

# EMpulse

JUL-AUG 2010

human trafficking

human

tuberculosis

exploitation

force

perform

servitude

smuggling

HIV

children

coercion

mental health

fraud

peonage

constraints

bondage

alleged

abuse

prostitution

involuntary

awareness

AIDS

victims

women

suffering

slavery

A hand holds a funnel made of a document, pouring coins and bills. The funnel is tilted, and a stream of coins and bills is falling from it. The background is dark, and the coins and bills are illuminated, creating a sense of motion and abundance. The text "Nobody does it better." is overlaid on the image in a large, white, sans-serif font.

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Published by:

**LynDee Press, Inc. dba Fidelity Press**  
649 Triumph Court, Orlando, FL 32805  
Tel: (407) 297-8484  
www.fidelitypress.us

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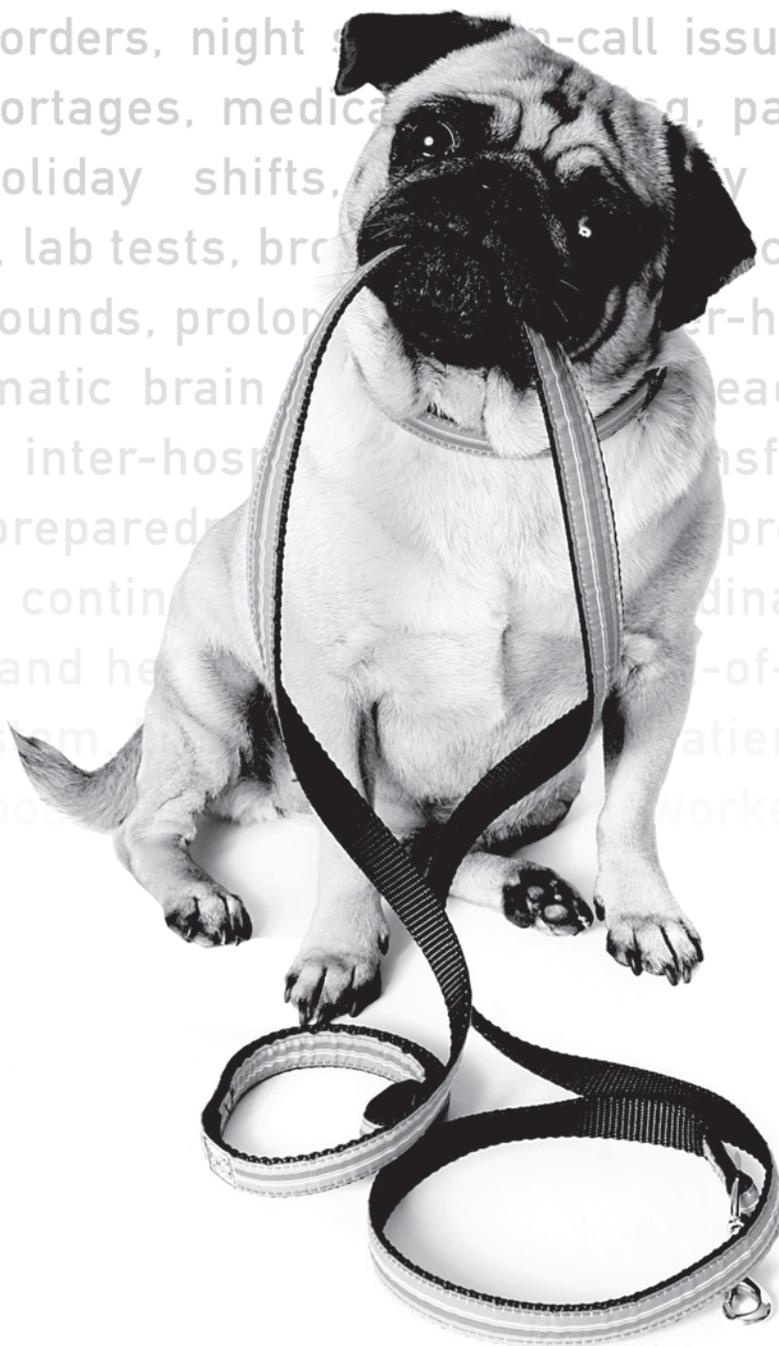
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discharge orders, night shift, on-call issues, overcrowding, staffing shortages, medical equipment, patient admissions orders, holiday shifts, family conflicts, tests, diagnoses, lab tests, bro... accidents, dog bites, gunshot wounds, prolonged... er-hours urgent care, mild traumatic brain... headaches, pediatric sedation, inter-hosp... nsfers, community disaster prepared... approvals, budgetary decisions, contin... dination of multiple providers and he... -of-hospital medical control system... patient transfer forms, tracking bo... workers comp forms



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Mylissa Graber, MD, FACEP  
President

# Thank You for the Opportunity

Thank you for the opportunity to serve you...

Another year has gone by and this is my final message as FCEP President. First and foremost I would like to thank you for the opportunity to serve as your President. We by far have one of the best and most organized state chapters in the nation and our legislative successes as well as our endeavors such as the EMLRC and the *EMpulse* magazine leave us way ahead of the rest. We still have a lot to accomplish to continue to make Florida a great place to practice EM and for patients to get the best emergency care, but we are well on our way.

This year for the first time our sovereign immunity bill was heard in the Senate and passed through a committee. As you may be aware, unlike the ED where things change at a moment's notice, the legislative process can take several years. However, we are one step closer to getting where we should be for the sake of our patients and our own ability to practice appropriately without the fear of liability. I think ultimately we will succeed but we have to be persistent and not let the legislative process get the best of us. If we persist, we will succeed because it is the right thing for our patients and EM.

This year landmark healthcare reform legislation has passed nationally, and although we have yet to feel the effects, we need to continue to watch closely and be proactive in making constructive

changes. Since the new bill will occur over a period of time, there will be opportunity to make changes in areas we think will hurt EM and we may actually find emergency care improve.

The devil is always in the details, but I know our leaders at national ACEP are watching very closely and working very hard to make sure our voices are heard and our practice and patients are protected.

This year we spent a lot of time working on our strategic plan, paving the road for FCEP's future over the next several years. In addition to sovereign immunity, we have testified before the Board of Medicine on several occasions to allow for emergency nurses under our direct supervision to give moderate sedation medications. We are awaiting the results of that endeavor.

We have also participated in amicus briefs and are monitoring several cases which could potentially overturn our caps, but so far the caps have been upheld. We also have spent a lot of time building our legislative alliances and have worked on several campaigns including the governor's race to ensure that we will meet our objectives over the next several years.

The Presidency of FCEP is a continuum and a group effort, we all take our turn leading at the helm, but we work together to take the future of EM to the next level. This year sets next year's agenda which

sets the following year's agenda, and so on.

Remember that we are all in this together. It is important for you all to stay involved, stay engaged and participate in the process by coming to meetings, coming to Tallahassee, getting to know your legislators and donating money so that we can continue to have a seat at the table and make a difference. That's the reality of the political process and we need to be a part of it. If we don't become engaged, somebody else will make decisions about how we practice for us.

Although my year as president is complete, my involvement in FCEP is far from over. This is a family, this is our profession, this is our livelihood, this is our lives and we all need to be a part of FCEP. We must continue speaking up on behalf of ourselves and our patients, so we can make our EDs what they should be, places where patients can feel confident they will receive the best possible care.

We need to make sure that EDs are staffed with well trained physicians who have the knowledge base and the resources to provide excellent emergency care, make the difference between life and death and provide quality of life for so many. It is our life mission; it is why we became EPs. Staying involved can make all the difference.

Thank you again for the opportunity to serve you. See you again soon.



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Leila L. PoSaw, MD, MPH, FACEP  
EMPulse Editor-in-Chief

## Supply + Demand = Chaos

Every issue might be thought of as a supply and demand equation. But it is the demand side which is totally and absolutely about us. Us, you and I: the consumer, the profligate and the miser, the thinker, the activist, the gardener, the queen of the couch. Whoever we are, we control demand.

And yet sometimes we lose sight of this. Bob, the golfer, would rather discuss tee-offs and birdies. Mary-Jane, the epicurean, says that discussions like this make her soufflé go flat. And there are others who would rather not say and for whom politics can ruin their best hair-do.

Unfortunately, for Bob and Mary-Jane, the equation includes them. Unfortunately for us, you and I, our world is full of Bobs and Mary-Janes, who live in the denial that any and all events take place beyond their control and without their complicit involvement.

Consider the British Petroleum oil spill fiasco. Every television channel is on high drama alert. British Petroleum, Transocean and Halliburton point fingers at each other, somebody else to blame. President Obama is looking for divine salvation. Many residents of Louisiana bemoan the loss of their pristine fishing waters and their “way of life.”

Others want to “stop the moratorium” and drill as soon as possible with complete disregard to deep water drilling safety precautions. While energy independence,

clean and renewable fuels are the buzz words of the day, you might have smartly observed that we linger on the supply side. Astonishingly, I have yet to hear individuals or communities come forward with plans on reducing individual demand, usage, and dependence on oil.

The biggest environmental disaster fails to bring forth individual commitment. What’s up people, step forward! If you’re angry about the oil spill, organize a car pool, eat less beef, live closer to work, and ride a bike.

This issue features human trafficking and modern day slavery which are becoming increasingly prevalent in our very own backyards. We, as physicians, are presented with strategies to recognize trafficked patients and to act on their behalf.

If we hunger for more, we could join organizations like the Not For Sale Campaign ([www.notforsalecampaign.org](http://www.notforsalecampaign.org)) which mobilizes smart activists to re-abolish slavery. This, of course, involves us working on the supply side. What then of the demand?

We buy stuff. However, the complexities of the global slave trade and limited insight into product supply chains make it difficult for us to grasp how we are connected to forced and child labor occurring within the global production cycle.

On [www.Free2work.org](http://www.Free2work.org), consumers can

search specific products, learn more about various labor standards and corporate practices, and engage through consumption decisions. Let’s be responsible for what we buy!

The disbelievers amongst us might still not be convinced of the opportunities that exist to make a difference through mitigating demand. I offer two more examples. First, we, you and I, could reduce the demand on healthcare by eliminating the one utterly useless, frivolous test which we might have grown accustomed to ordering.

For example, ordering a CT for every patient with syncope. Taken collectively, a single test per patient over a career can amount to a huge decrease in healthcare dollars spent by you.

Second, we could reduce our demand on petroleum by reducing consumption of petroleum based goods. Almost everything that is extracted, harvested, fabricated, sorted, processed, stored, frozen, labeled, and packaged depends on big oil. But, the idea is to change one small thing in our lives, like plastics. For example, no longer accepting plastic doggie-bags or eating with plastic utensils.

