



DIVISION OF EMERGENCY MEDICAL SERVICES
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REGION III

EQUITABLE TRUST BUILDING, SUITE LL-7 • 401 WASHINGTON AVENUE • TOWSON, MARYLAND 21204 • AREA CODE 301/828-5300

Neil Solomon, M.D., Ph.D., Secretary

October 19, 1976

Chris Papadopoulos, M.D., F.A.C.C.
Chief of Medical Staff
South Baltimore General Hospital
3001 South Hanover Street
Baltimore, Maryland 21230

Dear Dr. Papadopoulos:

Enclosed you will find a copy of revised CRT Program Standards that have been assembled during the past three months. As per our discussion, there existed a real need to make certain improvements in the Standards in order to insure better quality control of the program. The revisions were based on indepth discussions with both Physicians and lay CRT-Instructors throughout the State. Because the revisions were many in number, I would like to briefly summarize the important changes as follows:

* 1) The previous provision which allowed individuals to challenge the CRT examination; by prior experience and special permission of the Director of EMS, has been eliminated. If a person, including nursing personnel, desires to become a CRT, then that individual must go through the entire course and pass the examination.

2) The previous provision for allowing lay individuals to be appointed as CRT-Instructors, by the Director's special designation, has also been eliminated. Instead, a CRT-Instructor candidate has to go through a period of internship with the teaching of a CRT course. Following the internship, the candidate will then be subject to a peer review process conducted by other CRT-Instructors. Failure to obtain a favorable review will result in the candidate failing to become a CRT-Instructor.

3) Provisions have been included which limit the conditions and number of times a CRT candidate can sit for examination. (Section 1.2.3) "If a candidate fails the examination, he/she must repeat the didactic portion of another CRT course before retaking the exam. Failure to pass the 2nd exam requires a candidate to acquire an additional year's experience as an EMT in an ambulance company. After one year, a candidate must complete another entire CRT course before he/she is eligible for examination. Failure to pass this exam will result in permanent exclusion from the CRT program."

4) Recertification activities have been changed from a six month cycle to an annual cycle. The number of technical procedures to be performed has been doubled i.e., monitoring 10 patients having cardiac arrhythmias instead of 5 patients. This feature was included because the six month cycle was proving to be an administrative nightmare for the Division to manage. The CRT card that is issued to each CRT will have an annual stamp to be placed on the card.

5) Provisions have been made to include a mandatory CRT refresher workshop for all CRT's to attend. The goal is to have the CRT-Instructors go out to individual ambulance companies and conduct simulated clinical situations.

6) Course Content has been augmented to include a module on use of the Esophageal Obturator Airway. Also, CRT students will have to demonstrate effective CPR administration by producing a satisfactory print-out using the recording Rusci-Anne. The CRT Instructors have related the experience that their students are deficient in CPR skills even though they may possess a current certification card from the Heart Association. CPR will be heavily stressed in future CRT courses as well as during examinations.

7) Decertification of Cardiac Rescue Technicians. (Page 20) This feature is perhaps the most important addition to the Guidelines. (4.1 through 4.12) The problem of Maryland CRT's attempting to practice their skills in adjoining states has been addressed. Maryland CRT's must restrict their activities within the State of Maryland. We have several ambulance companies that operate near the Pennsylvania-Maryland state line. Until reciprocity can be arranged with other states, this restriction will have to exist.

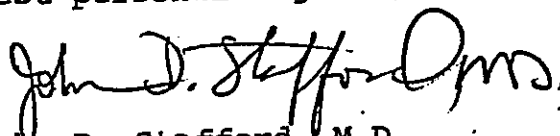
In addition, we have "borrowed" similar reasons for decertification of physicians to be applied to Cardiac Rescue Technicians. The mechanism now exists for decertifying a "bad" CRT who does not adhere to a professional type of conduct.

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I sincerely hope that the Board of Medical Examiners approves these revisions to the CRT Program Guidelines. If you need my assistance with further defining the proposed changes, do not hesitate to call on me.

Best personal regards,



John D. Stafford, M.D.
Associate Director
Office of Medical Programs

JDS/rll

Enclosure