Governor Listens to “Frontline Voices” in Fight Against Opioid Crisis
Daniel Hegg, MD
Harvard Affiliated Emergency Medicine Residency, Marlboro, MA

On January 26th, Governor Baker met with the MACEP leadership at its regular board meeting for a candid discussion about ongoing efforts to combat the opioid epidemic. While MACEP’s membership includes numerous active and longtime advocates in public health, this meeting provided a special opportunity for the organization to advance a dialogue about critical issues faced by emergency physicians practicing in the Commonwealth.

The Governor opened the conversation with friendly remarks before setting a tone of focused urgency. Referencing the bill his administration proposed in October last year, he briefly outlined strategies to empower clinicians to intervene with patients suffering from addiction, tighten control of prescribing opioids, and increase education about opioids and substance abuse disorder for clinicians and the Public. The Senate has already passed a variation of the bill, and the House recently put forth its own version. While the Governor conceded that this latest bill differs from his original proposal, he expressed his determination to move forward aggressively with a shared agenda, adding his now often repeated refrain: “People are dying every day because of this [issue].”

The MACEP leadership similarly affirmed its commitment to curbing the opioid crisis. Board members highlighted efforts to work with hospitals, communities, and partner organizations, including MACEP’s collaboration with the Massachusetts Hospital Association to establish opioid prescription guidelines. They cited promising results of individual and collective initiatives to reduce the amount of opioids prescribed in emergency departments across the State. One board member outlined an initiative to implement a comprehensive electronic information tool that would track prescription history, hospital utilization information, and other selected information in real-time.

The MACEP board also drew attention to the problem of boarding in emergency departments for patients with mental health dispositions. Since 2011, MACEP has collected data on length of stay and boarder characteristics from EDs across Massachusetts. These “point in time” surveys reveal staggering differences in the amount of time and access to definitive treatment for mental health patients as compared to medical-surgical patients. Citing the considerable overlap between mental health and substance abuse disorders, which now collectively fall under the umbrella of behavioral health, board members urged the Governor to reassemble the DPH task force to address such workflow challenges.

Throughout the meeting, the Governor listened attentively and asked incisive questions of those in attendance. He praised emergency physicians for their tireless efforts to serve at the “front door of medicine.” Attendees were similarly encouraged by the Governor’s response and his interest in expanding the dialogue to include additional public agency leaders at future MACEP meetings. “I was extremely impressed with the level of engagement that the Governor gave,” commented MACEP Treasurer Scott Weiner, M.D., M.P.H. “Kudos to Governor Baker for being the first Governor to address MACEP in this way, and for his genuine desire to work with us to help stop the opioid epidemic.”
Naloxone in Massachusetts
Nissa Ali, MD, M.Ed
Beth Israel Deaconess Medical Center

Naloxone, sold under the brand name Narcan, is an opioid antagonist that blocks the effects of opioids. Opioid-related deaths are increasing in incidence and are currently the leading cause of drug related deaths in Massachusetts, as demonstrated in Tables 1 and 2.

In response to the increasing rate of opioid-related overdoses, the Department of Public Health has sponsored a program to distribute intra-nasal Naloxone and overdose prevention education throughout the Commonwealth. Chapter 192 of the Acts of 2012 Massachusetts law established that Naloxone may be prescribed and dispensed to a family member or person at risk of an opiate-related overdose. The law also stipulates that the overdosed individual or bystander won’t be charged with possession of a controlled substance if they seek medical attention.

Pharmacy Access to Naloxone
There are two ways for patients to access a naloxone rescue kit from a pharmacy:

1. A prescriber may provide a prescription for the kit, in which the patient can take to any pharmacy that stocks Naloxone. Many pharmacies are able to fill Naloxone prescriptions or may order if they are out of stock. MassHealth covers the cost of Naloxone for its members.

