Preparing residents to give a deposition just got a little easier

The practice of emergency medicine, unfortunately, is filled with a minefield of legal issues. The modern emergency physician must deal with cases of child abuse, vehicular trauma, and human violence of all descriptions, along with chest pain, drug abuse, and other traumas. There are too many patients and too little time. The spectrum of practice in a busy emergency department is an exercise in the organization of chaos. Lawyers are attracted to this scene like vultures to carrion. They always follow conflict and carnage. The spectacle of malpractice is a common thread that binds all physicians. Emergency physicians today are experts in the federal mandates of the Emergency Medical Treatment and Active Labor Act (EMTALA) and the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Couple these issues with the reimbursement crisis of denials from managed (or mismanaged) care organizations and a constant flood of indigent patients needing care, and the chaos becomes complete. In spite of these challenges—or perhaps because of them—those of us who attempt to educate residents in the specialty of emergency medicine must teach the legal components of this branch of medicine.

Unfortunately, experience in handling the legal issues of emergency medicine is often limited. Many residents have no practice in the art of giving a deposition before becoming a defendant. Beginning on page 28 in this issue of the JAOA, Drs. Harrison and colleagues present a method for preparing emergency medicine residents for giving a legal deposition. A deposition is given with lawyers present but no judge. The information gathered is the result of a fact-finding effort, the results of which are used or presented in court. The method, described in the article by Dr. Harrison and co-authors, allows for a hands-on mock deposition, with the gathered information and experience intended to teach residents this facet of emergency medicine. Their article also describes a pretest and posttest evaluation tool to confirm the validity of their outlined teaching method.

A deposition may be required when the resident becomes a defendant, expert witness, or fact witness. Being placed in any of these roles may be a fear-inspiring event that shakes even the most solid emergency medicine resident. Most of us had little or no opportunity to practice giving a deposition before being called on to give the real thing. Dr. Harrison and colleagues should be commended for developing an approach to this medicolegal issue. The objectivity of their results is confirmed by statistical analyses, which revealed a statistically significant outcome.

Extensive efforts to educate emergency physicians in risk management have often included residents. This legal preparation, however, has been directed at avoiding the legal “quick-sand” that permeates malpractice litigation. Too often in our complex practices, legal issues become unavoidable. Time, money, and even peace of mind are lost in the approach of a legal proceeding, such as the deposition. A solid, well-delivered and well-prepared deposition can influence the legal opposition, provide critical facts to the court, and avoid additional suffering of all involved parties.

The spectrum of emergency medicine reflects the complexity of our daily existence. Vehicular trauma remains a leading killer of our young, most productive citizens. Virtually every motor vehicle accident has a lawyer attached to it. Commonly encountered in the emergency department, chest pain, alcohol and drug abuse, and infection with the human immunodeficiency virus all carry significant risk of litigation as well. Thankfully, some lawyers, such as law professors Mr. Palmer and Mr. Sutton, co-authors of the aforementioned article, are willing to support a factual deposition.

All of us in emergency medicine must prepare for the challenge of the 21st century. Dr. Harrison and colleagues have given us one additional tool to help prepare those residents who follow us in this challenging practice of medicine. Preparation and understanding of the legal process are important issues for all residents, and they remain a responsibility to impart for all of us who teach.

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References

Broader picture surrounding new pediatric labeling for topical corticosteroid therapy

In November, the Food and Drug Administration informed several pharmaceutical companies of new pediatric infor-
nformation that will be required on the labeling of all inhaled and intranasal topical corticosteroids. The new language is meant to alert physicians about the potential influence of topically administered corticosteroid therapy on the growth rate in children.

Over the past decade, physicians have become convinced that topical glucocorticoid therapy for the treatment of allergic rhinitis and asthma has a number of beneficial effects. Studies have clearly demonstrated that these therapies are superior to other forms of therapy in the management of these diseases. For the treatment of asthma, inhaled corticosteroids are the only agents that may prevent—or actually reverse—the airway changes due to chronic inflammation that are associated with this disease. Symptoms often improve, exacerbations and hospital admissions are decreased, and the use of rescue \( \beta_2 \) agonist therapy is substantially decreased. These are all markers of enhanced asthma control that have been associated with an improvement in overall quality of life. This improvement often translates into better school attendance and performance, not only in the classroom, but on the athletic field as well. It comes as no surprise, then, that inhaled corticosteroid therapy has become the so-called “gold standard” for the management of asthma and allergic rhinitis. The National Institutes of Health (NIH) guidelines for the management and treatment of asthma and allergic rhinitis consider these therapies to be first line for the management of all chronic and even mild persistent forms of this disease. Nine different corticosteroid products for treating rhinitis and 9 such products for treating asthma currently are available in the United States. Certain corticosteroid medications have been approved for use in children as young as 4 years of age.

Despite the benefit of these therapies, certain physicians and patients have been reluctant to use inhaled corticosteroid therapy for fear of certain associated key long-term effects. Adverse effects of this drug category have been carefully monitored in children. Growth suppression has been of particular interest. However, studies have been fraught with design flaws, because many patients who were treated with topical therapy had also been using systemic glucocorticoid therapy. Similarly, poorly controlled asthma by itself can induce growth suppression. More recent studies have examined the use of inhaled corticosteroid therapy for mild persistent disease in children at young ages who have both allergic rhinitis and asthma. Much of this latter research has been driven by the aforementioned NIH guidelines.

