



(L-r) MIEMSS staff Elizabeth Scanlan (director of nursing), Dr. R Adams Cowley (director), John Ashworth (executive director), and Malcom Maloof (nursing director of MIEMSS Rehabilitation Unit at Montebello) discuss the model of the new building for the Shock Trauma Center.



Maryland
**EMS
NEWS**

Vol. 11 No. 8 FEBRUARY 1985

New STC Building before Legislature

If all goes well, the legislature will approve the request of Governor Harry Hughes for nearly \$40 million for a 138-bed new MIEMSS Shock Trauma Center to be built on a three-quarter acre site adjacent to the University of Maryland Medical System and the current facility housing the trauma center. And if capital funds are approved by the end of the legislative session, construction will begin by fall 1985.

Governor Supports Project

The project has the support not only of the governor but also of the board of regents and chancellor of the University of Maryland at Baltimore, the Health Resources Planning Commission, and the Department of State Planning.

According to R Adams Cowley, MD, director of MIEMSS and founder of the Shock Trauma Center, "We've been petitioning for a new building since 1975. Now we're enthusiastically awaiting our chance to testify before the legislators, many of whom have come here to view the dire circumstances under which we struggle."

Despite rooms and corridors overcrowded with beds and equipment,

there are not enough beds for the center's patient population—critical patients with severe multiple trauma, spinal cord injuries, or head trauma. The annual occupancy rate is 93 percent, and as high as 105 percent in the summer months when many patients are placed in non-bed areas such as the operating or recovery rooms until beds become available in the critical care recovery unit. The number of admissions has been increasing to the point that it was 15 percent greater than last fiscal year. The current 73-bed facility cannot continue to handle this increasing admission rate; as a result, last fiscal year 61 patients needing the expertise of the Shock Trauma Center were flown to another center. This compromises not only patient care but the concept of a statewide EMS system where patients are transported to the appropriate level of trauma center capable of providing the particular level of care needed by specific patients.

Building Not Freestanding

John Ashworth, executive director of MIEMSS, points out that several demand studies concerning the type of building needed and the most appro-

appropriate site have been completed. The result was the proposal for a seven-story building with a roof-top heliport. Mr. Ashworth emphasizes that the proposed new building will not be a freestanding facility; "it is not a castle built off into a corner." What became clear in the feasibility studies that considered various sites for the Shock Trauma Center (such as Mt. Wilson, Montebello, and several community hospitals) was that the Shock Trauma Center is different because it is associated with an academic health center. Therefore it has available certain technologies related to equipment and manpower that would be difficult to duplicate at a site away from the University of Maryland Medical System (UMMS) and that could never be duplicated matching the current economics of scale. The proposed new building will not be segregated from UMMS but will continue to receive ancillary and general support services from the hospital (for example, the Shock Trauma Center has a pharmacy, but it is a satellite of the UMMS).

The Shock Trauma Center is based on the concept of moving services to the

(Continued on page 2)

(Continued from page 1)

patient as opposed to moving the patient to the services. According to Mr. Ashworth, "Where we can move the patient to services, we do, but obviously with the kinds of severely injured patients within our unit this is limited."

Dedicated Services

Of intense scrutiny during the review of the facility by the health planners was the issue of "dedicated" as opposed to "duplicative" services. "Based on our experience, we know what services must be immediately available and dedicated to respond to trauma patients—services that cannot be termed duplicative," says Mr. Ashworth. As an example, the operating rooms for trauma patients should not be on the seventh floor but should be immediately adjacent to the receiving area so that a patient with life-threatening injuries does not have to be moved and allowing for continuity of staff.

UMMS Renovation Not Feasible

Because of the Shock Trauma Center's integration with the UMMS, it was suggested that since the hospital had excess beds, the trauma center expand by renovating a part of the hospital to meet its needs. First, Mr. Ashworth counters, the UMMS has no excess surgical or ICU beds—the type needed by the trauma center. Second, he cites the feasibility study completed by architects which considered the renovation of the

"South Hospital" built in the 1930s. That study concluded that the renovation would not result in the necessary operational and functional relationships needed by the trauma center; in addition, cost and efficiency were considered. The renovation would cost almost as much as the proposed new building and the resulting renovated building would have maintenance problems in a few years and not permit optimal use of resources. Another point studied was the displacement of hospital patients currently occupying 200,000 square feet who would have to be moved to another part of the hospital. Most importantly, however, renovation of the UMMS would not solve the current crucial heliport problem where the patient is transported to the heliport atop University Garage, placed in an ambulance for a 3- to 5-minute drive, then taken past a garbage dumpster and into UMMS to be transported one-half block down a basement corridor and placed in an elevator to the STC's admitting area. (In the proposed new building, after landing on the roof-top heliport, the patient would be placed on the elevator and taken to the first-floor admitting area.)

Beds Increase

In the proposed plan, the number of beds would increase from 73 to 138. However, this will be done within the licensed bed capacity of the UMMS.