2. The second option is for a patient to go directly to a pharmacy with a Naloxone standing order and request a Naloxone kit. A prescription is not required at a pharmacy with Naloxone standing orders. A list of pharmacies with standing orders can be found at http://www.mass.gov/eohhs/docs/dph/quality/boards/pharmacy/pharmacies-so-naloxone.pdf.

The Naloxone Kit
Massachusetts Nasal Naloxone Rescue Kits contain two 2mL prefilled Luer-Jet-Lock naloxone syringes (concentration 1 mg/mL), two mucosal atomization devices (i.e. nasal adaptors) and the DPH Naloxone Pamphlet. For additional information on the kit and when to provide naloxone, patients can be referred to the Boston Public Health video on YouTube, at https://www.youtube.com/watch?v=Uq6AxrEY3Vk.

Patient Counseling
Both the emergency medicine provider as well as the pharmacist should provide counseling on the use and effects of the drug. Naloxone can work immediately or take up to eight minutes to have an effect and will generally last 30 to 90 minutes. Individuals should be warned that the effects of Naloxone may wear off before the effects of the opioids wear off and patients could have repeat symptoms of the overdose.

Patients and their families should also be counseled on the visible signs that may indicate an overdose, including: pale/clammy skin, infrequent or no breathing, gurgling noises, no response to stimuli (painful rubbing of sternum, shaking, etc), slow or no pulse, blue lips or fingertips.
Sample patient instructions regarding actions to take if an overdose is recognized include:

- Always call 911 for help
- Provide rescue breaths until the naloxone takes effect
- Assemble the atomizer and administer half of the naloxone dose (1 mL) in each nostril
- Repeat the dose if there is no response after 3-5 minutes
- Roll the patient on their side in a recovery position with their face turned to the side and knee bent to avoid a choking event if the patient vomits

Additional Resources:

- Massachusetts Substance Abuse Information and Education Helpline: 800-327-5050, [http://helpline-online.com/](http://helpline-online.com/)
- Learn to Cope: support group for family dealing with opioid addicts. [www.learn2cope.org](http://www.learn2cope.org)

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Situation.

I heard my name on the overhead and raced back to Room 20. Paramedics were quickly wheeling back a pale elderly lady who was in obvious distress. Although her eyes were closed, she appeared agitated yet had a certain resignation about her. “Let me die”, she moaned softly but clearly.

Over the next 60 seconds the room filled with an orchestra of sounds as the paramedics gave report.

“83 year old female with history of CAD, stents…”

“Just let me die!” louder this time, with more urgency.

“…she felt very unwell this morning and called 911.”

Blood pressure cuff inflating, the slow ping of her heart rate, alarms ringing.

“…When we arrived, she was bradycardic to the 20s, ECG looked like complete heart block…”

The crunch of removing the paper backing from the pacer pads, pads slapped onto the patient’s chest. The noise of the print-out of the ECG, confirming third-degree heart block.

“…We started an IV and gave atropine. Her heart rate came up to the 50s, but only for a few minutes. She keeps telling us to leave her alone.”

Despite the patient urging the paramedics to stop their interventions en route to the hospital, legally they couldn’t. Once activated, the paramedics cannot withhold or withdraw care without an up-to-date and properly completed DNR order.

After a brief period of questioning, it was clear that the patient understood everything that was happening. She had capacity to make her own decisions.

“Call my doctor, Dr. Smith”, she said. “She knows what I want done”. Luckily for us, the patient’s doctor had readily available online medical records with thorough documentation of the patient’s wishes for DNR/DNI status. “When the time comes, she would like to be made comfortable and does not want extreme measures taken,” Dr. Smith wrote.

The time had come.
“LET ME DIE” CONTINUED FROM P 4

are not adequately trained in how to thoughtfully and effectively speak with a patient and their family about goals towards the end of life, and furthermore how to effectively integrate this information during their emergency department course. While many emergency physicians are excellent and sensitive communicators regarding these issues, too often emergency physicians ask all-or-nothing questions, such as “do you want us to do everything?” rather than trying to gain a clearer understanding of a patient’s overall goals for treatment.

