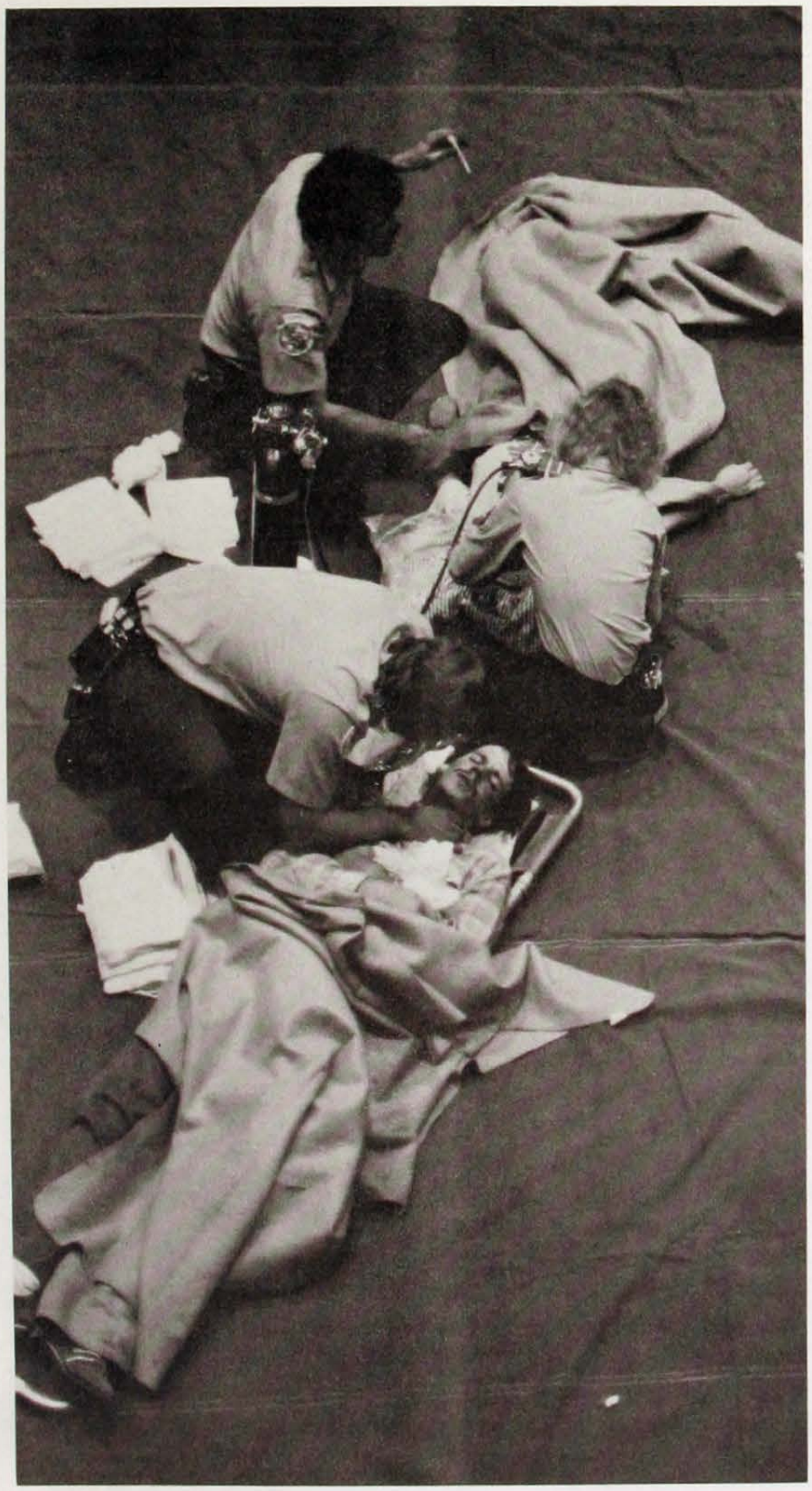
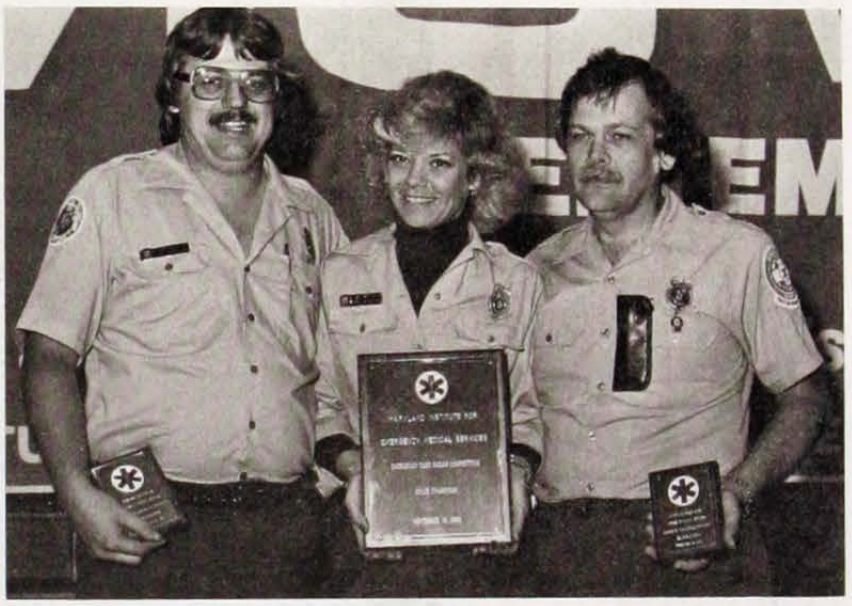
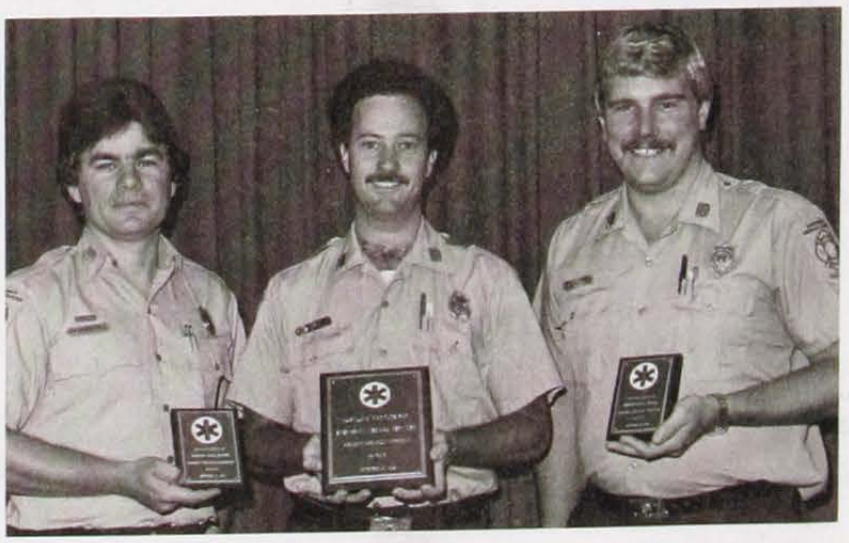
Maryland EMS NEWS

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS VOL.9 NO.1 OCT/NOV 1982







Maryland EMS NEWS

Cover: The top three teams in the skills competition of Maryland's Second Annual Olympics were (top to bottom) *Community Rescue Squad (first place); Odenton Volunteer Fire Company (second place); and the Baltimore County Fire Department (third place).* Left, *the Community Rescue Squad team demonstrates life-saving skills during the competition.*

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICE SYSTEMS VOL.9 NO.1 OCT/NOV 1982

MIEMSS Runs Montebello Trauma Rehab Unit

MIEMSS now has full responsibility for the rehabilitation care provided to spinal cord and orthopedic trauma patients who are sent to the Montebello Center.

This change is part of a larger development in which all medical care at the center has been transferred from the Department of Health and Mental Hygiene (DHMH) to the University of Maryland at Baltimore (UMAB).

MIEMSS took control of trauma rehabilitation care gradually during the summer. In August, the medical director of the MIEMSS trauma rehabilitation program, Saul Weingarden, MD, was installed.

