



Management

The monthly update on Emergency Department Management

Vol. 11, No. 11

Inside

- **Know the ABCs of NBC:**
Defining weapons of mass destruction 123
- **HazMat policy isn't enough:**
Develop a protocol for weapons of mass destruction. 124
- **Keep this chart:** Treatment of Biological Agent Exposure. 125
- **Should you stockpile antibiotics?** The answer may surprise you 126
- **How to handle 'hot' triage:** Your staff may be in protective equipment to assess patients. 126
- **Has there been a biological attack?** Your ED will be the first to know 127
- **Pediatric pain management:** Why you should be vigilant . . 128
- **Are your staff frustrated by difficult consultants?** Try these foolproof strategies. 129
- **When your ED staff is under attack:** How to react. 131
- **Enclosed in this issue:**
Bioterrorism response plan

November 1999

How would you handle a terrorist act involving weapons of mass destruction?

Your ED needs a solid plan to confront 'everybody's worst nightmare'

Add this to your long list of things to do to prepare for an accreditation survey: Surveyors from the Joint Commission on Accreditation of Healthcare Organizations are asking what EDs are doing to prepare for domestic terrorism, says **Robert Suter**, DO, MHA, FACEP, regional medical director for the North Texas region at Questcare Emergency Services in Plano.

"Seven hospitals that I consult for got Joint Commission visits this summer, and every single one was asked about domestic terrorism preparedness," Suter says. "This is very clearly on their question sheet."

From a Joint Commission standpoint, preparation for domestic terrorism is going to be as important as "conscious sedation" policies have been in previous years, Suter says. "Due to public awareness, there is a strong emphasis on this."

The Central Intelligence Agency recently looked into rumors that an encephalitis outbreak in the New York area was the work of terrorists and concluded it was not. In a 1995 incident in Toyko, Japan, cultists released the nerve gas sarin into the subway system. The attack affected 5,000 people, Suter says.

The threat of encountering a domestic terrorism incident involving nuclear, biologic, or chemical (NBC) agents in your ED is real, Suter says. And if an

Executive Summary

The American College of Emergency Physicians (ACEP), the Joint Commission on Accreditation of Healthcare Organizations, and the American Medical Association are focusing on preparation for terrorist attacks using weapons of mass destruction, which include nuclear, chemical, or biologic agents.

- A nuclear or chemical terrorism incident combines the problem of treating mass casualties with that of decontaminating patients.
- Joint Commission surveyors are asking about domestic terrorism preparedness.
- ACEP will offer a training course within 18 months for physicians, nurses, and paramedics.

EDM IS NOW AVAILABLE ON-LINE!

Go to www.ahcpub.com/online.html for access.

incident occurs in your community, the eyes of the world will be on your ED.

“When CNN broadcasts the first story, every hospital staff member within 200 miles is going to panic. You and your hospital better be prepared to offer them some evidence that you have thought about this,” says **Christopher Richards**, MD, chairman of the disaster committee and an attending physician at the department of emergency medicine at Brigham and Women’s Hospital in Boston. “If you don’t have enough gowns and run out of doxycycline before the end of the broadcast, the staff are going to be a problem, not to mention the patients.”

Those types of weapons are difficult to defend against, so they probably constitute the greatest threat, Suter says. “It’s very realistic to think that even a small group of terrorists could kill large groups using these means.” (See story defining NBCs, p. 123.)

A nuclear or chemical terrorism incident combines the problem of treating mass casualties with the problem of decontaminating patients, says Suter. “In the past, these have been looked at as separate problems. These scenarios are a combination of the two, which is everybody’s worst nightmare,” he says.

Joint Commission wants to know your plan

For some time, the Joint Commission has required EDs only to be able to decontaminate a single patient. “So theoretically, everybody’s disaster plan currently includes the ability to take care of at least one patient exposed to hazardous materials,” says Suter.

But that will change, he explains. “This is the same principle but on a larger scale.”

Right now, the Joint Commission’s expectations are fairly low, he notes. “They don’t introduce a new concept and flunk people right away. They will start asking questions about it and make everybody aware of this. Over the next few years, they will apply tougher standards.”

Although the Joint Commission was unable to confirm exactly how the standards will change, there is no doubt they will become more stringent, says a spokesperson. “The Joint Commission is aware of bioterrorism concerns, and we are looking at how to best address that in our standards,” the spokesperson says.

Right now, surveyors will ask what you have done to prepare. “They will want to know if you have plans for this and what your policies are,” Suter says. “Most hospitals do have some sort of [hazardous materials] policy, but they will want to know how you are integrating preparation for domestic terrorism into that policy.”

Acceptable answers include sending medical and nursing directors to domestic preparation training courses and integrating what they learn into your hazardous materials (HazMat) plans, Suter says.

However, over the next few years, expectations will be higher, Suter predicts. “They will expect to see either a separate policy or a section of the hospital disaster plan to address weapons of mass destruction,” he says.

The Joint Commission also probably will want to see specific drills addressing this issue, says Suter. “I expect that a hospital that has not had a separate disaster drill for large-scale decontamination will get at least slapped on the wrist.”

Also, EDs won’t be able to pass the buck, he stresses. “While it will be acceptable to say, ‘We will be working with the fire department,’ to say, ‘We will have the fire department do this’ will not be acceptable. Everybody will recognize that will not work,” he says.

To prepare physicians for a terrorist attack, the Chicago-based American Medical Association’s house of delegates voted to sponsor a bioterrorism conference before next December. The Dallas-based American College of Emergency Physicians (ACEP) also is developing strategies to ensure EDs are ready for bioterrorism, Suter says. ACEP formed a task force last year to develop special training courses to prepare EDs for terrorism.

“We have defined what emergency physicians, nurses, and paramedics need to know to respond appropriately to terrorism,” says **Joseph Waeckerle**, MD, FACEP, chairman of the ACEP task force.

The courses will teach ED personnel how to recognize a biological attack, notes Waeckerle. “There is currently no way available to detect and identify a biological agent quickly. So the early identification through clinical presentation is critical,” he says.

The task force is advocating a national public health surveillance system in which the ED would play a key role, he reports. “If you have a chemical attack, the

COMING IN FUTURE MONTHS

■ Managing conflicts with other departments

■ Empower your nursing staff

■ New color-coded products for children

■ ED-based system tracks epidemics

first responders are the fire department or HazMat people, and the scene is the site where the attack occurred. With a biologic attack, the scene becomes your ED, and the first responders are your staff.”

