Maryland
E·M·S
NEWSLETTER

Vol. 17, No. 8 | For All Emergency Medical Care Providers | April 1991

Bicycle Safety for Bicyclists & Motorists

Bicyclists, like motorcyclists, ride in traffic without the protection of a vehicle surrounding them. In a collision with a motor vehicle, the bicyclist always loses, no matter who was originally at fault. Although only 2 percent of motor vehicle accidents involve bicycles, many who are killed or injured are children. Since a bicyclist has the same legal rights and responsibilities on the roadway as the driver of a motor vehicle, education about bicycle safety is essential for both bicyclists and drivers.

According to the Insurance Institute for Highway Safety (IIHS), there were fewer bicycle deaths in motor-vehicle related accidents on US roadways in 1989 than in any year of the previous decade; 821 bicyclists were killed. About half of those killed were children 16 years old or younger. (The rate is highest among 10-13 year old males. At all ages males are involved in bike crashes six times more frequently than females.) The Maryland Department of Transportation (MDOT) reports that in this state there were 1,151 police-reported bicycle/vehicle-related accidents in 1989; MDOT figures show that 7 of the bicyclists were killed that year. MDOT reports there were 15 bicycle fatalities in 1990.

Fifty percent of the Maryland bicycle accidents took place within half a mile of the rider's home and within 2 1/2 miles of the motorist's home. Many were hit-and-run accidents. Bicyclists' deaths are most likely to occur during July and August between the hours of noon and 9 pm. Nationally, IIHS reports that deaths among adult bicyclists (21 years and older) increased from 31 percent of all bicyclist deaths in 1980 to 43 percent in 1989.

The National SAFE KIDS Campaign, a coalition of more than 50 national organizations participating in a program of the Children's Hospital National Medical Center in Washington, DC (one of the MIEMSS specialty referral centers) strongly supports having children wear bicycle helmets. They report that one in seven children suffer head injuries in bike-related incidents; 75 percent of all cyclist deaths involve head injuries; and nearly 70 percent of all hospitalized cyclists are treated for head trauma. Bike helmets reduce the risk of head injury by 85 percent and of brain injury by almost 90 percent.

Parents, schools, communities, and youth groups that actively promote bicycle safety are encouraged by the passage of a law mandating bicycle helmets in Howard County; Montgomery County is working on a similar bill. In addition, four bills concerning bicycle safety and education were introduced in the 1991 Maryland General Assembly by Del. James C. Rosapepe of the 21st District (northern Prince George's County).

John T. Overstreet, Jr., chairman of the Safety Awareness Committee of the Baltimore Bicycling Club, compiles Maryland bicycle injury/safety statistics in conjunction with the MDOT and the Maryland State Police. In addition, Mr. Overstreet presents bicycle safety workshops to bicyclists of all ages, particularly school-children. A recent presentation, given to first-graders at the Crofton Woods Elementary School, was arranged through Andy Trohanis,

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John T. Overstreet, Jr., gives first-graders at the Crofton Woods Elementary School bike safety tips.

Lt. Stinchcomb instructs EMT-A students on how to package the patient and transfer from the ground to the backboard, litter, and ambo lab.

Ambo Lab in Anne Arundel FD

All career personnel in the Anne Arundel Fire Department are required to have a minimum of EMT-A certification. To help career recruits gain greater understanding of EMS, the Training Academy found an innovative way to give them the experience of working in an ambulance while they are still in training. A fully equipped and operable "ambo lab" was made from the "box" of an ambulance that was taken out of service and mounted on a cart. It contains suction equipment, electricity, oxygen, an intercom system that simulates hospital consult, and equipment for various functions.

The students load and unload a patient on a litter; perform CPR and maintain an airway in the confined space of the ambulance; learn where things are located; and learn to work with a patient and two or three providers in the ambulance.

Capt. Steven K. Frye, officer in charge of EMS, originated the idea of the lab; Lt. William Stinchcomb, training officer, did the electrical work and installed the equipment; and the fire department maintenance division secured and mounted the ambo box.

