



Maryland EMS News

Vol. 23, No. 1

For All Emergency Medical Care Providers

November/December 1996

MIEMSS Breaks Ground for New Building



MIEMSS broke ground on September 10 for a new five-story building at 653 W. Pratt Street.

The new building, to be designed by Kann & Associates and built by Turner Construction Company, will allow more space for the training of paramedics and EMTs. The current Dunning Hall building that houses MIEMSS will be torn down and replaced with a new University of Maryland clinical building for women's and children's health programs, surgical services, and a new emergency room.

At the groundbreaking for the new MIEMSS building are (l-r) John Murphy (Administrative Director, MIEMSS), Chief Michael F. X. O'Connell, Jr. (Anne Arundel County Fire Department), Willie Blair, MD (EMS Board), Dennis Jones, RN (EMS Board), Steve Cox (President, Maryland State Firemen's Association), Victor Broccolino (EMS Board), Chief John Frazier (EMS Board), Bernie Koman (Statewide EMS Advisory Council), Donald DeVries, Jr., Esq. (Chairman, EMS Board), Robert R. Bass, MD (Executive Director, MIEMSS), Murray Kalish, MD (Statewide EMS Advisory Council), Capt. Milton Harrod (Statewide EMS Advisory Council), and Capt. Donald Lewis (Maryland State Police).

Nominations for National EMS Memorial Service

EMS providers who died on duty assisting sick or injured persons will be honored May 24, 1997 at the National EMS Memorial Service in Roanoke, VA.

All EMS personnel, volunteer and career, who died in any year as a result of an EMS call are eligible to be recognized. Nominations are due December 31 and will be reviewed by a national committee. There is no fee to submit nominations.

Since the Memorial Service was established in 1993, 96 providers from 27 states have been honored. The names of those honored will be

engraved on individual brass leaves that become part of the "Tree of Life," a permanent memorial in the national EMS museum in Roanoke to EMS personnel who died in the line of duty. A picture and brief biography will be placed in the National EMS Memorial Book. The service and permanent memorial are the only ones of their kind dedicated solely to EMS personnel.

During the service, family members and/or colleagues will receive an American flag that has flown over the U.S. Capitol and recognizes the EMS provider's community service, a single white rose signifying love of others, and a medallion representing their eternal memory.

To request a nomination form, contact: National EMS Memorial Service, 1904 Byrd Ave., Suite 211, Richmond, VA 23230-3028, phone 804-282-3311; or FAX 804-282-9847.

**EMS Week 1997
May 18-24**

**EMS: Making a Difference
...For Life**

Whom would you nominate for a statewide EMS award? Think about it! More information on award categories, criteria, and deadlines will appear in the next newsletter!

Dr. Haller, Pioneer in Pediatric EMS, Retires



Dr. J. Alex Haller, who retired from MIEMSS on September 30, 1996, is recognized by the EMS Board for his lifetime commitment to the health care of children. He is shown here with EMS Board Chairman Donald L. DeVries, Jr., Esq. and MIEMSS Executive Director Dr. Robert R. Bass.

J. Alex Haller, Jr., MD, is recognized across Maryland and throughout the country as a pioneer in the delivery of specialized care to children who are the victims of sudden injury and illness. In August 1992, Dr. Haller, Jr., was appointed the Associate EMS Medical Director for Children's Programs at MIEMSS to further the development of the Emergency Medical Services for Children (EMSC) program within the state EMS system. On September 30, 1996, he officially retired from MIEMSS and received an award from the Emergency Medical Services Board for a lifetime of dedication to the care of critically injured and ill children in the state of Maryland. The citation read: "Your commitment to improving the system of pediatric health care delivery and advocacy for enhanced resources to protect children will have a lasting impact on the children of Maryland."

Dr. Haller has held the positions of professor of surgery, pediatric surgery, pediatrics, and emergency

medicine at the Johns Hopkins School of Medicine since 1962.

Dr. Haller started the Children's Trauma Center at the Johns Hopkins Children's Center in the 1970s advocating that the same system of regionalized and specialized trauma care be available for all children. Dr. Haller's professional career began as a medical student at the Johns Hopkins University School of Medicine; he continued there as an intern, resident, and surgical fellow. Because of his long hours, Dr. Haller's family often said that he lived at the hospital. In fact, Dr. Haller and his wife Dr. Emily Haller at one time lived in the housestaff quarters within the dome of the Johns Hopkins Hospital during their residencies.

Dr. Haller has been on the national faculty for both the Advanced Trauma Life Support Course and the Advanced Pediatric Life Support Course. He has traveled around the globe delivering the message that "children are not small adults" and

About Dr. Haller. . .

"Dr. Haller always puts children first in word and deed. Many children and their families are unknowingly in his debt. His many contributions will have an indelible impact upon emergency services for children. We will miss his enthusiasm and conviction."

◆ *Martin Eichelberger, MD*
(Professor of Surgery and Pediatrics, George Washington University; Director of Emergency Trauma Services, Children's National Medical Center, Washington, DC)

"Alex always has a warm smile and kind word for everyone; even in heated debate he is a gentleman. He is a pioneer in building systems of care for critically injured children and we have all been blessed with working with him over the years toward improving the lot of those who have no voice in our society."

