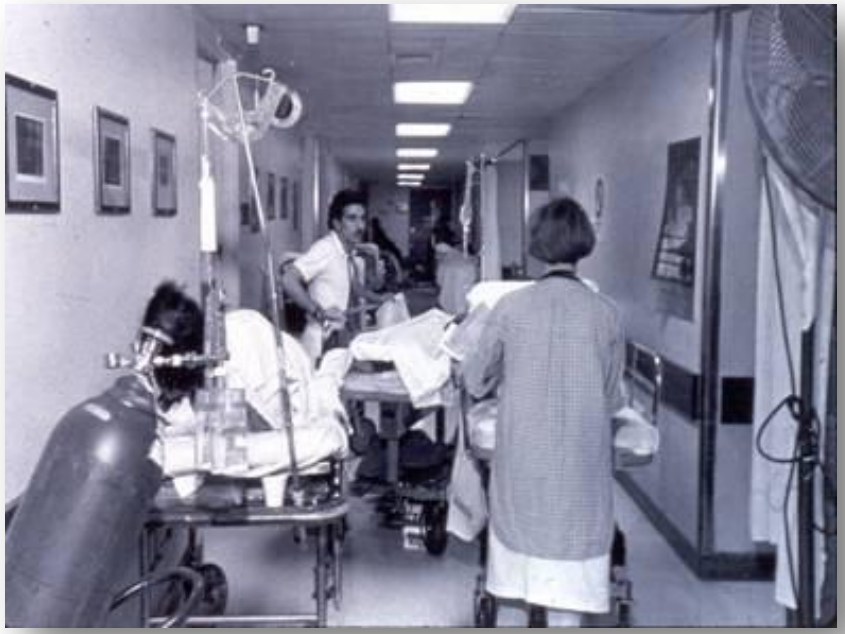
Emma Lazarus, 1849 – 1887

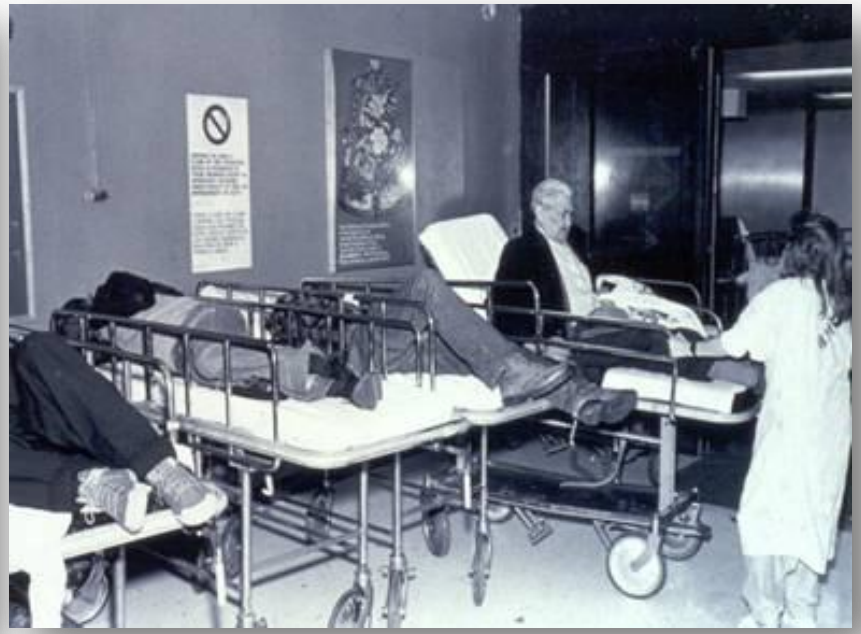
NYU School of Medicine
NYU LANGONE MEDICAL CENTER

Rudolf Virchow (1821 – 1902)

"Medicine is a social science, and politics is nothing more than medicine on a grand scale"