Region II Officers

The Region II EMS Advisory Council recently elected new officers. The new executive committee consists of: Jean Burns, RN (president); Eric Smothers (vice-president); H. Wayne Williams (secretary); Susan Nicol (assistant secretary); Robert Harsh (member-at-large); and Terry Shook (member-at-large).

Hats Off To . . .

To protect the health of its all-volunteer squad, Southern Garrett County Rescue Squad in Oakland (Region I) is providing hepatitis B vaccine to its members free of charge. President Rayma Weeks and Capt. Jeff Hinebaugh obtained the vaccine with the help of the Garrett County Health Department, which supplied it at a reduced price. This is the only squad in the region with such a program.

Trauma Disaster Course

The Western Maryland Trauma Disaster Short Course, cosponsored by MIEMSS, MFRI, and Garrett Community College (GCC), will be held May 4-5, 1991 on the GCC campus in McHenry. This year's theme will be "Surviving EMS in the '90s."

Capt. Steven K. Frye, officer in charge of EMS for the Anne Arundel County Fire Department Training Academy, is coordinating the curriculum. Topics will include the impaired provider; wellness and the provider; street survival; the terrorist threat; humor for the health of it; and many more. For further information, contact the Region I EMS office, 301-895-5934.

Promoting Excellence In EMS Care

May 18 & 19

Workshops for Prehospital Care Providers (2 days cont. ed.)

Ocean City Fire Headquarters

Contacts:
Debbie Patterson, Dawn Rose
301-289-4346

Workshops Offered

The following conferences are sponsored by the MIEMSS Department of EMS Nursing & Specialty Care (formerly Field Nursing), which is accredited as a provider of continuing education in nursing by the American Nurses' Association. Some of these courses also are approved for credits for prehospital care providers. For further information or for a complete calendar, call 301-328-3930.

Trauma Life Support: Beyond 1990, May 13-14, Washington County Hospital, Hagerstown; May 23-24, Sinai Hospital, Baltimore

Pediatric Advanced Life Support "PALS," May 2-3, Charles County Community College, LaPlata; June 6-7, Cumberland Memorial Hospital & Medical Center

Focus on Orthopedic Trauma, May 1, Howard Community College, Columbia

Quality Assurance & Risk Management, May 21, Memorial Hospital at Easton

Coping Strategies & Leadership Skills, April 23, Dorchester General Hospital, Cambridge; May 17, Allegany Community College, Cumberland

ED Administration Issues, May 6-7, University of Maryland at Baltimore, School of Social Work

Antepartal Surveillance, May 3, Southern Maryland Hospital, Clinton

Nursery Potpourri, June 6, Southern Maryland Hospital Center, Clinton

Women's Health Issues in EMS, May 22, Franklin Square Hospital Center, Baltimore

'Always Buckle Children' Campaign

During a press conference launching the "Always Buckle Children" campaign, Gov. William Donald Schaefer presents a teddy bear to Kimberly Dudek as her parents Andy and Kay Dudek and Barbara Beckett (Maryland Committee for Safety Belt Use) look on. Mr. Dudek, an officer in the Baltimore County Police Department, Kimberly, and her older brother Andy (not in the photo) survived a car accident because they were properly buckled up.

New legislation has been proposed by Governor William Donald Schaefer to expand the requirements for the use of child safety seats and seat belts. Although the life-saving, injury-reducing benefits of child safety seats and seat belts are becoming more widely acknowledged, there were 1,497 deaths among children ages 6-15 nationally in 1988. And in Maryland in 1990, there were 110 injuries to children 0-4 years; 436 injuries in the 5-9 age group; 364 injuries to children 10-14 years old; and seven children under 5 years of age killed in motor vehicle crashes.