UMMS officials have agreed to reallocate 65 hospital beds to the Shock Trauma Center.

Workload Management

Another argument frequently heard by Mr. Ashworth is that the Shock Trauma Center has an apparent fluctuating patient admission rate and that the highly trained medical staff is left "standing around when admissions are down." Although the admission rate is cyclical—that is, climbing during week-ends and during the summer—Mr. Ashworth notes that the unit is staffed for peak periods and that vacations are seldom granted for these periods.

During "down times," staff are engaged in teaching, research, and publishing functions, in keeping with their academic affiliation with the University of Maryland Medical School. Vacations are also scheduled during these "down times."

STC Anchors EMS System

According to Mr. Ashworth, what is most important in discussing the new building is the fact that the Shock Trauma Center is a statewide facility and anchors Maryland's statewide EMS system. The trauma center is the statewide receiving center for the severely injured—head-injured, spinal-cord, and trauma patients—referred by prehospital care providers or by hospitals or areawide trauma centers because of its special capabilities. The Shock Trauma Center last year received patients from 20 of Maryland's 23 counties, as well as from Baltimore City. According to Mr. Ashworth, "We know that all of our trauma centers are capable in terms of resuscitating and stabilizing patients." But many of the areawide trauma centers transfer patients to the Shock Trauma Center when problems occur in the post-resuscitative or critical care management phase because of the Center's special support services for 24-hour critical care management of patients. The Shock Trauma Center "allows other trauma services to do business efficiently without overwhelming their resources and gives the patient the best chance for survival because of the consolidation of such services as neurosurgery."

Areawide Trauma Center Support

Mr. Ashworth also notes that when the certificate-of-need process began in 1981, MIEMSS staff met with all of the Maryland trauma centers to explain the "why's and wherefore's of the need for the new facility" and received their support.

Anyone wishing further information on the new building should contact John Ashworth at (301) 528-3774.

—Beverly Sopp

Accuracy Needed in Runsheets

It's hard to believe what you see!

While we are getting much information from the Maryland Ambulance Information System (MAIS) runsheets, from time to time inappropriately written forms are submitted from the field that shut down the whole process.

It is important that particular care be taken filling in the response areas of the MAIS runsheet.

If recently reviewed forms are to be believed, patients are receiving treatment not authorized in particular areas or being taken to three different hospitals on the same trip.

These misreads occur when the provider fills out the form and makes inappropriate marks on the sheet. Remember—the scanner reads and records your marks. The machine is dumb. It doesn't understand what it is doing, it just reads the marks.

When a form is received with an "X" placed throughout an entire section, or an important phone number

jotted down on the form, if the carbon deposit (pencil mark) happens to be in the area that indicates "started 1—IV" and "receiving hospital—West Virginia University," the data will be transcribed exactly as the scanner reads it.

Remember that you should fill in only the areas that you actually intend to have recorded. The accuracy of the data you record is important to the patient, you, and your company, and is used as the basis for further refinements in patient care.

Please make the extra effort to ensure that your runsheets are an accurate record of your activities in rendering patient care.

As a final suggestion, be sure to fill in the ambulance code and dates appropriately, so you and your company can be given credit for your activities.

—Lou Jordan

Director, Prehospital Care,
EMS Field Operations

Continue CPR during Helicopter Flights

Many times EMTs question whether CPR can be performed on patients in cardiac arrest while they are transported by helicopter. The answer is definitely **YES!**

The vast majority of cardiac arrest patients transported by helicopter are accident trauma patients who have arrested as a result of the initial trauma or injury. Although the helicopter can transport two patients, only **one** who is in cardiac arrest can be transported. It is immensely important to administer uninterrupted CPR to the patient until the helicopter arrives, while the patient is loaded onto the helicopter, and until take off to a trauma center. Manual cardiac compressions as well as pulmonary resuscitative assistance must be continued while the patient is placed on a helicopter litter, carried to the helicop-

ter, and loaded onto it. Fluid administration as well as drug maintenance is to be continued.

If a Thumper cardiac unit is being used, it will be necessary to momentarily stop the unit and to switch the control arm to the right side of the patient prior to entering the helicopter. The helicopter doors cannot be closed if the Thumper unit's control arm is on the left side of the patient. Any extra oxygen bottles connected to the Thumper should be stowed under the litter on the rear floor of the helicopter. After the bottles are placed on the rear floor, the aviation trauma technician closes the helicopter doors and no further assistance by ground personnel is required. Remember to leave the helicopter at the front or side (never to the rear) and stay clear of the landing zone so that the