The nay-sayers might still whine “too little, will fail.” However, when big government legislation and too big to fail corporations run amuck then we, you and I, need to take charge.

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Steve Kailes, MD, FACEP  
Committee Chair

# The Gift that Keeps on Giving

The 2010 legislative session is behind us. It is “the gift that keeps on giving” because much of what was considered in 2010 will be back in 2011.

We must be prepared for the many issues which affect our practice and our patients.

I’m an optimist at heart so there are many things I feel good about. First, this year the issue of providing Sovereign Immunity for providers of EMTALA (and Florida Access to Care) moved further along the legislative process.

Most of us would agree that improving the liability climate would be a positive step for medicine and our patients. The possibility for some meaningful tort reform is large, but it won’t occur without an effort.

We will need your support (choose your combination of ideas, time and money) to help us make this a reality.

Second, you’ve heard a good offense can come from a great defense. As we did this year, we know we’ll again be playing defense against the insurance industry as efforts are made to force us into participation agreements with carriers.

This year there was a bill that would have required hospital-based physicians to enter into an agreement with an insurer within 90 days if that insurer contracted with the hospital.

Failure to do so would have resulted in a

termination of your contract with the hospital!

Imagine what little leverage you’ll have when negotiating that participation agreement.

This is part of the scheme to prevent us from billing our insured patients for the balance of our bill if we do not participate with the insurer.

We know that 2011 will bring another effort to ban balance billing and I know we will again need your support.

Third, we know the state must try to tackle Medicaid reform. While ideas like creating a “medical home” sound appealing, they will fail many patients since we don’t have enough providers to care for them.

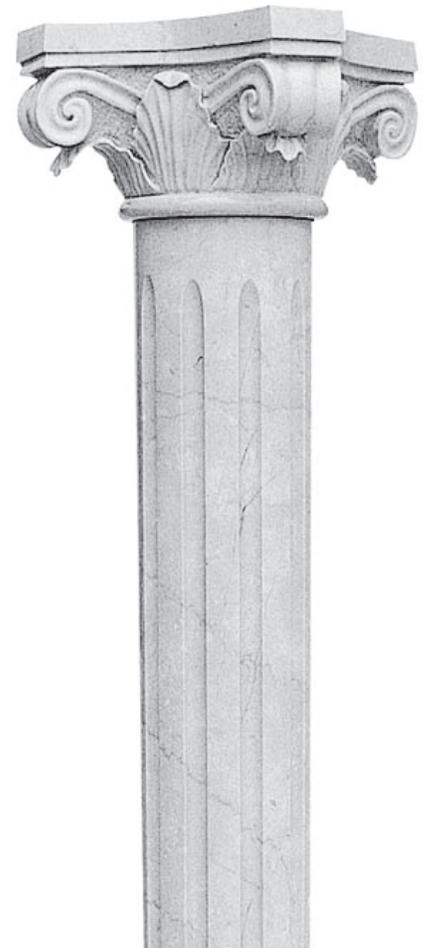
Many want Medicaid to be a completely managed care system. Whatever comes in 2011, we must be in the room and let our voices be heard since we are the safety net for the entire health care system.

Finally, there are numerous other issues to discuss. For example, we know the Department of Health will be reorganized in some way, new rules for EMS will be introduced, and non-physicians will want to expand their scope of practice.

We must be vigilant of issues that affect us indirectly, such as the current proposed Board of Nursing rule preventing most nurses from giving conscious sedation

medications unless they are essentially an CRNA.

What issues do you want us to focus on and how can we better serve emergency medicine and our patients? Let us know, give your support and get involved!



## CODINGtip



## ICD-10 Preparation

We know that ICD-10 will require more specific details for choosing appropriate codes. We are already seeing nonspecific codes denied for medical necessity. We can prepare for ICD-10 and improve our reimbursement now by adding details to our diagnoses. Asthma, hypertension, fracture wrist and abdominal pain may be denied. Acute exacerbation of asthma, elevated hypertension, fracture distal radius and RLQ abdominal pain will be covered as emergent issues.

Lynn Reedy, CPC, CEDC  
*Director of Coding Services*  
*CIPROMS South Medical Billing*

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Ashley Booth Norse, MD, FACEP  
Committee Chair

The 2010 Florida Legislative session has ended. It was the Medical Economics committee's top priority to defeat the "balance billing" legislation and this has been accomplished.

This bill was not so much balance billing legislation as it was legislation that would have mandated "contracting with all groups that are contracted with the hospital within 90 days of your contracted start date or risk termination of your contract".

This legislation will be re-introduced in some form next year so we will continue to monitor this legislation and work for fair reimbursement in any bill that is introduced.

At the last Medical Economics Committee, we looked ahead to issues facing EM. It seems that there are more groups in Florida losing their hospital contracts and hospitals in turn are hiring EPs as hospital employees.

This led to a long discussion about the practice of EM. There have traditionally been three types of physician practices - the independent contract groups, the large mega-groups, and the hospital or state employee model.

As in everything in life, there are positives and negatives to all three of these staffing options, but the reason for the trend toward the employee model remains the big question. Is it due to the push by CMS

and Joint Commission to bundle payments? With the Federal healthcare reform and insurance reforms beginning this year and with decreases in Medicare payments and state Medicaid funding are hospitals trying to save money by employing EPs?

While the reason for the trend is most likely multi-factorial, the bigger concern is what the change means for the future practice environment of EM, EPs, and their patients. Most independent groups practice for some sort of RVU or incentive based reimbursement system.

This keeps practices striving to achieve peak efficiency coupled with excellent patient care. If we move to a system in which a majority of EPs are employed, there are concerns about the new drivers of efficiency and patient care.

If a physician's reimbursement is purely salary based with no incentive for seeing increased numbers of patients, will this lead to higher LWBS and lower satisfaction scores? On the converse, what will the terms of the physician contracts with regards to due process, patient satisfaction, tort and other issues related to the practice environment be?

There have traditionally been areas with large numbers of hospital employed physicians. In some of these areas there has been the emergence of physician unions to protect physicians from unfavor-

able work environments. Some go so far as to impose caps on the numbers of patients each physician can see during a shift.

When these caps are met, another physician is brought in for the remainder of the shift. Others have duty hour limits similar to those that have been imposed by the ACGME on residents' work hours.

We have learned a lot from resident physicians with regards to unionization, patient caps, and duty hours. The question we have to ask ourselves is if this is the direction we are heading and whether this is this what we want for the future of EM.

The answers to some of these questions are not black and white. For full disclosure, I am employed by the University of Florida and not a hospital. I chose this over an independent group because I wanted to work with residents.

We need a lot more information on this topic. The FCEP Board of Directors has appointed a task force to look at these issues. This task force will gather information on the trends and the positives and negatives of different EM practice models in Florida.

I encourage you to get involved if this topic interests you. If you are interested in participating on this task force, please contact the Florida College of Emergency Physicians.

# The Future of EM Practice



Joseph A. Tyndall, MD, MPH, FACEP  
Committee Chair

## Research Activities at the Symposium

*Symposium by the Sea* will host a second annual emergency medicine research poster presentation. This year's poster session will be open to emergency medicine residents, faculty and any practicing physician in the State of Florida.

Research presentations first authored by residents will be judged by an independent emergency medicine faculty member for best overall research poster presentation based upon concept, original hypothesis, study quality and overall impact. In order for a poster to be judged as part of this competition, the individual who appears as the first author of each abstract must be an emergency medicine resident.

In addition, although not mandatory, the

resident should be available to present at the Symposium.

Topics will include the broad range of issues involving emergency medicine practice, education research, innovations in education and clinical as well as basic science research. Original hypothesis driven research, although not a prerequisite for submission, will be favored significantly in the judging. Abstracts presented at prior scientific assemblies (SAEM, ACEP) and other regional meetings will also be eligible for inclusion.

Again this year, accepted abstracts will be highlighted in the *EMpulse* publication after Symposium and posters will be on display in the exhibit hall during the meet-

ing with an opportunity to interact with presenters during the opening reception.

Emergency medicine research is vital to the evolution and progress of our specialty and I am grateful that FCEP and the EMLRC has continued to support physicians in training in allowing them to showcase their academic activity and involving members of the emergency medicine community at large in displaying their scholarly pursuits.

It is my hope that this activity will be well supported by our membership during the conference. For more information, please visit the FCEP web site - [www.fcep.org](http://www.fcep.org).

See you all there.





Paul Mucciolo, MD  
Committee Chair

# Welcome Aboard!

July is upon us! This is an exciting time for the residents who are about to start their careers in the real world. It does not have to be terrifying. Let me share with you a few rules I learned along the way which might be helpful.

*Number one: “You’re about to enter the greatest profession in the world!”*

The hepatologist seated next to me on a flight told me this when he found out that I was going to medical school. Emergency medicine (excuse my bias!) is truly the greatest profession in the world. In which other specialty could we extract a Lite-Brite peg from the ear canal of a three year old, reduce the dislocated shoulder of a surfer who fell off his bicycle riding to the beach, and then intubate a trauma patient with a head injury—all within an hour! Thankfully, that’s not a typical day! However, we EPs face a variety of challenges on a daily basis.

*Number two: “It’s what you learn after you think you know it all that really matters.”*

That was my senior resident’s mantra on my first few nights of call as an intern. No one knows it all, and you’re not expected to. Take the time to learn from other physicians, the nurses, the staff, and patients. There are many solutions to clinical problems, so keep your mind open. In larger EDs with multiple cover-

age, you might have somebody else there to discuss a difficult case. Don’t discount the advice seasoned physicians have to offer. I’ve been in full time ED practice for almost fifteen years and still turn to my colleagues, some of whom have been working for thirty years, for advice.

*Number three: “Don’t stand when you can sit and don’t sit when you can lie down.”*

This is a conservation of energy rule promoted by one of my attendings. A twelve hour shift is a long haul, no matter how fit you think you are. ED shifts do not have to be boxing matches. Save your mental and physical energies. Avoid distractions and eat healthily, trying to save a bit of energy for a walk or jog after work. That period of unwinding can be crucial to enjoying your time off. Give both your body and your mind time to recharge between shifts. There’s nothing wrong with turning off the phone. Your patients are counting on you to be well rested and focused.

*Number four: “Focus on the history and physical.”*

This was pounded into me in medical school, and it still holds true. That little tidbit of history may be pivotal in making a correct diagnosis. Listen, be patient, and give patients and family members the time they’re due when they remember some-

thing they think might be important. It often is! Sometimes the “Oh, by the way, Doc...” can turn out to be something life threatening.

