Policy Statements

Policy statements and clinical policies are the official policies of the American College of Emergency Physicians and, as such, are not subject to the same peer review process as articles appearing in the journal. Policy statements and clinical policies of ACEP do not necessarily reflect the policies and beliefs of *Annals of Emergency Medicine* and its editors.

Anonymous Complaints to State Licensing Boards by Third Parties
Approved by the ACEP Board of Directors June 2015

Clinical Pharmacist Services in the Emergency Department
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EMS Management of Patients With Potential Spinal Injury
Approved by the ACEP Board of Directors January 2015

Anonymous Expert Physician Testimony for a State Medical Licensing Board
Approved by the ACEP Board of Directors June 2015

Comprehensive Advanced Life Support
Approved by the ACEP Board of Directors June 2015

0196-0644/$-see front matter

Anonymous Complaints to State Licensing Boards by Third Parties

[Ann Emerg Med. 2015;66:444.]

The American College of Emergency Physicians (ACEP) believes several problems are created when state medical licensing boards permit anonymous reporting of complaints about physicians by individuals who were not directly aggrieved by the physician:

- Allows third parties not directly associated with the patient care (such as a plaintiff attorney anonymously reporting physicians before suing them) to file such a claim.
- Leads to difficulty in fully investigating the complaints. Anonymous reporting does not give an accused physician an adequate, fair opportunity to contest the accuracy of the reporting.

ACEP is strongly opposed to anonymous complaints made to state medical licensing boards from third parties not directly involved in the episode of care.

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Clinical Pharmacist Services in the Emergency Department

[Ann Emerg Med. 2015;66:444-445.]

The emergency department (ED) is a complex environment presenting unique challenges for medication selection, dosing, administration, and monitoring. In particular, caring for high-risk populations such as the critically ill, geriatric patients, pediatric patients, those with limited health care access, and those with multiple comorbidities often requires the use of high-risk medications and the need for time-sensitive medication decisions.

The American College of Emergency Physicians (ACEP) believes that pharmacists serve a critical role in ensuring efficient, safe, and effective medication use in the ED and advocates health systems to support dedicated roles for pharmacists within the ED. The emergency medicine pharmacist should serve as a well-integrated member of the ED multidisciplinary team who actively participates in patient care decisions, including resuscitations, transitions of care, and medication reconciliation to optimize pharmacotherapy for ED patients. The exact delivery method for these services can vary among institutions,

depending on their size, financial resources, presence of academic programs, and other factors.

ACEP encourages emergency medicine rotations for pharmacy residents and clinical research in regard to pharmacist access in the ED.

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EMS Management of Patients With Potential Spinal Injury

[Ann Emerg Med. 2015;66:445.]

The American College of Emergency Physicians believes that current out-of-hospital management practices for patients with potential spinal injury lack evidentiary scientific support. Practices that attempt to produce spinal immobilization include the use of backboards, cervical collars, straps, tape, and similar devices (eg, sand bags, head wedges). Evolving scientific evidence demonstrates that some of these current out-of-hospital care practices cause harm, including airway compromise, respiratory impairment, aspiration, tissue ischemia, increased intracranial pressure, and pain, and can result in increased use of diagnostic imaging and mortality.

Historically, the terms *spinal immobilization* and *spinal motion restriction* have been used synonymously. However, true spinal immobilization is impossible. Spinal motion restriction in this policy refers to the preferred practice, which attempts to maintain the spine in anatomic alignment, minimizes gross movement, and does not mandate the use of specific adjuncts.

Emergency medical services (EMS) directors should provide evidence-based spinal motion restriction protocols and procedures that describe specific indications and contraindications for application of spinal motion restriction. The role of adjuncts (eg, cervical collars) should be specifically addressed. The use of spinal motion restriction procedures and adjuncts should not interfere with critical airway management and other time-critical interventions, such as hemorrhage control, or rapid transport. Spinal motion restriction procedures may require modification for certain conditions (eg, rescue, vehicle racing, contact or extreme sports) as determined by the EMS director.

Spinal motion restriction should be considered for patients who meet validated indications such as the NEXUS criteria or Canadian C-Spine Rule. Spinal motion restriction should be considered for patients with plausible blunt mechanism of injury and any of the following:

- Altered level of consciousness or clinical intoxication
- Midline spinal pain or tenderness
- Focal neurologic signs or symptoms (eg, numbness, motor weakness)
- Anatomic deformity of the spine
- Distracting injury

Backboards should not be used as a therapeutic intervention or as a precautionary measure either inside or outside the hospital or for interfacility transfers. Spinal immobilization should not be used for patients with penetrating trauma without evidence of spinal injury.

EMS directors should ensure that EMS providers are properly educated about assessing risk for spinal injury and about neurologic assessment, as well as about performing patient movement in a manner that limits additional spinal movement in patients with potential spinal injury. Patient movement and transfer practices should be coordinated with receiving facility personnel.

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Anonymous Expert Physician Testimony for a State Medical Licensing Board

[Ann Emerg Med. 2015;66:445.]

The primary responsibility and obligation of state medical boards is to protect consumers of health care by ensuring that all physicians are properly licensed and comply with various laws and regulations pertaining to the practice of medicine. Anonymous physician expert testimony is permitted by some state medical licensing boards. Such testimony does not provide the accused physician the ability to respond adequately to the accuracy of the testimony. Although the courts have permitted anonymous testimony in rare cases of criminal litigation, they have done so only when there is a significant risk of harm to the individual or his or her family.

Therefore, the American College of Emergency Physicians (ACEP) endorses the following principles:

- State licensing boards should not accept anonymous testimony as expert opinions for or against a physician under review.
- ACEP will consider that any member who provides anonymous expert testimony for or against another physician shall have violated their professional ethical responsibility.

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