Formerly, Dr. Weingarden was medical director of the department of physical medicine and rehabilitation at Camino Hospital in Mt. View, California, as well as director of the residency training program in physical medicine and rehabilitation, the multiple sclerosis clinic, and the electro-myographic service at the Santa Clara Valley Medical Center in San Jose, California.

A diplomate in the American Academy of Physical Medicine and Rehabilitation, Dr. Weingarden has also been a consultant to the Social Security Disability and Determination Bureau and a clinical instructor at Ohio State University, both in Columbus, Ohio.

Dr. Weingarden will also oversee the MIEMSS rehabilitation program at the Shock Trauma Center. He will report to the deputy director of MIEMSS, John Siegel, MD.

Another new staff member, Patricia S. Engelhardt, RN, MS, was named assistant director of nursing for the MIEMSS rehabilitation program at the Montebello Center in July. She will report to Elizabeth Scanlan, director of nursing for MIEMSS.

Prior to her present position, Ms. Engelhardt was the rehabilitation services manager at Overlook Hospital in Summit, New Jersey. In that position, she helped plan, organize, direct, coordinate, market, and evaluate a comprehensive program of rehabilitation services.

Ms. Engelhardt is involved in numerous professional and community service activities. She was a charter member of the New Jersey chapter of the Association of Rehabilitation Nurses and has served on its board of directors. She is a member of the American Congress of Rehabilitation Medicine and has served on its pediatric rehabilitation committee. In addition, she has served on several committees associated with an independent living center for handicapped young adults.

In her new position, Ms. Engelhardt will be responsible for the planning, development, and implementation of the MIEMSS rehabilitation program at MIEMSS and the Montebello Center. She will be supervising a staff of registered nurses and licensed practical nurses, as well as nursing support personnel.

An active recruitment program is underway. Registered nurses interested in learning more about this program and attending an observation day should call Ms. Engelhardt at 889-3080, ext. 376.

In June, R Adams Cowley, MD, director of MIEMSS, addressed the staff and patients of the MIEMSS rehabilitation unit. Many of his comments during the meeting concerned patient flow to and from the Montebello Center.

"Previous to the MIEMSS program, patients were treated at the hospital and then shipped out to a rehabilitation center. Now, rehabilitation will start on admission to the Shock Trauma Center," Dr. Cowley said.

"The quicker you can start rehabilitation, the sooner you can get patients out of the hospital," he added.

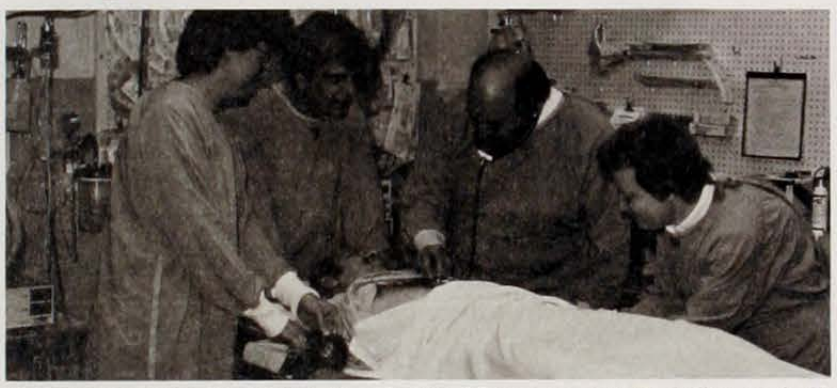
To maintain the continuity of care between the Shock Trauma Center and the Montebello Center, Dr. Cowley said staff members from Montebello will visit patients at the Shock Trauma Center before they are discharged.

When patients are ready to leave the Montebello Center, they will receive psychiatric help, social support, and educational retraining at the Center for Living, he added.

A follow-up program will be initiated to find out how patients are adjusting psychologically and physically to daily life. Patients who are not doing well will be referred to the end of this patient care system, where any remaining problems can be handled without tying up the medical resources farther back in the system, Dr. Cowley said.

Arrangements for the transition have been handled by Anthony Zipp, the administrator for the MIEMSS trauma rehabilitation program. —*Dick Grauel*

Hagerstown Trauma Center to Expand



Washington County Hospital staff (l-r): *Mary Beachley, ED nurse supervisor; Dr. William Joseph, ED Medical director; Dr. John Marsh, chief of surgery; and Lorna Christian, trauma coordinator.*

The effort and cost involved in becoming designated as an areawide trauma center are minor compared to the human and monetary expenditures required to function as a top-notch trauma center.

That point was stressed at a trauma symposium, held recently by MIEMSS for hospital administrators thinking of starting trauma centers. H. W. Murphy, president of Washington County Hospital in Hagerstown, can vouch for the truth of that statement.

The hospital, which became designated as an areawide trauma center in 1979, has embarked on a $28-million building program that includes the construction of a new emergency department, operating suite, intensive care unit, and facilities to meet the needs of trauma patients at various stages of recovery. Mr. Murphy has been the energizing force behind this ambitious project.

As important as improved facilities are to the quality of patient care, however, the medical staff provides the human element necessary to make full use of the material advantages of a trauma center.

For that reason, the hospital has added a traumatologist and a trauma coordinator to the staff to enhance the operational cohesiveness of the trauma center.

The traumatologist, Sayed Riaz Bokhari, MD, joined the emergency department staff in July. He trained at MIEMSS as a traumatology fellow.

Although the trauma coordinator's position is new, the person filling that position, Lorna Christian, RN, is a longtime employee of the hospital. For the last 15 years, she has been the supervisor of the intensive care unit. She also serves on the Region II Medical Advisory Committee.

The new addition to the hospital is a three-story structure that will be adjoined to the

(Continued on page 2)

EMTs, CRTs Can Cross State Borders, Give Care, Pact Says

A recently signed agreement between Maryland, Pennsylvania, Virginia, West Virginia, Delaware, New Jersey, and the District of Columbia gives EMTs and CRTs permission to cross state borders to render care on an emergency, mutual aid basis.

By signing the agreement, these states and the District of Columbia recognize the certification or licensure of EMTs and CRTs in the signatory jurisdictions that are contiguous to them.

However, the agreement only pertains to situations in which a fire or ambulance company in one jurisdiction is asked by a company in a bordering jurisdiction to cover for its community while its ambulance is out on a call.

The terms of the agreement state that both EMTs and CRTs are allowed to provide emergency medical care in a contiguous jurisdiction that is party to the agreement in accordance with the medical protocols of the *jurisdiction in which they are certified or licensed.*

In addition, advanced life support personnel from a contiguous, signatory jurisdiction may initiate invasive techniques under the supervision of a physician and in accordance with the medical control requirements of the *jurisdiction directly involved.*

Maryland EMTs and CRTs have responded to emergency calls for their services outside of the state in the past, but were not able to initiate treatment until the ambulance crossed back into Maryland. Now, they can initiate treatment at the scene in the other jurisdictions named in the agreement.

Although the agreement is an important step forward in interstate EMS cooperation, it does not cover CRTs who routinely respond to calls in a neighboring jurisdiction because the company they work for serves an area that lies almost completely in that jurisdiction.

The view of many of the CRTs in that situation is that they should be certified in the jurisdiction in which the company is located.

However, Alasdair Conn, MD, director of the MIEMSS field operations program, and EMS officials in other states assert that such CRTs should be licensed by the state in which they operate most of the time.

Dr. Conn says the Mid-Atlantic EMS Council is trying to resolve that issue, as well as the problem that a physician in one jurisdiction cannot provide consultation to prehospital care providers in a different jurisdiction.

—*Dick Grauel*

Washington Co. Expanding Trauma Facilities, Services

(Continued from page 1)

existing hospital by covered walkways. Atop the building will be a heliport for Med-Evac helicopters. Patients arriving by helicopter will be wheeled to a sheltered elevator on the roof that is reserved for the transport of trauma patients. The elevator will take patients directly to one of two trauma admitting rooms in the emergency department on the first floor.

The admitting rooms, located inside the ambulance entrance to the emergency department, will hold four critically injured patients, which is double the capacity of the area presently used.

Patients with less severe injuries will be treated in separate rooms: one containing eight treatment beds, another with four observation beds.

Patients who need surgery will be taken to the operating suite on the second floor. Two of the operating rooms will be reserved for patients with severe trauma.