The present Maryland law requires that children from newborns to age 3 must ride in a car safety seat; children ages 3 and 4 must be buckled in a car safety seat or a seat belt. The proposed legislation would require that children up to 4 years of age or weighing up to 40 pounds ride in a car safety seat; the seat-belt law would be subject to primary enforcement, which gives police officers the authority to stop cars and to ticket motorists if the drivers or front-seat passengers are not wearing seat belts; and children up to the age of 10 who are sitting in any position in the car must be in either a safety seat or a seat belt.

The proposed legislation augments a year-long child passenger safety awareness campaign that began in February 1991 with the theme, "It's as simple as ABC: Always Buckle Children." Sponsors of the ABC campaign are a coalition consisting of the Maryland Association of Women Highway Safety Leaders, Maryland Chiefs of Police Association, Maryland Child Passenger Safety Association, Maryland Committee for Safety Belt Use, Maryland Department of Health and Mental Hygiene Project KISS, Maryland Department of Transportation, MIEMSS, Maryland State Police, National Highway Traffic Safety Administration (NHTSA) Region 3 Office, and its newest member, the Maryland State Firemen's Association.

The coalition was dismayed in 1990 when six Maryland children were killed in motor vehicle crashes during the first 6 months of the year. A massive awareness and educational campaign was launched in the media and saw results; in the remaining 6 months there was one additional death. "Even one more death is unacceptable," says Barbara Beckett, executive director of the Maryland Committee for Safety Belt Use, "but if we had continued at the original pace we could have doubled the fatalities."

The coalition was originally composed of hospital-based and traffic safety personnel. Its increased efforts required the addition of another community group with significant impact, as well as the knowledge and the desire to help. Because fire/rescue personnel often respond to the scene as soon as law enforcement personnel and know the tragic consequences of the non-use and misuse of child safety seats, the Maryland State Firemen's Association was asked to join the coalition.

Using information provided by the coalition, volunteer fire departments (VFDs) in communities all over the state will invite the public to attend open houses throughout the year and give hands-on demonstrations of how to properly position and secure children in motor vehicles. Although in 1989 NHTSA estimated the child safety seat use rate in Maryland to be about 84

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(L-r) Margaret Chester (KISS), Bernard Smith (Maryland State Firemen's Association), Nancy Carrey-Beaver (KISS), Deborah Baer (Maryland Child Passenger Safety Association), Barbara Beckett (Maryland Committee for Safety Belt Use), Ameen Ramzy, MD (MIEMSS).

Bicycle Safety Awareness Tips . . .

(Continued from page 1)
director of information and media services for MIEMSS, whose son, Lee, is in the class. Mr. Trohanis says, "We at Shock Trauma see the damage that can happen when safety rules are not followed. Parents should buy helmets for their children and themselves when they buy their bikes."

Safety experts agree; head and neck injuries may be avoided if the rider is wearing a hardshell helmet that has been approved by the Snell Memorial Foundation or the American National Standard Institute (ANSI). Although at the present time only 5 percent of child cyclists wear bike helmets, it is hoped that eventually it will be as accepted to wear one for bike riding as it is for playing baseball or football or soaring into space. Mr. Overstreet encourages the children to wear helmets by saying, "Your head is the computer of your body—and we don't want anything to happen to it."

Most bicycle accidents involving children occur on sidewalks, in alleys, or on streets near their homes and do not involve motor vehicles. "The accidents result from poor bike-handling skills, equipment failure, or lack of concentration," says Mr. Overstreet.

Children must be taught that a bicycle is not a toy; it is a vehicle, and bike riders must follow the rules of the road. This includes obeying traffic lights and stop signs; stopping and looking around to be sure nothing is coming before pulling out of a driveway or crossing a street; riding in the same direction as traffic; and using hand signals for turns or stops. Children should "walk" bicycles through dangerous intersections.

