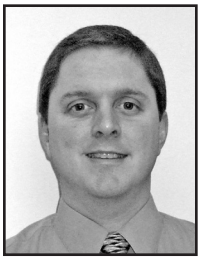
EDITOR'S Letter



Editor's Letter

David D. Vega, MD FAAEM

"Are You My Doctor?"

The American Association of Colleges of Nursing requires that all nurse practitioner degrees be offered only at the doctorate level by 2015.[1] The American Association of Nurse Anesthetists similarly supports requiring a doctorate degree for entry into nurse anesthesia practice by 2025.[2] This trend towards increasing doctorate-level education is not unique to nursing. It is available in many allied health professions that we deal with every day in the emergency department, including pharmacy, physical therapy, respiratory therapy and others.

The Doctor of Nursing Practice (DNP) movement, in particular, has seen great growth recently. The number of students enrolled in DNP programs increased from 3,415 in 2008 to 5,165 in 2009. There are currently 120 DNP programs in the United States, available in 36 states and the District of Columbia. Florida, Minnesota, New York, Pennsylvania and Texas rank among the states with the most DNP programs. An additional 161 DNP programs are being developed.[3]

Certainly, the availability of advanced education in any field is a good thing. However, there are a number of inconsistencies in the quality of education that is required to obtain these advanced degrees. The DNP degree is offered in a variety of formats to nurses with varying degrees of clinical experience. New graduates of a bachelor degree program in nursing can even pursue the DNP degree in a completely online program. The University of Massachusetts advertises "The Doctor of Nursing Practice program is a fully online degree program with an optional face-to-face orientation. Other arrangements can be made if you are unable to travel to the face-to-face orientation."[4] This is particularly interesting considering that the DNP degree is intended to focus on the clinical aspects of nursing (as opposed to research or teaching), unlike the Doctor of Philosophy (PhD) and Doctor in Nursing Science degrees.

continued on page 4

AAEM Mission Statement

The American Academy of Emergency Medicine (AAEM) is *the* specialty society of emergency medicine. AAEM is a democratic organization committed to the following principles:

1. Every individual should have unencumbered access to quality emergency care provided by a specialist in emergency medicine.
2. The practice of emergency medicine is best conducted by a specialist in emergency medicine.
3. A specialist in emergency medicine is a physician who has achieved, through personal dedication and sacrifice, certification by either the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM).
4. The personal and professional welfare of the individual specialist in emergency medicine is a primary concern to the AAEM.
5. The Academy supports fair and equitable practice environments necessary to allow the specialist in emergency medicine to deliver the highest quality of patient care. Such an environment includes provisions for due process and the absence of restrictive covenants.
6. The Academy supports residency programs and graduate medical education, which are essential to the continued enrichment of emergency medicine, and to ensure a high quallity of care for the patients.
7. The Academy is committed to providing affordable high quality continuing medical education in emergency medicine for its members.
8. The Academy supports the establishment and recognition of emergency medicine internationally as an independent specialty and is committed to its role in the advancement of emergency medicine worldwide.

Membership Information

Fellow and Full Voting Member: $365 (Must be ABEM or AOBEM certified in EM or Pediatric EM)
*Associate Member: $250
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Affiliate Member: $365 (Non-voting status; must have been, but are no longer ABEM or AOBEM certified in EM)
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Student Member: $50 (voting in AAEM/RSA elections only)
*Associate membership is limited to graduates of an ACGME or AOA approved Emergency Medicine Program.

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Washington Watch - continued from page 3

The court added that the decision should not be construed "to suggest that an EMTALA screening claim can arise from every delay that occurs after a patient arrives in a hospital emergency room… At this juncture in the life of this case, it is not clear whether Mr. Byrne's EMTALA screening claim will survive the summary judgment stage (should a defendant choose to pursue such a motion after discovery), but the allegations . . . are at least minimally sufficient to survive a motion to dismiss."

The motion was granted for the defendants to dismiss the plaintiff's EMTALA stabilization claim, "[C]aselaw makes it clear," wrote the court, "that EMTALA mandates stabilization only in the event of a transfer or discharge, and does not obligate hospitals to provide stabilization treatment for patients who are not transferred or discharged." Since Byrne was not transferred or discharged from CCH prior to receiving a catheterization procedure and being stabilized, the court determined that Byrne could not bring a stabilization claim under EMTALA. "[A]lthough a hospital's egregious delay in providing screening may provide the basis for an EMTALA screening claim, it does not provide a basis for an EMTALA stabilization claim."

