Volunteers Respond at I-70 Crash

Rescue efforts are underway at the site of a bus crash on I-70 in Frederick, where 11 of the 17 victims survived.

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It was almost 1 pm on Sunday, August 25, 1985 when Tfc. Robert Gunter, an off-duty Maryland State Police (MSP) trooper, was driving westbound on I-70 and noticed traffic backing up just ahead of the Linganore Road exit. Then he saw cars driving eastbound on the westbound shoulder. Both shoulders of I-70 were lined with cars, and he knew immediately that something was seriously wrong. A quick check with the Frederick barracks revealed that no problem had been reported in the vicinity. He continued westbound to investigate and, as he crested the hill, the Jug Bridge over the Monocacy River came into view. There he saw a bus turned into the left guardrail and nearly a score of victims strewn about I-70. Much of the concrete guardrail on the left side of the older westbound bridge spanning the river had been stripped away.

At 12:46 pm an ominously long series of tones broke the silence of what had been a dreary Sunday afternoon marred by overcast skies, fog, and drizzle. The tense voice of Assistant Chief Dispatcher John Knipple gave first notice of the disaster at hand. The first report indicated at least four fatalities.

The initial dispatch started four ambulances (A-39, 38, 29, 28), two squads (Sq-3, 2), an ALS chase car (Medic-1), and Co. 3 fire apparatus toward the scene. United Steam Fire Engine Company, Frederick County Co. 3 was first due on the call. Mark R. Fisher, Jr., Chief 3, lives just up the road from the incident. He was the first responding fire and rescue person on the scene two minutes after dispatch. As he went from victim to victim, he was impressed by the citizen involvement during the

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Volunteers Respond Expertly to Disaster

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first critical minutes of the incident. Some people were sitting with less severely injured victims trying to comfort them. Some were holding umbrellas to shield bus passengers from the rain. They talked with them and held their hands. One motorist used diapers to help control the bleeding of a victim. Some victims were obviously dead. The citizen involvement allowed Chief Fisher to complete his initial assessment quickly. As the sirens of the first wave of units sounded, Chief Fisher requested four additional ambulances (A-27, 239, 238, 159) and one additional ALS chase car (Medic-3). He gave instructions for incoming units to use the armory cut-over and come east onto the westbound lanes. At 12:50 pm the crew of Medic-1 requested that Frederick Memorial Hospital (FMH) be notified of the magnitude of the disaster. Once notified, Barbara Walter, RN, the nursing supervisor at the FMH emergency department, put their disaster plan into effect, quickly mobilizing the hospital to receive the victims. Chief 3 then requested that disaster kits be brought to the scene and a staging area set up. He established his command post on the east side of the bridge.

CRT John Droneburg, arriving on the scene, was assigned the duties of triage officer. A citizen reported victims over the side of the bridge, and the theater of operations was quickly expanded. At 12:51, Chief 3 requested a boat (Utility-1 with Boat-2) and two squads (Sq-24, 14) to handle the operations below the bridge. At 12:53 pm, Chief 3 requested the U.S. Jet helicopter (due to low visibility, MSP helicopters were not flying). By 12:54 pm, the Central Alarm began the transfers.

Three dispatchers were manning the 911 line, fire board, and sheriff's department positions. In addition to Knipple, dispatchers Yvonne Kesner and Phil Lambert were on duty. By 12:55 pm, U.S. Park Police and U.S. Jet helicopters were on their way. By 12:57 pm, Chief 3 requested that a nurse and a doctor from FMH respond to the scene to assist with triage. Car 2 was detailed to this assignment. Chief 3 requested that all victims be channeled through the triage area on the west side of the bridge for disposition and triage tagging. While fire and rescue personnel continued with operations, MSP and sheriff's department personnel diverted traffic and secured the scene. MSP Helicopter 3's crew responded by cruiser to assist. (Their helicopter was down due to bad weather.)

At 12:59 pm, Lt. Pat Brandenburg, who was directing the operations below the bridge, reported one fatality and one trauma patient. Stokes baskets were called for to effect extrication. Meanwhile Boat-14 was also requested, and both Boats-14 and 2 were directed to launch downstream and work their way upstream under the bridge. The river was low, at wading level; personnel on the bridge could see the bottom, but rescuers on the embankment could not.