Bicycling experts Barbara and Bob Lamborn (see article on next page) emphasize, "Bicyclists must be aware of road surfaces to avoid potholes, debris, or hanging tree limbs. Surfaces such as sand or gravel; wet streets, leaves, manhole covers, or metal grills on bridges; and wet paint that marks street lanes can cause a bike to skid. Bicyclists must also look out for pedestrians in their path and observe whether people in parked cars are about to open a door in front of them. Dogs can cause nasty accidents; some bikers try to swat at a menacing dog and are thrown off balance and into a skid by the effort. We have loud air horns that keep dogs at a distance." The Lamborns advise all bicyclists to wear helmets and form-fitting clothing that will not get caught in the gears. In

(Continued on page 5)

Motorists & Bicyclists

Mr. Overstreet urges motorists to become more aware of bicyclists in the following ways:

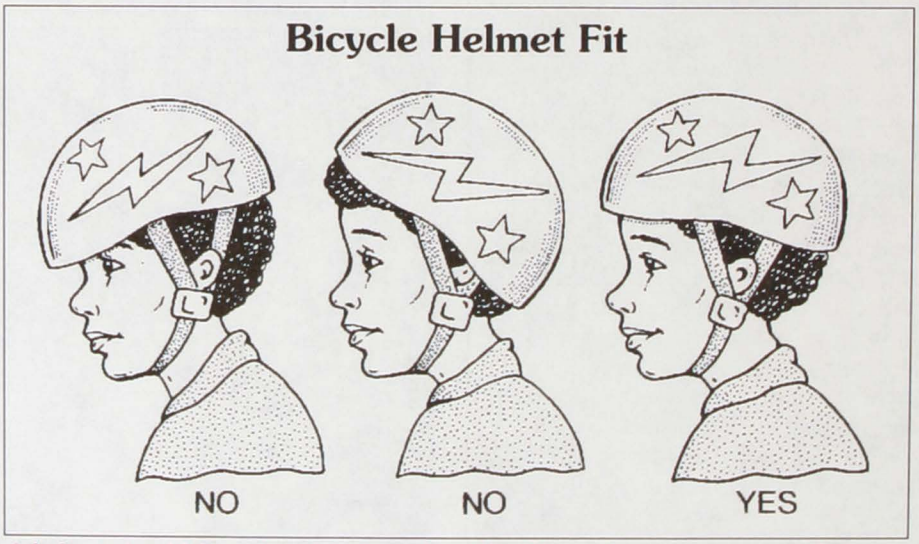
- In residential areas, watch for bicyclists in front yards or on sidewalks who might be ready to suddenly dart out into traffic.
- Leave plenty of room as you pass a cyclist.
- Use your directional signals if you intend to turn and remember that bicyclists use hand signals to indicate their intentions.
- Make sure the bicyclist is not in your "blind spot"—the right rear quarter of your vehicle—especially when you intend to make a right turn.
- Before opening your car door on the traffic side, check in your outside rear-view mirror for cyclists.
- Put on your turn signal before pulling out of a parking space.
- Be alert for wrong-way cyclists. Not everyone rides responsibly.
- If you must use your horn to warn a bicyclist, do it gently; a startled cyclist might swerve into traffic or lose control.
- Be courteous even if it slows you down; no one wins in an accident, so share the road.

Bike Helmets

According to the National SAFE KIDS campaign (a program of the Children's Hospital National Medical Center in Washington, DC, one of the MIEMSS specialty referral centers), mandatory bike helmet legislation has been *enacted* in California (1987); New York (1989); Massachusetts (1990); and Howard County, MD (1990). Legislation has also been *introduced* in Missouri (1991); New Jersey (1990); Pennsylvania (1991); and Montgomery County, MD (1990).

People may need to get used to the idea of wearing bike helmets. The following tips may help encourage the helmet habit.

- Let the child help pick the helmet and help him/her practice buckling it.
- Make a rule and enforce it: You can't ride your bike without your helmet because you can get hurt anywhere, even just down the street from home.
- Wear your own helmet when you ride together—your own good example can make a difference.
- Praise and reward the child each time the helmet is worn—take away some of the discomfort with words of support.
- Begin the helmet habit with the first bicycle.
- Encourage other parents to buy helmets—making helmet use common is the best way to eliminate the discomfort of being different from one's peers.