We in the emergency medicine community need better training in how to skillfully navigate conversations regarding end-of-life care. We need to learn more about palliative care principles that we can institute in the emergency department, which can improve a patient’s quality of life and improve our resource utilization. We need to learn how to better discuss these sensitive issues in productive, effective ways. We also need to understand more deeply what a dignified death means to patients and how this could influence their decisions to forgo treatment of a potentially treatable illness.

Some patients want aggressive care until the day they die, but many patients do not. Sometimes, helping someone can mean providing less aggressive but more thoughtful care. How do you feel, thinking about de-escalating care while in the ED? How comfortable to do you feel letting your patient die when you know there could be a medical or surgical solution? What influences how you feel about this – a patient’s age, medical comorbidities, their quality of life?

Health care decisions during critical illness and the end-of-life are complex issues that can take time for patients and families to work out. The more education regarding palliative care principles and communication techniques that emergency physicians have, the better equipped we will be to care for our critically ill patients appropriately and considerately at the end of their lives. Residents and attendings alike would benefit from increased expertise in communication when navigating end of life issues, just as we are expected to acquire invaluable procedural skills during training. We must become more comfortable with the often more challenging task of placing down our lifesaving tools when faced with a patient who is ready to die from a potentially treatable illness. It is only with more exposure and teaching that we will be able to better serve our patients when they are most vulnerable and in the direst need of thoughtful care.

Call for Annual Award Nominations

Please consider nominating one of your colleagues for the following annual MACEP awards. Awards will be presented at MACEP’s Annual meeting to be held at the Massachusetts Medical Society Conference Center, Waltham, MA on May 4, 2016.

The nomination deadline is April 22, 2016.

Emergency Medicine Physician of the Year
Recognizes and honors an emergency medicine physician who has made significant contributions to the advancement of emergency medicine in Massachusetts.

Emergency Medicine Resident or Fellow of the Year
Recognizes and honors an outstanding emergency medicine resident or emergency medicine fellow in Massachusetts whose combination of clinical promise, leadership, ability to think outside the box, and commitment to their patients and emergency medicine separate them from majority.

Medical Student of the Year
Recognizes and honors an outstanding medical student with an interest in Emergency Medicine. The award is intended to recognize students who excel in compassionate care of patients, professional behavior, and service to the community and/or specialty.

To submit a nomination, please complete nomination and submit to the MACEP office. All materials must be e-mailed (pearson@macep.org), postmarked (MACEP, 860 Winter Street, Waltham, MA 02451) or faxed (781-890-4109) by April 22, 2016.

Visit us online at www.macep.org.
Team Save
Zachary Testo, MD
Baystate Medical Center

In the increasingly stressful work environment of the Emergency Department, all members of the health care team face a high demand for excellence each day, each hour and with each patient. Increasing efficiency, reducing costs, minimizing or eliminating errors and improving satisfaction all feed into a common goal shared by health care workers; good outcomes for patients. Often the focus falls on pitfalls and mistakes that are used as learning points, with a goal of improving future outcomes. However, when a health care team comes together and patient care is delivered in an ideal manner, it is important to recognize what a terrific accomplishment that is. Focusing on positive outcomes redirects providers to concrete evidence that was learned from training, education and/or previous errors, which has has been put into best practice for the good of the patient.

A “Team Save” program at Baystate Medical Center, or other hospitals, would help the Emergency Department to learn from the successes of those within our community and hopefully inspire others to emulate their actions if ever presented with a similar case in the future. In addition it would work to build interdisciplinary relationships and to improve employee satisfaction.