Central Alarm advised that ALS personnel attending the Parascope Conference in Montgomery County were offering their services. The triage officer gave instructions to the incoming ambulances to stage ¼ mile up the road and one by one to back up to the triage area to pick up patients. The 9th through 12th ambulances were called for (A-238 [sic], 158, 249, 248). At 1:10 pm, Central Alarm reported that the U.S. Jet helicopter was going to be flying extremely low to try to come to the Frederick area. The triage officer directed Central Alarm to have the U.S. Jet land at Ft. Detrick or the airport helipad.

David Frazier, MD, Donna Seelye, RN, and Marlene Hartman, RN—all from FMH—arrived on the scene at 1:12 pm. Donna Seelye went down the embankment to assist in evaluating the patient below the bridge. As ambulances began to go enroute to the hospital, the Central Alarm left a med channel open dedicated to this incident.

After reassessing extrication routes for the patient below the bridge, the rescue team opted to load the patient onto a boat and float him down river to a waiting ambulance at the Tollhouse Road bridge landing versus trying to lift him out to the top of the bridge in a stokes basket. As it turned out, this patient was the bus driver. Boat-2, Utility-1, A-78, and Sq-24 were detailed to this rescue. At 1:15 pm, Co. 99 was dispatched to set up a landing zone at Ft. Detrick for the U.S. Jet helicopter. At 1:18 pm, Chief 3 requested that the MSP incident commander join him to consolidate a command post. A second landing zone was secured at the airport for U.S. Park Police by the remaining Co. 3 fire units. (However, due to lack of direct communications, all three responding helicopters landed on the median by the bridge.)

A search of the river was initiated by Boat-14 and a private canoe for any potential additional victims in the river. A manifest of passengers was not available and the driver was not sure of the total number on the bus. The "Baltimore Coach" bus had made at least two stops to pick up primarily elderly passengers from Baltimore en route to the Charlestown races. The bus had a capacity of 42–44, but at this point there were known to be only 17 victims.

By 1:35 pm, ambulances were being put back into service. All the patients except the one below the bridge had been transported within 34 minutes of initial dispatch. The only remaining patient was the driver who survived ejection from the bus and the more than 100-foot plunge to the bank of the river below the bridge. Amazingly the driver, although severely traumatized, was still conscious when rescuers got to him. His history of dialysis complicated his care plan, and he deteriorated during extrication. He was removed by boat to a waiting ambulance which transferred him to the waiting U.S. Jet helicopter. The driver's condition further deteriorated in the air and he coded en route to Suburban Hospital. A total of 54 minutes had elapsed.

With all the patients en route to definitive care, attention turned to salvage and protection of the incident scene for accident reconstructionists. The lack of a passenger manifest and presence of a stray diaper sent a new chill up rescuers' backs. Had a victim been unaccounted for? There was one victim of child-bearing age. Was someone's grandchild on the bus? A quick call to the hospital and interview of the least severely injured victims revealed that no child was on board. A collective sigh of relief was a high point to an otherwise tragic afternoon.

In all, there were 17 victims. Four were obviously dead at the scene. Eleven patients were transported to Frederick Memorial Hospital. One of these was later sent to MIEMSS by ground transport. One patient was

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Tragic Ending to Christmas 1983 . . .

Craig Coleman, a CRT in the Baltimore County Fire Department, was the first prehospital care provider to respond to a call reported as "a man going beserk" on Christmas night in 1983. When he arrived at the scene, he saw a man in the shadows at the back of a house. As Coleman approached him, he could see a limp child's body in the man's arms and the glint of a knife, illuminated by the emergency vehicle's lights, in the man's hand.

The events of that evening would affect Coleman's life, family, and coworkers and lead him to one of the most difficult decisions of his career. He shares his experiences in this traumatic event and his agony in the 10 months following it with the hope that other emergency care providers who need help in dealing with stress will seek it.