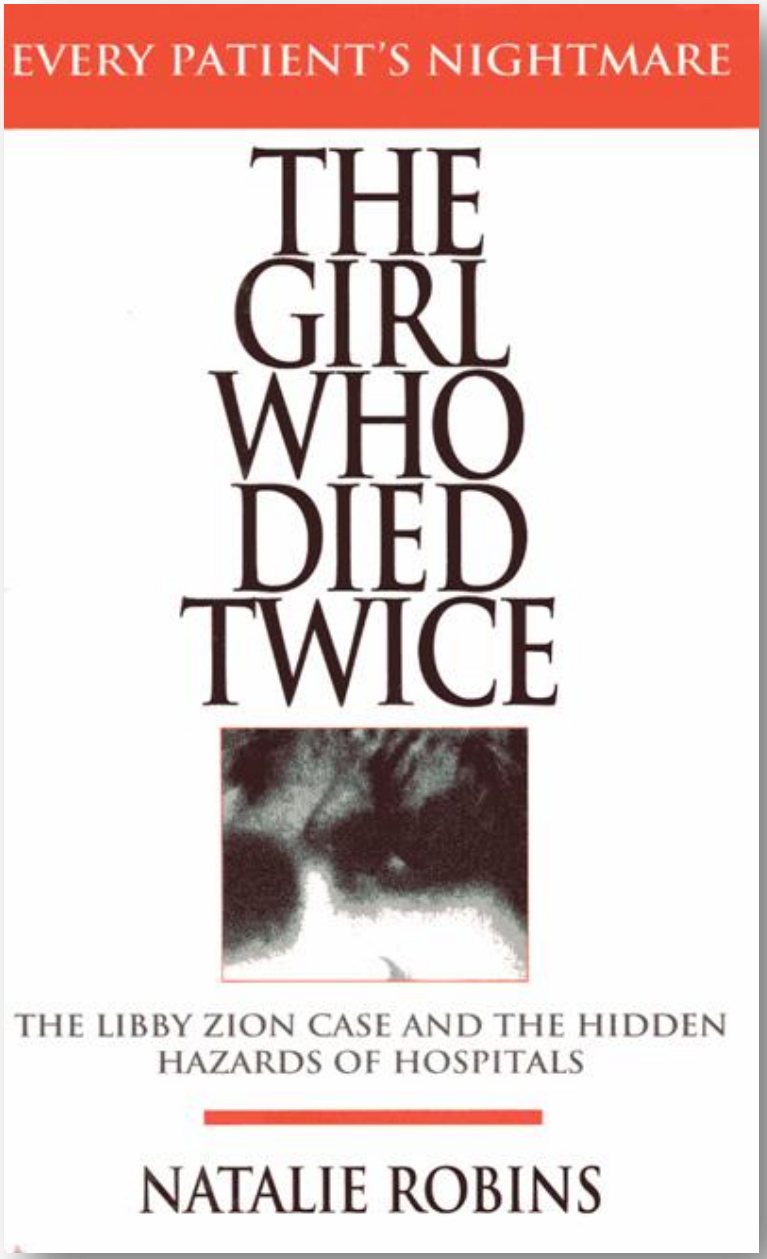
"The physicians are the natural advocates of the poor, and the social problems should largely be solved by them."





During my first hour in the Hopital X I had had a whole series of different and contradictory treatments, but this was misleading, for in general you got very little treatment at all, either good or bad, unless you were ill in some interesting and instructive way.

George Orwell, Down and Out in Paris and London. How the Poor Die, 1933.



1995

NYU School of Medicine
NYU LANGONE MEDICAL CENTER

On March 4, 1984 Libby Zion an 18 year old Bennington College student, child of Sidney and Elsa Zion journalists with powerful political connections was brought by family to the New York Hospital Emergency Department.

Her chief complaints were agitation, fever, chills, myalgias and arthralgias. A medical resident began her evaluation.

The young woman's private attending physician declined the parent's request to come to the hospital.

The resident made a diagnosis of "viral syndrome with hysterical symptoms," obtained blood cultures, and prescribed acetaminophen for fever and meperidine for agitation and shivering.

The young woman was admitted to the medical service under the care of a medical intern and resident.

The intern was called when the patient became restless and disoriented, and, rather than evaluate the patient, she ordered by telephone, physical restraints and haloperidol.

When the patient became more agitated and febrile to 42℃ the intern was again paged; she ordered, by phone, a cooling blanket.

Four and one half hours after admission, the patient experienced a respiratory arrest and died.

Grand Jury Probe Faults Misuse of City's Interns

By Joe Calderone

Interns and young doctors routinely practice medicine at New York's major hospitals without adequate supervision by more experienced physicians, sometimes with tragic consequences, Manhattan District Attorney Robert Morgenthau and a grand jury that investigated such "systemic" practices, said yesterday.

The grand jury, which investigated the case of an 18-year-old college student who died at New York Hospital eight hours after she was admitted for an earache and fever, recommended in a 55-page report that the state take specific steps to limit the duties inexperienced doctors are allowed to assume. The report also recommended that junior residents not be required to work two and three shifts in succession, sometimes totaling up to 36 hours, that are now a routine part of physician training.

"Evidence showed that junior interns were making life-and- death decisions without any supervision," Morgenthau said at a news conference. "This has to be changed."

The grand jury report stemmed from the case of Libby Zion, the daughter of former New York Times reporter Sid-

Continued on Page 21

Photo by R.A. Lutkey Jr.