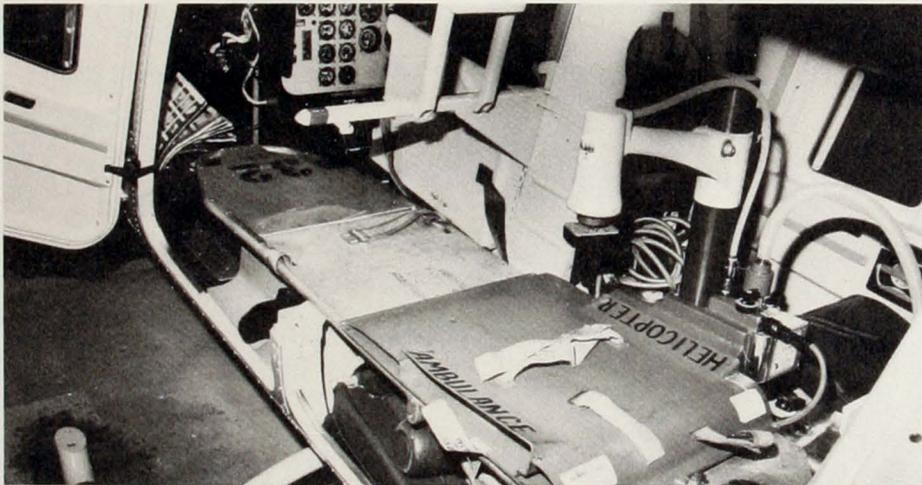
helicopter can take off.

Arrival at the hospital helipad requires a high degree of safety and assistance to the crew in off-loading the patient in an orderly and swift manner so that proper care can be continued. Notification of a CPR patient's ETA [estimated time of arrival] via helicopter is coordinated by SYSCOM to the receiving hospital. When the helicopter begins its descent to the hospital helipad, the pilot flashes the nose light on and off several times to indicate that a cardiac arrest patient is aboard. After the chopper has landed, one hospital attendant or nurse should report immediately to the right side of the helicopter, enter the rear door, and take over CPR. Once the aviation trauma technician is relieved, he/she can then open the helicopter's left side doors to further facilitate patient off-loading.

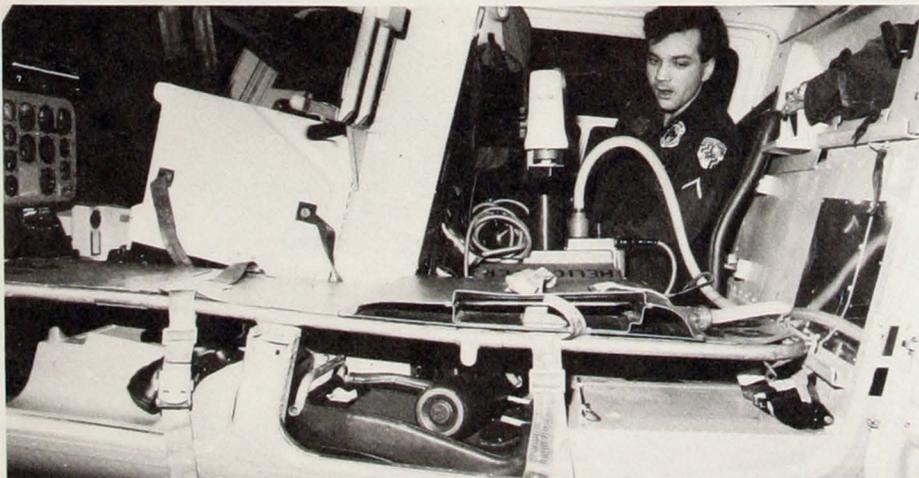
All doors **must** be opened and shut by the aviation trauma technician so that the fragile doors are not damaged. If the doors are damaged, the flight might have to be scrubbed and the aircraft grounded until it is repaired.

The above procedures provide a safe and orderly flow of patients in and out of the helicopter. Please assist in this procedure by following the directions of the aviation trauma technician. Don't rush. Use good common sense in getting the job accomplished safely and as quickly as possible.

—Major Gary Moore
Commander, Aviation Division
Maryland State Police



Ambulance personnel should remember that the control arm of the Thumper cardiac unit should be on the right side of the patient prior to entering the helicopter. It may be helpful for ambulance personnel to label the sides of the Thumper board as "Helicopter" and "Ambulance" as shown.



Maryland State Police TFC Mark B. Gabriele shows the correct placement of the Thumper control arm and the extra oxygen bottles for the Thumper stowed under the litter.

Correction

The Emergency Nurses Association (Maryland chapter) participated in Region III's EMS Day at Harborplace in September. This information was inadvertently omitted from the article on EMS Week in the November issue of the newsletter. We regret the omission.

Trauma Centers Studied

All of the areawide trauma centers will be evaluated this year. Frank Ehrlich, MD, chairman of the department of emergency services at Conemaugh Valley Memorial Hospital, in Johnstown, Pennsylvania, recently evaluated the Region V areawide trauma centers at Suburban Hospital in Bethesda and Prince Georges General Hospital in Cheverly. These were the first Maryland areawide trauma centers to be evaluated this year.



Ten years ago, he was the new kid on the block. Today his green scowling face is as familiar to Marylanders as the skull and crossbones he replaced. His name? Mr. Yuk.