Coleman asked the man (the child's father, who was allegedly under the influence of PCP) to give him the child. He did not know if the baby was dead or alive. The father ran into the dark kitchen and told Coleman to come in to get the child. Fearing for his own safety, Coleman did not enter the house, but continued to try to persuade the man to release the child. The father then ran through the house to the front, screaming, destroying furniture, and breaking out windows as he moved. Coleman, still outside, also went to the front of the house, and saw the man go upstairs. Coleman and a police officer then returned to the rear of the house and went up the back steps to a second-story porch. They located the father sitting at the top of the steps to the third floor. He held the child with his left arm around the corner of the stairway so that Coleman and the policeman still could not tell if the child was alive or dead. Coleman again asked for the baby. The father responded, "I killed the baby. There's nothing you can do." "Why did you kill the baby?" asked Coleman. "Because I wanted him to go to heaven," responded the father. Coleman replied, "If you want the baby to go to heaven, you have to give him to me so that I can take him to the hospital to have him baptized." The father then ran to the third floor with the child.

Coleman and the police officer started to follow him, then realized that they could get trapped, and returned to the second floor. The conversation between Coleman and the father continued for another 40 minutes. They talked about the father's drug use and his plans for his life, about their religious beliefs, and about the baby. Coleman sensed the father's remorse over the injury that he had inflicted upon his son. Despite the chaos, Coleman had gained the father's trust.

The phone rang. The father answered it. He said to the caller, "I have done something wrong. Come over now," and hung up.

Then the father came around the corner. The infant's head was hanging from a few threads of tissue. Coleman asked again for the child. The father came to the second floor, pushed the infant toward Coleman, and pulled the infant away. The father tried to leave the house, and Coleman wrestled him to the floor. During that struggle, the child's head came off.

The father was taken into police custody. The police sergeant asked Coleman to take the infant back into the house. Coleman lifted the baby's body by the arms and placed in on the bathroom floor. He returned to the second-story porch, picked up the baby's head, and took it to the bathroom. He was then faced with the problem of where to place the head. He put it in its normal anatomical position. It rolled to the side. He repositioned it, and it rolled away again. Paramedic Coleman sat on the side of the bathtub and cried. Then he stood up and put his fist through the wall.

He went back to the porch, where police officers had detained the father. Feeling great empathy for the child, Coleman then returned to the bathroom and baptized him.

Coleman telephoned his supervisor, Lt. Gary Warren, from the scene. While describing the events of the evening, Coleman started to break down. Lt. Warren came to the house to accompany Coleman back to the station. They started the 5-mile trip with Coleman driving the ALS unit and Lt. Warren following in his vehicle. Coleman pulled off the road and told Lt. Warren that he was disoriented and could not remember how to get back to the station. Lt. Warren led the way and then took Coleman home, where Coleman went to a quiet place to be alone. Lt. Warren described the ordeal to the Coleman family.

The next day, Coleman and Lt. Warren contacted the psychological support unit of the police department. Lt. Warren had already recognized symptoms of a post-traumatic stress syndrome in Coleman. Although Coleman had seen the "worst of the worst" accidents in his many years of emergency care service, he was particularly affected by the events of Christmas night. Lt. Warren noted that Coleman had trouble reenacting the scene while describing it to him. When they arrived home on the evening of the event, Coleman repeatedly looked at his son and daughter, both of whom were close to

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CRT Tells of Christmas Tragedy

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the age of the boy who had been killed. On the day after the event, Coleman said that when he closed his eyes, he imagined his son and daughter with their heads cut off.

Coleman described the next 10 months as "a wheel in perpetual motion, getting worse as it moved along." Although he denied that anything was wrong, he developed severe headaches, experienced nightmares during which he would jump from bed as if he was chasing someone or being chased, had dreams that were ludicrous but that all ended with his son being killed, and had angry outbursts toward his wife and children, sometimes for no apparent reason.

He continued his work as a CRT. Ironically, he responded to an unusually high number of homicides (5 involving children and 3 involving adults) in the months following the incident. On some of those calls, the stress was so great that he had to leave the scene.

One morning while he was showering, Coleman started to cry. "My wife describes it as a hysterical cry," he explained. "I cried until it hurt. It brought me to my knees and I was literally in pain. In 45 seconds, it was over. When I stood up, I knew that I was about to make a big decision about my career in the fire department." His decision was to leave his job as a professional CRT.

Craig Coleman has much praise and gratitude for the people who helped him through this difficult time: "The people in the Baltimore County EMS system are aptly known for what they do for people in the field. They were my support group. They saw that I got days off when I needed to. They saw that I got help when I needed it.