Before or after surgery, patients who need constant medical attention will be taken to an 11-bed intensive care unit, which will be on the same level as the operating suite.

Although the unit will accommodate the same number of patients as the present one, it will be larger and better equipped. The patient-to-nurse ratio will be two to one.

Patients with heart problems will be taken to the coronary care unit on the third floor. The new unit will have eight beds, two more than the existing unit holds.

When patients recover to the point that they no longer need the close medical and nursing attention provided in the intensive care or coronary care unit, they will be transferred to the progressive care unit. This third-floor unit will also have more beds than the present unit — 21 compared to 15.

From the progressive care unit, patients will be transferred to regular medical and surgical nursing units in the main hospital.

The rehabilitation process begins as early as possible in the recovery period. While still in the hospital, patients will receive extensive physical therapy in a facility that will be located on the first floor.

However, patients who need extended rehabilitative therapy will be referred to a rehabilitation center. Those who need relatively minor follow-up care will be treated in one of the first-floor outpatient clinics in the new building.

Dr. Bokhari will oversee the day-to-day operation of the trauma center and will act as the leader of the physician team that treats patients with critical injuries. He will also be responsible for the quality assurance, administration, supervision, and educational components of the hospital's trauma program.

A person was needed to act in this capacity because Edward Drawbaugh, MD, chairman of the emergency medicine advisory committee, and Jack Carey, MD, chairman of the trauma committee that oversees the functioning of the emergency department, both have other responsibilities that prevent them from giving their complete attention to the operation of the trauma center.

Dr. Bokhari obtained his medical degree from the King Edward Medical College in Pakistan in 1975, when he also received the Bakley Memorial Medal for the best performance in clinical surgery on his final professional examination. Dr. Bokhari attended college and medical school on a state merit scholarship. He recently became certified as an advanced trauma life support instructor.

Ms. Christian is responsible for coordinating the care of all trauma patients throughout their hospital stay. She visits patients daily to make sure they are receiving the best quality of care. She also oversees the arrangements for transferring patients from one hospital unit to another, and for discharging them.

In addition, the trauma coordinator collects statistical information on all trauma patients both while they are in the hospital and after they have been discharged. This information is used by the medical staff to evaluate the efficacy of different therapies.

The postdischarge follow-up procedure, which continues for three to six months depending on the severity of the patient's injuries, allows Ms. Christian to offer additional assistance to patients.

Another of Ms. Christian's responsibilities is serving as the liaison between the emergency department staff and field personnel. In this role, she organizes various educational sessions for field personnel.

Case reviews, for example, give hospital staff and field personnel an opportunity to critique the handling of specific cases with the goal of improving prehospital care in the future. Formal lectures and informal conferences are also held for field personnel.

In addition, practical learning experiences are provided. A recent change in hospital policy permits CRTs in the vicinity to "buddy" with emergency room nurses to gain additional experience in treating trauma victims. Conversely, emergency room nurses can ride advanced life support vehicles to see firsthand the problems with which CRTs have to contend. This new policy has produced a marked improvement in the relations between nurses and field personnel.

The physician and nursing staffs are well qualified for the work they do. All the emergency department physicians have advanced life support certification and some of them have been certified as advanced trauma life support physicians.

Virtually all the emergency department nurses have received advanced cardiac life support certification and 75 percent of the staff has passed the national certification examination for emergency nursing. Many of the nurses have attended trauma training programs held by the Emergency Department Nurses Association and MIEMSS. Arrangements are being made for a "buddy program" for Washington County Hospital nurses to work with trauma nurses at MIEMSS.

—Dick Grauel

Lewis, Eastham Join Faculty Of Emergency Health Program

An educator and a researcher have joined the burgeoning faculty of the emergency health services (EHS) program at the University of Maryland Baltimore County (UMBC).

Dr. John C. Lewis, formerly dean of technical and professional studies and of summer sessions at Spring Garden College in Philadelphia, assumed his post as assistant professor of EHS this month. He was responsible for all technical and vocational programs at the college and implemented both two-year technical and four-year professional programs.

James N. Eastham, Jr., accepted his position as EHS instructor in July. He came from the office of medical practice evaluation at the Johns Hopkins Hospital, where he was a senior research assistant, responsible for internal quality assurance projects.

Dr. Lewis, having a strong background in educational program development, will be involved primarily in designing courses for the EHS program. In addition to helping Dorothy Gordon, DNSc, director of the EHS program, to develop an EHS master's degree program, he will be designing undergraduate courses in instructor training methods.

In concert with these responsibilities, Dr. Lewis's research efforts will be directed at finding the best methods for training EMS instructors.

Mr. Eastham will help teach the introductory course in the EHS program and will be the faculty coordinator for the fieldwork practicum in EHS management. He is also developing a new undergraduate EHS course that will cover research methods, as well as accident and injury prevention.

Part of Mr. Eastham's research work will also concern the prevention of accidents and injuries. In addition, he will continue his evaluative research on the Abbreviated Injury Scale (AIS), which he began as a research assistant in the Johns Hopkins University's Health Services Research and Development Center in 1979. The validity of the AIS is the subject of Mr. Eastham's doctoral dissertation.

—Dick Grauel

ATLS Courses Scheduled

Advance trauma life support courses will be held at MIEMSS for providers of trauma care on the following dates: November 18 and 19, and December 1 and 2 in 1982, and January 13 and 14 in 1983. For information, call 528-2919.

Howard Co. Stations Pass Inspection; First County in State to Comply

Howard County has become the first county in Maryland in which all fire department ambulance stations have received certificates of excellence for successfully passing MIEMSS' voluntary ambulance inspection requirements.

The nine Howard County stations that received the certificates and vehicle decals are the following: Station #1 (Elkridge Volunteer District), Stations #2 and #8 (Ellicott City Volunteer District), Station #3 (West Friendship Volunteer District), Station #4 (Lisbon Volunteer District), Station #5 (Clarksville Volunteer District), Stations #6 and #9 (Savage Volunteer District), and Station #7 (Howard County-operated station).

According to Donald R. Howell, captain of the Howard County Fire Department Emergency Medical Services, county involvement in the inspection program started about two years ago when Station #1 requested and passed the inspection.

Discussions between the Howard County Fire Administration and the volunteer fire departments followed that first inspection, resulting in a mutual and voluntary commitment to request the inspection for all their ambulances to ensure maintenance of equipment and performance standards. To date, 43 companies throughout the state have been certified.

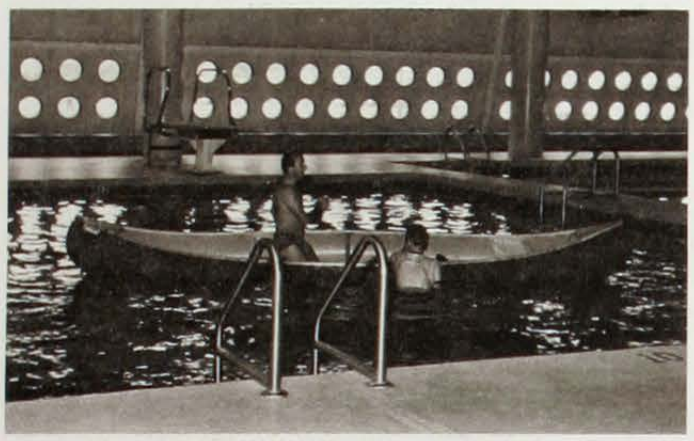
For each inspection, two or three MIEMSS officials check ambulance equipment, such as suction and breathing apparatus, for accurate performance and readings and inventory ambulance medical supplies. Each item is marked on a checklist developed in conjunction with the Maryland State Firemen's Association. (A copy of this checklist is available prior to each inspection for preparation purposes.)