A helmet should fit well and feel comfortable. Always fasten the strap. A helmet should sit on top of the head in a level position and should not rock back and forth or from side to side. (Courtesy of the National SAFE KIDS campaign.)

. . . For Bicyclists & Motorists

(Continued from page 4)

addition, they suggest that long-distance bicyclists wear goggles; biking shoes with a solid steel shank and double-tied laces; and biking gloves with padding in the palm to protect against the vibration and road jarring that creates a nerve-deadening effect on the hands. "Bikers should abide by the rules of the road and constantly try to improve their technique," explain the Lamborns. "The better riders we are, the more we will enjoy riding and the safer we will be."

Night riding is 20 times as risky as daytime riding and should not be attempted by children, says Mr. Overstreet. If they are stuck somewhere after dark they should call (collect from a pay phone, if necessary) to get a ride home. Many accidents at night, including 50 percent of night fatalities, are due to poor visibility. Reflectors on a bike are no substitute for lights. By law, at night a bike must have a white headlight, red taillight, and a red rear reflector; the bike should be visible from 500 feet away. A flashing yellow strobe light fastened to either the bike or to the bicyclist will also increase the bicyclist's visibility. White or light-colored clothing, preferably with reflective tape, is a must for the night-time rider. Pedal and spoke reflectors are highly effective. "Visibility cannot be overdone; the bicyclist must advertise his presence," Mr. Overstreet says.

Ronald D. Lipps, manager of the MDOT Safety Programs Division, which sponsors Mr. Overstreet's work, emphasizes, "We're pleased to work with various agencies at all levels of government, safety and bicycling organizations, and concerned individuals to improve the safety of bicyclists, the most vulnerable users of our streets and highways. The surging interest in bicycle helmet use is encouraging. We hope it will spur efforts to enhance bicycle safety training, much as the motorcycle helmet issue engendered motorcycle safety training."

◆ *Erna Segal*

Notes from the Persian Gulf

Editor's Note: T/Sgt. Edward Shuck, a Region I medic, was one of many Maryland EMS personnel who recently served in the Persian Gulf. He was in Saudi Arabia from October to December 1990 as an Air Force medical evacuation technician during Operation Desert Shield; before returning there on January 26, 1991, to be part of Operation Desert Storm, he shared some observations for newsletter readers.

"Maryland EMS personnel should feel right at home with the military system of EMS delivery," says T/Sgt. Edward Shuck. "Trauma medicine was originally based on experiences in military MASH units, and Maryland EMS uses a similar echelons of care system. It was like living *The Maryland Way* textbook."

T/Sgt. Shuck is an EMT field instructor for the Western Maryland office of MFRI, a MIEMSS evaluator, and a member of the Air National Guard in Martinsburg, WV. He runs as a CRT with the LaVale Rescue Squad. During his recent military service T/Sgt. Shuck was part of a medical crew of three medics and two nurses who flew in C-130s, which are 4-engine jet/prop planes. The C-130 can land on a small runway and is not affected by the sand as much as some aircraft.

"We used planes instead of ambulances, but it was organized the same way as EMS at home. The combat medic takes the patient to the aide station; from there he is brought to an area where he can be picked up by the C-130 to be taken to a field hospital. When he is stabilized, if more definitive care is necessary he will be flown in a C-141 to a US facility in Germany or England."

There are two types of assignments for medics: *tactical*, which is a swoop and scoop operation with flights ranging from 30 minutes to one hour; and *strategic*, in which the medics accompany patients on long-range flights from one major base to another. (The flight from the Persian Gulf to Germany takes 8 hours.) T/Sgt. Shuck usually functions as a tactical medic, but he also has made two trips to Germany. "We are supposed to be familiar with all types of planes so we can augment either type of crew. And I'm impressed with the quality of medical services—they are really top of the line," he says.

◆ *Erna Segal*

Bicycle Experts 'Pedal for Power'

The Lamborns prepare to "Pedal for Power Across America."