"My wife, Vicki, was there. She understood the problems and coped with them as best she could. I'm still amazed that she's with me today."

Vicki Coleman recognized that she and her husband had to work together. "In 80 to 90 percent of these situations, the result is separation or divorce. We were not going to become one of those statistics. It has taken a long time, and it's still not over, but we're dealing with it." She remembered times when she thought about leaving, but she stayed to be supportive and to work with her husband on solving the problems. The result has been that they feel closer to each other.

The worst part of the ordeal for Coleman was feeling that he had failed as a CRT. He explained, "My responsibility was to help that baby. I got within 20 feet of that man. I felt that if I had been more aggressive and had gone after him, even though it was totally dark and I knew that he had a knife, I might have had a chance to get him before he went into the house. With the result being death for the baby, I thought that I was guilty. I felt that I didn't do all that I could, although the baby might have been dead when I got there."

In addition to denial that anything is wrong, people with post-traumatic stress disorders experience depression and anger. It is important for people who are under stress to talk with someone about the phases of the reaction so that they can know what to expect. "Thirty to 35 percent of the U.S. population seeks help from a psychologist or psychiatrist sometime in their lives," said Coleman. "There's nothing wrong with that. It's the only way you're going to deal with a stress problem.

"I hope that anybody with a serious stress problem knows that help is available. There are people who will believe in you and who are really concerned.

"The stress is there. And stress will hurt you. If you don't admit everything that is bothering you and look at the total situation, seeing it as a traumatic incident, then you're not ever going to clear it up. You just have to be totally honest, dig up everything that you can about a particular incident and face up to it, and start reworking from there. If you don't, then you won't survive stress. I come in contact with other people who have similar problems and they keep putting them on the back burner. One day they're going to erupt. Their mental capacity and job future depend on how severe their breakdown is. They have to face those things. I would give anything to be a CRT in the fire department again, except my sanity. And that's what I was losing. And it hurts."

—Linda Kesselring

Editor's Note: Anyone wishing to contact Craig Coleman can call him at 301/526-6575.

Where Do I Turn?

Many people falsely believe that all mental health professionals have the same training and experience. Nothing could be further from reality. Picking the right kind of help from the right mental health professional can mean the difference between a speedy and effective resolution of personal problems or a disastrous complication of those problems.

Below are some guidelines for choosing a mental health professional to help you work through personal problems.

- First, realize that when a serious problem is prolonged (3 months to a year in duration, depending on the circumstances) or repetitive (occurring over and over with the same patterns) it is not likely to be overcome without some outside help.
- Second, the vast majority of people who seek counseling from a mental health professional are normal human beings who have just become overloaded with certain problems and need assistance in getting over a rough spot. You are likely to be normal. Seeking help when a problem gets too big is a sign of maturity and intelligence, not craziness or weakness.
- Next, different mental health professionals—psychiatrists, psychologists, and social workers—have different types of training and do different things.

A psychiatrist is a medical doctor with special training in the normal workings of the human mind, as well as its abnormalities. The psychiatrist may prescribe drugs and perform other medical procedures (such as ordering blood tests, etc.) when they are necessary. Some psychiatrists work with the severely mentally disturbed while others enjoy working with average people with average problems such as marital conflicts, rendering assistance in career choices, assisting parents with difficult children, sexual difficulties, etc.

Psychologists, on the other hand, are not medical doctors and may not prescribe drugs or perform other medical procedures. They are usually skilled in giving and interpreting diagnostic (psychological) tests. They generally use techniques similar to psychiatrists to help people. Most psychologists specialize in one form of psychology or another. That is, they may choose to work with individuals, children, families, marital issues, diagnostic testing, neuro-

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Where Do I Turn: Getting Professional Help

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psychology, medical psychology, industrial psychology, etc. They generally hold a doctoral degree or at least a masters degree.

Social workers usually hold a masters degree but their training emphasizes family and social group issues with less emphasis on diagnostic testing and the individual. Again the helping techniques they use are similar, if not identical, to psychiatrists and psychologists. They do not prescribe drugs or perform medical procedures. They may specialize in any one or more areas such as family or marital counseling, children, victims of violence, grief, etc.