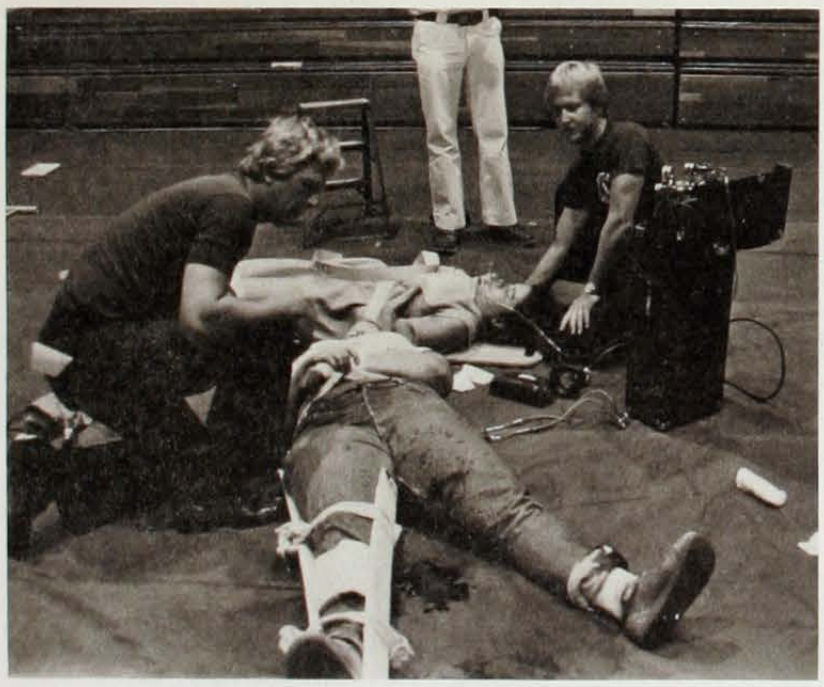
This inspection is *not* the first step toward mandatory inspection; it is strictly voluntary and a means by which ambulance companies can be self-regulating with regard to minimum equipment and manning standards. However, the certified companies must agree that their ambulances will not display the seal of excellence, which they receive for passing the inspection, unless they maintain those high standards.

Capt. Howell stresses that Howard county's commitment has not ended with the acquisition of the MIEMSS certificates. "We are seriously considering requesting the inspection on an annual basis to verify our maintenance of this standard of excellence as a commitment to better patient care."

—Elaine Rice

1982 EMS Olympics





EMS Week 1982, celebrated September 13–19, culminated with the EMS Olympics held at the Baltimore County campus of the University of Maryland (UMBC). Sponsored by MIEMSS and the emergency health services program at UMBC, the Olympics carried out the EMS Week theme: "Accidents Are the Cause; EMS Is the Cure." More than 4000 spectators attended.

The highlight of the Olympics was the skills competition for EMT teams throughout the state. The competition gave spectators an opportunity to see what EMTs and CRTs do at the accident scene. Students in the emergency health services program were realistically moulaged victims.

Many EMS-related agencies participated in the event. Besides the skills competition, activities included auto extrications, high-rise evacuation demonstrations, water and canoe rescues, and displays featuring emergency medical equipment, information, and vehicles.

Scenarios for Skills Competition

Fourteen EMT teams — each consisting of three persons — competed in the skills competition by responding to the following three simulated emergencies.

1. A handyman drilling into a wall strikes an electrical cable and severely burns the palm of his hand and both ankles. He falls from the ladder, injuring a fellow worker who receives open lower leg fractures and a broken wrist.

2. A pedestrian hit by a car is unconscious as a result of obvious head injuries. While he is treated by the EMTs, he has a seizure. A passenger in the car is also injured, with two open fractures of the knees and possible c-spine injuries.

3. As a result of a shotgun blast, a man has severe facial injuries extending from his ear to chin, and a damaged airway. A second victim who was beaten has respiratory problems and flail chest injuries, as well as assorted bumps and bruises.

The Winners

The top three teams in the skills competition of Maryland's Second Annual Olympics were Community Rescue Squad in Hagerstown, Odenton Volunteer Fire Company, and the Baltimore County Fire Department.

First-place winners Jay Frantz (captain), Mary Jane Roth, and Larry Pleasant received plaques and a check for $1000.

Winning competitions is not new to the squad members. Last year, they placed second in Maryland's skills competition. In 1980, another team from this company, which included Mr. Frantz and Ms. Roth, was declared the "World Champion Emergency Care Team" at the International Rescue and Emergency Care Association meet; in 1981, they placed second. According to Mr. Frantz, "We're volunteers, but this is business for us. We came here to win."

Team captain Lt. Michael Lovelace, Mark Praschak, and Keith Swindle brought Odenton to second place and won $750. Last year the team placed third in the skills competition.

Baltimore County Fire Department's James Barnes (team captain), James Westervelt, and Bruce Conrad won third prize of $500.

—Beverly Sopp

More than 20 area residents were honored for their exceptional contributions to EMS in Maryland at a special ceremony during the EMS Olympics.

EMS Supporters of the Year: Senator Rosalie Abrams (D-42) and the county commissioners of St. Mary's County.

Special Service Awards: William Kenny, Robert Dempsey, Barney Hidalgo, Kenneth Philbrook, MD, Deputy Chief J. S. Vayer, Chief Roger Simonds.

EMS Agency Awards: Corporal William S. Bernard (Maryland State Police), Leona Rowe (Maryland Council of Fire and Rescue Academies), Frank Barranco, MD (Maryland State Firemen's Association), Robert Lynch (Maryland State Ambulance and Rescue Association), Bob Wright (MFRI), William Cooke (Maryland State Fire Rescue Education and Training Commission).

Regional Awards: Captain William Turnbull (Region I), John R. Marsh, MD (Region II), Joseph I. Berman, MD (Region III), George M. Walker, Jr. (Region IV), J. Patrick Jarboe, MD (Region V).

Region I

AMBULANCE: "Medical Command, did you copy our transmission?"

MEDICAL COMMAND: "We're sorry ambulance _____ but you're breaking up. . . . Try your message again."

Poor radio signals can result in lost time when providing emergency medical care. Ambulance personnel need reliable hospital/ambulance communications when giving field treatment, and it is this need which has occupied the interest and work of MIEMSS and the Region I Council for the past year.

Because of the mountainous terrain and the existence of only two remote base station sites, Region I (Allegany and Garrett counties) has suffered from a UHF signal reliability of less than 85 percent. In some locales the hospital/ambulance communications experience so many dead spots that the rate dips to 65 percent.

To correct this, MIEMSS and the Region I Council applied for federal 1204 grant funds to erect additional remote base stations. These stations consist of towers and equipment which link the ambulance radios to the hospital ER consoles. With more sites, signal strength and coverage increase.

Since the council was successful in its attempt to obtain funds, steps are now underway for the construction of five new remote base stations. In Garrett County, remote base station sites are to be located at Eagle Rock, Elder Hill, and Hilltop. In Allegany County, the new stations are in the Westernport area and Sideling Hill.

The microwave system is also being expanded to permit remote control of the new base station and to provide additional communication linkages between the central alarms in Allegany and Garrett counties.

The total cost of this project exceeds $230,000 and was kept to this minimum by sharing existing towers with the Department of Natural Resources, Maryland State Police, Maryland Broadcast Service, and the Garrett County Roads Department.

Equipment is currently being installed. When the new stations are operational, Region I will realize a significant increase in signal propagation and additional channel capability for central dispatch centers. In both cases, the effects on the system will be improved EMS care for the residents and visitors of Region I.

—Dave Ramsey

Region II

Voluntary ambulance inspections have been catching on in Region II. Since March, one or two ambulance companies per month have been inspected.

Community Rescue Service, including their unit at Maugansville, has been inspected in Washington County. In Frederick County, the following companies have been inspected: New Market, Libertytown, Middletown, Junior Fire Company, Walkersville, Thurmont, and Graceham.

It is hoped that everyone will take the opportunity to participate in this worthwhile effort. Additional people are being trained to use the pressure and suction measuring equipment so that the inspection program can continue.

To participate in the inspection program, the company must: (1) have the inspected ambulance equipped with the minimum inventory suggested in the program standards; (2) have the inspected ambulance equipped with an EMS radio; (3) subscribe to the policy of having at least two EMTs on a call, with one EMT in the patient compartment, and having a minimum of 10 EMTs on the company roster; (4) agree to abide by the program standards as long as the seal of excellence is displayed on the inspected ambulance.

If more information is needed, or for scheduling information, the Region II office should be contacted at 791-2366.