Since 1975, when the Randallstown Jaycees, Blue Cross/Blue Shield of Maryland, and the University of Maryland School of Pharmacy provided the initial funding to bring this program to the Maryland Poison Center, his face has appeared in over a quarter of a million households in Maryland.

During National Poison Prevention Week '85 (March 17-23), the Maryland Poison Center will again focus on the Mr. Yuk poison prevention program. The Mr. Yuk symbol takes a dual approach to poisoning. Its primary role is to prevent an unintentional childhood poisoning by a program stressing identification and labeling of harmful items with the Mr. Yuk stickers, combined with an educational program for the child that teaches that Mr. Yuk means "No! Do not touch!"

However, no program or symbol is failsafe. The secondary role of the Mr. Yuk symbol is to facilitate emergency treatment if a poisoning should occur. The sticker is designed so that the parent will take the product with the Mr. Yuk sticker to the phone, call the poison center listed on the sticker, and then have all the necessary product informa-

EHS Chairman Named

John Lewis, EdD has been appointed acting chairperson of the emergency health services (EHS) department at the University of Maryland Baltimore County. Dr. Lewis replaces Dorothy Gordon, DNSc who has accepted a position as associate administrator for nursing at the National Rehabilitation Hospital in Washington, DC. Dr. Gordon started the EHS program in 1980. Over 150 students have attended the program which now offers a bachelor of science (in EMS management or paramedic training) and a master of science in emergency health services.

Poison Prevention Week Slated

tion (the exact name of the product, ingredients, etc.) to give to the poison information specialist. Hopefully, this not only will hasten emergency treatment but also will minimize the severity of the exposure.

A free sheet of 12 Mr. Yuk stickers, as well as a set of poison information cards, are available to anyone who sends a stamped, self-addressed business envelope to: POISON—NPPW-85, 20 N. Pine Street, Baltimore, MD 21201.

In 1983, the Maryland Poison Center, a division of the University of Maryland School of Pharmacy, handled over 54,000 calls. Of these 64.6 percent (21,223) involved children under five years of age. While most of these cases were non-toxic or sub-toxic exposures that were managed in the home, many of these incidents could have been

avoided with more active poison prevention intervention by the parents, including the use of Mr. Yuk stickers.

In case of a poison emergency, contact the Maryland Poison Center on either of its emergency numbers: (301) 528-7701 or toll-free (Maryland only) 1-800-492-2414. The center provides 24-hour emergency toxicity and treatment information to the general public and to health professionals.

On March 20, in conjunction with MIEMSS Field Nursing Program, the poison center will conduct a one-day workshop on the general management of the poisoned patient, selected toxic agents, and poison prevention strategies. For more information, contact Karen Burley, MIEMSS Field Nursing, at (301) 528-3930.

—Jacquie Lucy

MAST Procedures Explained

"We buy time until a patient can be definitively treated," said Ameen I. Ramzy, MD, associate medical director for EMS field operations at MIEMSS, and medical director for the paramedic training program at UMBC, describing the reason for using MAST garments.

Speaking at EMS Care '84, sponsored by MIEMSS in June, Dr. Ramzy said the procedure for applying MAST garments in adult trauma should be:

1. Check the blood pressure. If it is less than 80, there is an absolute indication for MAST use; between 80 and 100, a relative indication for use.
2. Inflate the legs.
3. Recheck the blood pressure.
4. Inflate the abdomen if needed.

Contraindications for inflating the abdominal compartment include:

- An article impaled in the abdomen (it could be pushed in further).
- Pregnancy (especially in the third trimester).
- Abdominal evisceration. (Dr. Ramzy adds, "If there is abdominal evisceration with only the smallest bit of tissue protruding—use MAST garments—inflate the leg portion, take the blood pressure, and call for a consultation. With profound shock, the physician may choose to take responsibility for inflating the abdominal segment if, in his judgment, the benefits outweigh the risks.")

Contraindications for using MAST

trousers are:

- Pulmonary edema.
- Massive uncontrolled hemorrhage above the level of the MAST garment.

Uncontrolled hemorrhage is another relative "judgment call." Dr. Ramzy explained, "If I'm dying with a laceration of my brachial artery and you can control it by putting pressure on it, use the MAST trousers."