- Don't go to the yellow pages to find a mental health professional. You might be lucky and get a good one but the emphasis is on "might be."
- A better way to find a mental health professional suitable to your needs is to research a few before you choose. Ask a friend or two who have gone for counseling for suggestions.
- If a friend doesn't know of a good counselor, ask a medical professional. They often refer their patients to private counselors. Hospital-based social workers and counseling centers in colleges and community mental health centers may also be very helpful in finding a good counselor for you. They frequently give two or three names from a resource list and you can then make the choice. Under any circumstance it is important to have a referral before picking a counselor.
- Before getting committed to a specific counselor, check the person out. Again, not all mental health professionals are equally trained and experienced and you may need to explore their abilities. Remember, you are buying a professional service and you have a right to expect the very best care you can get. You are paying for the professional's time. You want to make sure it is quality time that will help you to solve your problems in a timely fashion. Ask the professionals where they were trained, what their specific degrees are (PhD; MS; MSW, etc.) and what their specialization is. Also don't be afraid to ask them if they have had any experience with your type of problem.
- Always work out the details of the therapy process in advance. Know the expected meeting times, the cost, what happens if circumstances out of your control cause you to cancel a session, and whether your insurance will cover all or part of the charges. Also find out if the counselor is available by phone should there be an emergency.
- It usually takes about three months of work before the effects of counseling become apparent although some relief is usually found in the first few sessions. You have to give yourself, the professional, and the process time to work. Don't try to rush to a resolution immediately. Go for a more substantial and long-term resolution of problems and not just short-term relief.
- If the mental health professional you choose doesn't appear to be suitable to your needs or if you find no change or relief of problems within three months, you should consider finding another professional. But first, try to let the professional know that you don't feel the helping process is working and see if you can work something out.
- The helping process is a two-way street. You have to do your share of the work. Don't expect the professional to do your work. Professionals only guide and assist. It's your life and your problem. You have to work it out. So give it some time and energy. Use the professional as a coach.
- No truly professional person will ever attempt to get sexually involved with a client. If the helper starts to move in that direction, the helping process can no longer be helpful. In fact it is threatening and necessitates an immediate ending of the contact with that professional. Find someone else who can live up to the ethical standards required of true professionals.

—Jeffrey T. Mitchell, PhD
Assistant Professor, Emergency Health Services Program, UMBC

Injury Prevention Plan

It has long been recognized that injuries are the leading cause of death and disability in young people. Injuries kill more Americans between the ages of 1 and 34 than all diseases combined. In Maryland alone, approximately 40,000 persons are hospitalized each year due to injury.

MIEMSS has received a grant from the Department of Health and Mental Hygiene (DHMH) to develop a comprehensive state plan for the prevention of injury. A statewide advisory committee has been formed, chaired by R Adams Cowley, MD, director of MIEMSS, with Professor Susan P. Baker, from the Johns Hopkins School of Hygiene and Public Health, as vice-chairman. Together with representatives from Johns Hopkins Hospital, the state legislature, DHMH, and consumer advocate organizations they will review statewide data.

A committee report suggesting prudent strategies for injury prevention is expected in summer 1986. This is the first time such a plan will be developed anywhere on a statewide basis.

Videotapes on Stress

Two videotapes that can be used to train EMS personnel to recognize and alleviate stressful side effects of their work are available from the University of Maryland Baltimore County (UMBC).

"Critical Incident Stress" shows the psychological, physical, and cognitive side effects of emergency work. The videotape emphasizes strategies that may be used by individuals and organizations to alleviate harmful stress. An interview with Craig and Vicki Coleman (see article on page 3) is included in this videotape.

"Disaster Psychology: The Victim Response" describes typical psychological reactions to a disaster. Emergency workers are instructed in techniques for assisting disaster victims during and immediately after a crisis.

Both video productions use scenes from actual emergencies and major disasters; the footage was provided by fire departments and television news stations from the United States, Canada, and Australia. The scripts were written and produced by Jeffrey T. Mitchell, PhD, assistant professor of emergency health services at UMBC, and Meta Ann Donohoe, television producer for the UMBC Department of Instructive Media Resources.

The videotapes are available in one-half inch VHS ($85 each), three-quarter inch U-matic ($100 each), and PAL (the European video standard for use in foreign countries). For more information, contact Terri Clark, Instructional Media Resources, UMBC, 5401 Wilkens Avenue, Catonsville, MD 21228, 301/455-3208.