The task force is now developing the actual curriculum. “These will not be traditional course offerings,” Waeckerle notes. “Within 18 months, we will be offering a number of educational interventional strategies, including CD-ROM, self-learning texts, and courses with experts.” Separate courses will be developed for physicians, nurses, and paramedics, he explains.

Your ED already may have a protocol for an everyday HazMat incident, but you also need one for NBC agents, stresses Suter. “Your current policy on hazardous materials is an excellent start to preparedness for nuclear and chemical incidents,” he says. (See stories on creating a protocol for bioterrorism, p. 124, stockpiling supplies, p. 126, and triage strategies for patients after a terrorist attack, p. 126.)

Essentially, you need to expand that policy with an eye toward treating hundreds if not thousands of patients, says Suter. “Additionally, while bioterrorism could generate even more patients, preparing for victims of a biologic attack presents you with an entirely different set of issues,” he notes. (See story on recognizing a biologic attack, p. 127.)

If you look at disaster preparedness as a pyramid, NBC incidents are at the top of the pyramid, he says. “That means that what everybody has done historically to be prepared for regular disasters forms the basis for everything. This preparedness is a little more specialized, but it’s a manageable amount of things to learn and do.”

Preparing for weapons of mass destruction can enable you to save lives if an incident occurs, Suter stresses. “You cannot throw up your hands and say, ‘Everybody’s going to die anyway, so what is the point?’”

Sources

- **Christopher Richards**, MD, Department of Emergency Medicine, Brigham and Women’s Hospital, 75 Francis St., Boston, MA 02115. Telephone: (617) 732-5640. Fax: (617) 264-6848. E-mail: crichards@partners.org.
- **Robert Suter**, MD, FACEP, QuestCare, 101 E. Park Blvd., Suite 921, Plano, TX 75074. Telephone: (972) 881-8353. Fax: (972) 422-2208. E-mail: r.suter@questcare.com.
- **Joseph Waeckerle**, MD, FACEP, 4601 W. 143rd St., Leewood, KS 66224. Telephone: (816) 276-7665. Fax: (913) 402-9001. E-mail: wac@qni.com.

You already have the basic skills and problem-solving approach, he says. “With a reasonable amount of education about these threats, you can be prepared for these incidents as well.” ■

NBC incidents: Know these terms

“NBC” stands for nuclear, biological, and chemical agents, all of which involve weapons of mass destruction. Here are key differences between each type of incident:

□ **Nuclear.** This type of incident encompasses anything from detonation of nuclear devices to contamination of food or other products with highly radioactive materials. “For example, there have been some accidental exposures of people to highly radioactive plutonium pellets,” says **Robert Suter**, DO, MHA, FACEP, regional medical director for the North Texas region at Questcare Emergency Services in Plano.

There was an accident in South America in which a medical clinic closed that had a gamma accelerator for cancer treatment. “A junk dealer bought the machine as scrap metal and ended up opening a sealed capsule with plutonium capsules in it, which are fairly small, and distributed them,” Suter says. “Many people developed radiation sickness and died.”

The incident was accidental, but such an act could be done purposely, Suter warns. “Exposures to high-grade radioactive materials don’t necessarily have to be released by a bomb. However, a major nuclear incident would have extremely high damage but is also the least likely to occur.”

□ **Biologic.** This type of incident involves any living organism such as virus or bacteria or any spores of those agents. “This is the incident which is most likely to occur and can have a wide range of impact,” he says.

A 1986 incident in the United States involved a cult in Oregon that sprayed salmonella bacteria on salad bars so people would get sick with gastroenteritis. “Anybody could do that in their basement by growing toxic *E. coli* in a petri dish, transforming them to a larger liquid broth, and distributing them using window sprayers. It’s very low-tech and cheap,” says Suter.

On the other extreme, using a form of the Ebola virus to kill large numbers of people worldwide is more unlikely because the terrorists would need access to significant resources and technology in the preparation phase of the attack, he says.

□ **Chemical.** This type of incident includes any chemical compound used to harm or injure. For example, if a person took an industrial compound that was a blistering agent and disbursed it in a way intended to be harmful, it would be considered a chemical attack, says Suter. If terrorists intended to hurt people, they would likely use substances classified as chemical warfare agents, such as mustard Lewisite, he says.

Chemical weapons could kill hundreds or even thousands of people, stresses Suter. "It's relatively easy to disperse a chemical agent. While the deadliest forms take some technical expertise to compound, even these agents are considered available on the black market and could be smuggled into the U.S." ■

You can transform your HazMat policy

Here are things to consider when transforming your hazardous materials (HazMat) policy into a protocol for weapons of mass destruction, particularly nuclear and chemical agents, according to experts interviewed by *ED Management*:

□ **Be ready to decontaminate large numbers of people.**

Have a plan for decontaminating hundreds or perhaps thousands of people. For many hospitals, state-of-the-art decontamination means showers adjacent to the ED, says **Robert Suter**, DO, MHA, FACEP, regional medical director for the North Texas region at Questcare Emergency Services in Plano. "But when it comes to preparation for a terrorist attack, that's completely inadequate," he maintains. "It's the same principle but a difference of scale." (See **sample protocol, enclosed in this issue.**)

Be prepared to take your decontamination efforts into the parking lot, Suter advises. "Everybody has

space limitations, but you need a large area almost the size of a football field where you can do outdoor decontamination."

□ **Use reference tables.**

Reference tables can serve as a guide for ED managers preparing for weapons of mass destruction. Such tables list antidotes and decontamination supplies to have on hand. "So when you are planning out the logistics of your policy, it can serve as a shopping list to refer to," Suter explains.

Tables also can serve as a quick reference for staff. There is no substitute for formal education, and all ED clinicians should be familiar with the forms of chemical or biological agent exposure, Suter says. "Staff first need to know what to look for. But once you think you might have a chemical incident, you can go to that table to figure out which one it is and how it's treated." (See **table, p. 125.**)

□ **Direct minimally injured people to a holding area.**

A special category is needed for people who are minimally injured. "You need to instruct them to go to a holding area and wait for treatment so your staff can concentrate on the other people," says Suter. "Often, people who are not seriously exposed go rushing to the hospital and overwhelm the EDs." (See **story on first and second waves of patients, p. 126.**)

The biggest concern is security, he says. "These people may be very upset and agitated and demand somebody take care of them," Suter says. "This could distract you from people who really have physical effects from the attack."