District Attorney Robert Morgenthau, left, and assistant John Fried yesterday.

New York State Supreme Court

Recommendation

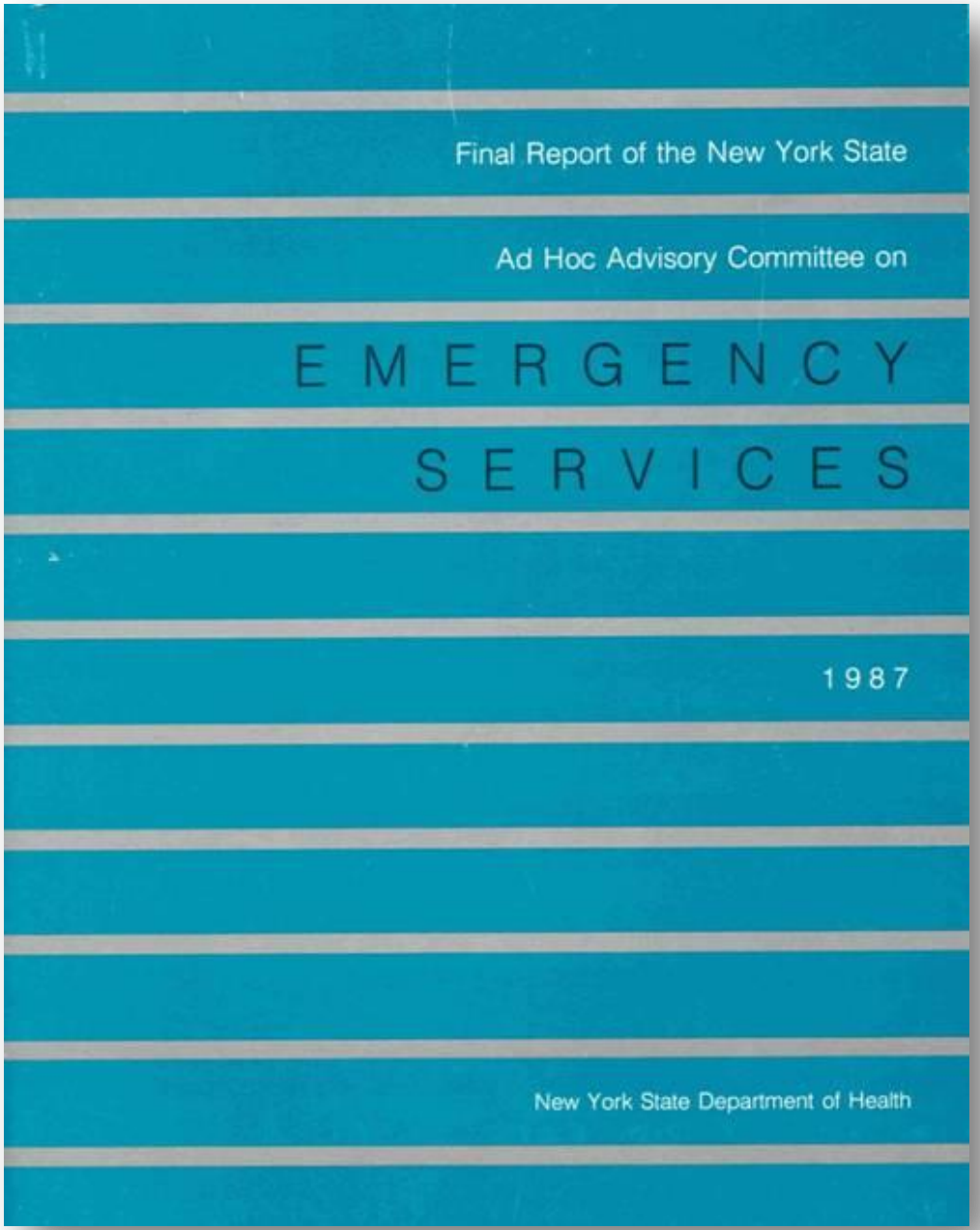
A. Level I ED Staff: 3 years training (for emergency)
B. Contemporaneous in person supervision: attendings or those who have completed 3 years training
C. Standards for restraints
D. Regulations for consecutive hours
E. Computerized drug ordering

NY State Supreme Court

Grand Jury April/May 1986

Conclusion

We have made these recommendations with the hope that future hospital patients will receive more experienced professional medical care than did this unfortunate young women.