MD Olympic Winners Meet Challenges

"Just wait till next year!" That's the reaction of the winners of the ALS and BLS Maryland EMS Olympics when they talk about their experiences in the national EMS competitions in Florida.

The three CRTs from Frederick County who made up the winning ALS team were Keith Roberson, from the Walkersville Community Ambulance Company, Rick Himes, and W. Dwayne Danner, both from the United Fire Company. They work together only rarely as a team, but got together specifically to compete in the Maryland EMS Olympics. Due to the demands on their time by their full-time jobs, the team was able to practice together only one time before they left for Florida. They gauged each other's strengths, and were able to switch leadership back and forth as the occasion demanded.

The ALS competition, CliniCon '85, was held July 10–11 in Orlando. There were 32 teams competing, the best of the best. All the teams assembled in a large area; six teams at a time were taken to a different room when it was their turn to compete. The team members were introduced to the doctors, nurses, and paramedics who would be their judges, and shown the equipment they would be using. The team was instructed to check their equipment. The defibrillator differed from the model used in Frederick County, so the Maryland team looked it over carefully. When they finished inspecting it, they were told, "Here's your patient."

They found out that their "patient" was a 76-year-old man with a history of taking nitroglycerine, who had been mowing the lawn. He entered his house and collapsed. He was pulseless. Unfortunately, information about an injury was inadvertently omitted when the patient was described—the most important clue to the problem was missing. (The manikin was not moulaged for injuries.) Not knowing about any wound, the team assumed he was in cardiac arrest.

They applied MAST garments, and a code was run according to the American Heart Association advanced cardiac life support. When the EOA was inserted, one of the judges said, "You have diminished breath sounds on the left side." The team told him that was impossible while they were using the EOA, unless there was some other injury they did not know about. For the second time, there was no mention of another injury. The Frederick medics were the only team to insert the EOA on the first attempt, and the only ones to start the IV on the first try. But they found out later, by comparing notes, that all the other teams had been told that the patient came into the house holding his left mid-axillary area. Not having that information caused them to miss the problem—a gunshot wound. Even with that disadvantage, they still ranked number 25 out of the 32 competing teams.

There are things that they will do differently next year, if they compete again. For example, they spent a lot of time memorizing drug dosages—and found out when they got there that it was permissible to have the drug list inside the lid of the drug box. The team members learned that in the future competitions they should explain step-by-step what they're doing, instead of taking for granted that the judges see everything. And most important of all, if the scenario is not read, they will make sure they do a more detailed job of history-taking.

The three-woman BLS team that won the Maryland EMS Olympics had a tough decision to make when it prepared for the International Rescue and Emergency Care Association (IRECA) competition in Jacksonville, August 19–23. Teams at the international competition were composed of two members only; how could they decide who would compete? Leona Rowe, Deborah Fiedler, and Lorraine Lawson, members of the Laurel Volunteer Rescue Squad, decided that all three members of the team would train as if they were to compete, and they would make the decision at the last minute.

A few days before the trip, they took three paper clips—two white and one black—and picked to see who would compete and who would coach and be an alternate. Leona (who has been associated with Laurel Volunteer Rescue Squad for about 20 years, is an EMT instructor, and is waiting for Maryland certification as a paramedic) drew the black clip. Deborah and Lorraine, EMTs with three years experience, would be the competing team. (Deborah is now a CRT and Lorraine plans on taking the CRT course soon.)

Leona had been a judge in other competitions. When Sgt. Jim Miller, of the Advanced Emergency Medical Services Bureau of the Prince Georges County Fire Department and first vice-president for this region of IRECA, discovered that Leona was not going to compete, he asked her to serve as a chief judge. (IRECA goes to considerable lengths to ensure that the judging is as objective as possible. They hold seminars in which EMTs and EMT instructors learn to be judges. The judge does not give a point score, but checks off each procedure performed or not performed. The score sheet is then given to a chief judge who uses an overlay to determine the score for specific procedures performed. A chief judge also sees that things run smoothly and settles conflicts.)