Ultrasound, CT, MRI and lab tests are not beneficial unless used judiciously. If you can’t figure out what’s wrong, go back and ask more questions. Re-examine the patient. Take a few minutes and ask yourself if you’re going down the right path.

*Number five: “Family first.”*

Take time to enjoy the things for which you’re working— family, friends and hobbies. Don’t veer off the path of enjoyment to become a workaholic. Today’s economic times are tough, but don’t make matters worse for yourself by immediately buying a large home, expensive car and boat. Take the time to enjoy having dinner with friends or taking in a movie.

It’s hard to relax with large debts constantly hanging over you. It is easier to start out with a relatively light schedule and advance when you’ve had an opportunity to settle in to your practice. Enthusiasm can lead to fatigue if not directed appropriately.

I wish all of those graduating from their residency programs the best in your careers as emergency physicians—welcome aboard!



Michael Lozano, MD, FACEP  
Committee Chair

## The State of Florida EMS

*Part 3 of a Series*

The 2010-2012 Strategic Plan for the Florida EMS Advisory Council (EMSAC) goes into effect next month. In this series of articles we have been reviewing the plan which covers the breadth of EMS activities in the state. In the last installment, we covered the first three of the ten plan goals.

The first goal covered professional development activities for the EMSAC. The second goal addressed data collection, public outreach, and accessibility to EMS incident-level data.

One of the measures of success for this goal is an increase in the number of agencies participating in the EMSTARS program, while another measure is linkage of the EMSTARS dataset with that of the Agency for Healthcare Administration (ACHA).

Linking these two databases would provide valuable outcomes information that hitherto has been impossible to obtain outside a formal research project. The third goal deals with injury prevention, ED overcrowding, and public education about EMS system utilization – especially for non-urgent conditions.

### Goal 4

This goal seeks to improve work-force education, performance, and satisfaction. Objective 4.1 seeks a legislative remedy for required biannual HIV CME by removing reference to f.s. 401 from f.s.

381.0034(1). Since 1991, EMTs and medics have had to take a four hour course on HIV every two years when they renewed their certificate. These required CMEs do not change much between license renewals.

Whereas physician CME requirements for HIV/AIDS have evolved, those for EMTs and paramedics have been frozen in time. The EMSAC seeks to have this requirement apply to initial certification only, and also seeks expansion of the scope of education to general instruction in infectious disease and blood borne pathogens. A bill to achieve this died in committee this past session.

Another area of training and education is that of emergency medical dispatch (EMD). In 2008, a voluntary certification program for 911 emergency dispatchers was initiated. Prior to this, dispatchers did not need to meet any minimum training standards.

After several high profile incidents of alleged negligence hit the press, the Legislature created f.s. 401.465 911 which required the DOH to establish educational and training criteria for initial certification and renewal for EMD. Since February 2009, 1034 dispatchers have been certified by the DOH. SB-742/HB-355 was passed by both houses and was sent to the Governor for signature.

This act entitled “Public Safety Telecommunicators/E911” redefines the

term emergency dispatcher to public safety telecommunicator, makes certification mandatory, sets standards for certification and renewal, sets fees, and allows for a grandfather clause.

All of these actions have reinforced and strengthened emergency medical dispatch as a vital link in our statewide EMS system.

The Florida Fire Chiefs’ EMS Section is the lead agency tasked with objective 4.3. They are tasked with determining the baseline level of overall satisfaction and the turnover rate for EMTs and paramedics.

It is well known that the supply of EMTs and paramedics is not aligned with the population distribution of the state. There is a relative oversupply in the urban and southern counties, and a relative shortage in the areas north of I-4, extending into the panhandle. Limited studies have indicated that job satisfaction is low in certain groups of EMS workers.

This objective seeks to identify and resolve potential areas of statewide EMT/paramedic dissatisfaction. The primary tools they will use are surveys associated with biannual certificate renewals.

Objectives 4.4 and 4.5 address two hot button issues. These are requirements for training center certification through the Committee on Accreditation of Educa-

tional Programs for the EMS Professions (CoAEMSP), and adoption of the EMS Education Agenda for the Future. In the next issue, we will review the current state of EMS education in Florida, and explore how training center accreditation and the Agenda will impact this.

We will also finish up our review of Goal four, and continue our review of the

EMSAC Strategic Plan.

<sup>1</sup> Margolis, G. , Levine, R. Wijetunge, G. "The Change in Full-Time EMS Provider Career Satisfaction in their First Three Years of Employment" Paper presented at the annual meeting of the National Association of EMS Physicians, Registry Resort, Naples, FL. 2009-05-25 from <http://www.allacademic.com/meta/p5585>

8\_index.html

<sup>2</sup> Brown WE Jr, "Compensation, benefits, and satisfaction: the Longitudinal Emergency Medical Technician Demographic Study (LEADS) Project" *Prehosp Emerg Care* - 01-JUL-2003; 7(3): 357-62

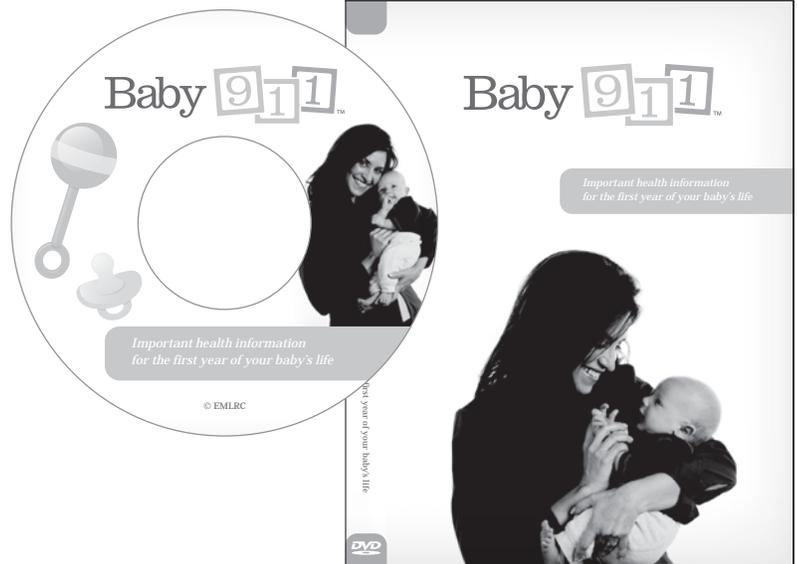
<sup>3</sup> <http://www.nhtsa.gov/people/injury/ems/EdAgenda/final/index.html>

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## Sex Slaves will not be Forsaken!

Deborah Mulligan, MD, FAAP, FACEP  
Director, Institute for Child Health Policy  
Nova Southeastern University

The young woman selling her body at the street corner could be your daughter, your sister, or your wife. Yet by and large, society chooses to ignore her pain, her imprisonment, and her cries for help. She is part of an estimated 14,500 to 17,500 women and children who are brought into the United States each year by human traffickers and forced into prostitution

If this trend seems alarming to you, it's just the tip of the iceberg. Human trafficking, which has been around for centuries, rakes in billions of dollars for criminal enterprises each year. The victims, some as young as 12, are kidnapped, beaten, raped, and forced to have sex with up to dozens of men each day. Their pimps brainwash them into emotional dependence. Pimps then teach their sex slaves to mistrust police, making escape from this vicious cycle extremely difficult.

Here are some cold hard facts. In the US, children comprise 50% of the human trafficking trade. Trafficking humans, a \$10-billion dollar industry, is now the third most profitable criminal activity behind drug and arms sales. The majority of human trafficking victims who enter the U.S. originate from Asia, Latin America, and Europe. Florida, California, New York, and Texas are the top four destination states for human trafficking.

Around the globe, it is estimated that human trafficking enslaves 27 million people, of which half are children and 80% are female. Victims will seek medi-

cal care at health care facilities with evidence of trauma, sexual exploitation and/or sexually transmitted diseases (STD). Thus, medical providers are the frontline of defense for victims.

Victims often come with their traffickers and receive medical attention but not the further help they need. Healthcare providers often miss the signs of human trafficking, mistake the signs for intimate partner violence, and are rarely aware of how to help. Instead victims are sent back "home" with their traffickers.

It's time for society to prioritize this crime and invest resources to reverse the trend. Resources must be spent on law enforcement and social services to help victims break the violence and regain their lives. Recognizing the seriousness of this problem, President Barack Obama declared January as National Slavery and Human Trafficking Month.

Nova Southeastern University followed President Obama's lead by holding an interdisciplinary CE conference on May 6th to address human trafficking. The conference brought together FBI agents, White House officials, State Department officials, National Geographic, the Not For Sale Campaign founder and healthcare providers to collaboratively seek solutions to fight the scourge of human trafficking.

Dubbed the International Child Health Forum, the conference was broadcast live

worldwide to academics, authorities and organizations dedicated to stopping sex traders.

The 2010 International Child Health Forum on Human Trafficking offered an interdisciplinary CE program for health professionals, educators and law enforcement that stressed the critical role they can play first in identifying the signs of trafficking in their practice, and then how to respond effectively and assist the victims to find help needed to free them from their at-risk environment.

To that end, the Institute for Child Health Policy at NSU and the Not For Sale Campaign in California will engage in ongoing collaboration through on-line curriculum development with law enforcement, governmental representatives at a local, state and national level, and community-based agencies that support freed victims.

These helpless victims need to know they are not forsaken. With your help, this situation can change and it must. Armed with the knowledge of how victims present and the proper treatment available for them, providers can save lives. [www.nova.edu/ichf](http://www.nova.edu/ichf)

*A member of FCEP and ACEP PEM Section, Dr Mulligan is a pediatric emergency medicine physician and the director of Nova Southeastern University's Institute for Child Health Policy.*



Robin Thompson, JD, MA  
Senior Program Manager  
Florida State University Center for the Advancement of Human Rights

## Human Trafficking and What You Should Know

*As I learned more about trafficking, I realized in retrospect, I saw folks who were trafficked (in my practice) and I didn't know to identify them as such. I saw situations with "mail order brides" and their husbands or overbearing employers that refused to leave the exam room, answering questions for the patients. When I learned more about trafficking, it seemed clear that this is another source of adverse lifetime experiences that we (physicians) have an obligation to help in the same way we help child abuse and domestic violence victims. (David McCollum, MD, Chair of the American Medical Association's National Advisory Council on Violence and Abuse.)*

Physicians, as well as all others in the health care profession, are vital links to helping victims of human trafficking. Understanding human trafficking and being able to assess your patients to see if they are current or past survivors of human trafficking will result in your delivering better care to that patient. Further, your ability to link patients to services that can help them to obtain benefits and other forms of relief to which they are entitled will further help them to heal.