—Mike Smith

Region IV

ALS Advisory Committee

As of June 1982, the Advanced Life Support (ALS) Advisory Committee, representing nine ALS ambulance companies on the Lower Shore, Peninsula General Hospital Medical Center, Maryland State Police Aviation, and the Region IV Office of MIEMSS, was organized as a structured forum for assisting in the evaluation and management of the prehospital levels of ALS systems involving Somerset, Wicomico, and Worcester counties.

The bimonthly meetings held at Peninsula General Hospital Medical Center are effective in interfacing with the Peninsula General Hospital Medical Center EMS Advisory Committee and the EMS Regional Council. This committee was organized by Colleen Getzey, RN, ALS nurse coordinator at Peninsula General Hospital Medical Center and vice-chairperson of the regional Emergency Medical Services Council, Inc.

CRT Lecture Series

The Lower Regional CRT Continuing Education Lecture Series has scheduled two programs in November. "Trauma and Neurological Problems" will be presented on November 2 at 7 pm in the Headquarters Building of the Salisbury Fire Department. This same program will be repeated on November 4 at noon in the Headquarters Building of the Ocean City Volunteer Fire Department.

PGH Trauma Day

On October 16, as an extension of EMS Week, Peninsula General Hospital Medical Center will sponsor its second regionwide "Trauma Day" program. General sessions will address trauma pathophysiology — the body's response to injury, pediatric trauma, and head/neck trauma.

Four workshops will focus on legal aspects and EMS, the emergency room nurse as the first responder, pregnancy and trauma, and thoracic trauma. An outline of the program and preregistration information, were sent to all Region IV providers. (For additional information, contact the Region IV Office at 822-1799.)

Nurses' Continuing Ed Committee

The EMS Region IV Nurses' Continuing Education Committee will meet on October 28 at Union Hospital of Cecil County in Elkton. This group brings together the nurse directors of in-service hospital education representing five general hospitals and the areawide trauma center at Peninsula General Hospital Medical Center in Salisbury. In addition, two state hospital facilities are represented within Region IV. This committee was organized in cooperation with the Region IV Office of MIEMSS and the MIEMSS Field Nursing Program so that training programs and managerial goals could be coordinated interregionally and statewide.

EMS Communications

As a result of a regionwide survey and through a series of meetings with representatives of County Central Alarms and Fire Departments, specific geographical areas are being studied for maximum effectiveness relevant to EMS communications. Currently, plans are being considered for relocating transmitting equipment to alternate locations in Cecil, Dorchester, Wicomico, and Queen Anne counties.

—Marc Bramble

Region V

CRT Recognition

On August 20, St. Mary's County honored its first graduating class of CRTs and their families at "CRT Recognition Night." This recognition is indeed deserved since these dedicated volunteers attended classes Friday nights as well as all day Saturday and Sunday every other week from January through April. In addition, many students traveled to Baltimore City Hospitals for clinical training under the direction of their instructor, Le Moyne Lindsay. A second CRT class began in St. Mary's County September 1, and ALS services are scheduled to start in January 1983.

Para Scope '82

Another pre-Labor Day regional highlight was "Para Scope '82: Assessment and Prehospital Management of Medical Emergencies," August 27–29. This annual national conference, sponsored by the Montgomery County Fire and Rescue Services, Emergency Medical Services, this year attracted more out-of-state registrants than previously — 260 registrants from 12 states. Friday night's program "It's Paramedic," a take-off on "It's Academic," a TV quiz program for high-school students was the hit of the weekend. Based on preliminary rounds, teams representing Medic I Bethesda-Chevy Chase, Medic V Silver Spring, and the Department of Fire and Rescue Services were challenged to demonstrate their knowledge by "It's Academic" host, Mac McGarry. Cheered on by their faithful supporters, the Department of Fire and Rescue Services came out with top honors.

EMS Week

EMS Week activities started with a crash in Region V — actually a staged crash to demonstrate emergency rescue to the crowds at the St. Mary's Air Fair in Hollywood, Maryland, September 11–12. The mini-disaster was just one of the many demonstrations and displays organized by the St. Mary's County EMS Council to highlight the EMS Week slogan, "Accidents Are the Cause; EMS Is the Cure."

That theme was carried into Landover Mall and Laurel Center with displays by all Prince Georges County hospitals, the American Heart Association, the Red Cross, the National Capital Poison Center, and Kids In Safety Seats (KISS).

The week culminated with a wide variety of EMS-related activities at the Charles County Fair, September 17–19, where Saturday (the 18th) was designated as EMS Day.

In addition, most regional hospitals presented a variety of displays, demonstrations, and recognition ceremonies. In Southern Maryland Hospital Center, there was a different EMS-related program each day. Local ambulance companies and county EMS councils also spotlighted EMS.

EMS "Week" activities in Region V won't finish up until October. The Calvert County Emergency Medical Services Council will join the Maryland State Police and other public service agencies in a series of displays and demonstrations for Patuxent River Appreciation Day, October 9–10, at Solomons.

Hazardous Materials Workshop

"Rescuer Not Victim: EMS Response to Hazardous Materials Accidents" will be offered this Spring at the Montgomery County Public Services Training Academy. This program will include a discussion of the Haz Mats Team concept. In addition, the "Tactical Simulator" will provide attendees with the opportunity to participate in a "Haz Mats Incident" through the use of multimedia simulators.

Trauma Day '82

Chest trauma is the topic of Trauma Day '82, to be presented at Prince Georges General Areawide Trauma Center on Saturday, October 30. The program will include prehospital and hospital management of blunt and penetrating trauma to the chest and include a panel discussion of case reviews. Benjamin Aaron, MD, the thoracic surgeon who performed emergency surgery on President Reagan, will be the keynote speaker.

—Marie Warner

Contact with Field Programs Director

I hope that this column can serve as a forum for informing the field about what is happening in the central office.

Reciprocity

The first thing that I wish to touch upon is the reciprocity agreement for advanced life support across state lines. This agreement has been signed. This means that advanced life support companies under existing mutual aid agreements are free to cross state borders and initiate advanced life support, providing that they are operating by the state protocols under which they are licensed. (See article on page 1.)

Other concerns expressed to the central office are: Under what circumstances can a CRT refuse to perform an order? If a physician arrives at the scene of an accident and offers assistance, what should EMS personnel do? We are currently working on the production of small cards to be carried by ambulance company personnel if they so wish, asking the physician for some form of identification before they accept his/her credentials and also delineating the physician's authority at the scene of an accident.

Paramedic Issue

This year we will also be considering the place of the paramedic within the State of Maryland. The advanced life support qualifications of a CRT are not recognized at this time in other states. The only nationally recognized level is the Department of Transportation paramedic (DOT-P) level, which is recognized by approximately 40 states. This, of course, does not mean that all ALS personnel in these states are at the paramedic level; indeed, in some states, there may be only relatively few individuals at this high grade.

The EMT and CRT are the "building blocks" of EMS in Maryland and will remain so — it is no use building a house unless one has a firm foundation. However, several jurisdictions are now considering or have proceeded toward a DOT-P program. I strongly support state recognition of paramedic programs. But prior to this recognition, we need to develop program standards and further delineate the skills and responsibilities appropriate to the CRT and to the paramedic, differentiating between the two levels and specifying the additional skills a CRT would be able to exercise at the paramedic level.

DOT-P programs should be available to any CRT who wants this level of training. This is a demanding course and the National Registry certification and recertification requirements are extremely strict. Unfortunately, because of diminished funding, no fiscal support for paramedic programs is available from MIEMSS.

EMT Exam

There have been several complaints in recent years about the EMT written exam, and we are now working to improve the EMT examination process. We are working with neighboring states to produce a test bank of approximately 700 questions. These questions have been examined by an expert in education, who tried to weed out ambiguous or difficult-to-understand questions. I am anxious that all examinations at the state level should test the knowledge of the individual rather than one's ability to take an exam.

We are also looking at ways to improve the EMT practical examination, trying to make it more meaningful in that the scenario encountered during the exam would more closely resemble a scenario that the EMT would encounter on the streets.

Three things will be changed in EMT policy this year.