There can be up to 10 people with psychological casualties for every one with serious effects, he says. "But it's still very difficult to deal with those people. You don't want 200 people threatening the staff, so you have to triage them into a holding pattern of the 'worried well.'"

Do check them to see if they are developing symptoms, he advises, but also have security there to keep them from becoming out of control.

□ **Don't factor in assistance from others.**

Many ED managers expect that all of the triage and decontamination of chemical patients is going to be done by emergency medical services (EMS) or another group before patients get to the hospital, says Suter. That's an incorrect assumption, he stresses. "The reality is that almost 80% of patients in these incidents go straight to the ED without seeing any EMS or fire department personnel whatsoever. Your disaster plan cannot be 'call 911,' because they will be busy and not able to come to help you."

Executive Summary

In addition to a protocol for everyday hazardous materials incidents, you need one for weapons of mass destruction, which include nuclear, chemical, or biologic agents.

- Direct minimally injured patients to a holding area.
- Have a plan for decontaminating hundreds or perhaps thousands of people.
- Have reference tables that list agents, symptoms, and the antidotes and decontamination supplies for various exposures.

(Continued on page 126)

Treatment of Biological Agent Exposure

AGENT	CLINICAL SIGNS AND SYMPTOMS	TREATMENT	OTHER	SECONDARY TRANSMISSION
Anthrax (spore)	Prophylaxis/treatment: Fever, malaise, non-productive cough, progressing to dyspnea, stridor, shock. Incubation 1-6 days.	Prophylaxis/treatment: ciprofloxin doxycycline, PCN licensed vaccine. IV therapy: ciprofloxin doxycycline, PCN licensed vaccine.	High mortality (>90%) even with treatment.	None except aerosolized body fluids.
Pneumonic Plague (bacteria)	High fever, chills, headache, hemophysis, toxemia, dyspnea, stridor, bleeding diathesis. Incubation 2-3 days.	Prophylaxis/treatment: vaccine, doxycycline, TMP/sulfamethoxazole. IV therapy: streptomycin (>1 yo), gentamicin, chloramphenicol.	Antibiotic treatment effective if begun early.	Strict isolation needed. Isolation mandatory for at least the first 48 hours of treatment.
Tularemia (bacteria)	Regional lymphadenopathy, fever, chills, headache, malaise, cutaneous ulcers. Incubation 2-10 days.	Streptomycin, gentamicin. Adult prophylaxis: doxycycline.	Low mortality (about 5%).	Rare, body fluid precautions only.
Q Fever (bacteria)	Fever, cough, pleuritic chest pain. Incubation 10+ days	Tetracycline, doxycycline.	Low mortality.	Does not require universal precautions.
Smallpox (virus)	Malaise, fever, rigors, vomiting, headache, backache; 2-3 days later lesions appear and quickly progress from macules to papules to pustular vesicles. Incubation 16-17 days.	Supportive — Vaccine available from CDC. Immune globulin may be available from CDC. No antiviral medication available.	Supposed to be extinct (doubtful).	Highly contagious.
Viral Equine Encephalitis	Supportive. No antiviral medication exists.	Ribavirin, supportive care.	Isolate patients in single room with an adjoining anteroom stocked with PPE. Negative air pressure if possible.	Body fluids. Otherwise infectious by vector (mosquitoes).
Viral Hemorrhagic Fevers	Fever, malaise, myalgias, headache, vomiting, diarrhea, easy bleeding, petechiae, shock.	Ribavirin, intensive care, convalescent plasma (Argentine HF), vaccine (yellow fever), blood replacement products for DIC.	Decontaminate with hypochloride or phenolic disinfectants.	Transmitted by bodily fluids. Strict barrier-nursing techniques. Limit patient transfers: may increase risk for secondary transmission.
Botulism (toxin)	Ptosis, weakness, dizziness, dry mouth, blurred vision, diplopia, descending paralysis. Incubation 24-36 hours.	Several antitoxins are available and effective if administered early. CDC vaccine good only for A and B.	Disinfect with hypochlorite and/or soap and water. Supportive long-term mechanical ventilation.	None.
Ricin (toxin)	Weakness, fever, cough, pulmonary edema, incubation 18-24 hours.	Supportive — oxygenation and hydration. No antitoxin or vaccine available.	Disinfect with hypochlorite and /or soap and water.	None. Derived from castor beans.
Staphylococcal Enterotoxin B (toxin)	Fever, headache, chills, myalgias, cough, nausea, vomiting, diarrhea, Incubation 3-12 hours.	Supportive — oxygenation and hydration. Ventilator support may be required.	Disinfect with hypochloride. Most victims recover.	Use PPE.

Source: Robert Suter, DO, MHA, FACEP, Questcare Emergency Services, Plano, TX.

Here are the supplies you should stockpile

Antibiotics are difficult to stockpile for a potential terrorist attack using a weapon of mass destruction, says **Christopher Richards**, MD, chairman of the disaster committee and an attending physician at the department of emergency medicine at Brigham and Women's Hospital in Boston.

"Doxycycline is likely the best choice to stockpile, but the costs are prohibitive as they have a defined shelf life," Richards says. "You would need to store much more than the average hospital uses during the shelf life of doxycycline."

Nerve agents are commonly used by terrorists because they are so deadly, says **Robert Suter**, DO, MHA, FACEP, regional medical director for the North Texas region at Questcare Emergency Services in Plano. "Even though they are hard to make, a relatively small amount can kill a large number of people," he says.

Atropine is the antidote for nerve agents and is a common drug in every ED crash cart, notes Suter. "But the problem is, the usual maximum dose for a patient for cardiac reasons is 2 to 3 mg. But a nerve agent casualty could easily use 20 or 30 mg of atropine. So essentially, just a couple patients could wipe out the entire hospital's stock of atropine in an hour or two."

Consider stockpiling atropine, Suter recommends. By doing that, "if you have a major incident, you can access it." Also stockpile bleach, he suggests. "To some extent, you can decontaminate everything with good planning and lots of water. But ideally, you would utilize bleach to decontaminate the deadliest chemicals. So consider stockpiling 55-gallon drums of bleach someplace where they could be quickly accessed and brought to a decontamination station at the hospital."

Ciprofloxacin is an antidote to many biological warfare agents, but there may not be enough to go around in your city, says Suter. "EDs should be aware of how to access these drugs," he explains. "When those sorts of resource issues come up, you need to know when to trigger a call to the National Disaster Medical System."