NYU School of Medicine
NYU LANGONE MEDICAL CENTER

New York State Health Code Regulations

Section 405

Residents limited to 80 hours/week

No more than 24 hours consecutively

At least 24 hours off per week

Maximum 12 hours in ED

Supervision Attending/Resident

Lack of Supervision

Function independently without experience

The ability of interns/residents to run hospitals

The history, physical examination and orders

The New York Times

January 19, 1989

Bellevue Board Members Call for Chief's Resignation

By HOWARD W. FRENCH

In a bitter dispute over the creation of a program to train emergency-room doctors at Bellevue Hospital, the hospital's community board has called for the resignation of its longtime chief of medicine, Dr. Saul J. Farber.

At least one member of the board of the New York City Health and Hospitals Corporation, which runs Bellevue, supported the call for Dr. Farber's

join the community board in asking for Dr. Farber's resignation."

Brother Patrick Lochrane, another Health and Hospitals board member, said of the situation, "The board of directors wants this program. Dr. Boufford wants this program. We believe the Mayor wants this program, and I feel it is outrageous that one man can block it."

Achieving Quality Care and Education

Patient Needs

Maximal Benefits	Minimal Risk
Maximal Control	Minimal Interference

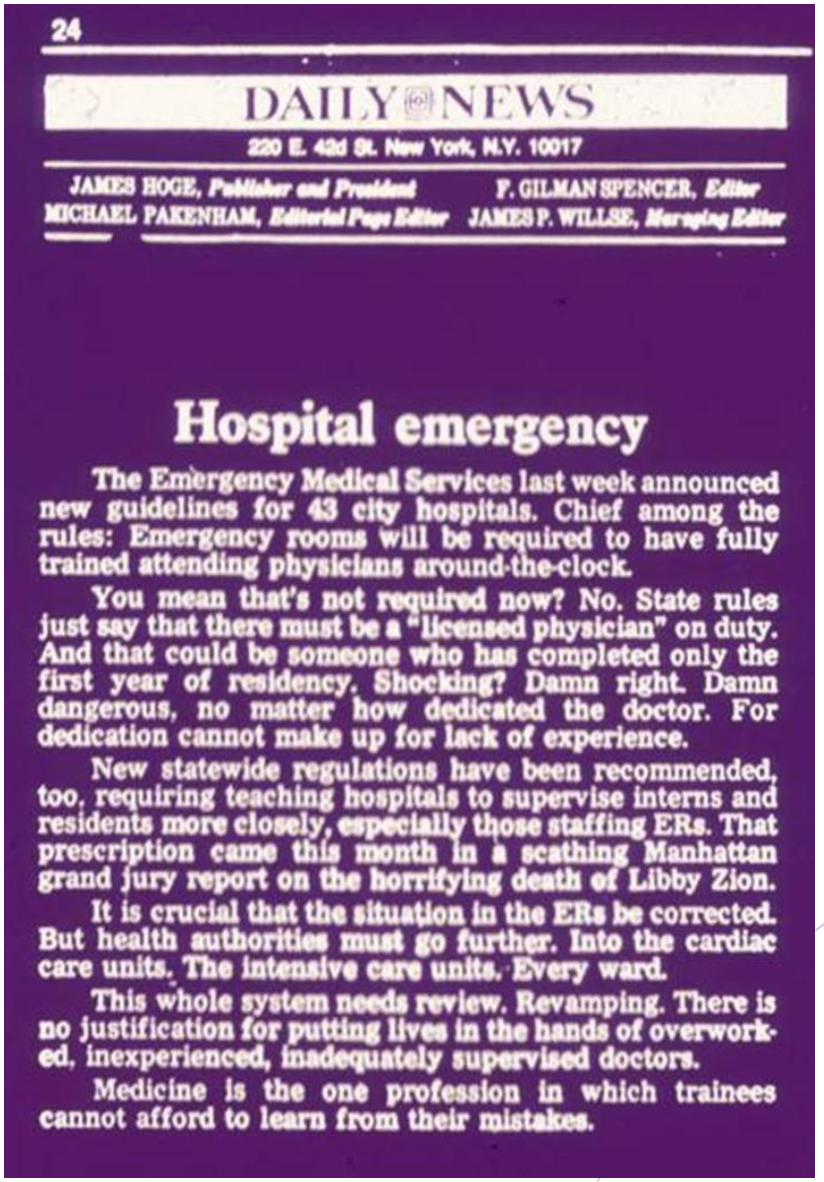
Educational Needs

Supervision

Independence vs. Dependence

Ambulance Systems

- Standards
- Supervision
- Specified Receiving Hospitals



24

DAILY NEWS

220 E. 42d St. New York, N.Y. 10017

JAMES HOGE, *Publisher and President* — F. GILMAN SPENCER, *Editor*
MICHAEL PAKENHAM, *Editorial Page Editor* — JAMES P. WILLSE, *Managing Editor*

Hospital emergency

The Emergency Medical Services last week announced new guidelines for 43 city hospitals. Chief among the rules: Emergency rooms will be required to have fully trained attending physicians around-the-clock.

