EDITOR'S CORNER

Planning Ahead

Marvin L. Birnbaum, MD, PhD

Destiny is not a matter of chance, it is a matter of choice. It is not a thing to be waited for, it is a thing to be achieved.

William Jenning Bryan

Those who study the behavior of organizations believe that there are four stages in the history of any organization. These stages are: i) Embryonic or Introductory; ii) Rapid growth; iii) Maturity; and iv) Decline. The National Association for Emergency Medical Services Physicians (NAEMSP), the World Association for Disaster and Emergency Medicine (WADEM), and *Prehospital and Disaster Medicine* have successfully negotiated through the introductory stage, and are well into their respective periods of growth.

The National Association of EMS Physicians is in the midst of a remarkable period of growth. Its membership has tripled in three years and approaches the 1,400 mark. Because of its significance in providing medical standards and assistance to EMS physicians and its promulgation of this journal, it is anticipated that this rate of growth will continue into the next century. By the year 2000, it will serve some 8,000 members. The Executive Board has revised its mission to one that is more in tune with the evolving discipline of Prehospital Emergency Medicine, and will serve its members even better. It is engaged in strategic planning, a process that is instrumental in becoming a mature and stable organization. Its leadership has demonstrated a remarkable ability to build consensus on directions and priorities for this young medical discipline.

As pointed out in the last issue, the WADEM has been reorganized, incorporated, and is extending its hand to Disaster Medicine organizations around the world. It now stands as the primary force for uniting Disaster Medicine across this globe—a much needed role as the scope of disasters is worldwide. As such, it stands to have a tremendous impact on international cooperation in coping with disasters.

In preparation for the 1993 meetings of both sponsoring organizations and the meetings of the Editorial Board of this journal which are a function of these meetings, I reviewed its mission and progress. *Prehospital and Disaster Medicine* is growing at a remarkable rate. As is evidenced by the increasing number and the quality of the manuscripts submitted for publication, its use as a forum for developing the science of Prehospital and Disaster Medicine is being accepted and sought after by many of the leading researchers in this exciting field. To accommodate this growth in quality materials, the number of pages in each issue has been increased from 80 to 116. The content also has been increased by making the size of the type smaller and by narrowing the margins. Currently, more words are packed onto each page than for any other leading medical journal. These changes allowed doubling the content without a substantial increase in the costs associated with production of the journal. Furthermore, with the help of our partners in industry, three supplements have been produced within this current volume.

Further evidence of this growth is provided in Figure 1. Perhaps, the best measure of this growth lies in examination of the size of the index that accompanies each volume. The standards used for indexing have remained constant since volume three. Because of the progressive compression of the content into the same space, the number of words rather than pages published, is another good measure of this growth. Most importantly, this growth has occurred primarily in the quantity of *original research* published. This growth has occurred because the volume of quality research submitted for publication is increasing progressively. The volume of good material has driven the acceptance rate for papers for publication from 85% in 1989 to 65% so far for 1993. More than 700 authors have

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contributed to the current volume.

As a consequence, the number of invited papers previously published in earlier issues such as Controversy, Collective Reviews, and Editorials has been decreasing as the amount of science published has increased. Thus, the journal has become increasingly science-oriented and less opinion-driven. This has occurred because more and more of you are submitting research that has been better conceived and conducted. This research produces results that are of ever increasing value to the shaping of this young science of Prehospital and Disaster Medicine. It has helped to establish our discipline as a scientifically sound entity.

Our discipline is gaining steam; it is growing at a remarkable rate (rapid growth stage). We are producing more and better research. This is the best indication that our science is maturing and is establishing itself as a respected part of the medical community. What is even more exciting is that we are developing new tools that define what we do and how we do it. We are defining our medical *and* social impact. It seems that there is more systems-type and outcome research being conducted in the field of Prehospital and Disaster Medicine than has occurred in any other medical discipline. We not only are becoming increasingly facile at conceiving and completing respected prospective, randomized studies, but increasingly we are competent with systems research: applying those qualitative techniques that allow us to identify what we do, and to apply these findings to improve the manner in which we provide our care. We really are ahead of the rest of medicine in this realm. And our timing is great. The scope of our practice is expansive; it involves interfacing with many, many disciplines within and without traditional medicine; more than for any other medical discipline. The ultimate scope of this practice is up to us. We are well-positioned.

