ACEP

"Maximally Aggressive Care, Everywhere": An Interview with Scott Weingart

Raghu Seethala, MD
Associate Newsletter Editor

Continuing our new column highlighting greats in the EM-CCM universe, we have an interview with Scott Weingart, ED intensivist and medical educator extraordinaire. His podcast, EMCrit, is one of the most popular medical podcasts currently out there. He has huge international followership and lectures extensively throughout the country on a host of EM-CCM topics.

What made you decide to pursue a career in emergency medicine (EM) and then critical care medicine?

Well, the order for me is a little bit reversed than most people in that I always knew pretty much from my first year at medical school that I wanted to do critical care. Then the question is which specialty to go through for residency training. The choices were between anesthesia and EM for me.

When I looked at both, I realized EM is the best preparation for a career in critical care there is, in my opinion, because you get exposed to so much of the pathology of resuscitation that then will lead to these patients needing intensive care, and it just seemed to be the best way to go. Anesthesia was appealing because you see so much applied physiology, but I think you will never get a better background than EM for a career in critical care.

Who were your major influences and mentors that focused your career, and how did you develop an interest in critical care medicine from medical school?

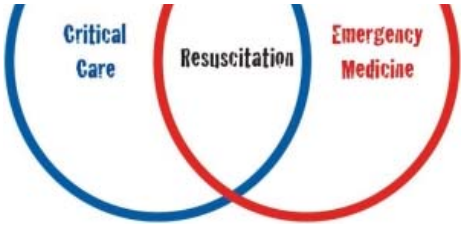
The people I would put as the heroes I had in the field of ED critical care were Manny Rivers and Peter DeBlieux. When you hear them speak and you hear the brilliance that these two guys express, you have a hard time not wanting to pursue the path they have. Manny had an ED critical care unit. Manny had the practice that I wanted for my career, and the fact that he was already doing it, the fact that he was able to bring upstairs care downstairs before I even coined that phrase let me know that it is not crazy—that it is possible.

Then, if you talk to someone like Peter DeBlieux, who's just the most charming, brilliant person, and just knows so much about both fields, EM and critical care. It's tough to aspire to anything else. The stuff I wanted to do in medical school was a career path that I was told repeatedly cannot exist by all of my mentors in EM. I just wanted a specialty where I took care of sick patients when they're at their sickest.

I always thought that was what EM was supposed to be, but it was made abundantly clear to me by my advisors that that's not what EM is at all. That EM is really providing primary care to people at any hour, when they're in need, and that the resuscitation portion was actually a small part of that career path. That never made sense to me.

When you listen to the words of Peter Rosen, who was a mentor I only got to meet recently, so he was a mentor in absentia, but when you hear him talk about why he helped to found the field of EM, it was because he wanted to take care of sick patients, and he thought we were the best field to do it. Somehow, I think EM has lost its way. It's become a field where we care more about customer satisfaction and patient turnaround than taking care of sick patients.

Now, you might say, "Well, obviously intensive care is the field that takes care of sick patients," and it is. I love it and there's so much to that specialty, but, again, I don't know if that's the ideal specialty to take care of patients during the most acute resuscitative



phase of their care. That kind of gets lost sometimes. There are intensivists out there who are fantastic resuscitators, but I don't think that one necessarily means you are the other, by which I mean there are intensive care doctors out there who are very good at critical care in the unit, but not excellent at that acute phase, those eight hours where the patient really needs an incredibly aggressive care package delivered in a very short time.

When you look at the Venn diagram of specialties, there's that overlap between EM and critical care that is resuscitation, and that's where I've tried to wind up in my career.

How do you stay current with the literature?

Yeah, well, I'm not a good person to emulate because my path is a non-sustainable path. Basically, I just read everything that's even tangentially-related to resuscitation, critical care, trauma, and EM, and at this stage, I think I'm up to reading 68 journals a month. It's not sustainable. It's basically, I got work, and I got my boy and wife, and then every other minute is devoted to just reading all of these journal articles. Each time a new journal comes around that's appropriate to our field, I have to add that to the list. It just drives me nuts that there may be some piece of literature or evidence out there that I'm not going to know about. That's what I do, but I don't say for other people to do it.

Now, I gave a lecture on this, and what I came down to is there's this concept called the Pareto principle: if you want 80% of the benefit, you really only have to do 20% of the work. If you read just 20% of the journals I did, which would be about 12 journals, you'd get 80% of the benefit, which is an enormous pay-off. Now, to get to that 100%, you have to jump up to reading 50 journals. It may not be worth it for that extra 20%. It might be okay for every once in a while to just miss something, if it means you could have a sustainable life.

I picked out the 12 journals for ED critical care that I thought were that way to achieve that 80% of the result, and I think it's very reasonable as a clinician with a real life to read 12 journals a month, because you don't read every single word. You read the abstract. You say, "This is not relevant. I don't care." I think you could do that and get almost all the benefit.

That's what I recommend, or you could take even a step further back and just say, "Look, I'm going to subscribe to the people I think are smart on Twitter. I'm going to read a few blogs, and let them be the filtration device, and let them figure out the good articles, and then they'll make a blog post or a tweet about them, and then those will be the ones I read. I think that's a very acceptable practice as well.

In 2013, what was the biggest game-changing study for you?