The BLS competition started with a 50-question written exam. Deborah received a perfect score; Lorraine missed two questions and scored 96. Their combined total of 196 points was the highest of any team in the competition. All 21 teams were lined up at the same time in a large hall. There were squares

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(l–r) Leona Rowe, Deborah Fiedler, and Lorraine Lawson were second runners-up in the national BLS competition.

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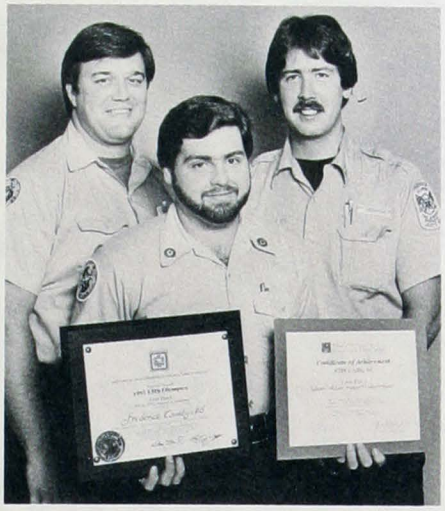
marked off in three columns, one for each kind of problem: medical, trauma, and extrication. All of the teams in a column did the same problem. When the problems were finished, the teams stayed in place and the judges moved to a different column. Out of a possible score of 1,360 the Maryland team reached 1,159, just 96 points behind the winner, and 44 points behind the first runner-up. The Maryland team became second runner-up.

The BLS teams were given written scenarios. The medical problem began with a call to check on the welfare of a man who didn't show up for work. According to the scenario, the team looked in the window and saw two victims, one unconscious in a chair, the other on the floor. The team members had to figure out how to enter the house, which was locked, avoid the hazards themselves, and then get the victims outside. Deborah and Lorraine suspected gas poisoning. When they were told that the victims, who were not moulaged, had cherry red lips, they knew they were dealing with carbon monoxide poisoning. Both victims had very shallow, poor respirations, and one arrested. Deborah began CPR on the victim in arrest—and had to keep it up for 17 minutes, until the time period for that problem was over. "That was a problem," she says. "We were already pretty tired at that point. But I think that some teams lost points because they stopped CPR when they felt they were ready for transport. They should have at least monitored the patient if they were supposed to be in the ambulance."

The trauma problem was an automobile/motorcycle accident. The automobile driver, who was still in the car, had no real injuries; he was just shaken up and confused. The motorcyclist, however, was pinned under the cycle. He had been riding without a helmet, and had head injuries. Neck and spinal injuries had to be assumed. Internal bleeding, injuries to the abdominal area, and a broken femur were found. The team concentrated on the cyclist, leaving the car driver with a "bystander."

In the extrication problem, the victim had fallen into a 15-foot hole with sheer sides. The rescue team had to be "lowered down"; take care of the victim's injuries to both legs, a hip, and an elbow; and package the patient so he could be moved. They treated his injuries, tied him to a backboard, covered



(l–r) CRTs Richard Himes, Dwayne Danner, and Keith Roberson represented Maryland in the national ALS competition. (Photo by Richard T. Meagher courtesy of "Frederick News-Post.")

him to guard against shock, and gave him oxygen in case he became shocky. Then they lifted the backboard, carried him to the other side of the hole, and placed him on a platform that had been lowered down to lift him out of the hole. (This was all simulated on the level floor of the testing area.) The BLS team did very well on their extrication problem, losing only 10 points out of 325.

Teams in the BLS competition do not have a captain. A judge is assigned to each team member.

The Laurel Volunteer Rescue Squad has a tradition of winning international competitions, and, in fact, all four of their first-place teams were all-female teams. The 1968 world championship was the first time an all-female team won an overall championship—and the team was from Laurel.

According to Leona, Laurel Volunteer Rescue Squad is a training-oriented organization. Members of the squad set up problems at their substation, and challenge one another to find solutions. Leona, Deborah, and Lorraine practiced two or three times a week to get ready for the competition, and more frequently as the contest date drew close.

The ALS and BLS teams enjoyed competing with teams from other locales. But the most important thing to remember is that these—and other volunteer and career health care providers—offer their skills to their communities not just one week a year, but throughout the years.