Health and safety education, research related to cancer and lung disease, and political and legal initiatives in support of bicyclists' safety and rights are causes that Barbara and Bob Lamborn (ages 61 and 72, respectively) take very seriously. They have bicycled more than 15,000 miles since their retirement in 1986. This spring—from May 11 to June 27—they will join with about 100 other bicyclists who will ride from Los Angeles to Boston as part of a fund-raising campaign, Pedal for Power (PFP) Across America. Their trip will cover 3,341 miles in 42 riding days, averaging 80 miles per day.

Their efforts are especially remarkable because Barbara, a former writer/editor, is a lifetime asthmatic who was critically injured in a bicycle accident 3 years ago and was treated in Maryland's EMS/trauma system. She spent almost two weeks in the MIEMSS Shock Trauma Center. Bob, an administrator in the field of education, is recovering from prostate cancer.

The Lamborns have pledged to raise a minimum of $10,000 for three charities; they hope to raise more. Of the funds they raise, 50 percent will go to the League of American Wheelmen, the oldest national bicycling organization, which was founded in 1880. The purpose of the League's Educational and Legal Foundation is to provide information about national and state laws affecting bicycling and to furnish legal assistance to bicyclists whose rights have been threatened. Donors may choose whether the other 50 percent will go to the American Cancer Society (ACS) or the American Lung Association (ALA). For further information, contact Barbara and Bob Lamborn, 301-997-9022.

'Always Buckle Children'

(Continued from page 3)

percent, many are used incorrectly. Common errors include facing the seats in the wrong direction; improperly routing the seat belt; and misusing toddler shields or harnesses. When car seats are used correctly, they are at least 80 percent effective in preventing serious injury and death. When used incorrectly, their effectiveness is reduced at least by half. Tom Mattingly, Sr., president of the Maryland State Firemen's Association and former fire chief of the Leonardtown VFD, says, "We are delighted to join the coalition and are confident that our coordinated efforts will prove fruitful in educating parents of young children. Fire/rescue personnel have seen first-hand that small children who are securely buckled up may be saved from critical injuries in a crash."

A child safety seat that has been involved in an accident should be replaced. Child safety seats are also effective in reducing childhood injuries occurring during non-crash events, such as sudden stops and turns.

In contrast to 1979, when Tennessee passed the first child passenger safety law in the nation, in 1991 all 50 states, the District of Columbia, Puerto Rico, and Guam have such laws. Seventeen states have upgraded their child passenger safety laws by raising the age limit, some beyond the 12th birthday.

◆ Erna Segal

Volunteers Earn Credits

Under a new policy adopted by the Washington County School Board, high school students will be able to earn school credit for approved volunteer activities in their communities; Region II fire and rescue services qualify for the program. Approximately 85 students currently are involved in the program.

Students will receive one-half credit per year, for a total of two elective credits, for their community service. The students must complete 66 hours of non-paid work, keep a log of their hours, and write a report at the end of the school year. (Summer activities may also be included.) The volunteer work may be divided among several different activities.

Other qualified volunteer activities include scouting, helping in hospitals or nursing homes, or working with other approved public service agencies.

Offered in Bethesda

April 25-28

1991 International Conference for Hazardous Materials Response Teams. Theme: "A Standard Approach." Marriott Hotel, Bethesda. Sponsored by Montgomery Co. HIRT & Montgomery Co. Dept. of Fire & Rescue Services. Contact: Asst. Chief Mary Beth Michos, 301-217-2099.

May 4-5

ACLS Provider Course, Suburban Hospital, Bethesda. Sponsored by UMBC's Office of Continuing Education & Emergency Health Services Department, MIEMSS, Maryland Affiliate of American Heart Association. Contact: UMBC, 301-455-2336.

August 23-25

Parascope, Marriott Hotel, Bethesda. Sponsored by Montgomery Co. Emergency Medical Services Division, Dept. of Fire & Rescue Services. Contact: Asst. Chief Mary Beth Michos, 301-217-2099.