The most recently published studies have involved younger patients with less severe asthma, thereby making it easier to examine the effects of inhaled corticosteroids on growth. Approximately 30 studies have been published in the past several years, most of which used predominately beclomethasone dipropionate or budesonide. A few of these studies were conducted using fluticasone propionate.

There is essentially no information on the effects of triamcinolone acetonide on the growth rates of children. Most studies lacked proper controls; they did not present baseline growth rate data, or they were inadequate with regard to study length. Furthermore, growth was assessed using a variety of less-than-accurate devices, rather than using a calibrated stadiometer. If one limits an analysis to perhaps the 6 best controlled trials that used a calibrated stadiometer for measurements, four studies discovered that children using inhaled corticosteroids for 7 to 12 months had statistically significant growth suppression. Beclomethasone dipropionate was the steroid tested in these four trials. Specifically, this steroid was tested at a more-than-low dose of nearly 400 mcg a day. Two reports that did not demonstrate growth suppression used budesonide or fluticasone propionate. Growth and growth velocity were not significantly affected in those children with mild-to-moderate asthma who were treated with low-to-intermediate doses of budesonide or fluticasone propionate.

A large percentage of children with asthma also use nasal topical steroids for the management of allergic rhinitis. A small degree of systemic absorption occurs through the nasal mucosa, most of which eventually is absorbed after it has been swallowed into the gastrointestinal tract. When given to children for 12 months, beclomethasone has been shown to slow growth rate. This particular inhaled steroid has a substantial degree of oral bioavailability. Therefore, certain steroids need to be considered for their systemic influence. Before prescribing a drug, physicians must balance not only the oral inhaled dose, but also the nasal dose delivered, and the amount of the drug that is swallowed into the gastrointestinal tract that makes its way into the body beyond those end organs being treated topically.

Growth suppression appears to be a real phenomenon with certain inhaled corticosteroids. Physicians should remain vigilant and take precautions in prescribing these topical corticosteroids when treating patients with asthma and allergic rhinitis. The lowest daily dose of the topical corticosteroid must be used. Also, physicians should step-down the dose of the topical steroid, while still maintaining adequate disease control. We need to remember that systemic influence by topical corticosteroids takes into account not only the dose that comes into the body and reduces the inflammation of the target organ, but also the portion of the dose that comes through the gastrointestinal tract and is not metabolized to inactive metabolites by the liver. In children, linear growth should be

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monitored, perhaps at 4- to 6-month intervals, by a trained individual, using an accurate stadiometer unit. Finally, greater emphasis should be placed on those nonpharmacologic approaches to asthma management, principally allergen avoidance and, in highly selected patients, immunotherapy.

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Manipulation for low back pain ahead of its time ... but now is the time

In 1980, an article appeared in *Manuelle Medicine* that presented the initial results of a double-blind (patient and experimenter), placebo-controlled trial of a manipulative treatment technique for low back pain. The follow-up article appeared in *JAMA* in 1981.2 This study essentially showed that the application of one high-velocity thrust technique caused immediate and significant reductions in pain in a select group of patients with low back pain, when compared with patients given the same set up who had received soft tissue massage. Measures of mobility, such as sitting down, reaching, and dressing, and the amount of pain associated with such activity were significantly better in subjects in the treated group. There were no differences between the groups in their knowledge of whether they had received the treatment or placebo. After 3 weeks,most of the differences between the groups diminished, with the only remaining difference being that more patients in the treatment group thought their treatment was effective. The study was performed by osteopathic physicians at the University of California Irvine Medical Center.

In 1994, the Agency for Health Care Policy and Research (AHCPR) issued guidelines for inclusion of manipulative treatment in the care of acute low back pain.3 The use of manipulative techniques in low back pain treatment has received much press since then. A recent article in *Hippocrates* highlighted the fact that more and more patients are requesting it, and that its use is becoming increasingly common in mainstream practices. What was significant about this article was that the providers of the manipulative treatment were chiropractic doctors.

In another article from the *Annals of Internal Medicine*, data were presented showing that chiropractic doctors provide appropriate manipulative care for acute low back pain in about the same percentage of encounters as do medical doctors for most medical modalities. In other words, the care chiropractic doctors provide is about as appropriate under the AHCPR guidelines as is other forms of care.

What happened to the data from the Irvine study? Why did it not have a greater impact on osteopathic medical practice standards? What is happening to the medical landscape in regard to manipulative care?

The Irvine study indicated an immediate effect of a single manipulative technique on patients with acute low back pain. The results produced little comment, presumably because of the lack of differences found 3 weeks after the end of the study. In hindsight, it makes sense that a modality producing a drop in pain levels and increased mobility should be used immediately, even if the underlying problem may go way on its own in a few weeks. Quality of life is important during those weeks.

What we are seeing is a real—and important—change in thought concerning the role of manipulative treatment in medical care. It is becoming accepted as part of the total care package, and it is expected by more and more medical care end users. Additionally, those providing manipulative care are using it appropriately.

Who is best prepared to deliver the total spectrum of care, including manipulative treatment, to the end user? Who better than the osteopathic physician?

In 1980, the Irvine study data were ahead of their time. But as the literature is clearly showing, that time is now.

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References