The National Disaster Medical System in Baltimore, MD, is an organization that pools resources in communities nationwide committed to supporting each other in case of disaster. ■

□ Don't assume you can direct patients.

No matter how well you plan, you won't be able to direct patients to the hospitals in your community. "Most of the time, patients will just show up," Suter says. "If you're the closest place, you'll get an overwhelming load and won't be able to disperse them throughout the community."

When the World Trade Center bombing occurred in 1993, all patients came straight to the nearest hospital. That day, Suter happened to be at Bellevue Hospital, a 1,000-bed comprehensive facility. "We were only 40 blocks away, but not a single patient came to us in the first hour or so," he recalls. "Instead, all the people walked to a relatively small community hospital across the street."

□ Protect staff from exposure.

For most agents, only simple respiratory precautions are necessary, notes Richards. "The space suits are great for TV but, for the most part, unnecessary," he says. "However, staff safety is a real problem, so stockpiling gowns and masks should be considered."

You might be surprised to find that a very limited number of supplies are actually on hand, Richards notes. "Even hospitals have adapted to the "just-in-time" business model for inventory. Gowns and masks used for standard precautions would likely run out in a matter of days but could likely be stockpiled since they do not expire." ■

Address contamination at the point of triage

When your ED faces chemical attacks or certain nuclear and biologic exposures, you need "hot" triage for patients who have not yet been decontaminated and "cold" triage for those who have, advises **Robert Suter**, DO, MHA, FACEP, regional medical director for the North Texas region at Questcare Emergency Services in Plano.

Post-decontamination procedures can be more consistent with your usual mass casualty considerations, Suter says. "Precontamination procedures are slightly different, and staff will have to be trained differently," he adds.

Personnel in the hot zone will wear protective equipment that will effectively prevent them from performing patient assessments in the manner they are accustomed to, he notes. "You'll be wearing gloves, so your palpatory capability will be diminished. You won't have the triage assessment tools you normally would." For instance, it will be difficult to take a blood

pressure because staff will have to go by breathing patterns or pulse, he says.

It has been many years since even the U.S. military has had to make large-scale decisions to triage potentially salvageable patients to “expectant” categories, which means victims are so severely injured they are expected to die, Suter notes. “We are accustomed to having the resources to try to save everyone. Decontamination is a heavy expenditure of resources. In a large-scale incident, tough decisions may need to be made. Drills and training courses will help people to get experience with this.”

Triage categories are dynamic and will change based on the size of an incident, he says. “What is ‘expectant’ and what is ‘immediate’ can vary depending on how many patients there are. If you only had five patients, they would probably all be immediate. But when you have 5,000 patients to take care of, if you take too much time trying to save one person, five people may die.” ■

ED will be first to notice a biological attack

With chemical and nuclear incidents, it may be obvious there has been an attack, but biological incidents are more insidious, notes **Robert Suter, DO, MHA, FACEP**, regional medical director for the North Texas region at Questcare Emergency Services in Plano.

“These incidents will require more vigilance on the part of the ED, because the ED will be the first place that a biological attack will be noticed,” Suter says. The biggest problem is at the beginning, he says. “You don’t recognize you have a problem.”

A bioterrorist attack is different from other types of terrorist attacks, stresses **Christopher Richards, MD**, chairman of the disaster committee and an attending physician at the department of emergency medicine at

Brigham and Women’s Hospital in Boston. “There will be no scene, no explosion, no collapsed building footage on CNN — just a ton of sick people in the ED,” he says.

The key is early recognition and early communication of a possible attack, says Richards. “Once it is clear, it is too late.”

Many of the biological agents, including anthrax, are highly treatable if discovered early. “But if you discover it late, the mortality rates approach 100%,” Suter says. Look for patterns of illness when trying to determine whether a biological attack has occurred, he advises. “When it hits full force and everybody is sick, by that time you’re dealing with huge numbers of patients,” Suter says.

When there was an *E. coli* outbreak at a county fair in New York state earlier this year, it took time for clinicians to realize why people were getting sick, Suter notes. “They assumed it was virus or flu. By the time they realized what was going on, people were in renal failure and died.”

In that case, the culprit was the cow manure, but could have as easily been a terrorist attack, says Suter. Someone could intentionally put that strain of *E. coli* in the water supply, he says. The common initial presentation of biologic terrorism is a flu-like syndrome. “So if you disburse a deadly biologic agent during a flu season, there would be a lot of dead people before doctors figured out what was going on,” he notes.

Be aware of significant patterns in your patient population, Suter says. During the flu season, it might be difficult to detect, he acknowledges. “But if you have what looks like a huge flu outbreak in July, that doesn’t make any sense,” Suter says. “So after three or four patients, somebody needs to think about calling the public health department.”

Communicate with the hospital lab, infectious disease and infection control departments, state public health agencies, and the Centers for Disease Control and Prevention (CDC) in Atlanta, Richards advises. Local entities such as emergency medical services, public safety, and emergency management agencies also are key in the communication process, he says.

For example, if you see unusual pneumonias and call the hospital’s infectious disease department, that alone can set a chain reaction in motion, he explains. “Per their policy, notify the infection control department, who notify the department of public health, who then make a call to hospital B just as a guy walks through the door with a cough and hemoptysis. Meanwhile, public health will have notified CDC, the Federal Bureau of Investigation, and public safety.”

Most cities already have this “chain” set up, you just need to activate it, he says. ■

Executive Summary

A terrorist attack using biological agents is harder to recognize than a chemical and nuclear incident.

- Communication with other departments and groups — such as the hospital lab, infectious disease and infection control departments, and state public health agencies — can help identify a biological attack quickly.
- Be aware of significant patterns in your patient population, such as a large number of patients with flu-like symptoms in the summertime.

Here's the latest research in pediatric pain control

Because pediatric patients are not in the same position as adult patients in terms of voicing concern for inadequate analgesia, they are particularly vulnerable to inadequate pain management, says **Arthur M. Pancioli, MD**, assistant professor for the department of emergency medicine at the University of Cincinnati College of Medicine. "Documenting the extent of a problem gives us a baseline from which to improve. In the case of pediatric analgesia, we have plenty of room for improvement," he notes.

Medical personnel should be more aggressive at identifying painful conditions, treating them quickly with adequate analgesics, and ensuring relief and adequacy of outpatient pain management, urges Pancioli.