Shock Trauma Gala

May 11, 1991
7:30 pm - 1 am
Towson Center
Towson State University

Gov. William Donald Schaefer, Honorary Chairman
Tom Clancey, Master of Ceremonies

For tickets and information for this black-tie event, call 301-328-8778.

EMS Communications . . .

Reflective foil sticker maps of the EMS Communications System, with tone codes and county-by-county medical channels, are being distributed through the MIEMSS regional EMS offices to EMS personnel for ambulances, chase vehicles, and central alarms. These stickers can be affixed to the vehicle wall adjacent to the radio. A laminated version that can be used on a lanyard or put in a pocket in a vehicle also is being distributed. In addition, small reflective stickers that can be affixed to hand-held portable radios are being given out. If you require these and have not received them, please contact your MIEMSS regional EMS office.

SENIORS CONTRIBUTE *. . . On behalf of the MIEMSS Shock Trauma Center, John Murphy (left), chief operating officer, accepts a check for $1000 from Robert Burns (center), president of Ateaze Senior Citizens Council, and Philip H. Pushkin, DDS (right), director of the Department of Aging, Baltimore County. Members of Ateaze also donated $1000 to the Baltimore Regional Burn Center and $1000 to the Children's Oncology Department of Johns Hopkins Hospital.*

Neurotrauma Center Holds Patient Reunion

Former neurotrauma patients at all stages of recovery, from those in wheelchairs to others seemingly unaffected by injury, gathered at the Omni International Hotel for a "reunion." They had all been patients at the Shock Trauma Center, some as far back as 1977, before the Neurotrauma Center was established as a separate unit in 1981.

Former Shock Trauma patients Janice Jackson and Karen Colvin, RN, at the Neurotrauma reunion.

The idea for the reunion came from the Shock Trauma Center neurotrauma subacute nurses; they worked closely with these patients and their families throughout the critical early stages and the difficult recovery period and they cared about them. There were questions the nurses would love to have answered—how are the patients doing; are they back at work; how are their families doing? Did the nurses' efforts really make a difference in the patients' lives? Linda Spring, RN, BSN, and Gena Stanek, RN, MS, CCRN, planned, organized, and coordinated the reunion.

More than 500 former patients and their families attended. It was an opportunity to relax, talk about events and accomplishments crucial to them, and look to the future. Twenty exhibitors had tabletop displays about services, support groups, and recreational activities available to the former patients. Although one young lady declined the invitation, the nurses were happy to learn that it was because on the same day she was walking down the aisle at her own wedding.

Two former patients gave insights into their recoveries and adjustments to life after neurotrauma. Chip Giardina was a patient at the Shock Trauma Center 5 years ago. He calls himself lucky, " ... because my accident happened in Maryland, where such excellent care is available. The Shock Trauma staff was responsive to the needs of the individual patient—flexible, imaginative, concerned, and caring—with a positive, but realistic, attitude. They made me feel good about myself." Mr. Giardina, who in the beginning had trouble processing information due to his brain injury, is the owner of two deli/restaurants.

Because former patient Karen Colvin, RN, is a nurse, she knew about the difficulties ahead of her as a quadriplegic. "But I never expected positive things." She is an activist for the disabled; speaks before civic groups and schools; is a member of the Board of Visitors of Shock Trauma; and is co-director and founder of the Spinal Cord Hotline. "Twenty years ago, many of us would have been in nursing homes; today there are ways to maximize our potential. You can sit home and eat bonbons and watch TV, but if you do not wish to, there are so many doors open to you to become involved. The Shock Trauma Center needs community support, fundraising, and speaking efforts. Tell people that Shock Trauma saved your life. Get involved in Montebello Rehabilitation Hospital. Get involved in the school system or the political process. Keep at it—and don't let anyone break your stride!"