You mean that's not required now? No. State rules just say that there must be a "licensed physician" on duty. And that could be someone who has completed only the first year of residency. Shocking? Damn right. Damn dangerous, no matter how dedicated the doctor. For dedication cannot make up for lack of experience.

New statewide regulations have been recommended, too, requiring teaching hospitals to supervise interns and residents more closely, especially those staffing ERs. That prescription came this month in a scathing Manhattan grand jury report on the horrifying death of Libby Zion.

It is crucial that the situation in the ERs be corrected. But health authorities must go further. Into the cardiac care units. The intensive care units. Every ward.

This whole system needs review. Revamping. There is no justification for putting lives in the hands of overworked, inexperienced, inadequately supervised doctors.

Medicine is the one profession in which trainees cannot afford to learn from their mistakes.

Community Roles—Emergency Medicine Residency

Daily News 27

A tug-of-war at Bellevue

By HEIDI EVANS

Despite crisis conditions in the emergency room of Bellevue Hospital, its medical board voted against a residency program to train doctors in emergency medicine.

The program has become the focus of a bitter tug-of-war between the powerful dean of New York University Medical School, which trains students at city-run Bellevue, and emergency room doctors.

The struggle has triggered a political stir as Bellevue's community board and two members of the Health and Hospitals Corp. board called for the resignation of Dr. Saul Farber, medical school dean, for blocking the program.

"It boils down to who runs Bellevue Hospital—the City of New York or Dr. Farber," said Dr. Kathleen Delaney, attending physician in Bellevue's emergency room.

Sources said hospital medical board members had been pressured by Farber, who has long opposed the training program, to vote against it.

Many of the same members had voted in favor of the program last November, but when Farber learned about it he reportedly declared their meeting and vote illegal.

Farber did not return a reporter's calls.

Bottom of the barrel

Until the 1970s emergency room medicine was considered the bottom of the barrel, Delaney said, a place for doctors who could not find work elsewhere or were moonlighting for extra money.

But it has become a specialty of its own—like internal medicine or surgery—and is thriving at such prestigious institutions as Johns Hopkins.

"If we are to cope with the flood of AIDS patients, the homeless and drug abuse patients in city emergency rooms, we have to train developing residents in emergency medicine," said Dr. Lewis Goldfrank, Bellevue's nationally recognized emergency room chief and the program's strongest advocate.

Ray of hope

The New York Times

January 26, 1989

Medical Training

A New Specialty in Emergency Care Causing Fierce Debate in Hospitals

By HOWARD W. FRENCH

In a major change over the past 10 years, emergency rooms in many American hospitals have begun to rely on a corps of doctors trained in an entirely new medical speciality: emergency room medicine.

The change, which entails new residency programs in emergency medicine, has prompted fierce debate, especially in the Northeast, where resistance has been strongest at some of the country's most prestigious and conservative medical schools.

Traditionally, emergency rooms have been staffed by junior doctors of medical or surgical departments, or part-time physicians starting or ending their careers. But supporters of the new programs in emergency medicine insist that specialists are better equipped to deal with emergency room crises.

Opponents of the new training and

nicipal Hospital and an associate professor of medicine at Albert Einstein Medical College. The college is one of three out of the seven medical schools in New York City that offer emergency residencies.

Lurking behind many of the objections to the new discipline, many doctors say, is an old-fashioned ego battle. Emergency rooms have long been dominated by departments of internal medicine or surgery. With the spread of emergency medicine, these

How to handle crises: change clashes with tradition, and some see a battle of egos.

Proponents of the new discipline say that the broad experience gained in emergency residencies prepares specialists to make critical diagnoses and initial treatment decisions much more rapidly than would be possible if a hospital had to call on the appropriate internist or surgeon each time a seriously ill patient was wheeled in.

Discipline Began in 1979

According to the American College of Emergency Physicians, 36 percent of the physicians practicing in emergency rooms nationwide are "board certified" in emergency medicine, meaning they have completed the residency programs or passed the written and oral examinations that were established in 1979, when the discipline was formally recognized.

In New York State, only 15 percent of emergency room doctors are board-certified.

Critics of the new programs say

The New York Times

February 15, 1989

Large Hospitals Have Less Need of Emergency Medicine Training

To the Editor:

The care of patients in hospital emergency rooms is much in the public's mind. This includes training of emergency medicine physicians, recent articles on which fail to describe the issues completely ("Medical Training: A New Specialty in Emergency Care Causing Fierce Debate in Hospitals," Health pages, Jan. 26). As senior chief medical resident at New York City's Bellevue Hospital, I am frustrated and angered by this.