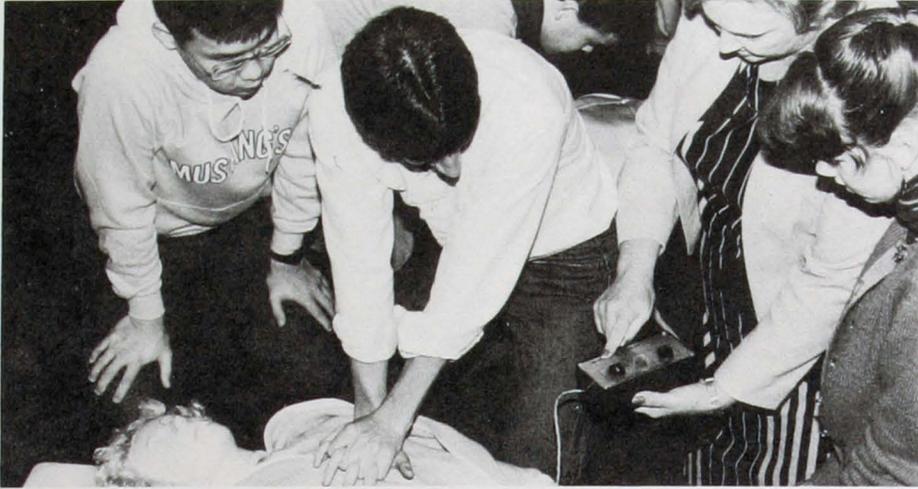
One possible problem with MAST garments is the inadvertent deflation of one of the compartments. "You've got to send the pump in," Dr. Ramzy said, "because the worst set of circumstances is to have a patient arrive with the pressure out of the leg compartments, and the abdominal portion still inflated. In this case, the abdominal portion does not improve circulation, but acts as a venous tourniquet for the lower extremities. Everything pools, rather than assisting the circulation. Be sure to send the pump in.

"In the case of groin hemorrhage, put pressure on the wound itself. If there is still a need for increased circulation by protocol criteria, put on the trousers.

"There is a myth," Dr. Ramzy said, "that MAST trousers cannot be used in cases of head injury. The fact is, there is no significant rise in intracranial pressure with the application of MAST trousers. What a person with a head injury needs is oxygenation, so MAST trousers can help buy time."

—Erna Segal

CPR Skill Taught in Maryland Schools



Helen Stemler checks the effectiveness of the CPR technique of a student at C. Milton Wright High School in Bel Air. (Courtesy of Harford County Public Schools)

To Helen Stemler, teaching cardiopulmonary resuscitation (CPR) in the schools is more than just the ABCs. It is teaching responsibility for one's fellow man, good citizenship, and the emotional rewards in experiencing "connectedness" with others. It is also teaching students new health promotion concepts so that the next generation's risk of developing coronary artery disease will be decreased.

Ms. Stemler, former supervisor of health and physical education in Harford County public schools who is now a physical education specialist for Howard County public schools, first became formally involved with CPR in the schools in 1972. At that time MIEMSS and the Maryland affiliate of the American Heart Association received grants for community education. Health and physical education supervisors in the local school systems utilized the training and materials provided through this initial grant to implement CPR in the school curriculum. In 1978, less than 20 percent of Maryland's counties had CPR programs, but this school year, all but four counties in the Eastern Shore and Western Maryland will be teaching the course to students ranging from seventh to twelfth grades.

Many localities offer the CPR course as a part of a larger program of comprehensive school health and physical education. Students increase their safety awareness by learning what to do in an emergency, and how MIEMSS and its network of emergency medical services operate. The main goals of the programs are to teach early warning signals of heart attack and how to deal with them, and to teach prudent, healthy life-

style behaviors that will reduce the risk of heart disease.

When deciding the best age to teach the CPR program, program coordinators worked to determine maturity level, educational readiness, and the possible effectiveness of the material. In the Harford County public schools, 14 was determined to be an appropriate age, although this varies from county to county.

Ms. Stemler provided leadership in local school system curriculum development that stressed emergency health concepts as early as kindergarten, when children are given an awareness of emergencies and accident prevention. Even as young as five, they may learn poison prevention; and at age nine, some elementary school students learn to stop bleeding by applying pressure and elevating the limb. Through grade five, the children may be taught the concept of 911.

Last year the Jarrettsville Volunteer Rescue Squad and the staff at Jarrettsville Elementary School organized a morning program over one school's intercom system. The children could actually hear the phone being dialed and a child calling for help. "My mother has fallen and she needs help," a little boy said. "We will help you. Tell us where you live and describe the streets near you," a voice assured. Later, the concept of intersections and locations was discussed. Children are also taught what to do in the event of fire, how to determine consciousness, how to get out, and how to communicate adequately to get help. "I truly believe that the primary responsibility for emergency training is in the home, with parents," Ms. Stemler

notes, "although the roles of schools, MIEMSS, the American Heart Association, and the American Red Cross are vital but secondary."

In many health and physical education programs of the Maryland school system, safety education is a gradual process with a little added each year, culminating with CPR and other health education classes in high school.

"I see this curriculum as more than just teaching the skill of CPR," Ms. Stemler reiterates. "It has the spiritual and emotional benefits of caring for others, learning to take assertive steps to help someone, and discovering that no one lives in isolation."

Last spring Raymond Barr, MD, emergency cardiac care committee member of the American Heart Association, helped to coordinate a statewide conference for teachers on CPR in the schools. The enthusiastic attendees learned the why's of CPR in the schools, along with the latest techniques and procedures.

For the future, involved agencies hope to expand CPR and emergency training to include every student in Maryland schools.