—Erna Segal

1986 EMS Olympics

"You have to play to win!" So plan to participate in next year's EMS Olympics. ALS and BLS regional competitions will be held Saturday, March 15, 1986. Winning ALS and BLS teams from each of the five regions will participate in the statewide playoffs, Friday, April 25 (part of the EMS Care '86 activities). Winners of the statewide EMS Olympics will then represent Maryland during the national EMS competitions. Call your regional administrator for additional information!

Effective Response At Bus Crash Scene

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transported by ambulance directly to Washington County Hospital, the Region II trauma center. The driver was transported by helicopter to Suburban Hospital. He and one other victim later died. In all, there were 6 fatalities and 11 survivors. A tremendous outpouring of resources in this rural, overwhelmingly volunteer county resulted in rapid care and transport of all the victims.

On September 9, 1985 a multi-agency critique of the incident took place at the Frederick County Communications Center. Although some areas needing attention were pointed out, the overwhelming feeling from all quarters was one of a job well done. In the intervening week, the county sheriff's department, the MSP, and the National Transportation Safety Board reconstructionists had pored over the scene and evidence trying to piece together what had happened. Extensive tests, including skid tests and a live test of the intact rear axle of the demolished bus installed in another bus, were conducted. The preliminary report indicated excessive speed and driver error as causative agents.

Since that time, the stripped guardrail has been patched by fresh concrete, a somber reminder of the tragedy to all involved. The downhill section of I-70 onto the bridge previous to the accident was plagued by rippled asphalt. Although this was eliminated as a cause of the accident, this section was repaved a few weeks after the accident. The ultimate irony is that a new section of I-70, including a new bridge, is due to open in the near future. This will avoid the on-grade intersections of I-70 east of

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Field Notes

By William E. Clark, State EMS Director

One of our major continuing efforts is in the area of training and certification of prehospital care providers. Much effort has been focused on the EMT-A program. Overall, we are trying to make all the programs as useful and user-friendly as possible. We want programs that attract and retain certified providers. And we want more local input and local options with multiple pathways for maintaining certification such as self study, continuing education, and local training.

Specific to EMT-As, as we work toward full implementation of the new 110-hour program in July 1986, we are also looking into a mechanism for allowing former Maryland certified EMT-As to regain their certification during a limited "grace" period. It is our firm belief that many volunteers would become active providers again if they could regain their certification.

We are also looking into a mechanism to make EMT-A recertification more useful and less stressful. We are trying to develop a system of continuing education credits plus limited classroom lecture with adequate time for repracticing practical skills with an instructor check-off. Our goal is to eliminate the currently required written recertification exam.

Another major continuing effort is the upgrading and replacement of the statewide EMS communication system. We are fully committed to keeping our communication system the best statewide system in the nation at no cost to the local jurisdictions. We are on our way to rebuilding the system with more and better equipment and with better signal coverage. And with the new lightweight repeater radios that are being developed for ALS units, we are planning to issue new monitor/defibrillator units. Specifications are now being developed for these units.

The technology being utilized for the new SYSCOM/EMRC amalgamated communications center will also be used for the upgrading and replacement of the EMS consoles that are located in central alarms in Regions I, II, IV, and V. At the present time we are facing a problem with the SYSCOM/EMRC merger because of the very long delays in getting the Dunning Hall renovations underway. This building will eventually house the EMS Field Operations programs, but we have been unable to get this authorized project underway because of what appears to be excessive bureaucratic red tape. However, we are hopeful this log jam will soon be cleared.

We are also fully committed to being as supportive as we can to local jurisdictions during unusual times such as mass casualty situations, disasters, and other major incidents and events. We are trying to enhance our ability to assist local jurisdictions by providing, on request, such assets as liaison personnel, mass casualty supplies, communications assistance, Disaster Medical Assistance Teams, and aeromedical support. Our goal is to be helpful to and supportive of local jurisdictions.

I-70 Bus Crash

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Frederick that might have contributed to the accident.

On October 2, 1985 Chief Fisher and John Droneburg, who served as triage officer on August 25, were honored along with other Maryland EMS personnel by Dr. R Adams Cowley at the annual EMS awards banquet. Although the community where these two men live is quiet again, all EMS personnel who participated and indeed the citizens of Frederick County can rest assured that the EMS system, even under stress, worked then and can work again when the need arises.

—George Smith