Karen Doyle, RN, BSN, nurse manager of the neurotrauma subacute unit, spoke for the staff when she said, "We are absolutely thrilled to see you and to see your progress! This feedback is extremely important to us. Patients who sustained brain injuries may not remember us—but we remember you. Thanks for sharing your lives. We share your hopes, fears, anxieties, and dreams. You, the patient, teach us the meaning of the words patience, determination, perseverance, strength, and hope. You teach us to never say 'never.' We hope we made a difference in your life—because you certainly made a difference in ours."

Celebrate
"The Team That Cares"
During
EMS Week
May 12-18

For information, call your regional EMS administrator.

Letter-to-the-Editor

I have been an EMT/CRT for 13 years and an EMT Instructor for 3 years. As I talk with EMTs in my travels over the state, I get the feeling that EMTs are considered second-class citizens in some local jurisdictions. I feel that this is wrong.

The EMT is the foundation of the whole EMS system. With the new guidelines of the NFPA Firefighter standards, the EMT is also the cornerstone for firefighter certifications. Now every CRT, EMT-P, and firefighter must be an EMT before continuing on to higher certifications.

Throughout Maryland, approximately 70 percent of all emergency medical calls could be handled by EMTs, if they are allowed to function. On most calls, a good CRT or EMT-P, because of certification level, is the lead person on the ambulance. The CRT or EMT-P should allow the EMT to assume some of the responsibility for treating a patient if the call is BLS in nature. Allowing EMTs to function and prove their worth will instill pride and encourage them to go on to become IVTs, CRTs, or EMT-Ps, which are greatly needed.

Our EMS system is a model for the entire country and we want it to stay that way. We can remain at this level only if our EMS foundation is strong. If the foundation starts to decay because of lack of use, then the system will fail.

As I stated before, the EMT is our foundation. By having strong, functioning EMTs, our whole EMS system will remain strong. Unity within EMS is essential to our success. If we all are allowed to work up to our certifications, unity will be maintained. Unity in EMS is a must.

◆ *Clarence H. Nalley, Jr., CRT*
EMT-A Instructor

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DATED MATERIAL

Retrieving Ambo Equipment from the Shock Trauma Center

Prehospital providers must sometimes leave essential equipment with the critically injured patients that they have transported to the Shock Trauma Center. Representatives from the trauma center and MIEMSS field operations met recently to try to facilitate the retrieval of this EMS equipment. Using as a basis the guidelines set up several years ago, they agreed on the following plan of action:

The Shock Trauma Admitting Area (AA) staff will:

- Take charge of all non-disposable prehospital equipment.
- Wipe down the equipment.
- Transport the equipment to the storage room located at the ambulance entrance.
- List all non-disposable equipment on a field equipment disposition form.

It is the EMS provider's responsibility to:

- Clearly mark all non-disposable equipment with the *unit number* and *county name*. (With more than 450 ambulances in the state, this is vital.) This marking should also be on all removable component parts, such as straps, pumps, and bags. The Shock Trauma Center cannot be responsible for the return of unlabeled equipment.
- Pick up equipment as soon as possible, preferably between 7:00 am and 3:30 pm. Go to the AA on the second floor of the Shock Trauma Center; a trauma technician will escort you to the equipment storage area. If it is not convenient to pick equipment up during those hours, contact a trauma technician in the AA to arrange an appointment. Call 301-328-8869.
- Please be understanding if you arrive at the AA at a busy time and the trauma technician must keep you waiting. Patient care must take priority.
- Inspect your equipment before leaving. Note damaged or missing equipment on the field equipment disposition form.
- Report any lost equipment within 30 days. A letter should be sent to: Ted Boggs, Trauma Technician Supervisor; MIEMSS; 22 South Greene St., Baltimore, MD 21201.

EMS CARE 91 MARYLAND

April 26-28, 1991

at the Greenbelt Marriott Hotel in Greenbelt, Maryland

Sponsored by
Maryland Institute for Emergency Medical Services Systems and the Region V EMS Advisory Council

Hosted by
Prince George's County Fire Department

For information, call 301-474-1485.