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EMERGENCY CARE NEWS

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Nebraska, Oregon Lead No-Coin Dialing Advance

In Nebraska and in Oregon, 85% of the Bell company pay telephones can be used without coins when necessary to seek medical or other help in emergencies. In Illinois the figure is 82%; in Ohio, 81%.

This puts these four states well ahead of most of the others in current availability of no-coin dialing, according to the American Telephone & Telegraph Co., which has supplied figures on 26 states. Progress in no-coin dialing is happening mainly where Bell companies provide service. They operate all but 58,000 or so of the 1.5 million pay telephones in the U.S., an AT&T spokesman says.

In Nebraska, no-coin dialing has been provided at the initiative of Northwest Bell as an accompaniment to equipment modernization, according to the state public service commission.

Tied to rate increase. The Arizona Corporation Commission recently required Mountain Bell to provide no-coin dialing in all of its pay phones in Arizona. It did so when granting permission for the company to charge 20¢ instead of 10¢ as the minimum for using a pay phone. No-coin service is scheduled to be complete by the end of 1977.

Elsewhere the present and/or projected percentages of Bell pay phones with no-coin dialing for emergencies are as follows:

North Carolina, 71%; Wisconsin, 70%; California, 1% (big increase due by 1980); Colorado 87% by the end of 1977; Connecticut, 7%; Delaware, 33%; District of Columbia, 20%; Florida, 12%; Georgia, 7%; Indiana, 11%; Iowa, 12%; Maryland, 14%; Minnesota, 2%; New Jersey, 53%; New York, 7%; North Dakota, 1%; Pennsylvania, 32%; South Carolina, 32%; South Dakota, 49%; Virginia, 63% by the end of 1977; Washington, 13%.

No-Coin—see p. 2

Establish 4 Facility Levels For Burn Care, ABA Urges

Health care policy makers and administrators are being urged by the American Burn Association to aim for the formal establishment of four levels of burn treatment facilities: hospitals with in-depth expertise and optimum facilities, hospitals with special expertise, emergency departments, and emergency care at the scene.

The Association asks also that the use of these facilities for each category of burn injury—major, moderate, and minor—be spelled out in emergency system procedures. ABA president Alan R. Dimick, MD says, "We feel these recommendations are needed because of the lack of standards for burn care in the United States."

Care of major burns. Second-degree burns of greater than 25% burned skin area in adults (20% in children) and all third degree burns with 10% BSA or greater are major burn injuries, ABA says. Also electrical burns, those with inhalation injury and all burns involving hands, face, eyes, ears, feet or perineum are major, as are complicated burn injuries involving fractures or other major trauma, and burns of poor-risk patients. Victims of major burns "would normally enter the system at the site of injury, and be transported to a hospital with optimum facilities (burn unit, burn center) dependent upon distance and time, burn complications (respiratory, shock) and bed availability."

"The importance of direct communications and transfer agreements is emphasized" where major burns are concerned, the ABA says. "If seriousness of the injury dictates transportation to the closest effective emergency department or special expertise hospital, then transfer to a hospital with optimal facilities should be arranged after cardiopulmonary stabilization and intravenous fluid therapy for shock are established. Rehabilitation (including corrective surgery for cosmetic and functional deficiencies) completes the therapeutic circle."

The Association prescribes along similar lines for the victims of moderate or minor burns, after first specifying in some detail what it means by each level of facility. It then offers specific criteria for the organization, equipment, personnel, laboratory, and other support it considers essential. The information appears in an 18-page document, "Specific Optimal Criteria for Hospital Resources for Care of Patients with Burn Injury."

Dimick told ECN it was his understanding that this document will soon be published in the *Bulletin* of the American College of Surgeons.

20% reach proper care. Of the 75,000 persons who suffer serious burns in the U.S. every year, only 20% are taken to where they can get proper care. So David R. Boyd, MDCM told the federal Interagency Committee on Emergency Medical

Burn Care—see p. 2

"WE'RE STILL TRYING to negotiate a settlement"—This was the word at publication time from Congressional staffers regarding a compromise bill to extend the U.S. Emergency Medical Services Systems Act of 1973. Each House of Congress has now passed, by a large majority, its own version of a bill to extend the Act. One sticking point is the extent to which local jurisdictions will be required to match system grants with cash.

BURN CARE, from p. 1

Service when it met on August 2 in Rockville, M Dimick presented the ABA criteria for bu are organization at this meeting.

The ABA president spoke of the necessity to transfer a seriously burned person to optimum facilities within 24 hours. He said also that if shock is treated properly in the first 12 hours, fewer kidney problems follow. Boyd added that regional care locations are needed for prompt and effective treatment of medium-severity burns.