Some Maryland schools are also working on the yearly recertification programs with success. Appropriately, every Valentine's Day, the C. Milton Wright High School in Bel Air is open to all CPR class graduates for a refresher program. The Student Government Association provides free breakfast for participants.

"Many people have spent a lot of time working to get a CPR/emergency care program into local school systems, and we've come a long way," Ms. Stemler says. "But we are looking toward 100 percent of our systems participating, along with active support from the EMS regions." Last year, Ms. Stemler, Robert Rhodeheaver, and David Ramsey, Region I administrator, developed a videotape and curriculum materials, and went to the local board of education and physicians' groups to convince them to add CPR to the curriculum in Garrett County public schools. The Maryland affiliate of the American Heart Association networked with Ray Clarke, Kent County schools supervisor, to assist that school system in developing a program.

According to Ms. Stemler, we need to vigorously promote the refresher programs and utilize up-to-date teach-

(Continued on page 6)

Medical Ethics Advisory Boards Sought

"With the advent of new technology that saves lives that were never saved before, the issues of economics and ethics have come into play, often at odds with each other." This was the concern of Paula Hollinger, RN, member of the Maryland House of Delegates from the 11th district, speaking at the Seventh National Trauma Symposium, sponsored by MIEMSS and the National Study Center for Trauma and Emergency Medical Systems.

Delegate Hollinger was night nurse in the emergency room of a hospital in Spanish Harlem in the 1960s, head nurse of a surgical ICU, and later worked in the stroke unit at University of Maryland Hospital. She said there is a big difference between working in the 1950s and 1960s and now. In those days, when a patient was dead, he was gone. In contrast, today there are patients who are totally decerebrate, being kept alive with respirators. Families come in day after day after day; insurances run out; they lose businesses and homes paying medical bills. Health professionals with the patient all day have mixed feelings as to whether they should be advocates of the decerebrate in the bed, or the family asking whether their loved one is going to get better. Mrs. Hollinger points out that this question is coming into focus just at the time the federal government, the state, and the private sector are grappling with cost-containment issues. Health providers have access to high technology tools of medicine that can prolong life but offer little hope of recovery, creating difficult choices. Doctors, patients, and families are feeling the impact of technology and costs on their decision-making.

"On the one hand, the feds are screaming cost-containment and DRGs, and on the other hand they're also screaming ethics, *vis-a-vis* the short-lived Baby Doe regulations." (In the Baby Doe case, the advice of attending physicians and the wishes of the pa-

rents of a severely handicapped infant were challenged by an individual with no connection to the case, who set himself up as protector of the baby's rights. The case cost the parents months of anguish and over \$100,000 in legal fees. The federal government stepped in, seized records—and took health providers off the floor, where they were helping sick people—to investigate.) In October 1984, President Reagan signed Baby Doe legislation into law and the regulations have just been issued.

According to Mrs. Hollinger, the deliverers of health care are caught in the middle. They have always tried to take into consideration the needs of the patient and the family, and the advice of the doctors, nurses, social workers, and clergy involved in each case. Now, however, they are faced with the government, special interest groups, and others coming into hospitals and petitioning them into the courts. Mrs. Hollinger said, "I consider this to be unacceptable."

The President's Committee on Biomedical Ethics studied the problem and recommended the establishment of biomedical advisory committees in hospitals, to bring all sides together.

Last year, Delegate Hollinger introduced House Bill 158 into the Maryland legislature, to establish hospital medical ethics advisory boards. (A board would consist of an MD and RN, neither of whom are directly involved with the care of the patient in question, social worker, chief executive officer or designee, and as many others, including members of clergy, as are deemed necessary.) The board could be convened or petitioned by a doctor, nurse, social worker, patient, relative, guardian, or person with power of attorney for a patient who is too sick or mentally impaired to make a competent decision for himself.

The bill was drafted with the help and support of the Maryland Hospital Association, Maryland Academy of Pediatrics, Medical and Chirurgical Faculty of Maryland, Department of Health and Mental Hygiene, Baltimore Association of Retarded Citizens, Maryland Nurses Association, and many private individuals.

Unfortunately, when the bill reached the legislature, it was linked with a Baby Doe bill. Sides were clearly chosen: hospital and health care providers were for the ethics advisory committee bill; organizations for the handicapped, the Catholic Church, and Maryland Right to Life promoted the Baby Doe bill. On the day of the hearing, the

Right to Life group demonstrated against the ethics committee bill on the grounds that family members might have much to gain by the patient's death and that absence of guidelines for the very young would lead to nontreatment of handicapped babies.

The Baby Doe bill did not pass in committee; the ethics bill reached the House floor. "We are left with nothing to help us," said Mrs. Hollinger.

"We, in the legislature, are anxious to hear from you. Are you willing to speak out? Keep in mind the purpose of this bill was just to set up an ethics advisory committee for each hospital."