Florida is often called third in the nation when it comes to human trafficking. Our state has many advantages that traffickers find appealing: very porous borders and many international airports, high demand for low-skilled and low-paying labor, a strong global and international flavor, a

vast service economy, an extremely transient population, a rampant sex industry, huge agricultural sector and limited enforcement resources. Clearly, this makes it very likely that you and those with whom you work will encounter human trafficking.

It is important to realize that almost anyone can be a victim of human trafficking. Traffickers prey on the very young and the elderly. They target people who are illiterate as well as the educated – such as one case involving nurses from the Philippines. Both U.S. and non-U.S. citizens are victims of trafficking with juvenile runaway girls being one of the largest groups of trafficked U.S. citizens. The key common feature of these victims is vulnerability and, for most, the desire of these victims to find a better life and to escape dire economic conditions.

Traffickers include males and females, organized criminal syndicates, "mom and pop" businesses, labor contractors, international business people, pimps and even diplomats. Many so-called legitimate businesses can be fronts for human trafficking. Victims have been forced to work in jobs ranging from agriculture and construction to the sex industry, to nursing homes, bars, restaurants and hotel house-keeping. Any place where one can find low-wage, low-skilled or unregulated labor, one is likely to find human trafficking.

Why are physicians, particularly those in

the ED important to assisting survivors of trafficking? There are many reasons: first and foremost is that you will see these victims. Traffickers themselves will sometimes take their victims for medical examination and assistance. In addition, trafficked persons will, upon escape, often seek medical advice in the U.S. for the first time in their lives. Good Samaritans might see a trafficked person who has a medical condition and take them to the doctor – very likely finding the emergency room the first place that they go to for help.

Victims of trafficking often have a host of physical and mental health care needs. Like refugees or victims of torture, health indicators for victims of trafficking include: sexually transmitted diseases, pelvic pain, rectal trauma and urinary difficulties, pregnancy/infertility, infections or mutilations caused by "doctors," chronic back, hearing, cardiovascular or respiratory problems, eye problems, malnourishment and serious dental problems (especially children), infectious diseases like tuberculosis as well as a wide range of mental illnesses such as depression and PTSD.

If you can envision the abusive working conditions into which trafficked persons are forced, whether in sweatshops, fields, restaurants, construction sites, behind closed doors in private homes, or in the sex industry you can then imagine the harm that comes to them. Such harm is inevitable as abusive employers/

traffickers force them into service in mostly unregulated labor situations.

Traffickers control their victims through a variety of brutal means. These tactics can include beatings, burnings, rapes, starvation, isolation, psychological abuses, threats of deportation, threats against the victim's family members in the home country, forced drug/alcohol dependency, withholding of documents and debt bondage. All of these will have immediate and lasting effects on the trafficked person. Moreover, these tactics can be very effective at controlling the victims and convincing them not to leave, call the police or seek any outside help whatsoever, even from the physician who is treating them.

It also is important to understand that these are health concerns are rarely resolved within weeks or even months of a person becoming free from a trafficking situation. Survivors report lifetime effects – from physical conditions like sterility to recurrent nightmares and other mental health issues.

## Identifying a Trafficked Person

In human trafficking cases, screening for human trafficking is very important. Physicians differ as to whether there should be universal screening or if screening should take place only when human trafficking is suspected. However, more and more report that some kind of universal screening question regarding working condition should be asked of all patients. Here are some sample questions:

- Will you describe your job and the place where you work?
- What type of work do you do?
- Are you being paid a fair wage?
- Can you leave your job if you want to?
- Can you come and go as you please?
- Have you or your family been threatened?
- What are your working and living conditions like?
- Where do you sleep and eat?
- Do you have to ask permission to eat/sleep/go to the bathroom?
- Are there locks on your doors/windows

so you cannot get out?

- Has your identification or documentation been taken from you?

You might deduce that the person is trafficked because you observe that he or she is being controlled, cannot move or leave job, has bruises or other signs of battering, is fearful or depressed, does not speak English, has recently been brought to this country and lacks passport, immigration or identification documentation.

In all cases where the patient does not speak and understand English well, it is important that you have access to a medical interpreter and never use family members or others to interpret for the victim. This was illustrated the case of a formerly trafficked woman who was interviewed by the Florida State University Center for the Advancement of Human Rights in 2003. The purpose of these interviews was to find out where there might have been an opportunity for victims to get help to and to escape from their traffickers. In one case, a survivor explained how the clinic staff called on the victim's trafficker to interpret for her (no one on staff understood Spanish). This made it dangerous and impossible for the victim to ever ask for help or explain her situation.

## Reporting Requirements

Florida does not have a law mandating that health care professionals report "human trafficking" to law enforcement. Specifically, Chapter 790.24, Florida Statutes, requires that a physician who is "knowingly treating any person suffering from a gunshot wound or life-threatening injury indicating an act of violence, or receiving a request for such treatment, shall report the same immediately to the sheriff's department of the county in which said treatment is administered or request therefore received." This means that health care providers must report these injuries regardless of the individual's status as a victim of a particular crime. This also is true for victims of domestic violence where Florida law also does not mandate reporting of domestic violence, unless there is an instance of a "gunshot wound or life-threatening

injury." A physician who knowingly treats such a wound or injury is obligated to report this fact to the sheriff's department in the locale where the treatment is given.

These reporting obligations are different from, and in addition to, those regarding reports to the Florida Abuse Hotline when there are identified or suspected injuries to a child, elder or vulnerable person. Chapter 415, Florida Statutes, states that any physician "who knows or has reasonable cause to suspect" that a child or elderly person (over age 60) is abused must report this fact to the Department of Children and Families. (The number for reporting is 800-96-ABUSE.) This is an anonymous report except the reporter's name is given to DCF investigators who followup on the report. Remember that many victims of human trafficking are minors, elders and vulnerable persons. Traffickers specifically target and prey on these most vulnerable people. Therefore, if a physician suspects that anyone who falls in these categories and is under his/her care is being trafficked, he/she must call that abuse into the Hotline.

## Being Informed and Building Trust

Establishing trust with someone who might be trafficked is a critical first step. In order to build this trust, the physician and staff must be informed about human trafficking, including knowing that victims of trafficking in the U.S. are eligible to receive a range of social service benefits and immigration relief. These benefits and relief come through different application processes that anti-human trafficking agencies of government and non-profit groups can help that person to receive. Therefore, knowing that these benefits exist and that there are organizations that can help will assist your patient enormously. These benefits include food, health care, cash assistance, transportation, housing, job training and English classes. Immigration relief can include receiving a four-year T Visa, which allows a formerly trafficked person to live and work in the U.S. and then apply for permanent status. This T Visa can also allow a trafficked person to bring certain relatives to the U.S. This is

an excellent aspect of the law as many traffickers threaten to harm family members in the victims' home countries.

As a health care provider, you are not expected to counsel and assist a patient with these benefits. However, you are an important link to these services and informing a patient of community services can be integral to building trust with that person. For instance, if a trafficked person knows that there might be help available, they may be more willing to disclose information to you that will help you to better treat them as well as provide safety to them.

One of the best ways to work with many survivors of human trafficking as well as domestic violence is to express support and empathy. Some suggestions include saying:

- “I believe you.”
- “You do not deserve to be abused and treated this way.”
- “Abuse is common – you are not alone”
- “There is help available – my staff and I can help you.”

Here are other messages that the U.S. Department of Health and Human Services offers that could help you build this trust. (This is neither a universal list of ways to build trust nor a list whose items will always apply.)

These messages include:

- We are here to help you.
- One of our top priorities is your safety.
- Under the federal laws, you may be able to apply for special visas or could receive other forms of immigration relief.
- We will give you the medical care that you need.
- We can help find you a safe place to stay.
- You have a right to live without being abused.
- You can trust us.
- You have rights.
- You may be entitled to assistance.
- We can help you get assistance.

- If you are a victim of trafficking, you can receive help to rebuild your life safely in this country.

Human trafficking is a horrific phenomenon that is as hidden as it is prevalent in today's world and in our communities. It is important that we all become informed about human trafficking and the help that is available.

## Resources

In recognition of this key role that physicians play in identifying and assisting victims of trafficking, the Florida Medical Association recently issued a new on line curriculum on domestic violence with a special focus on human trafficking.

In that publication, physicians will be able to build their understanding about domestic violence, fulfill their continuing Medical Education requirements, and become informed about human trafficking and the impact of this crime on their patients.

There is a variety of resources available in the area of human trafficking.

In Florida, they include:

- Florida's Statewide Task Force on Human Trafficking  
<http://www.dcf.state.fl.us/initiatives/HumanTrafficking/>
- The Center for the Advancement of Human Rights (CAHR), Florida State University 850-644-4550;  
[www.cahr.fsu.edu](http://www.cahr.fsu.edu)
- Florida Freedom Partnership, 866-443-0106
- Florida Immigrant Advocacy Center, (FIAC) Lucha Project – 305-573-1106
- Florida Department of Children and Families, Office of Refugee Services, 850-488-3791

Nationally, you can contact:

- National Human Trafficking Resource Center at 1.888.3737.888.
- Department of Justice Trafficking in Persons and Worker Exploitation Task Force Complaint Line 1-888-428-7581 (voice and TTY).

There are also other resources that can assist health care providers:

- Florida Medical Association. Domestic Violence in Florida, Special Focus on Human Trafficking (2009)  
<http://www.fmaonline.org/uploaded/Files/CME/files/domviolence.pdf>
- Family Violence Prevention Fund. Turning Pain into Power: Trafficking Survivors' Perspectives on Early Intervention Strategies (2005)  
[www.endabuse.org](http://www.endabuse.org)
- Rescue and Restore Campaign Tool Kit for Health Care Providers  
[http://www.acf.hhs.gov/trafficking/campaign\\_kits/tool\\_kit\\_health/overview.html](http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/overview.html) (this includes a screening tool).

\* \* \* \* \*

<sup>1</sup> (March 2005) Family Violence Prevention Fund. (2005) Turning Pain into Power: Trafficking Survivors' Perspectives on Early Intervention Strategies. Family Violence Prevention Fund. San Francisco, CA. Found at [www.endabuse.org](http://www.endabuse.org).

