

IDSA, and not inappropriately covering MRSA can improve patient's experiences and decrease their overall cost of care.

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## The Emergency Medical Treatment and Active Labor Act (EMTALA): Assisting physicians to honor medical oaths



Oath-taking in medical education is an integral part of becoming a physician. One hundred percent of medical schools confirm the practice of oath-taking amongst their medical students [1]. Central to these medical oaths is the principle of non-discrimination [2]. The value that all patients should be treated equally is fundamental to the practice of a physician. Emergency medicine is unique due to the passage of the Emergency Medical Treatment and Active Labor Act (EMTALA), that while protecting patients, can also assist physicians in upholding their non-discriminatory oath.

There is no unified medical oath used by medical schools. However, many medical schools select The Declaration of Geneva, while some schools still use an unmodified translation of the Hippocratic Oath [1]. The Declaration of Geneva states that a physician swears to serve “humanity”, without “considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, social standing, or any other factor” [3]. As medical oaths elude to, discrimination embodies many forms, including race, immigration status, and sexual orientation. Discrimination based on financial status also exists, yet is a practice in medicine that is regularly employed by many specialties. Physicians and hospitals can limit or deny care to an individual based on insurance status or their ability to pay for their care.

In 1986, EMTALA was passed in order to ensure that everyone within the borders of the United States had access to emergency medical care, regardless of their ability to pay [4]. EMTALA was created in response to a practice called patient dumping, where

uninsured patients were transferred to public hospitals before assessment or stabilization [4]. EMTALA is based on the principle that it would be unethical to withhold life-saving care, based on ability to pay, when a patient presents to an ED with an acute, life-threatening condition. Moreover, the law intentionally uses the language “any individual” in order to eliminate any opportunity to discriminate [4]. As a result, the law essentially eliminated financial discrimination through denial of care.

Working in an environment protected by EMTALA, emergency medicine physicians treat patients without consideration of ability to pay. Patients at the very least must be assessed and stabilized before insurance status is confirmed. Effectively, EMTALA established universal access to emergency care, allowing emergency medicine physicians to practice medicine while upholding their non-discriminatory oath to their patients [4].

Unfortunately, EMTALA does not apply to other medical specialties, where patients may be denied care if they are uninsured or unable to pay. Therefore, the evolution of healthcare financing and the business side of medicine may take higher precedence than the moral obligation to patients, as stated in medical oaths. Often physicians work within the constraints of institutions where healthcare administrators do not take similar oaths. The disparate moral obligations of those treating patients and those deciding who receives treatment potentially forces physicians into ethical dilemmas. As long as the moral obligations of healthcare administrators do not match those of physicians, we cannot expect physicians to act otherwise.

This also brings into question the relevance of medical oath-taking, if financial discrimination is not only acceptable, but commonly practiced. When surveyed, only one in four practicing physicians reported medical oaths taken during medical school as having a strong influence on their practice, instead relying heavily on their own sense of right and wrong [5]. Rather than providing ethical standards for practicing physicians, it may be that oath-taking is merely an expression of tradition and that there exists gaps in the application of medical oaths after medical school [1].

Whether intentional or happenstance, EMTALA assists emergency medicine physicians to honor the medical oath they likely recited in medical school, specifically pertaining to non-discrimination. Expecting physicians of specialties that EMTALA does not reach to provide care for all people is ignoring the for-profit nature of our healthcare system. There needs to be a legal framework, mirroring the implementation of EMTALA, that allows not only emergency medicine physicians, but all physicians, to uphold their moral obligations.

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**Attitudes of firefighters towards the use of supraglottic airways devices**

To the Editor,

In the article “Advanced airway management in out of hospital cardiac arrest: A systematic review and meta-analysis” by White et al. published in *The American Journal of Emergency Medicine*, the authors indicate that the overall heterogeneous benefit in survival with ETT was not replicated in the low risk randomized controlled trials, with no significant difference in survival or neurological outcome [1]. It is worth noting that endotracheal intubation is a highly specialized procedure, requiring from the person performing it a lot of knowledge and skills in its use. As Buis et al. indicate, the learning curve for direct laryngoscopy is about 50 intubations [2]. In the case of videolaryngoscopy it is much lower [3–5]. After all, because of the cost of videolaryngoscopes, they are relatively rarely used in pre-hospital settings. An alternative to them can be supraglottic airway devices, which in present times are used not only in pre-hospital settings [6,7], but also under operating theatre conditions [8].

The aim of the study was to assess the attitudes of firefighters towards the use of supraglottic airway devices.

The survey involved 78 firefighters working in the State Fire Service in Poland and participating in rescue operations as part of their professional work. All study participants took part in training in airway management. After the theoretical training, they had the opportunity to practice the practical application of various supraglottic airway devices in the conditions of simulated airway management. For this purpose an adult airway management simulator was used (Sakamoto Airway Management Trainer; SAKAMOTO MODEL CORPORATION; Osaka, Japan). The participants used the following devices: (1) standard Laryngeal Mask Airway (Skamex, Lodz, Poland); (2) iGEL mask (Intersurgical Ltd.,

Berkshire, UK); Ambu® AuraGain™ Disposable Laryngeal Mask (Ambu A/S, Copenhagen, Denmark); (4) Intubating Laryngeal Tube iLTS-D (iLTS-D; VBM Medizintechnik GmbH, Sulz, Germany); (5) EasyTube (Rüsch, Kenen, Germany). After the theoretical training, they completed a questionnaire, in which they assessed the preferences and ease of performing airway management in the case of various supraglottic airway devices. The ease of airway management was assessed on a 100-degree scale, where ‘1’ meant a very easy procedure and ‘100’ a very difficult procedure.

The average age of study participants was  $33.5 \pm 5.6$  years. The study participants did not have medical education. During the training, all participants performed airway management using each method. The most preferred supraglottic airway devices indicated by the participants were iGEL, then iLTS-D, and the least preferred were the standard LMA. The ease with which airway management could be carried out using different supraglottic airway devices varied and was adequate:  $10 \pm 8$  points for iGEL,  $17 \pm 8$  points for iLTS-D,  $23 \pm 10$  points for EasyTube,  $46 \pm 13$  points for AMBU, and  $52 \pm 23$  points for standard LMA.

As the above study indicates, there are differences in the use of different supraglottic airway devices. The iGEL laryngeal mask is the most preferred type of supraglottic airway devices among the firefighters surveyed. The training of rescuers in the use of SADs can be a key element of rescue operations, even more so that these devices in comparison with endotracheal intubation do not require from the rescuer high practical skills.

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