Please contact Delegate Paula Hollinger, RN, 3708 Lanamer Road, Randallstown, MD 21133, or call her Annapolis office on Tuesdays or Wednesdays, toll-free: from Baltimore, 841-3342; from Washington, 858-3342.

Update: A committee comprising physicians, the Maryland Hospital Association, and Catholic Consortiums is preparing a revised hospital medical care advisory committee bill, to be introduced in this session of the legislature.

—Erna Segal

MD—DC Task Force

A memorandum of understanding between Maryland and the District of Columbia is being developed at the request of Maryland's Governor Harry Hughes, who asked DC's Mayor Marion Barry to designate a team to be part of a task force to resolve problems of inter-jurisdictional emergency medical services between Maryland and DC.

The task force is composed of representatives from Maryland and DC healthcare and EMS organizations.

The memorandum of understanding will cover such issues as the utilization of the District's designated trauma centers as back-up adult trauma centers to Maryland's designated trauma centers (the five back-up adult trauma centers include the Washington Hospital Center and DC General, Georgetown University, George Washington, and Howard University hospitals); the delineation of helicopter and land surface transportation across jurisdictional lines; financing issues; and communications issues.

Although DC's specialty centers for burns, eye injuries, pediatric trauma, and neonatal problems have been a part of Maryland's EMS system for years, this is the first time an agreement has been delineated for adult trauma.

—Beverly Sopp

CPR Taught in Schools

(Continued from page 5)

ing materials. (Copies of *Teaching Cardiopulmonary Resuscitation in the Schools* and *Putting Your Heart into the Curriculum* can be obtained by calling Kathleen McCracken at the Heart Association office (301) 685-7074.)

"It's a beautiful feeling when over 100,000 young people have learned CPR," Ms. Stemler says.

—Rochelle Cohen

Dr. Conn Leaves MIEMSS for Boston



During his farewell party attended by EMS field providers and MIEMSS staff, Dr. Alasdair Conn (middle) received a certificate of outstanding contribution from Dr. Cowley (right). Dr. Ameen Ramzy (left) read the citation which included the following: "Alasdair's skills were crucial in the development of our EMS System that responds to more than 300,000 emergency calls for help annually. Dr. Conn also established himself on the national scene and has made major contributions to the field."

EMS Standards Input Sought

The American Society of Testing and Materials (ASTM) recently held its second national meeting on setting national voluntary EMS standards.

According to Alasdair Conn, MD, former medical director of field operations and deputy clinical director of the Shock Trauma Center at MIEMSS, who is vice-chairman of ASTM's Executive Committee on EMS Services, several concerns raised at the first meeting surfaced again during the December meeting in Philadelphia.

The primary concern was that the process of setting voluntary national EMS standards should involve people nationwide. In an effort to involve more people from mid-America and the west coast, the next ASTM meeting on national voluntary EMS standards will be held in Los Angeles in early April.

The question was also raised whether there should be funding to offset the expenses of people traveling to the national meetings. There is a limited amount of money available through the Department of Transportation (DOT) which the ASTM is actively seeking. According to Dr. Conn, DOT would like to see voluntary national EMS standards adopted for ambulances, EMS equipment, and prehospital provider certification, and he hopes they would look favorably on ASTM's request.

At ASTM's meeting last July, five subcommittees were formed. During the December meeting several subcommit-

tee structures were revamped but all subcommittees are actively working and beginning to develop standards for initial promulgation. In fact, the first voluntary national EMS standard—on EMT-As—should be ready for a vote by the April meeting, according to Dr. Conn. He says that ASTM is also trying to "fast-track" the national levels for trauma centers (these will be based on the American College of Surgeons' criteria).

Dr. Conn notes that it may take 18 months to two years for all of the standards to be promulgated and approved. After each standard is approved and published, it will be reviewed every four or five years to make sure that it is still valid.

Approximately 200 members of ASTM—mainly EMS organizations—are currently participating in the voluntary national EMS standard-setting process. Dr. Conn urges more people to join. "By joining, each of us can have one vote and actively participate in furthering the goals and destiny of EMS. If you have a valid concern it will be heard. No standards will be generated without your input."

An individual or organizational membership is \$50 and entitles one to minutes of all meetings, drafts of all standards, and the opportunity to participate on a task force. For further information on joining ASTM, contact your regional administrator.

— Beverly Sopp

Alasdair Conn, MD, a key figure in Maryland's EMS system and the MIEMSS Shock Trauma Center for the past five years, recently resigned to become associate professor of surgery at Boston University and medical director of the New England Life Flight Program.

While at MIEMSS, Dr. Conn held many titles including director of field operations (in which capacity, he was also editor of this newsletter), and most recently deputy clinical director of MIEMSS Shock Trauma Center, medical director of field operations, and assistant professor of surgery at the University of Maryland School of Medicine.