“**Targeted Temperature Management (TTM) at 33°C versus 36°C after Cardiac Arrest**.” I mean the trial was just fantastic, and a lot of people are saying, "Oh, well this just debunks the concept of hypothermia." Those people haven't read the study, or haven't understood it appropriately. TTM was a dose-finding trial and it's not a trial of hypothermia versus no hypothermia. It's a trial of tight temperature management at one temp or another. This would be the same thing if you wanted to find the dose of a drug. What we'll find now is that 36 maybe as good a dose as 33 degrees with potentially less complications, and that makes a lot of sense. It's still slight hypothermia. It's still preventing fever, and it's still accompanied by a profoundly aggressive and meticulous post-arrest care package, which was not seen in the control groups of previous trials. It makes a lot of sense, and it makes things easier, and that's been, for me, the big game changer.

How did you develop from a web site to the podcast to being an international leader in free open-access medical education?

What you're originally talking about now is called crashingpatient.com. That was just a compilation of everything I would read from the time I was a medical student on. That was for me, and it was publicly available, and I knew that people were using it, but it wasn't intended for that. That was just a fringe benefit, but that was my virtual brain. What I found is if you read something but don't write it somewhere and don't assimilate it, you never really learn it as well. If you had to put it in your own words and put it down somewhere, that act alone locks the information very differently than just browsing through a journal.

Also, since I was pugnacious as a resident, if I was going to quote a study to my attending, I'd better have the actual citation, or I was hosed. That's why crashingpatient.com was there. Now it's just become my mind castle for everything I read. It's there, but I don't publicize, and I don't talk about it.

What EMCrit has become is just through happenstance. It's now the most popular medical podcast in the world, at least by the stats I have as we're talking right now, and that was purely chance. When I first started, I think 4.5 years ago, I was listening to podcasts like Radiolab and This American Life, and I'm like, "Wow. This is really potent and just gets into people in this asynchronous matter." They could just listen whenever they want, on the subway, or what have you. I figured, maybe I'll give that a try.

Just the groundswell of support that came as that was in nascent stages was enough to keep me going, and just became my main outlet for medical education. It's just luckily enough well suited to what I like to do, which is I like to talk, I don't like to write, and I like to talk about the pragmatic and the logistic, and what, now, the pundits and academics call tacit knowledge. "How do we actually make this stuff happen?" There wasn't an outlet for that.

If you try to publish a journal article about nuts and bolts of getting stuff done, for the most part, those are hard sells. People don't want those. They want research assimilation. They want review articles that are talking about the evidence. They don't want to hear, "Well, here's how to actually do all this stuff we're being asked to do."

Find an article on how to prone a patient safely, not why we prone a patient, not the most recent evidence of it, but actually where your hand should be. What the person holding the tube should be doing. I haven't found that one yet. It might be out there, but that's insanely important because as you know, it's very easy to kill a patient when you turn him over when they have multiple lines and ET tubes, and that's the stuff that I care about, and that's what EMCrit's about, and people seem to like it.

You've done so much already. What is the future hold for you?

Well, so I'm moving to a new institution in August, and what I hope to start up is a Resuscitative extracorporeal membrane oxygenation (ECMO) program. I think this is the future of post-arrest management. I've watched far too many patients who we actually got ROSC on, and they're in the midst of cardiac stunning, and they have a reversible cause. They have something we could fix, but they never get it fixed because they go down the spiral of hemodynamic decompensation, and we can't get them to where they need to go. We can't get their thrombectomy, we can't get their left anterior descending artery open. We can't do the things we need to do.

I think ECMO has come so far that this is going to be the answer in a bunch of patients and the preliminary work that's come out looks very impressive, and I want to be part of that. I don't want to have to read these stories and interview people on my blog and not be able to do it myself. I'm moving to a center where that's going to be potentiality a reality, and hopefully, we'll save some lives.

Starting February, we will have the site out, **ED ECMO** , which will concentrate on taking any emergency physician or resuscitationist, and hopefully bringing the logistical skill set necessary to start VA ECMO on a patient post-arrest. Look out for that.

What do you like to do in your free time?

I like to make cocktails. That's what I like to do. Unfortunately, now with a three-year-old, there's not much free time when you take out work and everything else.

Lastly, I know that your wife's an anesthesiologist. Do you guys ever have medical arguments or debates? Who's the actual airway expert between you?

We've made a truce on that front, but it brings up a bigger point, which I think is worth making: the longer I practice medicine, the more convinced I am that giving anyone a level of knowledge or skill set based on their specialty is a failure, and shouldn't be done. That attributing anesthesiologists with best airway management, or EM is the best airway ... That's all crap. I've not found that to be a helpful system, and each practitioner needs to be approached on their own base, on their own individual skill set, and desire to be excellent. That's really the only way to evaluate.

Feedback

Yeah, you can make broad generalizations like every surgeon should be able to perform a certain procedure, but beyond those broad generalizations, I don't think it's very helpful. Just because someone's an anesthesiologist, attributing them "master of the airway" and just give some to the EM doc, and they're excellent, and we're not. I just don't find it to be relevant. It's harder. I mean, it would be nice if we could just say, "Well, he's from that sub-specialty, so he knows everything EKGs if he's a cardiologist," but I just don't think it's ... it's too facile and I'm not impressed with it for its actual accuracy. I say you've got to judge every clinician on their own.

Well said. Is there anything else you want to say to our readers?

I will say that the tagline of EMCrit initially was “Bringing upstairs care, downstairs,” and over the years, I've gotten a lot of push-back because there are people who come to me and say, "Well, that's saying that the upstairs is the exemplar of ideal resuscitative and critical care, and sometimes our ICUs are not doing what we want."

We've actually changed the motto as a result because we don't necessarily want the upstairs care of some places, and so now we just say "maximally aggressive care anywhere."

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