The court also granted the defendants' motion to dismiss Byrne's state law breach of implied contract claim. Under Pennsylvania law, the court concluded that "Mr. Byrne cannot proceed with a claim for breach of implied contract on the facts alleged, where his contract claim is based on an alleged delay in treatment, and not the treatment or specific result itself." That is, a breach of contract claim against a health care provider only is permitted when the parties have contracted for a specific result.

To read the decision, go to: http://www.paed.uscourts.gov/documents/opinions/10D0137P.pdf

Editor's Letter - continued from page 2

In some specialties, such as family medicine, patients have some degree of freedom in choosing which provider they will see. In emergency departments, however, patients have less freedom in this regard. They select only the location, and then a caregiver is assigned to them. When a caregiver introduces themselves as a "doctor", most patients assume they are being cared for by a physician. One can envision a point in the future where emergency department patients will be cared for by a multitude of doctors simultaneously: attending physician, doctor of nursing practice, doctor of respiratory therapy, doctor of social work, et cetera. This certainly could cause confusion for patients in figuring out who is in charge of their care. Opinions may vary among all of these doctors, adding to a patient's confusion: "One doctor told me this, but another said something different. Who should I listen to?" Patients deserve to have a good understanding of the qualifications of anyone providing a medical opinion.

The point of this article is not to imply that everyone with a doctorate wants to give the impression that he or she is a physician. However, the confusion that this creates for some patients is real. Anyone who has masters-level nurse practitioners in their department can attest to the confusion that already exists among some patients about their caregiver's credentials. In a 2009 blog, an editor of the journal "Advance for Nurse Practitioners" reported that a pending survey at the time showed 33% of NP's would use the title 'doctor' if they had a doctoral degree.[5] This suggests that this issue is going to become much more prominent over the next few years.

Nothing in this column should be construed as minimizing the value of nurse practitioners and other providers with advanced degrees. In fact, nurse practitioners fulfill an important role in helping to provide care where physician shortages exist. In an ideal world, every emergency department would be staffed with board-certified emergency physicians. Currently, however, there just are not enough of us to meet the existing need. When used appropriately in the ED, nurse practitioners can provide much needed coverage in busy emergency departments unable to provide adequate physician coverage. Patients, though, deserve to know the qualifications of the persons providing their treatment. In the clinical environment, patients usually equate "doctor" with "physician". Providers describing themselves as a doctor must ensure that their credentials are correctly represented.

(Endnotes)

1 "Frequently Asked Questions, Position Statement on the Practice Doctorate in Nursing." American Association of Colleges of Nursing Website. American Association of Colleges of Nursing, March 2010. Accessed July 28, 2010. <http://www.aacn.nche.edu/DNP/dnpfaq.htm>.

2 "AANA Announces Support of Doctorate for Entry into Nurse Anesthesia Practice by 2025." American Association of Nurse Anesthetists Website. American Association of Nurse Anesthetists, September 20, 2007. Accessed July 28, 2010. <http://www.aana.com/news.aspx?id=9678>.

3 "Fact Sheet: The Doctor of Nursing Practice (DNP)." American Association of Colleges of Nursing Website. American Association of Colleges of Nursing, March 2010. Accessed July 28, 2010. <http://www.aacn.nche.edu/Media/FactSheets/dnp.htm>.

4 "Doctor of Nursing Practice (Amherst)." UMassOnline. University of Massachusetts, March 5, 2010. Accessed July 28, 2010. <http://www.umassonline.net/degrees/Online-Doctor-Nursing-Practice.cfm>.

5 Ford, Jennifer. "PA Says DNPs Shouldn't Be Called 'Doctor'" AdvanceWeb. Merion Matters, Inc., February10, 2009. Accessed July 28, 2010. <http://community.advanceweb.com/blogs/np_1/archive/2009/02/10/pa-blogs-about-the-dnp.aspx>.

CONGRATULATIONS *to*

Mark T. Steele, MD FAAEM

who has assumed the office of
President of the
American Board of Emergency Medicine
(ABEM).