Dr. Conn's new appointment at Boston University, effective February 1, includes teaching, patient care, and some administrative duties. The New England Life Flight program, still in its beginning stages, is the provisional name for the helicopter program that serves the 12 major health care institutions in Boston. These institutions formed a consortium to help finance their helicopter program, and they have since purchased a BK-117 configured for med-evac needs. Initially, Dr. Conn will be involved in expanding the communications, transportation, and training components.

Dr. Conn describes his new position as "professionally challenging" and feels that EMS systems and especially helicopter transport will become more important in the future. "We'll see hospitals having to close and hospital beds having to close, yet as a health care system we still need to provide the same quality of care. So if you can't get the services you need at the local hospital, you may have to travel to the appropriate institution. And that to me says two things. First, that EMS systems are becoming more important and second that helicopter transport will be more important."

Looking back at his five years at MIEMSS, Dr. Conn finds the experience "very rewarding." In that time, he has seen "the EMS system mature. The problems and concerns that we had in the late 70s haven't all been ironed out, but now we have a forum for ironing them out. We've definitely made progress—and we're all speaking to one another. ALS is stronger and widely recognized. And I think the citizens of Maryland do get better care due to the cooperation of everyone involved. And I hope that I'm somewhat responsible for that in a small way."

— Beverly Sopp

7215 Rolling Mill Rd., Baltimore, MD 21224
Address Correction Requested

Director: R Adams Cowley, MD
Editor: William E. Clark,
(301) 528-7800
Managing Editor: Beverly Sopp,
(301) 528-3248

University of Maryland at Baltimore
22 S. Greene St., Baltimore, MD 21201-1595

Published monthly by the
Maryland Institute
for
Emergency Medical Services Systems



Region II Trauma Days

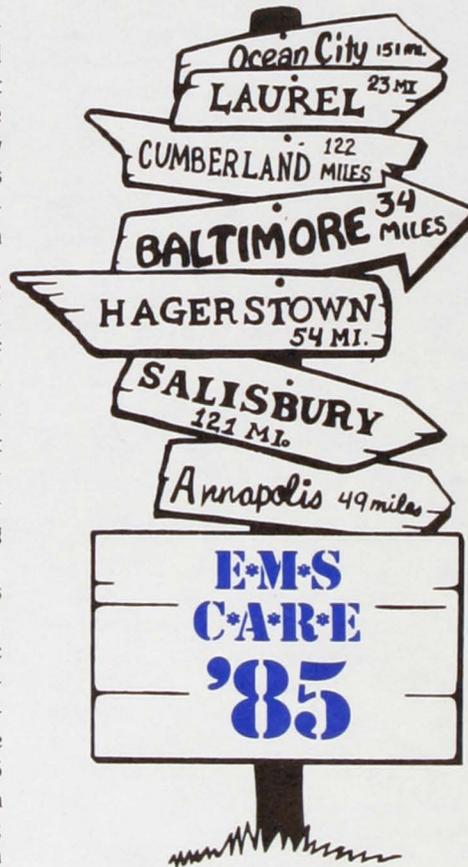
The Region II Trauma Days Symposium will be held March 22, 23, and 24 in Hagerstown. A concerted effort was made this year to expand the scope of the symposium and invite nationally known speakers to give presentations on topics of interest to emergency medical providers in Region II as well as from adjoining areas.

The program for Friday, March 22 will be devoted to a clinical track primarily for hospital personnel, but will be of interest to many ALS prehospital providers. Proposed topics include orthopedic assessment; nursing management of a patient with a pelvic injury; prevention of orthopedic complications; AV sequential pacemakers; and a cardiac drug update.

Saturday's and Sunday's programs will be devoted to prehospital tracks. Topics planned include pediatric trauma; EMS response to a HazMat incident; infection control, decontamination, and radiation safety; self-defense for EMS; overview of Maryland's EMS System—where do I fit in?; trends in prehospital care; EMS product update; and mental health care and the law in the prehospital setting.

For a program announcement, registration form, or additional information, contact the Region II Office in Hagerstown, (301) 791-2366 or 293-1749.

— George Smith
Region II Administrator



June 21-23, 1985
Bethesda Marriott
See March newsletter
for additional information.

Stress Symposium

"Stress and Behavioral Emergencies," an international conference sponsored by the emergency health services department of University of Maryland Baltimore County (UMBC), MIEMSS, and Psychosocial Clinicians in Emergency Medicine, will be held April 11-14 at UMBC.

Participants will attend sessions of general interest, as well as workshops. These are divided into three tracks: stress control and reduction for emergency personnel, psychosocial issues relating to behavioral emergencies, and disaster psychology and assistance to victims and rescuers involved in catastrophic events.

Speakers will provide practical, realistic, and applicable strategies for intervention in the crises of others or helping oneself control emergency services stress.

The conference is designed for paramedics, EMTs, psychologists, nurses, social workers, police officers, firefighters, administrators, dispatchers, pastoral counselors, and other emergency support staff.

Registration fees are \$105 (before March 15), \$125 (after March 15), or \$45 per day.

For additional information, contact Jeffrey Mitchell, PhD, at (301) 455-3223.