A major misconception exists about the care of patients in an emergency room. The quality of such care is linked by some to emergency medicine residency training; this is untrue. At Bellevue, for example, patients may wait a long time to be seen because of overcrowded facilities. After evaluation, patients are admitted or released within several hours.

Admitted patients may physically remain in the emergency room for days because of a lack of inpatient he or she has nothing to do with continuing patient care after deciding to admit. The problem is thus one of limited beds and unavailable nurses, not a lack of emergency room physicians.

The merit of emergency medicine residency programs is debatable. Major medical centers have highly trained specialists available to patients within minutes. The argument by Dr. Lewis R. Goldfrank of Bellevue, that emergency room physicians do not "compartmentalize" patients and are presumably better physicians, is flawed. Emergency medicine physicians inherently compartmentalize by time, seeing patients for a brief period only. Their "broad-based" training precludes comprehensive medical or surgical expertise. Their subsequent experience excludes clinical follow-up and psychosocial aspects of patient care. The "hip-shot judgments" mentioned are often left for the inpatient staff to amend.

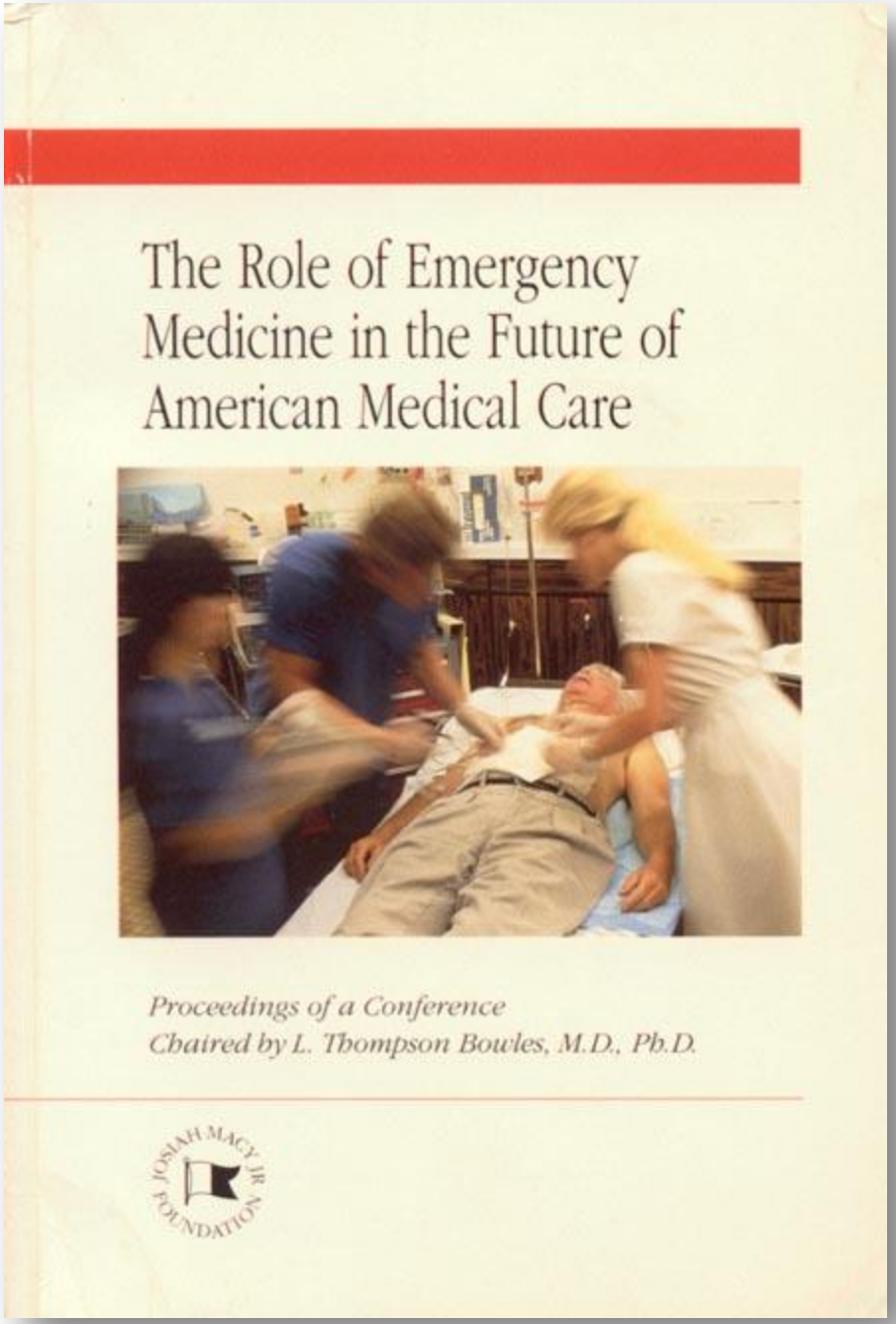
Finally, the statement by Dr. Jacek B. Franaszek, president of the American College of Emergency Physicians, about care for the uninsured and undesirable patient is absurd. Bellevue traditionally has treated patients regardless of financial status or diagnosis and will continue to do so. The physicians, nurses and other employees provide excellent health services under difficult circumstances.