<sup>2</sup> [http://www.acf.hhs.gov/trafficking/campaign\\_kits/index.html](http://www.acf.hhs.gov/trafficking/campaign_kits/index.html)

<sup>3</sup> U.S. Department of Health and Human Services. Health Care Provider Assessment Card, [http://www.acf.hhs.gov/trafficking/campaign\\_kits/tool\\_kit\\_health/health\\_assessmentF.pdf](http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/health_assessmentF.pdf)

<sup>4</sup> The Mindset of a Human Trafficking Victim, [http://www.acf.hhs.gov/trafficking/campaign\\_kits/tool\\_kit\\_health/identify\\_victims.html](http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/identify_victims.html)

<sup>5</sup> [http://www.cahr.fsu.edu/sub\\_category/thereport.pdf](http://www.cahr.fsu.edu/sub_category/thereport.pdf)

<sup>6</sup> For a very complete review of benefits and the laws regarding human trafficking see <http://www.dcf.state.fl.us/initiatives/HumanTrafficking/docs/LegalBestPracticesOct2009.pdf>

<sup>7</sup> [http://www.acf.hhs.gov/trafficking/campaign\\_kits/tool\\_kit\\_health/comm\\_victims.html](http://www.acf.hhs.gov/trafficking/campaign_kits/tool_kit_health/comm_victims.html)

<sup>8</sup> See [http://www.fmaonline.org/Layout\\_1Column.aspx?pageid=2722](http://www.fmaonline.org/Layout_1Column.aspx?pageid=2722) for the curriculum entitled: Domestic Violence CME with a Special Focus on Human Trafficking.

<sup>9</sup> This 24 hour a day, seven day a week hotline can help you determine if you have encountered victims of human trafficking, identify local resources and social service organizations. For more information on human trafficking visit [www.acf.hhs.gov/trafficking](http://www.acf.hhs.gov/trafficking).



Adriane P. Reese  
President Broward Human Trafficking Coalition

## Who is in Your Waiting Room?

Every day, you the physician have the unique opportunity to heal and change lives forever.

The faces of the trafficked are of every nationality and gender, and include women, children, men, and boys.

They share a common bond, in that they are trapped through force, fraud, or coercion to engage in activities that range from back-breaking forced labour to acts of prostitution.

In 2009, a study conducted by Shared Hope International, found that Broward and Miami-Dade counties had a “high number of domestic minor sex trafficking victims, many of which do not have access to appropriate treatment and care.

Nonetheless, the dedication of many organizations working together to fight trafficking in their communities demonstrates the potential to eradicate the exploitation of South Florida’s children.” (Domestic Minor Sex Trafficking Broward and Miami-Dade Report, June 2009)

More recently, the arrest and indictment of a Boca couple led to fifty lives being changed forever. The Sun Sentinel Headlines read, “Boca Raton business owners accused of running human trafficking ring- Sophia Manuel, 41, and Alfonso Baldonado Jr., 46, indicted by federal grand jury.” (Sun Sentinel, Burdi, Jerome and Peantes, Erika, April 29, 2010)

In Broward County, the Broward Human Trafficking Coalition (BHTC) is committed to ending this form of modern day slavery by raising awareness: in our communities people are being bought, sold, beaten, raped, starved, exploited by greed, and forced to suffer and endure hardships that we cannot fathom.

The Coalition has held information sessions to create awareness and change outcomes. It has also adopted and disseminated materials from the Federal Government Department of Health and Human Services, Administration for Children and Families, Rescue and Restore Program.

This material is aimed at three specific professional groups: law enforcement, social services, and medical professionals.

The following is an excerpt for medical professionals:

“Common Health Issues Seen In Victims of Human Trafficking: Trafficking victims may suffer from an array of physical and psychological health issues stemming from inhumane living conditions, poor sanitation, inadequate nutrition, poor personal hygiene, brutal physical and emotional attacks at the hands of their traffickers, dangerous workplace conditions, occupational hazards and general lack of quality health care.

Preventive health care is virtually non-existent for these individuals. Health issues are typically not treated in their

early stages, but tend to fester until they become critical, even life-endangering situations.

In many cases, health care is administered at least initially by an unqualified individual hired by the trafficker with little if any regard for the well-being of their “patients” – and even less regard for disease, infection or contamination control.

Health issues seen in trafficking victims include the following:

- Sexually transmitted diseases, HIV/AIDS, pelvic pain, rectal trauma and urinary difficulties from working in the sex industry.
- Pregnancy, resulting from rape or prostitution.
- Infertility from chronic untreated sexually transmitted infections or botched or unsafe abortions.
- Infections or mutilations caused by unsanitary and dangerous medical procedures performed by the trafficker’s so-called “doctor.”
- Chronic back, hearing, cardiovascular or respiratory problems from endless days toiling in dangerous agriculture, sweatshop or construction conditions.
- Weak eyes and other eye problems from working in dimly lit sweatshops.

- Malnourishment and serious dental problems. These are especially acute with child trafficking victims who often suffer from retarded growth and poorly formed or rotted teeth.
- Infectious diseases like tuberculosis.
- Undetected or untreated diseases, such as diabetes or cancer.
- Bruises, scars and other signs of physical abuse and torture. Sex-industry victims are often beaten in areas that

humiliation, shock, denial or disbelief.

- Cultural shock from finding themselves in a strange country.

New organizations solely dedicated to medical professionals such as Doctors At War are developing all over the country. Doctors At War was founded by Dr. Bercu, a Tennessee resident, whose medical specialty is emergency medicine.

He became involved in early 2006 hoping to make a difference in the lives of Human

trafficking victims. The vision that he shares of the organization that he founded is simple.

In summary, the conclusion provided by Drs. Barrow and Finger says it best: "healthcare professionals have a responsibility to be educated about the ever-growing phenomenon of human trafficking for two reasons.

First, they are among the few in a unique position to see these victims while they are still in captivity and thus have a chance to free them.

Second, as a result of their horrific ordeal, these victims suffer from many unique health consequences that require accurate diagnosis and treatment from properly trained professionals.

Only then can they begin to rebuild the parts of their lives that have been so brutally taken from them." (Southern Medical Journal: May 2008 - Volume 101 - Issue 5 - pp 521-524, Human Trafficking and the Healthcare Professional, Barrows, Jeffrey DO, MA (Bioethics); Finger, Reginald MD, MPH)

Please join us in the fight, by looking beneath the surface of those patients that you see each and every day. You may also help by requesting the BHTC Speakers Bureau to present at an upcoming Grand Rounds or CME function.

We also invite participation at our Coalition meetings. Visit [www.bhtc.us](http://www.bhtc.us) for a calendar of events. We will gladly reach out to hospitals, clinics, practices, nursing associations, and other groups to provide awareness sessions.

If your patient is a victim of human trafficking, call the National Human Trafficking Resource Center at 1.888.3737.888. This hotline will help identify local resources to coordinate protection and social services.

For more information on human trafficking visit: [www.acf.hhs.gov/trafficking](http://www.acf.hhs.gov/trafficking).



won't damage their outward appearance, like their lower back.

- Substance abuse problems or addictions either from being coerced into drug use by their traffickers or by turning to substance abuse to help cope with or mentally escape their desperate situations.
- Psychological trauma from daily mental abuse and torture, including depression, stress-related disorders, disorientation, confusion, phobias and panic attacks.
- Feelings of helplessness, shame,

He hopes to educate more physicians to recognize trafficking victims, develop a global database of shelters and medical mission trips abroad, as well as be a clearinghouse to connect specialists "such as plastic surgeons and infectious disease doctors with patients that cannot otherwise get medical care, develop medical school chapters to pass on this mantle to the next generation, and in general develop an 'army' of doctors who will use their talents and resources to truly make a



Katariina Rosenblatt Juliao, LL.M.  
Chair, Faith Based Initiative  
Broward Human Trafficking Coalition

## In our Sunny Florida Backyards

It seems that human trafficking would be safe if it were just in movies like *Taken* and not here into our own neighborhoods. Unfortunately, like most things, real life is much different. Children are being bought and sold here in Florida in our own backyards.

Some are local girls, who have been enticed by a “boyfriend” or “father” figure. They are so desperate to be loved that they miss the cues in the grooming process. The cues are similar to that of abusive relationships where there is intense affection at first only to be followed with required compliance to any form of maltreatment, abuse and even the sale of their bodies for drugs. Some of this vulnerable population come from abusive homes, are runaways, or are in foster care.

They may leave a bad situation only to find themselves in a more precarious predicament. American children, Florida’s children are being bought and sold at alarming regularity. This is the white American slave trade!

The average age for a child to be brought into prostitution is 12-14. When I was a child growing up here in South Florida, someone tried to purchase and someone tried to sell me for sex; I was only 13. Neither of them owned me nor had the right to try and take me away from my mom.

They groomed me and then produced a buyer who posed as a father figure.

Thankfully, circumstances prevented the sale from going through, though they drugged me and left me for dead. Other girls may not be so fortunate.

This is how the cycle begins. The life of prostitution and trafficking is under the control of a trafficker who wants to sell bodies and innocence to the next available buyer. When the victims are sick or old and are no longer useful, they are discarded.

Today, in the world there are 27 million people in slavery with no way out. Of these, 80% are women and children. We need help from the community to get these people out.

One hope is the Florida Safe Harbor Act which is up for consideration in the House. This will help identify victims and provide resources for them once they are rescued.

Ending the demand side is also crucial for this atrocity to end. One organization making an impact is Shared Hope ([www.sharedhope.org](http://www.sharedhope.org)) which goes out to truck stops in South Florida and interacts with truckers.

They equip them with the national human trafficking hotline phone number so that they will know what to do if they come across anything suspicious.

Trafficking also takes the form of labor, where people are enticed to come over to

America to work and obtain employment. They leave their financially desperate situation only to find themselves yet again in another desperate and unfortunate condition.

Recently, in Boca Raton several Filipinos were rescued from modern day slavery. They had been promised work as servers in several Boca Raton country clubs and hotels.

However, they were forced to live without adequate food and water and work without compensation. Their papers and documents were kept from them. They were rescued by a tip from the community. (Burdi and Pesantes, Sun Sentinel, April 29, 2010).

<http://www.sun-sentinel.com/news/palm-beach/boca-raton/fl-indictment-boca-human-trafficking--20100428,0,1712648.story>

Human trafficking takes place not only in far off countries, but here in our own backyards. Call in tips to the national human trafficking tip line (1-877-3737-888) or local law enforcement (911).

