Rap #41
Post: Human factors in resuscitation

Author: Chris Hicks & Anand Swaminathan  Reviewed by: Jon Heimler

I scored the above BEEM rating because:

Interesting and a good refresher but doesn’t really add to our knowledge. Our program does a good job of preparing you to be an effective team leader in resuscitations, we already do TTA and code blue time outs, emphasize closed loop communication, have defined team roles, and try our best to improve and simplify processes.

The educational pearls include:

- I like the idea of using graded assertiveness. Expressing concern about something that is happening is received differently than directly challenging a team member.
- Talking about divisional team structure and defining roles allows members of the team to give input and possibly expand their role. This allows the team leader to focus on the big picture.
- It could be helpful to train as a team (sim cases with RNs/RTs) to be more realistic.

I chose the above EBM rating because:

No studies mentioned in this post. Seems to be mostly expert opinion. They do mention an article from 2018 for further info on the topic.

Edited by Diliana Stoimenova, Zach Finn, Andrew Hasebrook, Ryan Johnsen, Jake Binder and Joe Walter
I scored the above BEEM rating because:

For ED physicians who work in a similar setting to what is described in the study (community ED with close relationship to an outpatient substance abuse treatment facility), this could encourage someone to pursue a DEA certification to prescribe Buprenorphine. The results are pretty impressive with just over 50% (33/62) of patients who were prescribed Buprenorphine from the ED still receiving treatment at 90 days.

The educational pearls include:

For patients in this particular setting/location who receive buprenorphine, 81%(50/62) made it to their first treatment follow-up visit, 86% (43/50) of those were still engaged at 30 days, and 66% (33/50) of those who presented for initial follow up were still in treatment at 90 days.

I chose the above EBM rating because:

The study was just reporting their data on 62 patients who were given a buprenorphine script and close follow up at an outpatient treatment center. There data reported was pretty straightforward. My main questions have to do with the selection of these patients, the feasibility of such an intervention in other practice sites, and the correlation of their rather limited data with other research done on this topic.
I scored the above BEEM rating because:

This episode was mostly a discussion about homelessness, as a social determinant of health, and brought up some ideas of how to address teaching this in residency programs. There was discussion about the methods the New York hospital has for cold weather days and allowing homeless people to sleep in the waiting room. However, this episode did not bring up new information or guidelines. It is important to keep these topics in mind, but nothing was introduced as a potential for changing practice and no solutions were offered.

The educational pearls include:

- Homeless patients have significantly increased mortality and health issues compared to non-homeless people their age.
- Keep “geriatric syndromes” in mind.
- Keep in mind that these are people, and have feelings, hopes, and dreams. This reminded me of the session we did with Dr. Paddock in small group sessions about social determinants of health.

I chose the above EBM rating because:

They did quote studies citing that homeless patients have high rates of “geriatric syndromes” as well as higher mortality rates, and on average die 20 years earlier than their non-homeless counterparts. Other than that, this was a discussion/opinion based podcast.
Post: **Time to adjust the dimer?**

**Author:** Anand Swaminathan  
**Reviewed by:** Melanie Mercer

<table>
<thead>
<tr>
<th>BEEM Rater Scale</th>
<th>Score - choose only 1</th>
<th>Educational Utility</th>
<th>Score - choose only 1</th>
<th>EBM</th>
<th>Score - choose only 1</th>
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</thead>
<tbody>
<tr>
<td>Assuming that the results of this article are valid, how much does this article impact on EM clinical practice?</td>
<td>Are there useful educational pearls in this article for residents?</td>
<td>Is this article reflect evidence based medicine (EBM) and thus lack bias?</td>
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<tr>
<td>Useless information</td>
<td>Low value: No valuable pearls</td>
<td>Not EBM based, only expert opinion (and thus more biased)</td>
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<td>Not really interesting, not really new, changes nothing</td>
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<td>Interesting and new, but doesn’t change practice</td>
<td>Yes, but there are only a few (1-2) valuable or multiples (&gt;3) less-valuable educational pearls</td>
<td>Minimally EBM based</td>
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<td>Interesting and new, has the potential to change practice</td>
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<td>New and important: this would probably change practice for some EPs</td>
<td>Yes, there are several (&gt;3) valuable educational pearls, or a few (1-2) KEY educational pearls that every resident should know before graduating</td>
<td>Mostly EBM based</td>
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<td>New and important: this would change practice for most EPs</td>
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<td>This is a “must know” for EPs</td>
<td>Yes, there are multiple KEY educational pearls that residents should know before graduating</td>
<td>Yes exclusively EBM based (unbiased)</td>
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**I scored the above BEEM rating because:**

Study goal is to show the safety of using an adjusted D-dimer threshold based on clinical pre-test probability in the assessment of pulmonary embolism to increase specificity of the test and reduce unnecessary advanced imaging (comparable to raising the D-dimer threshold with age). Specifically, results demonstrated the application of a higher D-dimer threshold in low C-PTP patients.

**The educational pearls include:**

- In a group of low pre-test probability patients for pulmonary embolism based on a Wells < 4, the D-dimer threshold can be safely set to 1000 ng/ml FEU (500 ng/ml DDU).
- Data on using D-dimer in moderate risk group inconclusive due to low number of patients in this cohort.

**I chose the above EBM rating because:**

Mostly EBM based as the REBEL EM site author summarized the NEJM article with minimal personal opinion, though he did give his own interpretation and viewpoints at the end (which had very close similarity to the NEJM article).
Post: When healthcare becomes a crime
Author: Jenny Vaughan  Reviewed by: Bjorn Westgard

I scored the above BEEM rating because:
Compelling stories that are important for all EPs. We practice in a healthy environment, but you don't have to travel far to discover how many institutions and states are not that healthy of a medicolegal practice environment.

The educational pearls include:
- Useful terms: just culture, breach of duty of care, corporate manslaughter, cover-up culture.
- Useful ideas: learn not to blame, black and minority practitioners are at risk, qualities of caring place, EPs at risk for MH sequelae, everything is still sepsis.

I chose the above EBM rating because:
here is plenty of evidence to back this up, but it's not presented.