- Recertification dates have been changed. EMT cards will expire on June 30 or December 31 of any one year. No EMT will be certified for less than three years, but some will now be certified for up to 3½ years. This will help simplify and improve the coordination of scheduling recertification training programs throughout the state.
- There will be pilot practicals this year; students will be informed ahead of time if they will be participating in a pilot practical.
- The third change is based upon a state of New York decision — that an EMT must be able to read. The court ruled that an EMT must be able to read prescriptions, changes in policy, etc.

In Maryland, we are asking that an EMT candidate who can read but who would have trouble reading the EMT exam questions and completing the exam in the allotted time, send MIEMSS a physician's explanation of how he/she would be able to function as an EMT. This explanation must be sent 30 days prior to the exam to the Office of Prehospital Education and Training.

If MIEMSS can help you with any of your concerns, do not hesitate to contact your regional EMS coordinator. The central office has a weekly meeting to discuss issues and changes in the field. Following this, there is a conference call with all the regional coordinators so that any concerns or problems can be quickly addressed. My best regards to all of you. *Alasdair Conn, MD*

Southeast Hospital Joins Communications System

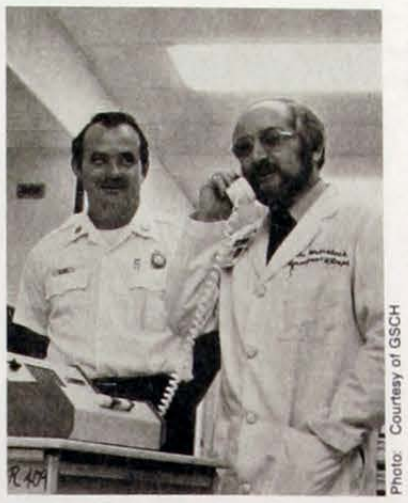


Photo: Courtesy of GSCH

PG Fire Department's Capt. Duncan Monro instructs Michael Weinstock, MD, director of emergency medicine at GSCH, how to use the new communications console.

It took a full year of intense negotiations to accomplish it, but the emergency department at the Greater Southeast Community Hospital in Washington, DC, has been tied into the Maryland EMS communications system.

In June, a communications console was installed in the hospital's emergency department so that the medical staff could prepare better to treat patients from Prince Georges County.

Southeast Community Hospital is the first non-Maryland hospital to acquire a Maryland EMS radio console, making possible the first interjurisdictional EMS communications system in the Maryland-Virginia-West Virginia area.

"This is a terrific step forward in terms of interjurisdictional cooperation," said Jane Morgenstern, the hospital's nursing systems coordinator.

The console permits the emergency medical personnel at Southeast Community Hospital to listen to consultations between the closest areawide trauma center — Prince Georges General Hospital and Medical Center in Cheverly — and prehospital care providers in nearby Prince Georges County.

It is a long-standing practice to take emergency patients in southwestern Prince Georges County across the Maryland-DC border to Southeast Community Hospital because the distance to it is much shorter than the distance to the county's areawide trauma center, or to any of the county's community hospitals.

Southeast Community Hospital is the second most frequent hospital of destination for Prince Georges County residents, according to Capt. Duncan Munro, public information officer for the Prince Georges County Fire Department.

An average of two runs per day are made to Southeast Community Hospital, said Capt. Munro.

Before the console was installed, the emergency department staff at Southeast Community Hospital was notified of incoming patients and told of their conditions via a phone call from Prince Georges General.

The information provided by the areawide trauma center was old because it had been relayed by the Prince Georges County Central Alarm from the medic unit in the field, Ms. Morgenstern pointed out.

Furthermore, because delays occurred in relaying patient information, patients often arrived in Southeast's emergency department before the communication from Prince Georges General was completed, she said.

Ms. Morgenstern stressed that now Southeast can find out immediately what has happened to the patient, what the prehospital care providers have done to treat the patient, how the patient has responded to that treatment, and when the patient will arrive at the hospital.

In addition, a recent change in policy of the Prince Georges County Fire Board allows basic life support units to radio Prince Georges General directly without going through the county's Central Alarm, which will save even more time, Capt. Munroe said.

—Dick Grauel

Regional EMS Advisory Council (REMSAC)

At the May 27 meeting of the Regional EMS Advisory Council (REMSAC), the following comments were made regarding the proposed EMT practical examination.

- Only single-person administration of CPR is tested, which is not sufficient for American Heart Association certification.
- With the two-station practical examination, half of the candidates would not be tested on some of the major skills and the most commonly used skills.
- The treatment of long bone fractures, other than femural fractures, is not assessed.
- More than one person is needed to evaluate the performance of certain procedures that require multiple skills.
- Evaluation of such procedures as the application of the half backboard and the treatment of burns and medical emergencies cannot be completed in the allotted time.

Although individual council members made numerous suggestions for improving the EMT practical examination, the council as a whole passed a motion that a task force be established to evaluate the entire EMT teaching and testing process, including instructor certification and requirements.

In other old business, the council reviewed the sixth draft of the MIEMSS decertification policy for MIEMSS-certified prehospital care providers. The policy changes reflected in this most recent draft are:

- Recognition of EMS authority shall be based on legal liability for the actions of the providers and the recommendations of the authorities having jurisdiction.
- The certification of incapacitated personnel will be suspended only as long as the incapacitation lasts.
- Disciplinary action may be ordered by MIEMSS after a formal hearing before the director of MIEMSS or his designee. Written notice of the hearing shall be sent by certified mail to the person concerned and to the local EMS authority at least 30 days prior to the hearing.
- Nothing in the policy shall serve to abrogate, supersede, or otherwise interfere with the authority and responsibility of local EMS providers to discipline their members or employees.
- Decertification policy shall be reviewed regularly and is subject to amendment at the discretion of the director of MIEMSS.

The council members agreed to take the new draft to their local jurisdictions for approval or disapproval. Recommendations for further changes were discussed at the

(Continued on page 6)

REMSAC

(Continued from page 5)

next REMSAC meeting (September 23), scheduled after this newsletter went to press.

New business included announcements of newly elected officers of the EMS Advisory Councils in Regions III and V. The Region III officers are: Kay Edwards, RN, PhD, chairperson; Judy Sussman, vice-chairperson; and Mary Ann Hohenberger, RN, secretary. The Region V officers are: Capt. Mary Beth Michos, RN, chairperson; Leon Hayes, vice-chairperson; and Capt. Duncan Munro, secretary.

In addition, the Region IV EMS Advisory Council is revising its by-laws, as well as its goals; the Region II Council is working on a 1204 grant, and the Region I Council has established regional triage and transfer protocols.

Finally, the council passed a motion to ask the director of MIEMSS to attend at least one REMSAC meeting each year so that its concerns can be conveyed to him directly.

Ad Hoc Committee on Testing, Certification

At the last meeting of the Ad Hoc Committee on EMT Training, Testing, and Certification on August 10, Lou Jordan and Ron Schaefer, the MIEMSS representatives for prehospital care, and testing and certification, submitted a progress report on the two-station practical. The results of using the two-station practical at Forest Hills and MFRI were distributed to committee members.

Alasdair Conn, MD, director of the MIEMSS field operations program, reported that all regional EMS councils have agreed with the concept of an abbreviated practical, but that there is some disagreement over what should be included in the practical. Thirty pilot practicals have been scheduled during the coming year.

In addition, a three-station practical, as proposed by the Metropolitan Chiefs Association, will be evaluated in another pilot study. The Region II Advisory Council has suggested that copies of the association's proposal for a three-station practical be sent to all regional EMS councils for review and comment.

At the start of each class, students will be told which type of practical test they will receive at the end of the course.

A letter from the Office of the Attorney General, stating that MIEMSS is responsible for the certification of EMTs, was distributed to committee members. Chief Paul Reincke, of the Metropolitan Fire Chiefs Association of Maryland, said the letter clarified the issue of whether one agency should both train and test EMT candidates.

Copies of the final draft of the *Maryland Way* EMT manual have been distributed to all certified EMT instructors in Maryland and will be distributed to all committee members, as well as other interested agencies and organizations. Several committee members expressed the view that the manual would be extremely useful in resolving the training and testing problems that have been experienced in the past. [The *Maryland Way* manual is scheduled for publication in summer 1983 and will be available to students at that time.]

Chief Reincke suggested that any changes issued to instructors after the final version of the *Maryland Way* manual is distributed should include a form that instructors would sign to acknowledge that the changes have been received and entered into their copies of the manual.