Here are key findings of three recent studies that examined pediatric pain management in the ED:

□ Analgesic use in children differed among EDs.

One study looked at analgesic use in children vs. adults in three types of ED settings: an academic center with separate adult/pediatrics EDs, a community academic medical center with combined adult/pediatrics ED, and a community hospital with a combined ED. Forty adult and 40 pediatric charts of patients presenting within 12 hours of an isolated long bone fracture were randomly selected for review at each of the institutions. The main findings were as follows:

- Overall, 63% of patients received some form of analgesia in the ED.
- The community ED offered less analgesia (51%) than the academic combined ED (73%) but not the separate ED (66%).
- Pediatric patients received significantly less analgesia than adults (53% vs. 73%). This difference was

Executive Summary

Because pediatric patients are at high risk for inadequate pain management, ED staff should be vigilant about identifying painful conditions, treating them quickly with adequate analgesics, and ensuring adequacy of outpatient pain management.

- Studies have shown that analgesia was given to pediatric patients less frequently than adults in the ED.
- Research shows that pain management is better when protocols are used to manage pain.
- Often, parents feel that their child's pain management is inadequate.
- Staff education, including regular lectures or informal inservicing, can lead to better management of pain.

significant at the academic combined ED and the community ED but not the separate ED.

- 81% of patients received discharge analgesia, with no difference between pediatric and adult patients. However, pediatric patients (27%) were more likely than adult patients (3%) to receive inadequate doses of analgesics on discharge.¹

"The good news is that the use of analgesics appears to be increasing," reports **Emory Petrack, MD, MPH**, chief of the division of pediatric emergency medicine at Rainbow Babies and Children's Hospital in Cleveland and the study's principal investigator. "This reflects an increasing recognition of the role of the ED in appropriately addressing painful injuries and procedures."

Unfortunately, there continues to be a gap in the provision of adequate analgesia to children when compared with adults, notes Petrack. "Continued education and discussion regarding the need for good pain management in infants and children is essential if this gap is to be eliminated. Child life specialists have played an increasingly important role in this effort."

□ Protocols can improve management of painful conditions.

One study conducted at Children's Hospital Medical Center of Cincinnati looked at ED management of three painful conditions: vasoocclusive crisis (VOC or sickle cell crisis), isolated lower-extremity fractures less than 12 hours old, and second-degree burns less than 12 hours old.² The findings were as follows:

- Frequency of use: VOC 100%, fracture 31%, burns 26%.
- Use of recommended initial dose: VOC 78%, fracture 69%, burn 79%.
- Mean time in minutes to initial dose: VOC 52%, fracture 86%, burn 29%.
- Notation of pain relief in the chart: VOC 88%, fracture 19%, burn 29%.
- Instructions for home analgesic use: VOC 100%, fracture 74%, burn 27%.

Analgesic use was suboptimal in terms of frequency for burns and fractures; initial dosing was often below recommended initial doses; delays were relatively long for initial dosing; and too little documentation of pain relief and instructions for home pain control was found, says Pancioli, one of the study's investigators. "It was very interesting to us that the best pain management occurred with VOC where there are protocols for managing this type of pain," he reports. "It may be that similar protocols would substantially improve pain management for other conditions."

□ Parents' perceptions of children's pain management improves with staff education.

Parents often feel that their children's pain management is inadequate. "Parents want relief for their

Sources

- **Arthur Pancioli**, MD, Department of Emergency Medicine, University of Cincinnati College of Medicine, Mail Location 670769, Cincinnati, OH 45267-0769. Telephone: (513) 558-8114. E-mail: pancioam@ucmail.uc.edu.
- **Emory Petrack**, MD, MPH, Division of Pediatric Emergency Medicine, Rainbow Babies and Children's Hospital, 11100 Euclid Ave., Mail Stop MATH6097, Cleveland, OH 44106-6019. Telephone: (216) 844-8716. E-mail: emp4@po.cwru.edu.
- **Lisa Chan**, MD, FACEP, University of Arizona, 1501 N. Campbell, P.O. Box 245057, Tucson, AZ 85724-5057. Telephone: (520) 626-2542. Fax: (520) 626-2480. E-mail: lisac8@dakotacom.net.

child's pain, but research has shown satisfaction rates as low as 33%," says **Lisa Chan**, MD, FACEP, assistant residency director at the department of emergency medicine at the University of Arizona in Tucson and the principal investigator for a study on parents' perceptions of their children's pain management.³

In a study on satisfaction of parents, charts were pulled for children who came to the ED with six painful diagnoses.⁴ "We telephoned the parent a week after the child was discharged and asked if they thought the pain was controlled adequately," says Chan. The satisfaction rate was 91%, which the researchers attribute to quarterly inservicing for ED staff that results in better pain management. Speakers address pain management in the ED. "As attendings, we remind the medical students and residents to treat pain while seeing patients," she says.

Staff education should include conferences, regular lectures, or informal inservicing, Chan recommends. Speakers at University of Arizona review dosing and different medications used for pediatrics.

"Children may not be able to verbalize the fact that they have pain, so we need to be proactive in treating it," she says. "In turn, this improves parents satisfaction with the care their child receives."

References

1. Petrack EM, Christopher NC, Kriwinsky J. Pain management in the emergency department: Patterns of analgesic utilization. *Pediatrics* 1997; 99:711-714.
2. Friedland LR, Pancioli AM, Duncan KM. Pediatric emergency department analgesic practice. *Pediatr Emerg Care* 1997; 13:103-106.
3. Wilson AE, Pendleton JM. Oligoanalgesia in the emergency department. *Am J Emerg Med* 1989; 7:620-623.
4. Chan L, Russell TJ, Robak N. Parental perception of the adequacy of pain control in their child after discharge from the emergency department. *Pediatr Emerg Care* 1998; 14:251-253. ■

Handling confrontations with consultants in the ED

(Editor's note: This is the first of a two-part series on management of conflicts between the ED and other hospital departments. Next month, we will cover other departments, and a guest column will discuss why the ED is a frequent source of conflict in hospitals.)

Interactions with consultants are among the most challenging for ED staff, says **Kathy Clem**, RN, emergency medicine division chief at Duke University Medical Center in Durham, NC. "Consultants really don't understand what we do. They are convinced they can do what we do better and make a sport of second-guessing you. You need to have a proactive plan on how to deal with consultants." (See related story, p. 131.)