“Team Save” would begin with recognition by staff at the time of a successful outcome. Any member of the team can communicate within a chart to a resident chief with a subject “Team Save” and can provide a very quick description of the events surrounding the patient as well as why it should be considered for recognition. The cases will be reviewed quarterly and a specific case would be chosen as a patient encounter that exemplified excellent patient care, efficiency, or implementation of new protocols that led to a great outcome. Examples include a technician who helps start the process for a goal door to PCI time, a nurse who implements the start of a septic workup as soon as abnormal vital signs are recognized and involves all important staff members, or superior communication between consultants for a patient requiring surgery. Teamwork, communication, fund of knowledge, and initiative would be identified and appreciated. “Team Save” would be an instrument for health care workers to acknowledge the success of teamwork and evidence based patient care by saying “this is how we should strive to deliver care to every patient”.

Nurse managers and attendings would also be strongly encouraged to nominate cases for review, as they have the experience and objectivity to recognize such exemplary patient care. It merely takes a few clicks within a patient chart for the case to be communicated. The positive effects can help benefit future patients.

After nomination, resident chiefs can select a case to be presented briefly at a quarterly interdisciplinary conference. All Emergency Medicine residents and many supervising physicians attend a weekly educational conference. Once per quarter the terminal portion of the conference would be devoted to interdisciplinary themes. All staff will be invited to attend, including techs, nurses, orderlies, secretaries and other ancillary staff. The goal of this interface is to encourage camaraderie and to allow different views to be expressed, as goals and concerns are not always uniform across different levels of care. “Team Save” would work as a part of this model. A brief case presentation with the names and pictures of staff members would be projected. The emphasis would be placed on the individual efforts made that improved a patient’s life or experience. Subsequent discussions would then review how others can best emulate the events in the future, either by teaching about specific evidence based medicine or a protocol or guideline that demonstrates best practice.

Furthermore, a small “Team Save” poster would be hung in the break room for staff members that were not present to appreciate the work of their colleagues. Educational materials could be provided along with the case in order to disseminate best practice information.

There are some residency programs that are beginning this practice within the residency by pointing out successes of physician providers. However, a literature search revealed no current programs aimed at recognizing multiple providers throughout different levels of patient care. As the Emergency Department model begins to focus more on community and communication, this program fits in well with an initiative to bridge the gap between all individuals necessary to deliver quality emergency care. The drawbacks are few but the benefits, no matter how small, are numerous.
Expanding Wavelengths of Emergency Ultrasound
Tim Gleason, MD
UMass Medical Center

A 32 year-old G4P3003 at 6 weeks gestation by LMP presented to the Emergency Department complaining of acute onset of lower right-sided abdominal pain radiating to the groin. The pain had begun the prior day and was worsening. She denied vaginal bleeding or discharge or other associated symptoms. There was no history of prior ectopic or pregnancy complications, surgery, or sexually transmitted illness. On exam she appeared in moderate distress, vital signs were normal, there was tenderness of the lower abdomen, and pelvic exam revealed a closed os with no bleeding or lesions. Urine pregnancy test was positive. A bedside trans-abdominal ultrasound performed by the Emergency Physicians showed an empty uterus, a small amount of free fluid, and adjacent to the uterus there was a hypechoic cystic structure with a hyperechoic ring within it highly suspicious for an ectopic gestational and yolk sac. The OB/GYN specialist was consulted and the patient was taken to the operating room where she was found to have a leaking, right ovarian ectopic pregnancy.

