it was considered non-feasible. If any of the physicians could implement the technique it was considered feasible. Implementation was defined as creating chest rise during a ventilation attempt.
Results: No method other than the TAD could be implemented due to a lack of access to the oropharynx. The TAD could be placed but did not produce significant chest rise.
Conclusion: Most standard airway techniques are not viable in trapped drivers with closed face helmets. The trumpet airway device may help oxygenate such drivers, however, adequate ventilation using this device should be further studied. Motorsports medical personnel should focus on basic airway maneuvers and rapid extrication with helmet removal rather than wasting valuable time attempting more advanced airways in drivers with full face helmets trapped in their race cars.
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5 Survey of State Licensure Boards Regarding Inter-state Practice of Sports Medicine

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Purpose: State licensure boards assure the public health, safety, and welfare of their state by providing licensure and regulation of physicians. In the field of sports medicine, duties of team physicians may include traveling out of state with their teams and practicing medicine. Currently, the certification of sports medicine does not address inter-state practice of medicine. The purpose of this study is to see if state licensure boards have addressed this inter-state practice of medicine which is inherent in sports medicine.
Methods: This is an observational study using survey forms sent to each of the 50 state licensure boards. The primary question was whether the state had a provision which addresses the ability of an out-of-state physician to assess and treat a contracted athlete, club, or team while they are in that state. Additional questions addressed the type of provision, limitations and regulations, and means of access. Three separate mailings were made over a total of six months.
Results: Thirty-five out of 50 states responded; 20 states have no provision and require full state licensure for the practice of medicine within their state. One State had no provision, but specifically stated the allowance of visiting team physicians as a courtesy. Fourteen States have some form of provision: within their licensure statute (6), a temporary or emergency license (4), a special event license (2), or a temporary license requiring in-state-physician supervision (2). Thirteen of these states provided further information through websites.
Conclusion: This survey demonstrates that there is no uniform policy regarding the practice of inter-state sports medicine since there are both states with licensure provisions allowing for out-of-state team physicians, as well as states which strictly require in-state licensure. Since only 28% of states have confirmed they allow out of state practice of sports medicine, this is a significant problem. It will only grow worse if not addressed as interstate travel becomes increasingly necessary due to the expansionary nature of national sporting leagues and rise in popularity of younger leagues. This study also reveals that states without provisions in their original medical practice act have in recent years created addendums allowing for event licensure and temporary licensure. These findings encourage us to push for legislative action to allow sports medicine physicians the privilege of inter-state practice of medicine. In the words of our honorable colleagues in North Carolina, "a bill may be proposed in legislative session."

6 Comparing the Evaluations of a Case-Based Reasoning Decision Support Tool by a Single Expert Reviewer with Those of End Users.

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Background: The development of decision support tools (DST) requires end-users feedback. This is labor intensive and logistically difficult. These difficulties would be eased if the evaluation of a single expert evaluator accurately reflected that of the end users.
Objective: To determine the agreement between physician evaluation of the performance of a case-based reasoning (CBR) DST with that of a single expert reviewer
Methods: Ten EPs and three midlevel providers were presented with the results of a CBR-based DST designed to predict disposition of children presenting to the ED with bronchiolitis. Each evaluated the predicted disposition, explanatory case, and explanatory dialogue generated by the software using a five-point descriptive scale. The expert reviewer relied on case notes and was blinded to actual disposition. Agreement was measured using the kappa statistic.
Results: The case notes and DST output of 109 patients were evaluated. Where the end user and expert evaluator agreed