

Opinion Corner: Defining quality of care for airway management in emergencies

With growing data from airway management registries it is time to move away from a defensive strategy of publishing to make the case that emergency physicians can safely perform advanced airway management. While this data has been helpful for our relatively new specialty (PS congrats to the new RCEM) as we continue to battle for acceptance in a larger more historically established medical system, it is time for EM to define meaningful quality measures for emergency airway management.

First off lets stop reporting ultimate/overall ETI success as a primary outcome in airway management studies. Success should never be measured by placement of an endotracheal tube alone. Patient outcomes in emergency airway management are determined by what happens along the way to 'getting the tube'. We know that maintaining oxygenation and tissue perfusion clearly influence patient outcomes and that complication rates increase with each additional attempt at intubation. Clinical studies that aren't powered to demonstrate an effect on mortality should be expected to report first attempt success and the incidence of hypoxia and hypotension as representative surrogate measures of outcome. So what should we strive for as reasonable quality measures for airway management? How about a goal of 90s: a 90% 1st attempt success rate, with saturations over 90% and a SBP greater 90 mmHg within 90 seconds (blade in to + EtCO₂). I know... you shouldn't design quality goals based on a rhyme. Registry data would suggest that these goals are not realistic based on current data and that that these quality expectations are too simplistic. Perhaps this is true however these may represent reasonable goals that are within our reach and if strived for may lead to improved patient outcomes. We currently don't 'own the airway' but lets aspire to do so, with achievable goals and for the right reasons.