A training course was developed for residents and attending physicians based on the "ABCs of interaction repair with consultants" — A. Identify the consultant's Agenda. B. Look at the Big picture. C. Communicate. The ABCs were created by Clem and a colleague at her former post at Loma Linda (CA) University Medical Center and Children's Hospital.

Here are several commonly heard remarks by consultants and expert tips for how to handle each:

• **"The patient doesn't need to be admitted."** Listen to the consultants first, because they may have information to contribute. After listening, if you still think the patient needs admission, don't back down. "Acknowledge their comment but hold your ground," she advises. Say, "I still feel the patient needs admission. Feel free to send me a copy of the discharge summary, or after you see the patient, let me know what you think." Sometimes you have to say, "I'm the doctor seeing the patient right now, and this is my assessment."

• **"That patient was in the ED for four hours, and you don't know if his grandmother had hypertension."** Explain that you have done a complete work-up, but that bit of information didn't help you care for the patient, she says. "You need to communicate with a sense

Executive Summary

Demand respect when consultants second-guess your clinical decisions or behave rudely.

- Address consultants' specific complaints and don't respond to generalizations about the ED.
- Establish credibility by having radiologists confirm your X-ray readings in front of consultants.
- If consultants are rude, don't hesitate to confront them.

of humor by saying, "That's right, I don't know that. We did the ED work-up and left something for you."

• **"I don't care if I am on call. I'm not coming in."**

Before you react, give the consultant the benefit of the doubt. "Perhaps there was something about the presentation you weren't clear about," says Clem. If that isn't the case, be firm with the consultant. Say, "I can understand your position, but this isn't the time for this discussion. Let's discuss it at the staff meeting on Monday." Ask the consultant, "If you're not coming in, which colleague would you like to call to take your place?"

• **"Why didn't you call me sooner [or later]?"**

The consultant may have wanted a call when the patient got to the ED or after the X-rays were read. "Explain to them, 'If I had known what was going on sooner, I would have called you sooner. It's to my advantage to get you involved early. I'm glad to know what your preference is. Next time I'll do it this way,'" she says.

• **"I'll be in to see the patient. In the meantime, get a stat mammogram."** The consultant thinks a mammogram is needed but doesn't realize that test isn't typically done in the ED. "Say, 'Yes, I'm glad you thought of that test, but we generally schedule that after the patient is admitted,'" says Clem.

• **"You dumb ED docs always admit every chest pain patient."** This is one of the hardest scenarios to respond to, because the consultant is not only attacking your work-up, but also you and your colleagues, Clem explains. "All of us have heard something like this. Their agenda is they are angry you've called them, and they think you're being overzealous."

The best strategy is to address the specific complaint, instead of the generalization. "Tell the consultant, 'No, we don't always admit chest pain patients. In fact we've sent home four tonight, but this one needs to go in,'" she says. If a consultant is rude, don't hesitate to confront him or her about it. "Say, 'There is no reason to be rude to me or my staff. Let's talk about this.' Sometimes they need a mirror held up to see how they're reacting."

• **"What do you mean, the X-ray hasn't been done yet?"** Consultants want the right tests and procedures to be done for their patients, and they're impatient if they have to wait. "Explain that the lab is backed up, the nurses are all busy, and suggest they add it as part of the admission orders. Or have them admit the patient and call them later with the results," Clem suggests. The idea is to find creative ways to work around what is going on in the ED. "Explain to the consultant, 'I'll be the first to admit things don't always go as smoothly as we like. So let's work together to solve this problem.'" she says.

• **"Couldn't I just see this patient tomorrow in my office?"** You need to explain why, in your opinion, it wouldn't be safe for the patient to wait. "Or the

Expanding the Practice of Emergency Medicine

Providing Emergency Care for the Child and Young Adult

FEBRUARY 24-27, 2000 • GRAND HYATT • ATLANTA, GEORGIA

from the publisher of *Emergency Medicine Reports*, *Pediatric Emergency Medicine Reports*,
and *Emergency Department Management*

Program Topics

- Clinical Pearls to Improve Cosmetic Results in Facial Laceration Repair
- Using Interventional Radiology in the Pediatric Emergency Department
- Central Venous Catheters — Complications and Current Management Strategies
- Recent Updates from the Pediatric Infectious Disease Literature
- New Diagnosis and Therapeutic Options for Managing Upper Airway Obstructions
- Recent Updates in Alternative Medicines and Drugs of Abuse
- Emergency Awake Intubation and Adjuncts in the Difficult Airway Algorithm: The Anesthesiologist's Perspective

Special Pre- and Post-Conferences:

- Pre-conference on Geriatric Emergencies
- Post-conference on Neonatal Emergencies - Delivery Room Emergencies in the Emergency Department

Mark Your Calendar!

February 24 - 27, 2000

Grand Hyatt • Atlanta, Georgia
Space is limited! Register Today!

\$100 "Early Bird" discount deadline is Jan. 21, 2000

February 2000						
S	M	T	W	T	F	S
	1	2	3	4	5	
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29				



Call 1-800-688-2421 or
E-mail customerservice@ahcpub.com
On-line www.ahcpub.com

PDC00 51020

consultant may say, "I just saw this patient today." Explain to them, "Yes, that is the same patient, but things have changed," says Clem.

• **"OK, I'll come in and see the patient. Start an IV and put them on oxygen."** Patronizing comments can be irritating. "But try not to take it personally because the consultant may just be thinking out loud," she says. "Instead, explain that 'Our medics do that. We are a full-service ED and have already done the basics.' Convey that you know your stuff and that you've already done what they're asking."

• **"Don't call me unless the attending radiologist has read the C-spine films."** Consultants don't want to come in unless it's necessary, and they don't trust your reading of the film. "You can tell them, 'The films don't look normal to me. Come in and tell me what you think,'" says Clem. "You can establish credibility by having the radiologist see for themselves and confirm what you are saying. Then the next time you call the consultant, I doubt they'd say that to you."

• **"You can see the patient, but don't do any labs or X-rays."** The agenda here is often an HMO's

Source

- **Kathy Clem**, RN, Emergency Department, Duke University Medical Center, P.O. Box 3869, Durham, NC 27710. Telephone: (919) 684-5537. Fax: (919) 684-8489. E-mail: tkclem@intrex.net.

requirement, she says. "But the big picture is that the patient is in the ED. Legally and morally, we're required to stabilize the patient, so communicate that to the consultant." ■

What to do when your expertise is under attack

Consultants can be disrespectful to you or your colleagues and fail to recognize your expertise. Be prepared to respond in a professional manner, says **Kathy Clem**, RN, emergency medicine division chief at Duke University Medical Center in Durham, NC.