Yet another case of how an ultrasound probe in the hand of an Emergency Physician can aid in the immediate diagnosis and management of patients at the bedside. What was different and interesting was this case took place at Muhimbili Hospital in the East African nation of Tanzania. It was just one of many examples I witnessed where bedside ultrasound guided care without the aid of resources that are typically available in an American Emergency Department setting. In Tanzania, radiologic services such as CT, X-ray and ultrasound were outside the department and availability was dependent on if the equipment was out of service as well as the patient’s ability to pay. In what seemed a constant stream of motorcycle accidents and assorted trauma, e-FAST (extended Focused Abdominal Scan for Trauma) exams identified pneumo/hemo-thoraces that were quickly managed by the emergency physicians; or if fluid in the abdomen was seen, the operating room was activated. RUSH (Rapid Ultrasound in Shock/Hypotension) exams were used to evaluate hypotensive patients, most commonly due to sepsis, hypovolemic and cardiogenic shock. Lung ultrasound identified and guided drainage of pleural effusions, revealed pneumonias, and helped guide diuresis and hydration with serial b-line measurements. Echocardiogram revealed congenital and rheumatic heart disease, tubercular pericardial effusions, and was of course utilized during cardiac arrests.

Ideally, a full array of diagnostic resources would be available and accessible to all (and utilized appropriately). However, the current reality in most developing countries is that while a CT scanner may not be accessible, ultrasonography has become increasingly prevalent and is improving patient care. There is a large body of literature supporting the utility of bedside ultrasound by all types of providers in rural and developing areas for emergency medicine, obstetrics, cardiology, and surgical specialties.1 I do not expect this is very surprising to anyone reading this – we see the utility of ultrasonography during every shift. Its indispensability, though, has never been so striking to me as it was during an elective rotation in the Emergency Department at Muhimbili Hospital.

Muhimbili National Hospital is the primary national referral hospital in Tanzania. It is located in the coastal capital Dar es Salaam, home to more than 4 million people. The Emergency Department opened in 2010 as the first public and full capacity ED in the country. The department sees a high volume of referred critically ill patients, trauma, and pediatrics with an 80% admission rate. It is also home to the country’s first Emergency Medicine residency program, which graduated its first residents in 2013. Many of these initial residents are now leading the development of emergency medicine and the training of future specialists at Muhimbili Hospital and throughout the country. It was a privilege to work with this amazing group of faculty, residents, and staff.

Practical Tips/Tricks for EM Procedures
Nissa Ali, MD, M.Ed
Beth Israel Deaconess Medical Center

Ear Foreign Bodies
• Use 2% viscous lidocaine to kill insects prior to removal.
• If irrigating, use warm saline or water for patient comfort.
• A Day ear hook can be used to extract objects. If a hook is unavailable, an alternative hook may be created using a paper clip secured to a pen, using a hemostat clamp to bend the tip.
• Tissue adhesive may be applied to the wooden end of a Q-tip, inserted into the auditory canal and adhered to the foreign body for removal (taking care to not touch the canal surface).

Nasal Foreign Bodies
• Occlude the unaffected nostril and have the patient blow hard to push out the foreign body using positive pressure.
• Pediatric patients: After occluding the opposite nare, apply positive pressure either by having a parent “kiss and blow” into the patient’s mouth or with a bag valve mask.
• A 1:1 mixture of afrin and lidocaine with epinephrine may help reduce nasal swelling.
• Coat a balloon catheter with 2% lidocaine jelly, insert it past the foreign body and inflate. Withdraw the inflated catheter to pull out the foreign body.
• Flexible nasopharyngoscopy may be used to help visualize foreign bodies.

Peritonsillar Abscess Drainage
• Use a laryngoscope blade or a speculum as a light source. Instruct the patient to hold the blade in their mouth and apply downward pressure to their tongue. Patients can also be given the suction to give them an active role in the procedure.
• To protect from carotid artery from injury, trim the plastic guard of a spinal needle so <1cm of the needle is exposed. A second needle can be trimmed to 1.5cm if a longer exposure is needed. Medial and superior incisions are generally safer for the carotid artery, which most often lies lateral and posterior to the tonsil.

Central Lines
• To prevent an air embolism: use trendelenberg, always occlude the catheter hubs, aspirate all air, insert on patient exhalation when possible.
• If having difficulty advancing the guide-wire, withdraw the wire slightly, rotate and then advance.
• Always recheck that the guide-wire is in the vein before dilating!