The mission of the Broward Human Trafficking Coalition is to raise awareness. The Coalition serves as an information, education, and networking resource for organizations as well as the community. [www.bhtc.us](http://www.bhtc.us)

## BRIEFLY



### **WELCOME** to the Florida College of Emergency Physicians

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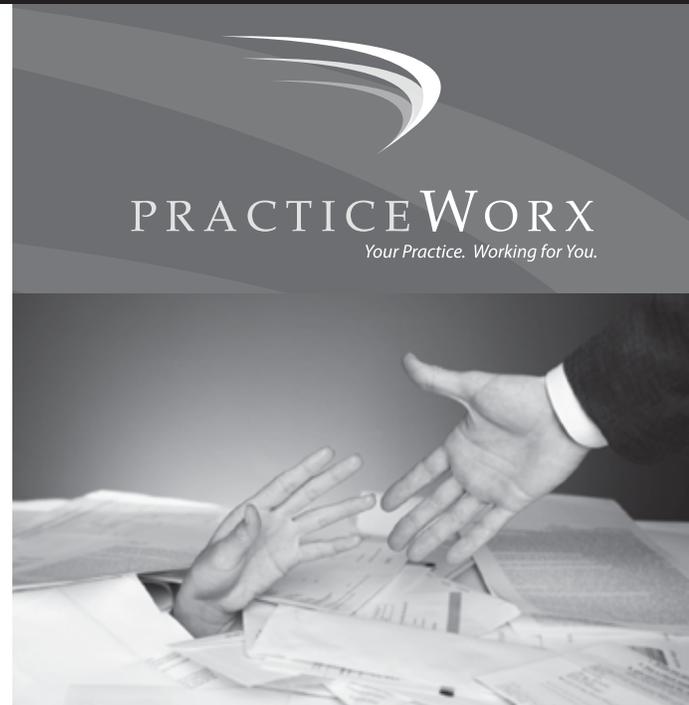
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# A 32 Year Old Woman with Typical Chest Pain

Kissinger P. Goldman DO, MBA  
Andrea Apple, DO  
David Bohorquez, DO

## INTRODUCTION

A 32 year old female presented to the ED with chest pain. The pain was intermittent, mid-sternal, and had been occurring intermittently for approximately 7 hours. The chest pain worsened with exertion and was relieved with rest. She described the pain as “severe pressure.” At the time of presentation, the pain had become constant and was associated with diaphoresis, dizziness, and dyspnea.

She admitted to being anxious, but denied having any other significant medical history including cardiac disease, and denied having similar episodes of chest pain in the past. Both her parents had hypertension, but there was no history of early onset cardiac disease or sudden cardiac death. The patient denied smoking, alcohol use, or illicit drug use. She worked as a lawyer. She was not currently on any home medications.

Physical exam yielded stable vital signs: temperature 98.6 degrees, pulse rate 82, respiration rate 18, blood pressure 131/82, and pulse oxygen 100% on room air. Her height was 5’4” and weight was 143 pounds.

Physical exam was unremarkable. Specifically, cardiovascular exam yielded regular rate and rhythm with no gallops, rubs or murmurs and peripheral pulses were intact. No carotid bruits

were noted. Lungs were clear to auscultation bilaterally and there was no chest wall tenderness. No pulsatile masses were noted in the abdomen.

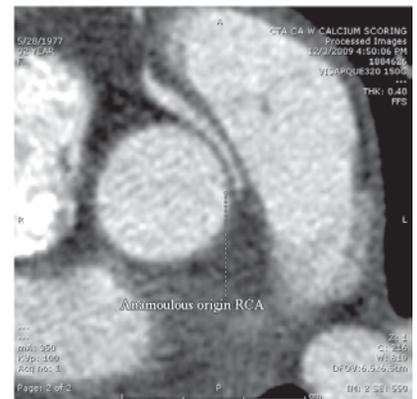
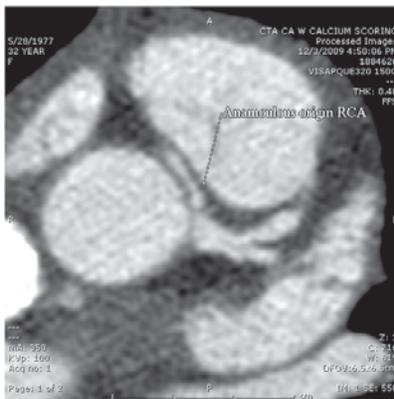
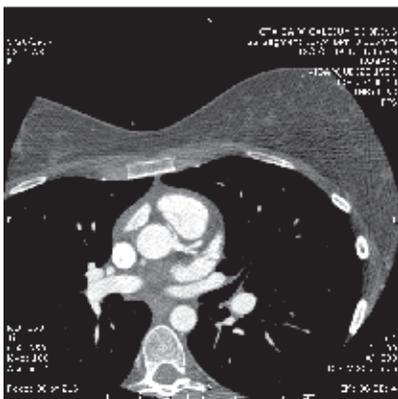
CBC and CMP were within normal limits. Urine drug screen was negative. The first set of cardiac enzymes was negative. The cholesterol panel was normal. EKG showed NSR, normal axis, with no ST elevation or depression or T wave changes. CXR showed clear lungs with no acute findings.

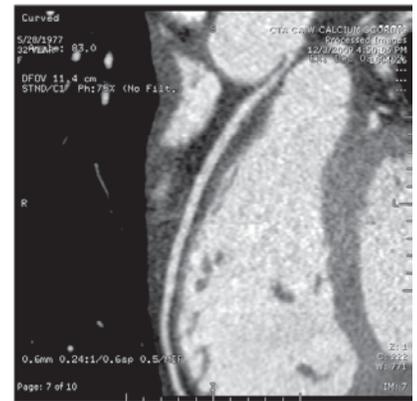
CTA with calcium score was ordered. This study found an anomalous origin of the right coronary artery arising from the left coronary sinus. The RCA traveled between the right ventricular outflow tract and the ascending aorta. In addition, the proximal RCA had 60-70% stenosis. The calcium score was 0.

The patient was consequently admitted with a cardiology consult. An additional two sets of cardiac enzymes were negative. Per cardiology, there was no evidence of cardiac ischemia. The patient’s chest pain completely resolved and vital signs remained stable. She was discharged the next day with instructions for close follow up.

## DISCUSSION

Coronary artery abnormalities are rare, occurring in less than 1%





of the population in the United States.<sup>1</sup> Anomalous origin of the coronary arteries is a significant problem in that 30% of these patients experience myocardial infarctions, both fatal and nonfatal, and sudden cardiac death.<sup>2</sup>

Further, anomalous coronary artery origins in regards to the sinus of Valsalva are a major cause of sudden cardiac death for athletes, second only to congenital cardiomyopathy.<sup>3</sup>

Some researchers suggest that in young athletes presenting with a history of syncope or chest pain with exercise, it is important to consider anomalies of the coronary arteries.<sup>4</sup>

Sudden cardiac death secondary to coronary artery anomaly, however, is rare after 35 years of age.<sup>3</sup>

Normal coronary artery anatomy includes the location of the right and left coronary arteries' ostia in the right and left sinus of Valsalva, respectively. Anomalous origin of the right coronary artery (RCA) specifically is known to cause myocardial ischemia and sudden cardiac death.<sup>5</sup>

The incidence of an anomalous right coronary artery is 0.26%.<sup>6</sup> The right coronary artery originating from the left coronary sinus of Valsalva (ARCAOLS), which accounts for the majority of RCA anomalies<sup>6</sup>, has an incidence range of 0.03-0.71%.<sup>7</sup>

Of the three main subtypes of ARCAOLS-retroaortic, interarterial, and anterior to the pulmonary trunk<sup>8</sup> - the most common is interarterial, i.e., the path between the aortic root and the pulmonary trunk.

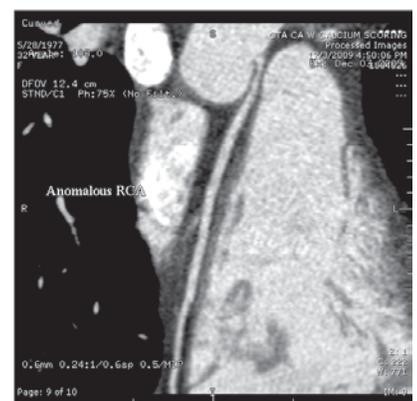
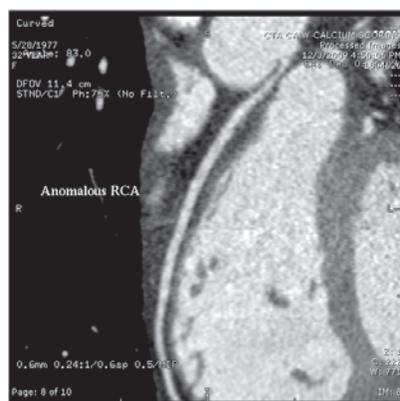
In addition, the pathway between the aortic root and the pulmonary trunk is considered a malignant variation in that it presents with the highest risk of exercise-induced ischemia and myocardial infarction.<sup>9</sup>

Furthermore, this pathway has an increased incidence of sudden cardiac death, and is overall the most common anomaly associated with sudden cardiac death.<sup>10</sup>

The etiology of myocardial ischemia due to anomalous coronaries is uncertain, but is proposed to be secondary to spasm of the coronary artery, compression of the artery as it passes between the pulmonary artery and the aorta, and a "flaplike" closure of the artery at its orifice.<sup>2</sup>

Patients with ARCAOLS present with smaller coronary artery ostium with a more narrow proximal diameter in comparison with normal anatomy. Also, the angle between its origin and its track to the aorta is more acute.<sup>2</sup>

Another study suggests that the intussusception of the anomalous



# CASereport

artery within the aortic wall (at its origin) possibly leads to ischemia.<sup>11</sup>

Symptomatic patients with anomalous coronary arteries should undergo surgical correction.<sup>3</sup> Transthoracic echocardiography can identify an anomalous origin of coronary arteries.<sup>12</sup> A recent study supports the use of dual-source computed tomography to

determine the diameter changes of the RCA in the evaluation for myocardial ischemia.<sup>2</sup> Other studies support the use of magnetic resonance coronary angiography.<sup>13</sup>

However, it is debated whether or not surgical correction should be done for the patient who has a negative exercise stress test.<sup>3</sup> Indeed, it is important to note that ischemia can occur even in asymptomatic patients.<sup>14</sup>

## CONCLUSION

Even though the patient's presentation was classic for coronary artery disease, the patient's age, gender, and current health status made cardiovascular disease seem unlikely.

It was the unbiased acceptance of the patient's history of present illness which prompted a workup and the CTA showed an anomalous RCA with proximal stenosis.