"Part of our daily job is to interact with our colleagues in medicine," she says. "While it's rewarding to problem-solve together, and it's part of the variety of emergency medicine we all enjoy, it's also one of the biggest sources of stress."

Here are tips for dealing with such situations:

- **If a consultant insults you or your colleagues, don't be defensive.** "Maintain a perspective. Accept the fact that you practice fishbowl medicine in the ED, and as a rule, consultants can outshine you in their area. It's enough to practice excellence in the ED," stresses Clem. Project confidence, and don't apologize for doing your job, she advises. "It's OK to use blameless apologies. Saying, 'Sorry I woke you up,' is not implying you're incompetent. But it's not OK to apologize for involving them in patient care with you, because that's what you're both there for."

- **Accept that not all facts will be known in the ED.** "People outside the ED will always use a retro-scope to second-guess you," says Clem. "In the ED, a concrete diagnosis is not always reached, and that's OK."

- **Share strategies.** If a clinician has an unpleasant encounter with a consultant, bring it up at a group meeting. "That way, you can determine as a group what is effective. You should have a unified-front strategy for consultants who are difficult to work with," she says.

- **Categorize problems.** When you have a difficult interaction, write it down and put it into a category, she suggests. "When you collect them over a month or so, you will have several categories and can develop a

CE objectives

After reading this issue of *ED Management*, the continuing education participant should be able to:

1. Discuss and apply new information about various approaches to ED management. (See *How would you handle a terrorist attack involving weapons of mass destruction?*; *NBC incidents: Know these terms; You can transform your HazMat policy*; and *Here's the latest research in pediatric pain management*.)
2. Explain developments in the regulatory arena and how they apply to the ED setting.
3. Share acquired knowledge of these developments and advances with employees.
4. Implement managerial procedures suggested by one's peers. (See *How to handle difficult situations with consultants*.) ■

ED Management® (ISSN 1044-9167) is published monthly by American Health Consultants®, 3525 Piedmont Road, N.E., Six Piedmont Center, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodical postage paid at Atlanta, GA. POSTMASTER: Send address changes to **ED Management**®, P.O. Box 740059, Atlanta, GA 30374-9815.

ED Management® is approved for approximately 18 nursing contact hours. This offering is sponsored by American Health Consultants®, which is accredited as a provider of continuing education in nursing by the American Nurses' Credentialing Center's Commission on Accreditation. Provider approved by the California Board of Registered Nursing, Provider Number CEP 10864, for approximately 18 contact hours. American Health Consultants® is accredited by the Accreditation Council for Continuing Medical Education to sponsor CME for physicians. American Health Consultants® designates this continuing medical education activity for 18 credit hours in Category 1 of the Physicians' Recognition Award of the American Medical Association. This activity was planned and produced in accordance with ACCME Essentials. **ED Management**® is also approved by the American College of Emergency Physicians for 18 hours of ACEP Category 1 credit. Physician members of American Health Consultants® 1999 Continuing Medical Education Council: Stephen A. Brunton, MD; Dan L. Longo, MD; Ken Noller, MD; Gregory Wise, MD and Fred Kauffman, MD, FACEP.

Subscriber Information

Customer Service: (800) 688-2421 or fax (800) 284-3291 (customerservice@ahcpub.com). **Hours of operation:** 8:30 a.m.-6 p.m. M-Th; 8:30 a.m.-4:30 p.m. F, EST. Subscription rates: U.S.A., one year (12 issues), \$399. With 18 Category 1 CME hours, \$449. For 21 ANA hours, \$449. Outside U.S., add \$30 per year, total prepaid in U.S. funds. One to nine additional copies, \$319 per year; 10 or more additional copies, \$239 per year. Missing issues will be fulfilled by customer service free of charge when contacted within 1 month of the missing issue date. Back issues, when available, are \$67 each. (GST registration number R128870672.) Photocopying: No part of this newsletter may be reproduced in any form or incorporated into any information retrieval system without the written permission of the copyright owner. For reprint permission, please contact American Health Consultants®. Address: P.O. Box 740056, Atlanta, GA 30374. Telephone: (800) 688-2421. Fax: (800) 284-3291. World Wide Web: <http://www.ahcpub.com>.

Opinions expressed are not necessarily those of this publication. Mention of products or services does not constitute endorsement. Clinical, legal, tax, and other comments are offered for general guidance only; professional counsel should be sought for specific situations.

Editor: Staci Bonner.
Group Publisher: Brenda Mooney, (404) 262-5403, (brenda.mooney@medec.com).
Executive Editor: Park Morgan, (404) 262-5460, (park.morgan@medec.com).
Managing Editor: Joy Daugherty Dickinson, (912) 377-8044, (joy.dickinson@medec.com).
Production Editor: Terri McIntosh.

Editorial Questions

For questions or comments, call Joy Daugherty Dickinson, (912) 377-8044

Copyright © 1999 by American Health Consultants®. **ED Management**® is a registered trademark of American Health Consultants®. The trademark **ED Management**® is used herein under license. All rights reserved.

EDITORIAL ADVISORY BOARD

Executive Editor:
Larry B. Mellick, MD, MS, FAAP, FACEP
 Chair and Professor
 Department of Emergency Medicine
 Director of Pediatric Emergency Medicine
 Medical College of Georgia
 Augusta, GA

Maryfran Hughes, RN, MSN, CEN
 Nurse Manager
 Emergency Department
 Massachusetts General Hospital
 Boston

Tony Joseph, MD, MS, FACEP
 President
 American Medical Consulting
 Dublin, OH

Marty Karpel, MPA
 Ambulatory Care Consultant
 Karpel Consulting Group
 Long Beach, CA

Thom A. Mayer, MD, FACEP
 Chairman
 Department of Emergency Medicine
 Fairfax Hospital
 Falls Church, VA

Kathleen Michelle Regan-Donovan
 RN, BSN, CEN
 Principal
 Ambulatory Care Advisory Group
 Chicago

Richard Salluzzo, MD, FACEP
 Chief Medical Officer
 Senior Vice President
 for Medical Affairs
 Conemaugh Health System
 Johnstown, PA