In my experience the medical leadership of Dr. Saul J. Farber and New York University is the guardian of quality patient care at Bellevue in the face of budget cuts, overregulation and political assaults. To imply that the objection to emergency medicine training results from financial con-

Obligations of Hospitals Participating in Medicare (EMTALA 1986)

- Provide any patient who "comes to the emergency department" with an appropriate medical screening examination (MSE) to determine whether an emergency medical condition (EMC) exists
- Provide necessary stabilizing treatment for EMCs and labor
- Provide for an appropriate transfer of a patient if patient requests
- Not delay examination and/or treatment to inquire about insurance or payment status

Rosenbaum S. Health Aff (Millwood). 2013 Dec;32(12):2075-81. The enduring role of the Emergency Medical Treatment and Active Labor Act.


The Role of Emergency Medicine in the Future of American Medical Care
Proceedings of a Conference
Chaired by L. Thompson Bowles, M.D., Ph.D.
JOSIAH MACY JR FOUNDATION

The USPHS in its next "Statement of Public Health Objectives for the Nation," should specify, as a new goal, that access to high quality emergency medical care should be available for all persons who need such care.

Macy 1

Rosenbaum S. The enduring role of the Emergency Medical Treatment and Active Labor Act. Health Aff (Millwood). 2013;32:2075-2081.

Federal, state, and local governmental organizations, including COGME should ensure that the number of residency positions in Emergency Medicine is not reduced as planning for health care reform proceeds.

Macy 2

JCAHO should revise the classification of emergency departments. The classification should reflect the level of care available for emergency patients, and indicate whether or not the facilities are adequate and appropriately qualified and credentialed emergency physicians are available 24 hours a day.

Macy 3A

In addition, this classification of EDs should establish minimum qualifications for physicians, nurses, and other health professionals who provide services in EDs with special attention to the qualifications of 'moonlighting.'

Macy 3B

SPECIAL CONTRIBUTIONS

Emergency Center Categorization Standards

LEWIS GOLDFRANK, MD, PHILIP L. HENNEMAN, MD, LOUIS J. LING, MD, JOHN E. PRESCOTT, MD, CARLO ROSEN, MD, ANDREW SAMA, MD, FOR THE EC CATEGORIZATION TASK FORCE

Abstract

"should revise the classification of emergency departments… To reflect the level of care available in emergency departments, and indicate whether or not facilities are adequate and whether appropriately qualified and credentialed emergency physicians are available 24 hours a day."

Acad Emerg Med 1999;6:638-655

State medical licensing boards, the NBME, LCME, and medical school deans and faculties must ensure that every medical student had acquired the appropriate knowledge and skills to care for emergency patients. The education must be provided through educational experiences supervised by appropriately qualified emergency physicians.