This adds to her risk of cardiac ischemia and sudden cardiac death as ARCAOLS is generally smaller in diameter at the orifice. Furthermore, this patient had an interarterial pathway, the most malignant variation of ARCAOLS.

It would be prudent for the EP to add anomalous origin of the coronary arteries to their differential diagnosis of chest pain.

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Arlen R. Stauffer, MD, MBA, FACEP

# A Rock Always Beats a Brain

The rhythmic rumbling that rolled up from the three Harley's was music to Bull's ears. He was cruising; life was good. A cool, bright Sunday afternoon....yes!

Bull's braided locks floated behind his head. There was nothing like that feeling of freedom and energy he got when he rode his bike.

The three rolled around a gentle bend on the rural, narrow road, Bull and his bike trailing behind his two buddies. Bull didn't notice the loose gravel in time to slow his motorcycle on the curve.

His Harley skidded down to the pavement. Some of the tattoos on his bare arms peeled off on the rough asphalt. Then his head – protected only by his long hair – met a rock at the edge of the road.

That feeling of freedom and energy suddenly went dark. Bull would never be free again.

“Yes, this is Medic 67.” The radio sparked to life in the ER. “I'm only about two minutes out with a 44-year-old victim of a head injury from a motorcycle accident.”

There was a collective moan from the ER staff.

The paramedic continued, “He's been unconscious since the accident; the only obvious trauma is to his head, and there's the usual road-rash on his arms and shoulders. His GCS is only three, BP is 170

over 90, pulse 60, and respirations about 10.”

Emergency physician Tammy Cortez took a deep breath. The entire team began pulling on their gowns, gloves, and face shields again. They stood silently for a moment in Trauma 3, waiting for this next patient.

“Probably another guy with no helmet,” Phil said to another nurse while shaking his head.

Phil had been the ER nurse in the trauma suite during the past five motorcycle traumas. The entire trauma team was weary; there was a vulgar sense of repetition, a recurring bad dream.

But, they were professionals; they would do their jobs.

“I suppose he had no head protection,” Cortez said as the paramedics slid Bull onto the trauma stretcher.

“Duh!” the paramedic said as she handed an IV bag to a nurse. “He hasn't moved or made a sound since we got to him. He really wasn't going that fast, but his head...well, you know, a rock always beats a brain when they collide. I didn't have time to try to tube him yet.”

While three nurses hooked up the monitoring equipment, drew blood, and inserted a catheter, Cortez moved quickly up toward Bull's head. The blood coming

from his ears and scalp was obvious, and there was a deep dent in the top of his skull.

“Let's get him intubated.”

With Phil protecting Bull's neck, Cortez slid the ET tube into place after suctioning some blood and a little dirt from his oropharynx.

“I got it....and he has no gag. Let's start getting some imaging studies.”

Just outside the doorway, some commotion developed, and a man could be heard shouting.

“I just want to see how he is!”

One of Bull's riding buddies bulled his way in through the doorway. He caught the attention of Cortez just as she was running her hands along Bull's chest wall. The look of fright on the intruder's face caused Cortez to stop her exam process.

“He's not doing very well, Sir.” She tried to use a calm tone. “He has a significant head injury.”

“Oh, no! No!” The friend backed out of the doorway and hurried off.

Satisfied that there were no obvious injuries to Bull's chest or abdomen, Cortez resumed her close examination of his head, and of what brain function remained in this battered cranium.

As the neurosurgeon walked in, Cortez shot a frustrated look in his direction.

“Another guy with no helmet,” she reported. “His long hair wasn’t much protection, I guess,” she added sarcastically.

As the neurosurgeon finished a quick assessment of Bull’s neurologic status, he scowled and backed away from the bed.

“I doubt that there will be much left to salvage in there,” he said in a matter-of-fact way. “But we’ll see what the CT

“It’s ridiculous!” she said as she reviewed some of Bull’s X-rays on the monitor back at the desk.

Even though it had been a couple years since the repeal of the mandatory helmet law, there was still a sense of disbelief every time another Bull rolled in. There was just no way it could ever make sense to those working in the ER.

“Yeah. What an idiot!” Phil chimed in. I just don’t understand why these crazy guys....”



looks like before we start talking about whether he’s dead or not. Who knows, maybe he’ll be another organ donor.”

As he turned toward the door, he added, “I see he has a wedding band. Any word from the wife yet?” He paused a moment and thought out loud, “How many is this – six of these this week?”

As Bull’s bed rolled toward the CT suite, Cortez looked down and swore quietly. She was feeling the frustration – almost rage – of the ER team that had to confront these traumas every day.

At that moment, they heard a sob, and noticed a woman standing nearby, eyes torn open with a look of fear. By the tears and that look, everyone knew that this must be Bull’s wife.

And, they knew that she probably overheard that last exchange of unkind words. Everyone looked at the floor. Cortez walked slowly toward the woman.

The National Highway Traffic Safety Administration reports that more than 4000 motorcycle occupants were killed during the most recent year reported, and

the risk of a fatality occurring per specified distance traveled is more than three times as high for motorcycle occupants than for occupants of other vehicle types. Motorcycle riders wearing an approved helmet reduce the risk of death by 37%.

\* \* \* \* \*

Effective July 1, 2000, Florida eliminated the legal requirement that all motorcycle riders wear helmets. State law now requires helmet use only by riders under the age of 21, or older riders who do not carry at least \$10,000 of medical insurance. Observational surveys and crash reports indicated that helmet use dropped substantially following the law change. Motorcyclist fatalities increased by 81 percent comparing 2001-2003 to 1997-1999, compared to +48 percent nationally.

Non-fatal serious injuries began increasing in the first six months of 2000, increased by 32 percent in the first year following law repeal. There was a 40 percent increase in the number of injured motorcyclists who were admitted to hospitals. Admissions for head injuries increased by 82 percent. The average head injury treatment cost increased by almost \$10,000, to \$45,602 Registrations increased an average 33.7 percent in this time period.

Some of the increases in fatalities and other injuries in Florida were probably due to this increased ridership. The expected number of motorcycle fatalities as a result of the increase in registrations was 242. The actual number who died in 2002 was 301, 56 (+24 percent) more motorcycle fatalities than expected as a result of increased registrations alone.

Nationally in 2001 and 2002, motorcycle miles of travel declined compared to earlier years. Given the large registration increase in Florida, it is unlikely that this national pattern held in the State. From: Evaluation of the Repeal of the All-Rider Motorcycle Helmet Law in Florida, DOT HS 809 849, Robert G. Ulmer and Veronika Shabanova Northrup, August 2005. [www.nhtsa.dot.gov](http://www.nhtsa.dot.gov).

## Letter to the Editor

I was recently "facebooked" by an inquisitor who sent me a picture of herself and her 10 year old child. As it turns out, she is a handsome 40 year old African American woman who asked me if I delivered babies in Cleveland in 1969 and then moved to Cockeysville, MD.

She was the offspring of a then pregnant University Hospitals of Cleveland woman who I met as a first year medical student. As planned in the curriculum I was fortunate to be present at the birth of her child and then I followed the 2 of them, mother and child in the Pediatric Clinic for the next 2 years, until I hit the wards

running as a 3rd year medical student.

We exchanged Christmas cards with pictures of our families thereafter for about 14 years until the family moved from Cleveland to the Appalachia of Southern Ohio.

The "facebooker" (Terri is her name) lives with her mother and her 10 year old 3rd generation daughter in Jacksonville, FL.

I can't wait until graduation season dies down and I return from my Haiti medical mission trip next week to pursue a reunion!



Rep Kathy Castor (D) - third from left, Dr. Lou Hobbs (Past President FCEP) left Dr. Amy Conley (President FCEP), Dr. Rene Campbell (EMRAF-FCEP Board) Dr. Scott Stirling (USF EM Resident) right



Rep. Gus Bilirakis (R) - left, Dr. Rene Campbell (EMRAF-FCEP Board) Dr. Amy Conley (President FCEP), Dr. Scott Stirling (USF EM Resident) right Dr. Lou Hobbs (Past President FCEP) right



## Coral Snake Conundrum

Denise Becker, Clinical Nurse  
Michelle Rutledge, Pharm D.  
Cynthia R. Lewis-Younger, MD, MPH  
Florida Poison Information Center - Tampa

A small black head ringed with yellow and circumferential red bands touching yellow bands are the distinguishing characteristics of the venomous Eastern coral snake (*Micurus fulvius*). This shy and reclusive snake is found only in the southeastern United States. There is an average of 47 coral snake bites in Florida each year.

Although small, the coral snake has powerful neuro-toxic venom, which is frequently injected into victims. This venom can kill, but over the last forty years, only one death has occurred in an individual who declined treatment. North American Coral Snake Antivenin® has been available to save lives. Now, this antivenom is no longer being manufactured, and currently there is no alternative product licensed in the U.S. Consequently, EPs must weigh the neurotoxic and potentially lethal effects of the venom against using the last of the dwindling antivenom stock.

Accurate history and physical assessments are crucial to ensuring that limited anti-venom is administered only when envenomation has occurred. Health care providers must be able to differentiate an envenomation versus a “dry bite,” know the indications for administration, understand the issues of the antivenom shortage, and know how to locate the limited supply of FDA approved antivenom.

Obtaining the best possible description of the snake is instrumental in determining if it was truly an Eastern coral snake. The

victim’s account of the bite and the appearance of the site are further clues to the possibility of envenomation. Localized symptoms are typically minimal and onset of systemic symptoms can be delayed for 12-18 hours.



Historically, antivenom was administered prophylactically but the short supply has necessitated changes in treatment guidelines. This means patients must be closely monitored for 24 hours. Bulbar palsies are usually the first signs, which may progress to full flaccid paralysis within hours. Onset may be delayed, but usually occurs within 4 hours of the bite. When coupled with strong supportive care, prognosis following antivenom treatment is excellent and a full recovery can be expected. This stands in sharp contrast to the alternative outcome of 3 to 6 weeks ventilatory support needed without antivenom treatment.

In 2003, Wyeth ceased production of coral snake antivenom. Over the last year, Wyeth merged with Pfizer. One lot of antivenom, although labeled with an

expiration date of October 31, 2008, has been tested and FDA granted an extension. Currently, its expiration date is October 31, 2010. The antivenin has been stable, and will be tested again in October 2010, with the plan to further extend the date at that time. That lot can be obtained directly from Pfizer. The Florida Poison Information Centers are a direct source from which providers can obtain the most up to date information and treatment recommendations.

By tracking snake bite reports and stock of the antivenom, the poison centers are working to facilitate optimal provider response to snake bite victims. In addition, Florida’s Poison Centers are dedicated to working closely with health-care facilities through this crisis.