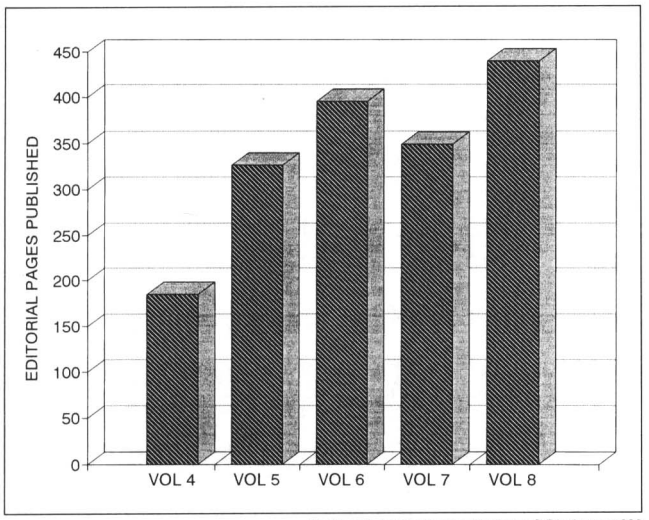

Figure 1—Editorial Pages Published in *Prehospital and Disaster Medicine* Since 1989

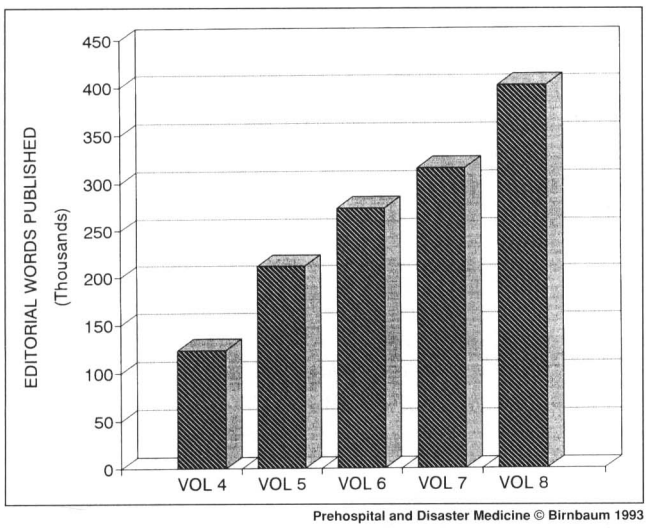

Figure 2—Total Number of Words Published in *Prehospital and Disaster Medicine* since 1989

We are discovering what we are about. The rest of medicine would do well to look toward us as the model for cost-effective health care. We are the only sector of medicine that provides universal access to health care at a very low relative cost. By continuing along this path of self-discovery, we set the example. We have no need to follow the path selected by other components of a failing delivery system characteristic of the many other sectors of medicine in the United States. As pacesetters, we already have programs in place that enhance the delivery of health care both in the United States and around the world. We practice our special medicine in a glass house for all to see, and we are beginning to understand how we do it. We have continued to apply these discoveries into our daily practice. We drive the systems for which we are responsible to deliver care in better and more efficient ways. Our continuous scrutiny of how our systems operate has made our science and our practice better. If we continue to develop this aspect of OUR science, we will get even better. Nowhere else in medicine is there such concern for the enhancement of the quality of care that we deliver to every patient. Medicine, take note.

Further evidence for our acceptance within our own discipline has been the progressive augmentation in the membership of both the NAEMSP and WADEM. But even more striking, is the fact that these organizations have matured to a point sufficient to allow them the opportunity to readjust their respective missions to be more in tune with the social and scientific needs of their members and the communities their members serve. Each is increasingly aware of the social impact generated by the medicine they provide. An even greater mark of the increasing maturity of these disciplines is that they are able to agree on their goals and objectives, and are able to codify these in the form of strategic planning. Their leadership is focused and the paths have been forged. I wish each a happy and fruitful journey down these paths. But, we must keep looking-up to avoid the morass in which the rest of medicine finds itself. We are leading each other to a new level of scientific proficiency and acceptability. There have been a few turns on the way and likely will be more to come, but we are off to an exciting start.