Bougie-Assisted Cricothyroidotomy
• Stabilize the larynx with the left hand and identify the cicothyroid membrane. Make a vertical skin incision. Make a horizontal incision through the cicothyroid membrane and then turn the blade 90 deg. Slide the bougie along the blade into the trachea. Remove the scalpel and advance a 6.0 endotracheal tube over the bougie. Confirm placement.1

Ocular Injuries
• If a patient is unable to tolerate opening the eye, apply tetracaine ophthalmic drops to the medial canthus while the patient is supine. Instruct the patient to blink the drops in.
• Continuous eye irrigation can be achieved by attaching a saline bag with IV tubing to a nasal cannula. Position the nasal cannula to irrigate while the patient is supine (over the nasal bridge will irrigate bilaterally). 10mL of 1% lidocaine can be placed into the saline bag for anesthesia. The patient’s head may be placed in a cut basin to catch the saline.

Epistaxis
• Tape two tongue depressors together and apply to the cartilaginous portion of the nose for direct pressure.
• For topical anesthesia and vasoconstriction, use a combined 1:1 mixture of Afrin and lidocaine with epinephrine. Apply to a cotton applicator and apply pressure for 10 minutes.
• Injectable tranexamin acid may be considered for anterior epistaxis. Suggested application is 25mg (0.25mL) topically to the anterior nasal mucosa.2
• Applying ice to the palate may reduce nasal blood flow up to 23%.3

Do you want to write for the EM Advocate?
The EM Advocate is looking for intelligent, creative, and interesting articles to highlight resident thoughts and opinions throughout the Commonwealth of MA. Subject matter can include topics of social responsibility, interesting cases, scientific advances, emergency medicine subspecialty issues, grass roots activism, and opinions regarding public or hospital policies, etc.

Please contact your residency’s MACEP representative (listed on front page of this newsletter) or the EM Advocate Editor (Nissa Ali, MD at njali@bidmc.harvard.edu) for opinions, ideas, and article submission. We look forward to hearing from you!
TIPS/TRICKS CONTINUED FROM P 8

Laceration Repairs
• Use local or peripheral nerve blocks when applicable.
• Add bicarb (1:10 dilution) to the lidocaine, warm the syringe under water and inject slowly to minimize patient discomfort with the lidocaine.
• Be aware that local lidocaine infiltration will distort tissues, consider marking where wound edges approximate before injecting.
• Patients should be advised that sun exposure worsens scarring and encouraged to use sunscreen.
• Lacerations over joints may benefit from splinting after repair.

Nasogastric Tubes
• Place the tube tip in ice water, which may stiffen the tube and help with insertion.
• If the tube curls in the pharynx, flex the patient’s neck to change the angle.

Ring removal
• Wrap a penrose drain or phlebotomy tourniquet tightly around the finger and ring. Elevate the hand. After 5 minutes, unwrap and attempt to remove the ring with lubrication.
• Place a string or suture material with one end under the ring and wind the other end tightly around the finger. Pull up on the end of the string under the ring to slide the ring down the finger.
• Place the finger in cool water to decrease swelling.

Meaningful Moments
Melisa Poulos, MD
Boston Medical Center

By the time we reach the final stages of our training as Emergency Medicine physicians, we take pride in knowing that we have compiled an impressive bag of tricks which we will use in our careers to diagnose and fix extensive injuries and illnesses. We all can identify with the burst of satisfaction that comes with successfully resuscitating a critically ill patient, placing a chest tube in an unstable trauma patient, or effectively intubating that patient who is in respiratory distress. Doing any one of these effectively can make for a “good day” as an EM physician. And let’s face it, it’s those “good days” which help sustain us when we are depleted: during a particularly long and difficult stretch of shifts, days with too many patients and too little time, or feeling spread too thin in both our professional and personal lives. The “good days” are what motivate us to keep doing this work despite the many challenges it poses. Lately, as I’ve been thinking about life beyond residency, I’ve begun to reflect on what gives me greatest satisfaction and reward in my work, and in doing so, conjured up this memory.