The ABA is concerned about the lack of complete data on the incidence and severity of burns. It is now surveying the location and staffing of every U.S. burn treatment facility, along with referral patterns, and it may have survey results by this fall.

The ABA wants to set up standards for pre-hospital burn treatment, Dimick said. In travels across the U.S. he has observed much inadequate care. In one community he found a patient at the scene being packed in ice — "The patient would have had frostbite by the time he reached the emergency department."

Boyd said his office, the Division of EMS in the Department of Health, Education & Welfare, is "looking at" a demonstration project for burn care. He said DEMS was asking each region to review its vertical facilities and capabilities for the treatment of burns.

Dimick asked for a single federal focus for the variety of federal activities related to burn care, and suggested the Interagency Committee on EMS form a sub-committee or council for the purpose.

EMERGENCY CARE NEWS

Emergency Care News is an activity of The Emergency Medical Services Technical Assistance Program (EMS-TAP). EMS-TAP is conducted by a consortium of Public Technology, Inc.; the Center for the Study of Emergency Health Services, Department of Community Medicine, University of Pennsylvania; and Kahl Associates. It is partially funded by the Robert Wood Johnson Foundation. Through EMS-TAP, low-cost technical assistance is provided to cities, counties and regions working to improve the quality of their emergency medical services.

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Don't Omit Consumers, New Council Guide Says

The American Medical Association's Commission on Emergency Medical Services has issued a fresh version of its widely-distributed booklet, "Developing Emergency Medical Services—Guidelines for Community Councils." Though adhering to the old format, the new version contains substantive changes. One is the inclusion of consumers among four main groups whose representation is "essential to the success of almost any council."

The other three groups are providers, public agencies and community leaders. These three alone were described as essential to an EMS council in the original version of the Guidelines.

The Guidelines were first published in 1969 and have been reprinted several times without change. Some 40,000 copies have been distributed and demand has hardly slackened, according to the AMA. Some parts of the new version, especially where it touches central dispatch, show little difference from the original or need of it. Elsewhere the new edition can be taken as a reflection of much evolution in EMS.

Citizen training. Where the original Guidelines **(A)** listed basic components of an emergency care system, they began with: "broad-based training, for on-the-spot first aid." By contrast the new version **(B)** begins the list of components with: "broad-based training of citizens for on-the-spot first aid."

Further differences between the old and new versions include the following:

A said the school system might have "a role in the teaching of first aid." **B** says the school system might have "a role in the teaching of first aid and basic life support." **B** says further that cardiopulmonary resuscitation should be taught in secondary schools, colleges and industry.

A included among necessary EMS system components "a communications system which assures prompt response to the need." To this **B** adds, "preferably a single access number."

A: In communications planning, it is important to involve "technical experts and decision-making executives from the communications industry." **B:** It is important to involve executives "from the persons concerned in the fire and police communications network."

A: In community evaluation, the council needs to know "the extent to which advanced first aid training is required of police and fire personnel." **B:** The council needs to know "the extent to which emergency medical technician training is required of police and fire personnel."

A: "Emergency departments should be evaluated in terms of facilities," **B:** EDs "should be categorized in terms of facilities," etc.

A: In the ideal sequence of events in response to a traffic accident, "the ambulance arrives promptly and its trained personnel evaluate the injuries, provide necessary on-site care... and radio the dispatcher to find out the nearest hospital with space and appropriate facilities." **B:** "The ambulance arrives promptly and its trained personnel, emergency medical techicians, evaluate the injuries, provide necessary on-site care ... and radio the hospital best equipped to handle the type of injury..."

A: The hospital emergency staff and services "should be available seven days a week—24 hours a day." **B:** (adding to the foregoing) "While it is generally felt that the EMS system stops at the 'back door' of the Emergency Room, the Council should assure itself that adequate means of follow-up care are available for the emergency patient."

Advanced EMT training. Going beyond the original Guidelines, the new edition calls for the two emergency medical technicians on every ambulance to be given "advanced [EMT] training ... with basic EMT training required as a prerequisite." A had called for the two EMTs on every ambulance to be given "basic emergency care training ... with advanced first aid training required as a prerequisite."

William A. Burnette, director of AMA's EMS department, told ECN it is the view of the EMS Commission that advanced EMT or paramedic level training are feasible only where appropriate equipment is on hand. He said that not all volunteer units could be expected to have such equipment.

In other additions, the current Guidelines say:

— Ambulance-hospital telemetry should be part of the 24-hour capability of emergency communications.

— A model ambulance ordinance, or statute regulating ambulance service, should be endorsed and promoted. (Reference is made to the ordinance prepared by the Traffic Conference, National Safety Council, as revised November 1974.)