In other business, the committee voted that students who are unable to read would not be accepted as students in the EMT course.

Dr. Conn proposed that the EC I exam be eliminated in future classes. A decision on this matter was postponed until the next meeting so that other people's views on the issue could be heard. Currently, only about 150 EMT candidates in Maryland have passed the EC I exam but have not yet taken the EC II exam.

MIEMSS director R Adams Cowley, MD, a member of the US Army Science Board, gave committee members a summary of technical reports, prepared by the US Army Research Institute, which discusses the retention benefits derived from repeated testing.

Dr. Cowley reported that Utah's EMS system uses a document, called "What to Do Until the Ambulance Arrives," as part of the state's driver education program. He said this booklet could be used to further enhance the image of EMS to students in public schools and to recruit volunteer and career personnel for fire and ambulance services. Copies of the booklet will be distributed to committee members at a future meeting.

Another idea for enhancing recruitment was mentioned by Charles Riley, of the Maryland State Fireman's Association and the Maryland Fire Rescue Education and Training Commission. He suggested implementing sequential training for EMTs. Such training would create a career ladder for EMTs; their position on the ladder would depend on the amount of training they have had. Dr. Cowley said that if a sequential training program could be developed, he personally would seek funds for a pilot program.

After much discussion, the committee agreed that the existing bylaws of fire and ambulance services should be changed to allow women to become more involved in fire and ambulance service activities.

In a discussion of the length of the CRT course, Dr. Cowley reconfirmed that the number of hours in the curriculum has not been increased.

DOT funding for EOA/MAST training and testing is no longer available. The cost of the EOA/MAST program for the 1983 fiscal year would be $28,000.

A brief summary of the text, "The Post Land Grant University, The University of Maryland Report," was given. It does not refer to the *service aspects*, such as fire and EMS, in which the University is involved.

The committee decided to review the third edition of "Emergency Care," published by the Brady Company, at its next meeting.

John W. Hoglund of MFRI reported that the Regional Training Centers Committee has completed its report and forwarded it to the chancellor for final review and approval by the president of the university. Upon the president's approval, copies of the report will be distributed. Dr. Cowley asked Mr. Hoglund to chair a committee to study existing EMT training and recommend changes to the committee. Mr. Hoglund accepted the task and said his committee's report will be ready in about 90 days.

The committee agreed that state funding should be sought for the EMT program and that the principals should meet to discuss the possibility of obtaining state funding.

It was announced that the Mid-Atlantic Council has expanded its membership to include New Jersey and New York. In addition, North Carolina, South Carolina, and Florida have expressed an interest in becoming members of the council. Consequently, the name of the council has been changed to the Atlantic EMS Council.

Governor Harry Hughes and Sgt. Carl Marshall, Med-Evac pilot assigned to the new Cumberland unit.

Governor Hughes Helps Dedicate Med-Evac Helicopter in Region I

The fifth Med-Evac helicopter was officially dedicated July 2 at the Ali Ghan Shrine Club Grounds in Cumberland.

Governor Harry Hughes, as well as numerous political dignitaries and Maryland State Police officers, pointed out the much needed service the Med-Evac unit would provide. The new unit, based at Cumberland, will respond to emergency calls in Allegany and Garrett counties and to calls in a 30-air-mile radius from Cumberland (including some in West Virginia and Pennsylvania).

Two Med-Evac teams are currently assigned to the unit: Sgt. Carl Marshall (pilot) and Cpl. Henry Pilch (aviation trauma technician); and Cpl. Brian Brinsfield (pilot) and Tfc. Tom Barker (aviation trauma technician). When not responding to Med-Evac calls, they will assist police in search and rescue activities, criminal investigations, and highway traffic patrols.

More than 100 people attended the dedication which master of ceremonies Capt. William Turnbull, head of the western troop of the Maryland State Police, called the "kickoff of a community effort." John J. Coyle, president of the Board of Allegany County Commissioners, traced the history of the commission's 2½ year efforts to obtain funding for the Med-Evac unit.

Community involvement in obtaining support for the Med-Evac unit was also noted by Governor Hughes who cited the "persistence, insistence, and tenacity of the county commissioners."

Governor Hughes praised the Med-Evac system with its 85 percent survival rate and pointed out the necessity for speed in assuring high-quality trauma care. "Five minutes can make a difference. That's why it's important to have a helicopter in the region. Seventy percent of the fatal accidents in the state are in rural areas where we cannot get to the victims as quickly as in urban areas."

Governor Hughes also praised Dr. Cowley who attended the ceremony, calling him the "father, mother, and guardian" of the shock trauma and EMS system, which is "recognized as the best in the world." The governor later announced his support for the National Center for the Study of Trauma and EMS, to be located at MIEMSS.

In closing remarks, Capt. Turnbull said that we "will have the real inauguration when the first patient is picked up. And we will have a rededication each time after that."

Ed. Note: The first official transport was July 2 and 37 transports were made in July and August. —*Beverly Sopp*

Maryland EMS News

Published by the
Maryland Institute
for Emergency Medical
Services Systems
22 S. Greene Street
Baltimore, Maryland 21201
Phone: (301) 528-6846

Director:
R Adams Cowley, M.D.

Editor: Beverly Sopp, 528-3248

Designer: Jim Faulkner

Ambo Runsheets: Merits Outweigh Problems

Any new system is bound to have bugs in it that need to be worked out. The new system of reporting on ambulance runs, which involves filling out computerized runsheets, is no exception.

However, the problems that have arisen in using the new runsheets are minor, while the information that can be derived from them may help tremendously to improve the management and quality of prehospital EMS resources.

One of the problems is that prehospital care providers sometimes do not press hard enough for the recorded information to come through on all copies of the runsheet, said Kerry Smith, EMS coordinator for Region III.

When this happens, the copy of the report provided to the fire or ambulance company, the hospital of destination, or both, may be useless.

Another problem, said Mr. Smith, is that the technicians do not always record the patient's vital signs on the runsheet, which upsets the physicians at the receiving hospitals.

On the other hand, the technicians have complained that a lot of information must be recorded on the runsheets and that there is not always enough time to record all the required information during the prehospital phase of care, according to Mr. Smith.

Mr. Smith countered by saying the disgruntled technicians may not realize that they do not have to darken the circles, which must be done for the computer to read the runsheet, until after their clinical work is done.

All they have to do to satisfy the hospital physicians is to record the patient data on the runsheet in longhand, just as they did on the old form, he said. They may even write on the computer copy as long as no stray lines enter the circles. The circles are only for the computer; the computer copy of the runsheet is the last to be submitted so there's plenty of time to fill it out, he explained.

Field technicians have also commented that the narrative section of the report, where additional observations are recorded and "other" responses are explained, is too large.

The technicians used to complain that there was not enough room on the old form for narrative, Mr. Smith said. Now that they have almost a full page for narrative, they feel compelled to fill it up. But that is not necessary; the extra space is there only if it is needed, he said.

Another suggestion from the field is to replace the circles on the runsheet with the familiar double vertical lines because, supposedly, they are easier to fill in, he added.

The problem of not pressing hard enough in recording data does not affect the MIEMSS evaluation and analysis department, which tabulates the runsheet data, because the computer scans only the top copy.

However, not providing all the pertinent information on each patient is a problem, according to Kathy Paez, the department's data entry supervisor. She prepares monthly statistical reports, based on the runsheet data.

Another problem is that the runsheets are not always filled out correctly. Before the data is tabulated, the computer checks the runsheets for contradictory information. For example, if the patient's pupils are reported as being both equal and unequal, the computer ignores that information and it is left out of the statistical reports, Ms. Paez said.

The reports we compile must be accurate to be useful, and they can only be as accurate as the information we receive, she said. Therefore, it is essential that prehospital care providers fill out the runsheets completely and correctly.

Ms. Paez said she also has encountered several minor problems, such as getting runsheets with staples in them or with torn or rumpled edges. The computer rejects such forms.

Even though some problems have arisen in using the new runsheets, they are swept away by the enormous advantage of having runsheets that can be read by a computer — statistical feedback that can be used to judge whether EMS equipment and personnel are being used to best advantage and whether EMS services need to be improved.