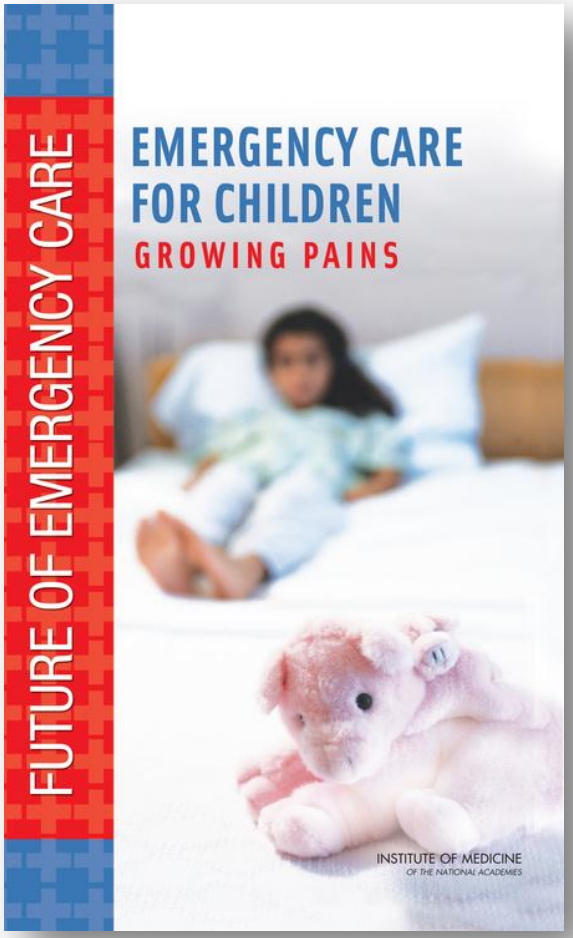
Macy 4

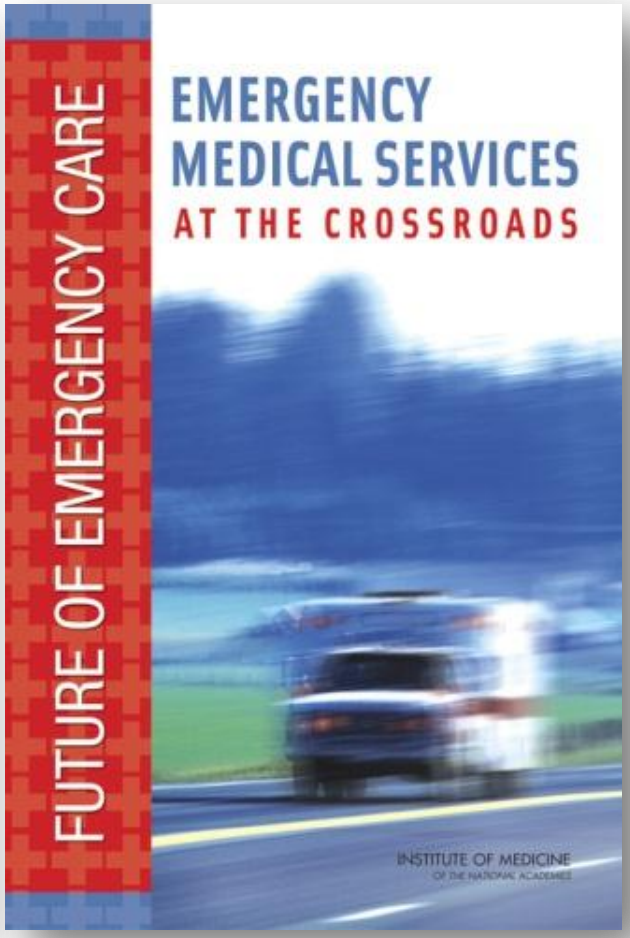
ACEP and SAEM should quickly convene a conference to develop an agenda for research in Emergency Medicine and to define strategic options for implementing that agenda.

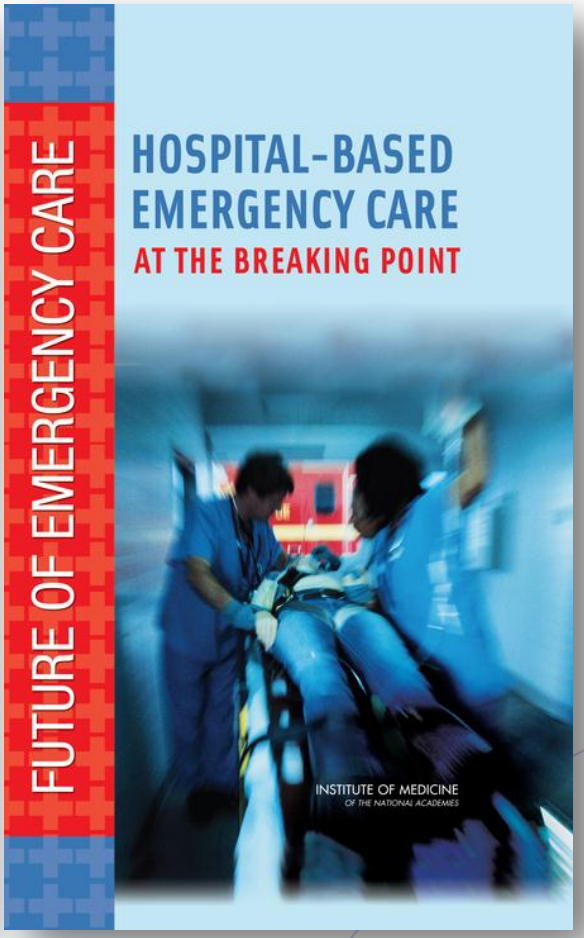
Macy 5

The deans and faculty at all LCME-accredited medical schools, with the assistance of the AAMC and the AAHC, should establish in their schools appropriately stated and supported academic departments of Emergency Medicine

Macy 6







http://www.iom.edu