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There is only one automatic Epinephrine Injection.

For self administration in any allergic emergency...

EpiPen®
EPINEPHRINE AUTO-INJECTORS

Just remove safety cap and press into thigh.

Brief summary: Before prescribing, please consult package insert.

DESCRIPTION: The EpiPen Auto-Injectors contain 2 mL Epinephrine Injection for emergency intramuscular use. Each EpiPen Auto-Injector delivers a single dose of 0.3 mg epinephrine from Epinephrine Injection, USP, 1:1000 (0.3 mL) in a sterile solution. Each EpiPen Jr. Auto Injector delivers a single dose of 0.15 mg epinephrine from Epinephrine Injection, USP, 1:2000 (0.3 mL) in a sterile solution. Each 0.3 mL also contains 1.8 mg sodium chloride, 0.5 mg sodium metabisulfite, hydrochloric acid to adjust pH, and Water for Injection. The pH range is 2.5-5.0.

CLINICAL PHARMACOLOGY: Epinephrine is a sympathomimetic drug, acting on both alpha and beta receptors. It is the drug of choice for the emergency treatment of severe allergic reactions (Type 1) to insect stings or bites, foods, drugs, and other allergens. It can also be used in the treatment of idiopathic or exercise-induced anaphylaxis. Epinephrine when given subcutaneously or intramuscularly has a rapid onset and short duration of action.

INDICATIONS AND USAGE: Epinephrine is indicated in the emergency treatment of allergic reactions (anaphylaxis) to insect stings or bites, foods, drugs and other allergens as well as idiopathic or exercise-induced anaphylaxis. The EpiPen Auto-Injector is intended for immediate self-administration by a person with a history of an anaphylactic reaction. Such reactions may occur within minutes after exposure and consist of flushing, apprehension, syncope, tachycardia, thready or unobtainable pulse associated with a fall in blood pressure, convulsions, vomiting, diarrhea and abdominal cramps, involuntary voiding, wheezing, dyspnea due to laryngeal spasm, pruritis, rashes, urticaria or angioedema. The EpiPen is designed as emergency supportive therapy only and is not a replacement or substitute for immediate medical or hospital care.

CONTRAINDICATIONS: There are no absolute contraindications to the use of epinephrine in a life-threatening situation.

WARNINGS: Epinephrine is light sensitive and should be stored in the tube provided. Store at room temperature (15°-30°C/59°-86°F). Do not refrigerate. Before using, check to make sure solution in Auto-Injector is not discolored. Replace the Auto-Injector if the solution is discolored or contains a precipitate. Avoid possible inadvertent intravascular administration. Select an appropriate injection site such as the thigh. DO NOT INJECT INTO BUTTOCK. Large doses or accidental intravenous injection of epinephrine may result in cerebral hemorrhage due to sharp rise in blood pressure. DO NOT INJECT INTRAVENOUSLY. Rapidly acting vasodilators can counteract the marked pressor effects of epinephrine.

Epinephrine is the preferred treatment for serious allergic or other emergency situations even though this product contains sodium metabisulfite, a sulfite that may in other products cause allergic-type reactions including anaphylactic symptoms or life-threatening or less severe asthmatic episodes in certain susceptible persons. The alternatives to using epinephrine in a life-threatening situation may not be satisfactory. The presence of a sulfite in this product should not deter administration of the drug for treatment of serious allergic or other emergency situations.

Accidental injection into the hands or feet may result in loss of blood flow to the affected area and should be avoided. If there is an accidental injection into these areas, go immediately to the nearest emergency room for treatment. EpiPen should ONLY be injected into the anteriolateral aspect of the thigh.