About once a month, the evaluation and analysis department generates two reports for each political jurisdiction that uses the computerized runsheets. They are called "Management Information" and "Clinical Assessment."

For each ambulance in a particular jurisdiction, the management information report gives such information as the average elapsed times at or between the various points of destination while in service, the number of calls for basic or advanced life support and for each shift and day of the week, and the number of patients taken to particular hospitals or specialty centers.

The clinical assessment report, which also contains data for each ambulance, summarizes such information as the types of injuries or illnesses sustained; the treatments provided, including intravenous therapy and medication; and measures of the patient's heart rhythms and of cardiopulmonary and neurologic function.

The information in the reports should be very useful, according to the EMS personnel who have had an opportunity to study the statistical reports that have come out already.

Chief Jim B. Lyons III, of the Joppa-Magnolia Volunteer Fire Company in Harford County, who originally opposed the new runsheets, said the reports will be important in managing EMS resources.

Chief Michael Jachelski, of the Baltimore City Medical Bureau, agrees. He and Chief Lyons said it may be possible to equip ambulances differently, depending on which supplies are used most often in each unit.

The same information might be used to keep an inventory of supplies and equipment and to anticipate changes in the need for various items during the course of a year, noted Chief Lyons.

In addition, Chief Lyons said the number of basic and advanced life support units a company has could be adjusted according to a community's demonstrated need for each kind of care. Furthermore, he said, the data could point to the need for retraining in procedures that are not used often in the field. The data also could be used to acquire funding for buying and testing new equipment, he added.

From the point of view of a volunteer fire company, Chief Lyons said the MIEMSS-generated reports make record-keeping by individual companies unnecessary, saving them many hours of staff time.

The ultimate value of the reports to some volunteer companies may be that their very survival could hinge on what the reports show, said Chief Lyons.

If the statistics prove that the performance of volunteer companies is comparable to that of paid companies, he said the political pressure to convert to paid ambulance services may dissipate given the current restrictions on governmental budgets.

The first supply of runsheets is expected to run out by the end of the year. Each regional coordinator has been given the opportunity to submit feedback from the field on possible changes in the format of the runsheet prior to the next printing. *—Dick Grauel*

First Graduate of EHS Program Receives BS Degree at UMBC

The first person to graduate from the emergency health services (EHS) program at the University of Maryland Baltimore County (UMBC) received his degree in June. His name is John Donohue.

He is also the first person in the world to hold a bachelor of science degree in emergency health services, since the EHS program at UMBC is the first of its kind.

This 22-year old Perry Hall resident recently reflected on his experiences in the EHS program, which emphasizes management and administration, and looked ahead to his future in the field of emergency medicine.

"The people [in the program] really cared if you passed or failed. Their doors were always open when you needed to discuss a problem — academic or personal," Mr. Donohue said.

"The EHS program does prepare you for a job, especially the internship," said Mr. Donohue, referring to the 15-credit, semester-long internship that all EHS majors must complete.

He spent half of his internship with the coordinator for Region I, David Ramsey, and the other half with Mary Beth Michos, RN, captain of the EMS division of the Montgomery County Fire and Rescue Services and chairperson of the Region V EMS Advisory Council. He said both experiences were extremely beneficial to him.

Mr. Donohue became known as "Ramsey's shadow" while he was working in Region I. "He became involved in everything we're doing," Mr. Ramsey said.

Mr. Donohue handled the office work involved in organizing a CRT program and developing triage and assessment protocols — two of the region's top projects at the time, said Mr. Ramsey. He also attended all committee meetings, including those of the medical advisory board, he added.

In Region V, Mr. Donohue helped update the practices of the Hazardous Incidents Response Team (HIRT). For example, he assisted the medical director of the team in updating the medical protocols used, reevaluated the appropriateness of the equipment and supplies carried on the HIRT unit, and designed an incident report form, which the HIRT team now uses to record patient data.

It took Mr. Donohue less than three months since his graduation to land a job in his chosen field. In August, he joined the staff at MIEMSS as the associate coordinator for Region III under Kerry Smith, the region's EMS coordinator. He is also a CRT at the Cowenton Volunteer Fire Company in Baltimore County.

Mr. Donohue said he had investigated openings in the EHS field in New York, West Virginia, Washington, DC, and Georgia, as well as in Maryland. EHS graduates must be willing to relocate.

Two of the positions he had applied for fell through because of budget cuts, but he is optimistic about the future of EMS. The field is still growing, especially in the administrative area, he said.

However, he added, that EMS is becoming more sophisticated as requirements for employment in the field increasingly include a baccalaureate or master's degree.

Eventually he would like to enroll in the graduate level EHS program at UMBC, which is in the development stage, or to get a master's degree in public administration.

Perhaps by that time, the master's program in EHS will be ready for Mr. Donohue and he will be ready for the program.

—Dick Grauel and Bill Kutson

STATT Unit Named

A new name and a new logo for the areawide trauma center at Prince Georges General Hospital and Medical Center — STATT (Shock Trauma Advanced Treatment Team).

Maryland EMS News
Maryland Institute for Emergency Medical Services Systems
University of Maryland at Baltimore
22 S. Greene Street, Baltimore, Maryland 21201

Address Correction Requested
7215 Rolling Mill Rd./Baltimore, Md. 21224

MIEMSS Evaluates Area Trauma Centers

A MIEMSS evaluation team has completed the first round of site visits to Maryland's nine areawide trauma centers and expects to report on its findings this fall.

The group, headed by Frank Ehrlich, MD (former director of the emergency department at St. Agnes Hospital and current director of a hospital emergency department in Johnstown, Pennsylvania), evaluated one areawide trauma center each month between October 1981 and June 1982.

Other members of the team are: James Abate, special assistant to MIEMSS Director of Field Operations Alasdair Conn, MD; Trauma Nurse Coordinator Carole Katsaros, RN; MIEMSS Associate Director for Business and Finance Walter Augustin III; and Ameen Ramzy, MD, or Charles Wiles, MD, both surgeons at the Shock Trauma Center. Dr. Conn headed the team during the final site visit, to Washington County Hospital in Hagerstown.

Ideally, each visit would have coincided with the arrival of a trauma patient so that team members could observe the trauma service in action. But such timing is purely a matter of chance. It happened that way only last October, when the group evaluated Suburban Hospital.

The team will follow up with unannounced visits at all centers in order to see how trauma cases actually are handled.

The evaluation effort also has focused on each center's facilities, equipment, staffing, administration, use of appropriate medical protocols, relationships with field personnel, and cooperation in providing trauma registry information.

The information gathered by the evaluators should help MIEMSS identify ways of improving trauma care statewide. The agency is involved not only in gathering data and setting standards. MIEMSS also offers continuing education workshops for nurses and physicians as well as assistance with medical staff recruitment, equipment purchases, data collection, and administrative or operational problems.

According to the project's coordinator, the purpose of the site visits is quality assurance. The centers' designations are not in question. The evaluators are looking at the way the system actually works. The information will be used as a basis for improving the quality of care and for bringing the Maryland Echelons of Trauma Care more in line with functional realities.

The Echelons of Trauma Care document, which sets standards for areawide trauma centers, was revised most recently in December 1980. It is both more stringent and more specific than comparable guidelines developed by organizations like the American College of Surgeons. As a result of the evaluation effort, some of the more specialized protocols, like that for shock lung prevention, may be dropped; greater flexibility may be reflected in other standards.

Differences in regional needs, resources, and demographics have made it logical for each areawide trauma center to implement the Echelons of Trauma Care a bit differently. Thus, each trauma center is unique, even though all provide a comparable level of care.

For example, the trauma services at both Suburban Hospital and Peninsula General Hospital in Salisbury are staffed cooperatively by private surgeons. In contrast, the trauma center at Prince Georges General Hospital in Cheverly employs four trauma surgeons as well as providing training for rotating trauma fellows.

—Judie Zubin

Correction

In the June 1982 issue of the *Maryland EMS News,* the caption and headline for a photo of Stanford Rothschild and Dr. Cowley erroneously stated that Mr. Rothschild was presenting a $5000 check to MIEMSS on behalf of the Associated Jewish Charities and Welfare Fund, Inc. The donation was, in fact, a personal contribution by Mr. Rothschild. MIEMSS regrets the error.