— The pediatrician should bring his expertise to bear in emergencies.

The new Guidelines offer sample bylaws for the EMS council. The bylaws are available free from the AMA's Department of Emergency Services, 535 N. Dearborn, Chicago 60610; 312/751-6000. The new Guidelines edition itself costs 75¢ apiece for one to 99 copies, and less for more. Order from: OP 386, Order Dept., AMA, same address.

NO-COIN, from p. 1

In many states, no-coin dialing is going forward in step with the establishment of 911 as the universal emergency access phone number. In California and Illinois, state laws require this. But no-coin dialing is expected to take longer than 911 to achieve nationally. The cost of converting to no-coin dialing is greater, AT&T says, especially for small independent phone companies serving non-urban areas.

out to be 706 hours.

Burn Foundation
of Greater Delaware Valley

OCTOBER 1976

newsletter

AFRICAN ACCIDENT VICTIM FLOWN TO PHILADELPHIA FOR BURN TREATMENT

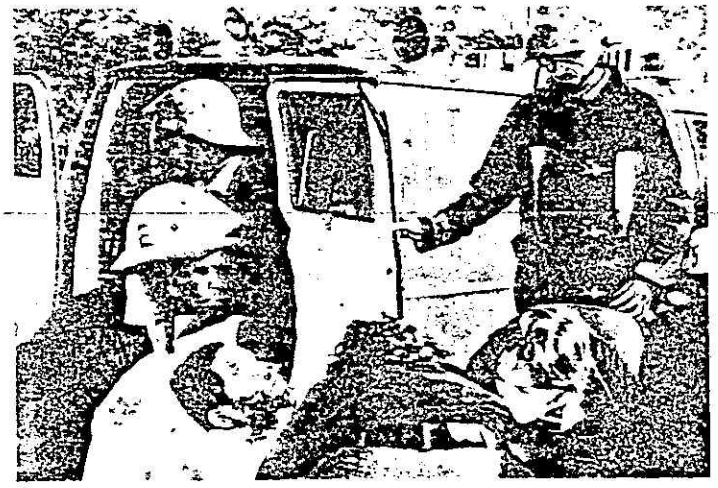
A 24-year-old electrical engineer is recovering rapidly in the St. Agnes Burn Center after an arduous transfer of 5,500 miles, following a recent accident deep in the Libyan Desert.

Gregory Twombley of Hillsdale, New Jersey was working alone, installing high voltage equipment at an oil field construction site, when he accidently contacted a multi-thousand volt current. Despite electrical burns affecting 35% of his body, he managed to drive his pickup truck several hundred feet to the nearest co-workers, who put into motion a sequence of steps culminating in the victim's admission to the St. Agnes Burn Center five days later.

The Twombley admission represents the first intercontinental transfer to one of the Burn Foundation centers, and demonstrates further that long-distance transfer of severe burn victims, particularly in the early days following injury, is a reasonably safe procedure. During the Vietnam War, for example, most American military burn victims were flown directly to the Brooke Army Surgical Research Center in Texas.

The referral to St. Agnes Medical Center resulted from a telephone call made by Twombley's father to his personal physician in North Jersey, who recommended that the Burn Foundation's service be contacted. In the meantime, the petroleum company at whose location the accident occurred had already made arrangements to fly the injured man 450 miles to Tripoli, the capital of Libya. Emergency care including fluid therapy was initiated there four hours after the accident, while arrangements were completed to transfer the patient to England.

Twenty-two hours later and 2,000 miles away, the patient was hospitalized at the Queen Mary Hospital in Roehampton, a suburb of London. Twombley's parents flew to London to be near him, and waited until surgeons at Queen Mary, a distinguished burn facility, determined that he was sufficiently stabilized to be flown to the United States.



Fire medics from the Philadelphia Fire Department, assisted by helicopter personnel, transfer burn victim Gregory Twombley to rescue vehicle for five-block trip to St. Agnes Burn Center. Twombley was burned at a construction site in Libya five days previously.

In a series of trans-Atlantic calls, arrangements were made to transport the patient on a commercial flight to New York, where he was met by St. Agnes Burn Center director Frederick DeClement, M.D. at J.F. Kennedy Airport. Following seemingly interminable customs checks of the patient's parents and nurse, the Horsham Township police helicopter transferred the entire group to Philadelphia. Like all burn patients transferred by helicopter to St. Agnes, Twombley was landed at Marconi Plaza, five blocks south of the hospital, and transferred to the hospital by a Philadelphia Fire Department rescue squad.

PRESIDENT FORD SIGNS EMS/BURN INJURY ACT

On October 21 President Ford signed into law the Emergency Medical Services Amendments of 1976, which authorizes a $22.5 million burn injury demonstration program over the next three years.