It was over three years ago, yet I remember it like it was yesterday – the unspoken worry in her dark, brown eyes, her quiet disposition, her large and loving family surrounding her hospital stretcher. Mrs. B. was a Haitian woman in her late 60s who arrived at our ED directly from Logan Airport where she had flown from Haiti. She had come to Boston for one simple reason, to receive medical care. She and her family reported that until three months ago, she had not seen a doctor in over 30 years. A few months ago she began to have some urinary symptoms which she thought might be an infection. She somehow got antibiotics without seeing a doctor initially, but when her symptoms persisted for weeks and weeks, she finally did seek medical attention in her country. The doctor there gave her a different antibiotic for a longer course and told her to follow up if she did not get better.

By the time I had performed the physical exam, I was quite concerned about malignancy. Within several hours of her arrival in our ED, a CT scan confirmed the presence of a 6 cm mass in the rectum with evidence of erosion through the vaginal wall. This finding made it clear why the patient had been having months of persistent symptoms. Mrs. B. finally had an answer, an explanation for her symptoms. But the explanation was not a positive one.

I sat down next to Mrs. B., who was surrounded by her family, and told them directly that she had a large mass that most likely was cancer. I remember holding her hands as I told her. And eventually when I went to draw my hands away, she held on tightly and did not let go. I remember my eyes filling with tears at that moment in response to the raw pain and suffering that was present in that small exam room. Mrs. B. was admitted that night and had major surgery the following morning and embarked on what would be a long, frightening, painful and uncertain pathway.

MEANINGFUL MOMENTS CONTINUED ON P 10
MEANINGFUL MOMENTS CONTINUED FROM P 9

I left that encounter feeling deeply saddened for the patient and her family. But I also felt that it was one of my most meaningful and memorable days as a physician. One might wonder how I could possibly feel that way. I did not fix her medical problem, I did not have definitive answers to her questions about the future and her prognosis. I could not tell her that it would all be okay and that she would be fine. Then how could it possibly be a good day? What I was able to do for her was provide compassionate care despite my inability to cure her condition. For me, a sense of purpose is revealed during the “meaningful moments” that occur between me as the physician and my patients. In the case of Mrs. B, it was a privilege to bear witness to the humanity and vulnerability within her, and to be granted the honor of walking alongside her during a most frightening and stressful time in her life. In the absence of a solution to her medical problem, and no clear-cut answers to offer, I was left with the challenge of impacting her in other ways. I did so by conveying to her a sense of empathy, caring, understanding and respect as a fellow human being.

I am grateful for the exceptional training I have been given throughout my residency, and value the technical skills I’ve developed that I will use to impact and save lives. I’ve come to realize more and more that in addition to the technical skills, an effective physician must practice with compassion, and without it, we do a disservice to both our patients and ourselves. So as I prepare to embark on the next phase of my journey as a physician, I try to remind myself of some of the key components to providing compassionate care, in hopes that I will strive to provide this to all of my patients in the future:

- Know that humility, humility, humility is the foundation
- Fixing is not the be-all-end-all
- Keep in mind the privilege of what we do
- Never underestimate the power and value of “being fully present” as a key intervention
- Look to colleagues’ examples of compassionate care to inspire you
- Compassionate care of others requires compassion toward yourself

Regardless of where you are in your training or career, I encourage you to reflect on what nourishes and sustains you. For me, it is undoubtedly the moments of humanity and exchange of compassion in the midst of our medical encounters. Without these “meaningful moments”, our work would quickly leave me burnt out and depleted. What is particularly encouraging is that when we maximize the compassion we provide to our patients, we all benefit, both we as the physicians as well as our patients.