PRECAUTIONS: Epinephrine is ordinarily administered with extreme caution to patients who have heart disease. Use of epinephrine with drugs that may sensitize the heart to arrhythmias, e.g., digitalis, mercurial diuretics, or quinidine, ordinarily is not recommended. Anginal pain may be induced by epinephrine in patients with coronary insufficiency. The effects of epinephrine may be potentiated by tricyclic antidepressants and monoamine oxidase inhibitors. Hyperthyroid individuals, individuals with cardiovascular disease, hypertension, or diabetes, elderly individuals, pregnant women, and children under 30 kg (66 lbs.) body weight may be theoretically at greater risk of developing adverse reactions after epinephrine administration. Despite these concerns, epinephrine is essential for the treatment of anaphylaxis. Therefore, patients with these conditions, and/or any other person who might be in a position to administer EpiPen or EpiPen Jr. to a patient experiencing anaphylaxis should be carefully instructed in regard to the circumstances under which this life-saving medication should be used.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Studies of epinephrine in animals to evaluate the carcinogenic and mutagenic potential or the effect on fertility have not been conducted.

USAGE IN PREGNANCY: Pregnancy Category C: Epinephrine has been shown to be teratogenic in rats when given in doses about 25 times the human dose. There are no adequate and well-controlled studies in pregnant women. Epinephrine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

PEDIATRIC USE: Epinephrine may be given safely to children at a dosage appropriate to body weight (see Dosage and Administration).

ADVERSE REACTIONS: Side effects of epinephrine may include palpitations, tachycardia, sweating, nausea and vomiting, respiratory difficulty, pallor, dizziness, weakness, tremor, headache, apprehension, nervousness and anxiety. Cardiac arrythmias may follow administration of epinephrine.

OVERDOSAGE: Overdosage or inadvertent intravascular injection of epinephrine may cause cerebral hemorrhage resulting from a sharp rise in blood pressure. Fatalities may also result from pulmonary edema because of peripheral vascular constriction together with cardiac stimulation.

DOSAGE AND ADMINISTRATION: Usual epinephrine adult dose for allergic emergencies is 0.3 mg. For pediatric use, the appropriate dosage may be 0.15 or 0.30 mg depending upon the body weight of the patient. However, the prescribing physician has the option of prescribing more or less than these amounts, based on careful assessment of each individual patient and recognizing the life-threatening nature of the reactions for which this drug is being prescribed. With severe persistant anaphylaxis, repeat injections with an additional EpiPen may be necessary.

HOW SUPPLIED: EpiPen and EpiPen Jr. Auto-Injectors are available singly or in packages of twelve.

CAUTION: Federal (U.S.A.) law prohibits dispensing without a prescription.

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Help make effective disaster and emergency medicine a world-wide reality

Our members represent different medical specialities and nationalities, all having a common vision: an improved universal quality of prehospital and emergency care, for citizens of all nations. Our goal cannot be reached without relentless efforts in the fields of public education, continuing medical education, scientific research, and analyses of field practices.

Please join us as we work to find the best ways to provide immediate health care in disaster and emergency settings.

JOIN

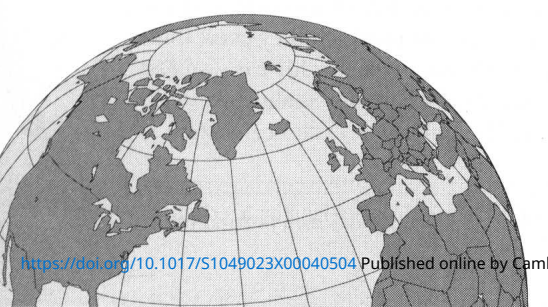
THE WORLD ASSOCIATION FOR DISASTER AND EMERGENCY MEDICINE

(founded in 1976 as The Club of Mainz)

ASSOCIATION MONDIALE POUR LA MÉDECINE DE CATASTROPHE ET D'URGENCE

Membership includes

- Annual subscription to *Prehospital and Disaster Medicine*
- Biannual newsletter
- Membership directory
- International recognition and preferred rates at World Congress meeting



MEMBERSHIP APPLICATION

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Please complete this application form and send it with your *curriculum vitae* and your check for US $100 (US currency only) for annual dues to:

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