The new legislation does not authorize specific numbers of burn care facilities or personnel. It is designed mainly to determine what types and amounts of Federal support are needed to establish an effective, efficient program of burn care throughout the country. (Cont. Page 2, Col. 2)

FIREBIRDS HOCKEY GAME TO AID BURN FOUNDATION

The Burn Foundation will benefit from the sale of tickets to a hockey game between the Philadelphia Firebirds and the Johnstown Jets of the North American Hockey League, on Thursday December 2. A large block of $4.50 tickets to the game, which starts at 7:45 p.m. at the Philadelphia Civic Center, is being distributed by the Burn Center Volunteers of South Jersey.

Half the proceeds from all tickets sold by the Volunteers will be presented to the Foundation. Those wishing to purchase tickets to help the Foundation should contact the Volunteers' office at 609/428-0241. The Foundation will benefit only from those tickets sold by the Volunteers.

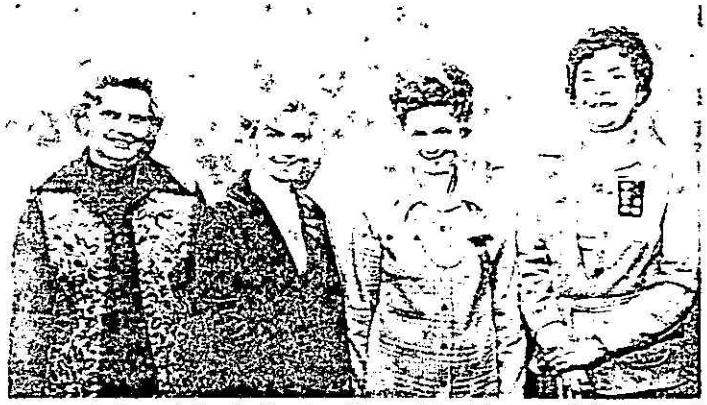
YOUNG GIRLS SKIRT DEATH WITH NEW CLOTHING STYLES

Changing styles in female clothing have been credited with a dramatic decline in burn deaths among girls over the past 15 years. Two John Hopkins University researchers have singled out the switch from skirts to pants as the major factor in a 55% drop noted between 1960 and 1974 in deaths from burns among girls aged 5 to 9. Deaths among boys during the same interval also dropped, but the decrease was only about 15%. The possible impact of better treatment and improved fire prevention education were assumed by the researchers to apply equally to boys and girls.

The findings were presented by John Hopkins researchers G. Stewart Young and Susan Baker in a report prepared for delivery at the annual meeting of the American Public Health Association in Miami. The period of the study, for which records of the National Center for Health Statistics and the Baltimore City Medical Examiner's Office were used, roughly parallels the rise in popularity of pants among females, they noted.

The change is particularly noticeable since the late 1960's. Until then, girls under 10 had death rates that were much higher than for boys, a situation unlike that for any other area of injury-related deaths. The higher rate of burn deaths among girls, the report notes, could be attributed to loose-fitting, easily ignited dresses and nightgowns.

Burn Foundation statistics, dating from 1973, indicate that burn admissions in the grade school age group are divided about 75:25 between boys and girls. The total ratio of males to females among Burn Foundation patients is about 70:30 across all age groups. Between 5 and 65, males predominate. Above that age, female admissions are higher than their proportion of the population. This suggests that lower acceptance of tight-fitting clothing, especially nightwear, among elderly females is reflected in a relatively high incidence of burn injury.



Representatives of the Ladies Auxiliary of the Firemen of the State of New Jersey visited the two Burn Centers of the Burn Foundation on October 26 to present checks totalling $5,000. Pictured left to right are, Mrs. Sophia Mate, Publicity Chairman, Burn Committee Co-Chairmen Mrs. Patti Willever and Mrs. Shirley Powell, and Mrs. Helen Dolci, President.

EMS/BURN ACT SIGNED

(Cont. from Page 1, Col. 1) The explanatory report from the Joint House/Senate Conference Committee places responsibility for the burn program within HEW's Division of Emergency Medical Services, in the Health Services Administration.

While the language of the burn injury section is quite general, it reflects close communication over the past year between Congress, HEW and the American Burn Association. Further reinforcement of the basic intent of the Act was provided by a recent report to Congress by an HEW Task Force on Burn Care, on which the Burn Foundation was represented.

Over the next few months, a monitoring committee with representatives from the public and private sector will be established to help guide the new Federal program. No grants or contracts under the program can be made until appropriations legislation passes, sometime after the new Congress convenes in January, and specific program guidelines are promulgated by the Secretary of HEW.

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