Norman J. Schneiderman, MD, FACEP
 Medical Director, Department
 of Emergency Services
 Trauma Center
 Miami Valley Hospital
 Associate Clinical Professor
 Emergency Medicine
 Wright State University
 Dayton, OH

Michael J. Williams, President
 The Abaris Group
 Walnut Creek, CA

Charlotte Yeh, MD, FACEP
 Medical Director, Medicare Policy
 National Heritage Insurance Company
 Hingham, MA

Nancy Auer, MD, FACEP
 Director of Emergency Services
 Swedish Medical Center
 Seattle

Kay Ball, RN, MSA, CNOR, FAAN
 Perioperative Consultant/Educator
 K & D Medical
 Lewis Center, OH

Larry Bedard, MD, FACEP
 Director of Emergency Services
 Doctors Medical Center
 San Pablo and Pinole Campuses
 San Pablo, CA
 Pinole, CA

William H. Cordell, MD, FACEP
 Director, Emergency Medicine
 Research and Informatics
 Methodist Hospital
 Indiana University School of Medicine
 Indianapolis

Caral Edelberg, President
 Medical Management Resources
 Jacksonville, FL

James A. Espinosa, MD, FACEP, FAAP
 Chairman, Emergency Department
 Overlook Hospital, Summit, NJ
 Director, Quality Improvement
 Emergency Physicians Association

Gregory L. Henry, MD, FACEP
 Clinical Professor
 Section of Emergency Medicine,
 Department of Surgery
 University of Michigan Medical School
 Vice President—Risk Management
 Emergency Physicians Medical Group
 Chief Executive Officer
 Medical Practice Risk Assessment Inc.
 Ann Arbor, MI
 Past President, ACEP

United States Postal Service

Statement of Ownership, Management, and Circulation

1. Publication Title ED Management		2. Publication No. 1 0 4 4 - 9 1 6 7		3. Filing Date 9/24/99	
4. Issue Frequency Monthly		5. Number of Issues Published Annually 12		6. Annual Subscription Price \$399.00	
7. Complete Mailing Address of Known Office of Publication (Not Printer) (Street, city, county, state, and ZIP+4) 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, Fulton County, GA 30305					
8. Complete Mailing Address of Headquarters or General Business Office of Publisher (Not Printer) 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305					
9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor (Do Not Leave Blank)					
Publisher (Name and Complete Mailing Address) Brenda Mooney, 3525 Piedmont Road, Bldg. 6, Ste. 400, Atlanta, GA 30305					
Editor (Name and Complete Mailing Address) Staci Bonner, same as above					
Managing Editor (Name and Complete Mailing Address) Joy Daughtery Dickinson, same as above					
10. Owner (Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual. If the publication is published by a nonprofit organization, give its name and address.)					
Full Name		Complete Mailing Address			
American Health Consultants		3525 Piedmont Road, Bldg. 6, Ste 400 Atlanta, GA 30305			
11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box <input type="checkbox"/> None					
Full Name		Complete Mailing Address			
Medical Economics Data, Inc.		Five Paragon Drive Montvale, NJ 07645			
12. Tax Status (For completion by nonprofit organizations authorized to mail at nonprofit rates.) (Check one) <input type="checkbox"/> Has Not Changed During Preceding 12 Months <input type="checkbox"/> Has Changed During Preceding 12 Months (Publisher must submit explanation of change with this statement)					

PS Form 3526, September 1998

See instructions on Reverse

13. Publication Name ED Management		14. Issue Date for Circulation Data Below November 1999	
15. Extent and Nature of Circulation			
a. Total No. Copies (Net Press Run)		Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
1488		1488	1461
b. Paid and/or Requested Circulation			
(1) Paid/Requested Outside-County Mail Subscriptions Stated on Form 3541 (Include advertiser's proof and exchange copies)		1259	1261
(2) Paid In-County Subscriptions (Include advertiser's proof and exchange copies)		0	0
(3) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution		0	0
(4) Other Classes Mailed Through the USPS		0	0
c. Total Paid and/or Requested Circulation (Sum of 15b(1) and 15b(2))		1259	1261
d. Free Distribution by Mail (Samples, Complimentary and Other Free)			
(1) Outside-County as Stated on Form 3541		0	0
(2) In-County as Stated on Form 3541		0	0
(3) Other Classes Mailed Through the USPS		0	0
e. Free Distribution Outside the Mail (Carriers or Other Means)		13	13
f. Total Free Distribution (Sum of 15d and 15e)		13	13
g. Total Distribution (Sum of 15c and 15f)		1272	1274
h. Copies Not Distributed		216	187
i. Total (Sum of 15g and h)		1488	1461
Percent Paid and/or Requested Circulation (15c divided by 15g times 100)		99	99
16. Publication of Statement of Ownership Publication required. Will be printed in the <u>November</u> issue of this publication. <input type="checkbox"/> Publication not required.			
17. Signature and Title of Editor, Publisher, Business Manager, or Owner <i>Brenda J. Mooney</i> Publisher		Date 9/24/99	

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

Instructions to Publishers

- Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
- In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation. In item 11, if none, check the box. Use blank sheets if more space is required.
- Be sure to furnish all circulation information called for in item 15. Free circulation must be shown in items 15d, e, and f.
- Item 15h, Copies Not Distributed, must include (1) newsstand copies originally stated on Form 3541, and returned to the publisher, (2) estimated returns from news agents, and (3), copies for office use, leftovers, spoiled, and all other copies not distributed.
- If the publication had Periodicals authorization as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published; it must be printed in any issue in October or if the publication is not published during October, the first issue printed after October.
- In item 16, indicate date of the issue in which this Statement of Ownership will be published.
- Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of second-class authorization.

PS Form 3526, September 1998 (Reverse)

strategic plan for each. Then you can take your negotiations off the emotional plane.”

The best negotiators communicate in a professional, calm manner with a well-thought-out strategic plan. “If you do, you will work well with colleagues,” she says.

• **Be clear when communicating.** Give a one-minute presentation to the consultant. “They want to know who, what, why. So give them exactly what they need,” she says. “Make sure when you’re through talking to them, they understand exactly what it is you want them to do. If you don’t know, they certainly won’t.”

• **Don’t expect praise.** If you want compliments from consultants, you’ll be disappointed. “It’s important that you know you practice excellence in emergency medicine. If you need someone to remind you of that, use one of your ED colleagues who knows what you do.” ■