POLITICS AND PRESCRIPTION PICK-UPS CONTINUED ON P 11
So to what can we attribute the discrepancy?

Part of the answer may come from the field of behavioral economics. At discharge, most patients fully intend to pick-up their prescription, but in practice, many never follow through and make it to the pharmacy. Researchers in behavioral economics who study the science of decision-making call this scenario an action-intention gap.

EDs may be able to do a better job of helping our patients follow through and close these action-intention gaps by adopting strategies from the unlikeliest of places, presidential campaigns. In that scenario, many potential voters who fully intend to vote never follow through and make it to the voting booth on Election Day. Campaign strategists have leveraged insights from behavioral economics to close that action-intention gap and increase voter turnout in their candidate’s favor.

In 2008, behavioral economist and Harvard Kennedy School professor, Todd Rogers, set out to test novel interventions focused on increasing voter turnout during the 2008 Democratic Presidential Primary.\(^5\)

His team added an intervention to phone call scripts which were to be read to over 280,000 potential voters by campaign volunteers during standard *get out the vote* house calls. The call scripts contained messaging designed to remind potential voters about the election and their duty to vote.

To this standard script his team added a simple but powerful behavioral economics intervention called an *implementation intention* which consisted of three follow up questions designed to facilitate voting plan making: what time they would vote, where they would be coming from, and what they would be doing beforehand.

Implementation intentions work because we create a cognitive link between an anticipated future situation and the intended behavior by articulating the when, where, and how of following through on an intention. In other words, our plan for following through on a future behavior takes the form “if situation Y, then trigger behavior X”.

By creating this link upfront we can increase the probability that we will follow through on that action.

Figure 1 (page 12) provides an example of a *nudge*. A nudge is a concept in behavioral economics which influences an individual’s decision-making by leveraging subconscious processes.

Rogers found that by adding this costless nudge to the pre-existing script, his team was able to increase voter turnout by 4.1% over the control. To put this effect size into context, in the 2012 Presidential Election increasing voter turnout among eligible voters by just half that amount for one candidate’s supporters would have changed the outcomes in Florida, Ohio and North Carolina.

Building on these findings, in the 2010 general election, his team tested another nudge called a *threat of accountability*, which holds that by subtly reminding an individual that they may be held accountable for following through on a future action, they will be more likely to follow through on that action. By adding the phrase, “We may call you after the election to talk about your voting experience.”, to a piece of standard voter mailing they were able to increase voter turnout by approximately a percentage point.\(^6\) Both of these strategies have now become common staples of modern-day campaigns and are being implemented in the 2016 presidential primary race by candidates across the political spectrum.

How could this be applied to help increase prescription pick-up rates?

Imagine, as part of the discharge paperwork, patients were asked a similar battery of questions: what time they will pick up their medication, where they will be beforehand, and how they will get there. This research shows that by weaving simple but validated nudges like this and a threat of accountability into pre-existing practices, EDs may be able to help patients close the action-intention gap and follow through to pick up the medications we prescribe them at zero marginal cost.

The intersection of emergency medicine and behavioral economics is rich terrain for exploration and nudging may yet be the tool that helps us design and integrate a model of care that works best for our patients.
Figure 1: 2010 Midterm Election Mailer with Nudging Interventions Highlighted

1Eric H. Kajioka, MS, MDa, Erick M. Itoman, MDa Pediatric prescription pick-up rates after ED visits The American Journal of Emergency Medicine 2013;19(9):734-740
2Margaret K. Pasquale, PhD; Anthony M. Louder, PhD, Am J Manag Care. 2013;34:86-91
3Roehr, B. Access to healthcare is highest in Massachusetts, lowest in Texas, finds scorecard.BMJ. 2012;344:e2101
4Rosman, Samantha L. MD; Dorfman, David MD et al. Predictors of Prescription Filling After Visits to the Pediatric Emergency Department Nursing. Clinical Medicine. Health Professions.
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