Call your regional poison center at 1-800-222-1222. You can also find more information at <http://www.poisoncentertampa.org/antivenin/coral-snake-antivenin.aspx>

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# RESIDENCY*matters*



University of Florida, Gainesville  
*David Nguyen, DO*

Greetings from Gainesville!

I would like to thank Dr. Rita Fairclough for passing the torch to me! Dr. Fairclough and the rest of the third year graduating class will be missed. This exceptional class has set high standards with their excellent patient care, hard work, and dedication. They will move on to Texas, Alabama, and Florida. Good luck!

The start of a new residency year in July will be exciting. A new intern class will be the first to train entirely in our new ED. We proudly matched within our top 25 choices, with four in the top eight. We look forward to including Brandon, Alok, Jonathan, Melinda, Jason, Shalu, Katrina, and Coben to our Gator family. Welcome class of 2013!

We will also welcome many new faculty members. Dr. Borenstein, former Chairman of the Newark Beth Israel Medical Center, will serve as our new Residency Program Director. We welcome Drs. Stead, Elie, Falgiani, Flach, Van Dillen, and Marchick to the faculty!

We recently have had to say goodbye to one of our favorite attendings, Dr. Liam Holtzman, who served as Trauma Liaison, Associate Medical Director, and Disaster & Tactical EMS Coordinator. Dr. Holtzman has accepted a faculty position in the East Coast, returning to his roots. We hope he will soon tire of the cold winters and return to sunny Gainesville!



Florida Hospital  
*Vu Nguyen, MD*

It seems like yesterday we were fresh faces trying to make sense of a seemingly overwhelming situation. Fast forward some months, and we are eager to accept our new leadership roles as second and third year residents. As we look ahead to a new year in the next few weeks, we are confident and excited to make this transition as smoothly as possible.

Drs. Gonzalez and Garcia, our new Chiefs, have quickly acclimated to their new roles and are providing our program effective guidance. Working with our core faculty, they are developing a new schedule to better suit our full roster in the coming year. Our soon to be PGY3s are very excited and ready to exercise great leadership in our ED. Dr. Brittany Thomas, one of our PGY2, has just returned from ACEP Leadership and Advocacy Conference in Washington D.C. She had a great time and gained a lot from the experience.

Florida Emergency Physicians (FEP) is known to hold great symposiums on EM. Our next FEP sponsored conference will be the Critical Care Symposium on June 12. Our residents are always present at these conferences because they are full of valuable information.

We are also looking forward to the Symposium at the Sea. Drs. Breckon Pav and Javier Gonzalez will make us proud at this year's presentations. Until next time, take care from Florida Hospital East Orlando.



University of South Florida  
*Jason W. Wilson, MD*

The power of organized medicine continues to amaze me as I bear witness to the opportunities we as physicians have to impact the legislative process.

Recently, I wrote about our programs great turn out and support for EM Days in Tallahassee. This past month our program again made a great showing on Capitol Hill. Our Program Director (Dr. O'Keefe) decided to meet and exceed the EMRA Chair Challenge by sending 3 residents with full support to Washington, DC! Veronica Tucci, Scott Stirling, and I attended the ACEP Leadership and Advocacy conference. The first thing I noticed at the reception was just how active our FCEP chapter is compared to some other states. We had multiple members of FCEP leadership present and they were all quite accessible to the residents from all the Florida programs.

Next, ACEP did an excellent job preparing us for meetings with representatives and introducing us to legislative issues. Finally, we headed to the hill and our group of five (which included the current and past FCEP president and 3 residents!) met with two house representatives and their staff. The meetings went well and I was impressed with the attentiveness on both sides of the aisle as we discussed the SGR crisis.

Our residency program continues to provide opportunities for both clinical training and the skill set needed by physician leaders.



University of Florida, Jacksonville  
*Oscar D. Espetia, MD*

Greetings from UFCOM-Jacksonville!

As the year winds down we are sad to see our senior class part ways and head off to make their mark in the field of EM.

As we reach the end of the academic year here's a little information on what's happening in Jacksonville.

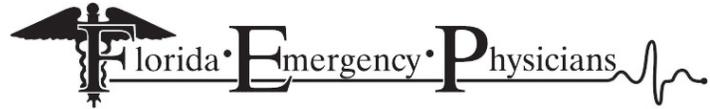
Dr. Phyllis Hendry was awarded the Florida State Emergency Medical Services for Children (EMSC) Heroes Award.

This award honors a health care professional or organization for outstanding achievement in the care of ill or injured children (18 years of age or younger) in at least one of these areas: education, clinical care, and community service or disaster management.

The winner must successfully implement a program or initiative that supports the fulfillment of the Florida EMS Strategic Plan.

Good luck to everyone presenting at SAEM this year in Phoenix! We have our own Drs. Spencer Topp and Andrew Vihlen presenting a CPC case to represent UF/Jax Emergency Medicine this year.

We wish them the very best.



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## People for Access to Emergency Care

Emergency medicine is the leader in promoting patient access and safety. In order to achieve our goal of taking emergency medicine to the next level of policy influence in Tallahassee, the Florida College of Emergency Physicians has formed an advocacy entity called "People for Access to Emergency Care" (PAEC).

PAEC provides a means for our friends in the business world, such as billing companies, physician groups and other organizations, to assist FCEP in supporting legislative leaders and policy makers, and it ensures that emergency medicine has a seat at the table with key leaders in the Florida House and Senate.

PAEC allows FCEP and its partners in emergency medicine to act with a unified voice in Tallahassee. Its members are

groups and organizations dedicated to promoting emergency medicine in Florida and providing better access to quality emergency care to our patients.

In order to be successful at securing emergency medicine's place at the table, we need you to join People for Access to Emergency Care and joining is easy.

There are three levels of membership:

- Platinum \$15,000 per year
- Gold \$10,000 per year
- Silver \$5,000 per year

PAEC's goal is to raise \$200,000 for the 2010-11 legislative cycle. With these funds we will be able to help elect candidates who support your issues. This will enable us and your organization to participate in the decision-making process.

To find out more about contributing to PAEC, or to join our 2010 contributors, contact Beth Brunner at: [bbrunner@fcep.org](mailto:bbrunner@fcep.org).

2010 Platinum Members:  
Florida Emergency Physicians, Inc.

2009 Platinum Members:  
Emergency Physicians of Central Florida  
Florida Emergency Physicians, Inc.

2009 Silver Members:  
Comprehensive Medical Billing Solutions  
Jacksonville Emergency Consultants, PA  
Martin Gottlieb & Associates, LLC  
Southwest FL Emergency Physicians, PA

2009 Other Members:  
Tampa Bay Emergency Physicians, PL.



## Emergency Physicians of Florida

Emergency Physicians of Florida (EPF), formerly known as the Florida College Political Action Committee (FLACPAC), is one of the primary advocacy tools that enables individual physician members of FCEP to make a difference at the legislative and regulatory level. In order for us to have a positive influence on our legislators, both at home and in Tallahassee, we need your help.

Please consider "giving a shift" from personal funds. You can even donate online at: [fcep.org/flacpac.htm](http://fcep.org/flacpac.htm).

Thank you to all who have donated since the 2009 Symposium by the Sea!

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 Dr. David J. Vukich, Professor & Chairman, [vukich@ufl.edu](mailto:vukich@ufl.edu)

E-mail your letter of interest and CV to:  
 Dr. Kelly Gray-Eurom, Associate Professor & Search Committee Chair, [kelly.grayeurom@jax.ufl.edu](mailto:kelly.grayeurom@jax.ufl.edu)

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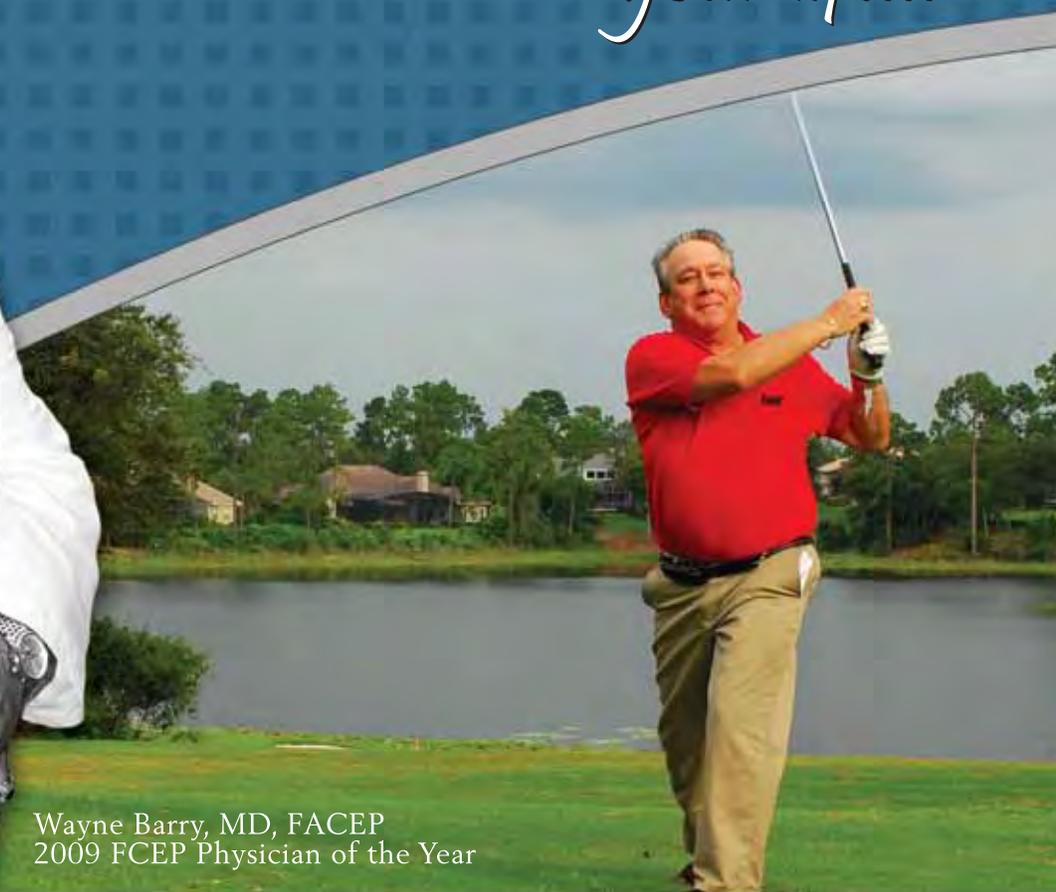
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