Table 1
Patient demographic and stress tests information.

Patient demographics		
	Frequency ($n = 57$)	Percent
Gender		
Male	20	35%
Female	37	65%
Ethnicity		
White	24	42.1%
Black	21	36.8%
Hispanic	10	17.5%
American Indian	1	1.8%
Asian	1	1.8%
Age		
Mean Age	53	
Min Age	33	
Max Age	79	
Stress test		
	Frequency (n = 57)	Percent
Exercise stress ECHO	33	57.9%
Pharmacologic stress ECHO	22	38.6%
Pharmacologic nuclear stress	2	3.5%

Table 2
2 × 2 table for positive CIMT on either side.

	Stress Pos	Stress Neg	
CIMT Pos	4	26	30
CIMT Neg	1	26	27
	5	52	57

Table 3
2 × 2 table for positive composite average CIMT.

	Stress Pos	Stress Neg	
CIMT Pos	4	16	20
CIMT Neg	1	36	37
	5	52	57

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Consent for emergency treatment: Emergency department patient recall and understanding

Informed consent is a crucial component of patient autonomy and shared decision-making. Previous studies have shown that comprehension of a variety of types of informed consent by patients is poor [1-3]. This study was undertaken to identify patient recall and understanding of the emergency department (ED) Consent for Treatment document.

In this prospective survey study design, eligible participants included ED patients age 18 and older, who were able to communicate, not in distress, and consented to participate. After signing informed consent document per ED registration protocol, a convenience sample of patients meeting the inclusion criteria were invited to participate.

A total of 293 patients consented to participate (95% participation rate). The mean age was 52 and the majority of participants were female (58%) and White (62%). The majority of participants stated that they had signed a consent document ($N = 272$; 93%). A minority of patients read the entire document (7%) or read part of the document (11%). Most patients did not read the document (36%) or received only a verbal explanation (45%) (Table 1). Many patients did not recall anything about what they signed ($N = 107$; 39%). The most frequently recalled elements of consent included consent for treatment ($N = 144$; 52%), information regarding finances and billing ($N = 36$; 13%), and privacy rights ($N = 12$; 4%) (Table 2).

Reading the document prior to signing was associated with African American ethnicity ($p = 0.01$). Age, gender, mode of arrival, and triage level were not associated with reading the document (Table 3). Respondents who indicated they didn't know what they had consented to were significantly older (median 56 years) than respondents who remembered something from the consent form (median 47; $p = 0.01$). A

Table 1
Did you read the document prior to signing?

Yes, I read the entire document	20 (7%)
Yes, I read part of the document	31 (11%)
No, I did not read the document	101 (36%)
No, I did not read the document but I received a verbal explanation	126 (45%)

Table 2
What did you consent to?[a]

Don't know	107 (39%)
Treatment	144 (52%)
Attending physician	0 (0%)
Privacy/HIPAA	12 (4%)
Photography	0 (0%)
Finances, billing	36 (13%)
Personal property	0 (0%)
Patient rights	9 (3%)

[a] More than 1 response possible. Percentages are calculated based on $n = 276$.

Table 3
Associations with reading the document prior to signing.

	N	1. Read all	2. Read parts	3. Did not read	4. Did not read but verbally explained	*p*-Value
Age (years, median [IQR]	278	44 [34–55]	53 [34–60]	55 [40–68]	49 [32–64]	0.13
Male	117	9 (7.7%)	12 (10.3%)	50 (42.7%)	46 (39%)	0.25
Female	161	11 (6.8%)	19 (11.8%)	51 (31.7%)	80 (50%)	
African American	95	9 (9.5%)	14 (14.7%)	22 (23.2%)	50 (53%)	0.01
White	170	11 (6.5%)	15 (8.8%)	74 (43.5%)	70 (41%)	
Walk-in	201	18 (9.0%)	24 (11.9%)	73 (36.3%)	86 (43%)	0.22
Ambulance	74	2 (2.7%)	7 (9.5%)	26 (35.1%)	39 (53%)	
Triage level						
2	74	4 (5.4%)	8 (10.8%)	29 (39.2%)	33 (45%)	0.16
3	175	16 (9.1%)	18 (10.3%)	66 (37.7%)	75 (43%)	
4	27	0 (0%)	5 (18.5%)	5 (18.5%)	17 (63%)	

higher percentage of walk-in respondents (56%) recalled consenting to treatment compared to ambulance arrivals (41.1%; $p = 0.02$). Respondents with higher triage levels more frequently recalled consenting to treatment ($p = 0.02$).

When asked for comments about the consent for treatment process, the majority had no problems with the process or no specific comments (237 (81%)).

Informed consent is an important ethical and legal component of medical care. In this study, we demonstrated that the majority of ED patients in this study recalled signing a consent document, but most were not aware of elements of the consent document they had signed. Despite this lack of awareness, the majority of participants indicated they were satisfied with the current process. These data speak favorably of patient trust in ED providers.

Health literacy is an important component of communication with patients. Poor health literacy is common among ED patients [4]. The Institute of Medicine (IOM) reports that over 90 million people, nearly half the adult population lack proper health literacy skills to understand their health [5]. Improving understanding of one's health is crucial to maintaining patient's autonomy and decision-making capacity. Some studies have reported a variety of approaches to improving patient health literacy [6-8].

In conclusion, the majority of ED patients in this study recalled signing a consent document. Most were not aware of elements of the Consent for Treatment document they had signed. Walk in patients were more likely to recall the document than patients who arrived by ambulance. Patients high lower triage acuity recalled consenting to treatment compared to higher acuity.

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Comparison of Quick Track™ and Melker™ for emergent invasive airway management in Simulated Obese Model

To the Editor,

Emergent cricothyrotomy is the final step in managing difficult airways [1,2]. The Quick Trach II™ (QT; VBM Medizintechnik GmbH, Sulz am Neckar, Germany) was developed for direct placement in the trachea using the catheter-over-needle technique. In contrast, the Melker Set™ (Melker; Cook Group Incorporated, Bloomington, IN) uses a guide-wire for placing the cannula with the Seldinger method. It remains controversial which of direct placement or the Seldinger method is optimal for invasive airway management.

While invasive airway management is known to be difficult in obese patients, no comparison of efficacy of QT and Melker devices have been performed in this patient population. Against this backdrop, the present study aimed to compare the performance of QT and Melker devices in terms of efficacy of cricothyrotomy on an obese manikin.

Ethical approval was deemed unnecessary by the institutional review board of Osaka Medical College, and written consent was obtained from each participant. Participants were 15 doctors specialized in critical care such as emergency medicine or anesthesiology who were recruited from a difficult airway training course at Osaka Medical College. Participants had 7.5 ± 4.9 years of clinical training, and had used the QT 4.8 ± 3.9 times and the Melker 6.6 ± 3.2 times for cricothyrotomy in clinical or simulated situations.

The SimMan® 3G (Laerdal, Sentrum, Stavenger, Norway) manikin was used in this study. The obese model was constructed by attaching 1 cm of simulated subdermal tissue (CVC training pad, Kyotokagaku, Japan) to the cricothyroid membrane (Fig. 1a, b). In the Melker trial, participants used the Melker set, which consisted of a needle, a syringe, a guide-wire, a scalpel, a dilator, a 5-mm cannula with an inflatable cuff, and a syringe for blocking the cuff. In the QT trial, participants used the QT set, which consisted of a syringe, a conical-shaped needle, a plastic 4-mm cannula with an inflatable cuff, and a stopper [3]. Participants were given 30 min to practice these techniques, with the instructor available for advice. A trial started when the participant picked up the QT or Melker and ended