◆ *James Seidel, MD, FAAP*
(Director of National EMSC, Resource Alliance, Torrance, California)

"Dr. Haller was the first pediatric surgeon to not only advocate for improving the care of the injured child but also to develop the tools, methods, and standards for all surgeons and physicians to use in the care for these children."

◆ *Paul Colombani, MD*
(Pediatric Surgeon-in-Charge, The Johns Hopkins Hospital, Baltimore, Maryland)

ensuring that developing health care delivery systems have the benefit of the model programs available in Maryland and the United States. As a member of the American Academy of Pediatrics' Committee on Pediatric Emergency Medicine and a member of the American College of Surgeons' Committee on Trauma, Dr. Haller has provided a link between both groups in developing national standards so that a child in an emergency situation has access to the most appropriate level of care in the most timely manner.

Joining MIEMSS in 1992, Dr. Haller identified the need for a pedi-

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Dr. Haller Retires

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atric advisory group that represented all of the regions within the state EMS system as well as the pediatric resource centers in Maryland. The Pediatric Emergency Medical Advisory Group (PEMAG) was established in the winter of 1993. The PEMAG was developed to facilitate the identification of needs for pediatric illness emergencies, trauma, and critical care and to recommend statewide enhancement initiatives. This group also acts as an advocacy voice for children in the development and revision of standards, protocols, and regulations in the delivery of emergency care to children in Maryland. PEMAG serves as the steering group for the Maryland EMSC Enhancement grant representing the interdisciplinary regional pediatric subcommittees in each of the five EMS regions in Maryland and the three pediatric specialty hospitals serving Maryland patients. Dr. Haller has served as the co-project director for the Maryland System

Enhancement for EMSC Programs grant awarded by the Maternal Child Health Bureau of the Department of Health and Human Services.

Dr. Haller has been one of the strongest voices across the state advocating for injury prevention initiatives. He has provided expert testimony in the Maryland legislature on the need for handgun safety and has led his medical colleagues in recognizing that the number of young victims of violence is increasing. Dr. Haller will continue to work with the pediatric advocates for injury control and injury prevention initiatives here in Maryland and across the country.

In 1993 Dr. Haller received the Curtis Artz Award for outstanding contributions to the field of trauma with a focus on pediatric trauma care from the American Trauma Society. In 1995 he was awarded the Gold Medal of the British Association of Pediatric Surgeons, the association's highest honor. Dr. Haller has received many additional awards and served on many committees at the state and national levels. He has provided the citizens of Maryland with a

lifetime commitment to caring for critically ill and injured children and to eradicating the need for such care through prevention measures.

Today when one talks with Dr. Haller about the most important things in life, he focuses on every child's right to be protected from harm and to receive the same care he would want for his own children. Of course, if you ask him what the most important events of the summer are, you will hear about all of his four children's wonderful accomplishments as adults and even more important--the achievements of his 13 grandchildren. As they pursue their leisure activities, we wish both J. Alex and Emily Haller their well deserved freedom from beepers and time to travel and enjoy their families. The commitment they have given to children will serve as a challenge to those trying to follow in their footsteps. We look forward to hearing about the fishing in Virginia and the shells from Sanabel Island, and count on the promise that J. Alex will still be "carrying the flag" for the safety of children in Maryland.

♦ *Cyndy Wright-Johnson, MSN
EMS-Children's Program
Administrator*

**Help us save our children -
follow the law!**

Maryland's Revised Child Passenger Safety Laws *Effective October 1, 1996*

- A child younger than four years (regardless of his/her weight) or who weighs 40 pounds or less (regardless of his/her age) must be secured in a federally approved safety seat according to the safety seat and vehicle manufacturer's instructions.
- A person may not transport a child younger than 16 years unless the child is secured in a child safety seat or a vehicle's seat belt.
- A child younger than 16 years may not ride in an unenclosed cargo bed of a pick-up truck.

**Questions? Call Maryland Kids
in Safety Seats at 800-370-SEAT.**

Legislative Update 1997

The EMS Board has approved four proposed bills to the 1997 Maryland General Assembly. The first is based on former house Bill 1052 which will transfer the authority to oversee advanced life support EMS providers from the Board of Physician Quality Assurance to the EMS Board. The second bill involves modifying the EMS Law to allow the Board to set and charge fees in the designation and verification of trauma and other specialty referral centers. These fees will represent the actual cost that MIEMSS will incur. The third proposed bill relative to EMS will modify the language in the commercial ambulance legislation to allow MIEMSS to carry any unexpended balance from one fiscal year to the next. Another bill proposes adding an anesthesiologist to the Statewide EMS Advisory

Council (SEMSAC), increasing its membership to 29.

Because of the controversy last year regarding the terms of "licensure" and "certification" in former house Bill 1052, the Maryland State Firemen's Association (MSFA) polled its members regarding the current proposed bill. According to Charles Wills, the chair of the EMS Committee of MSFA, 2,275 surveys were returned and a majority favored the legislative proposal by a ratio of 4.5 to 1. A large majority (8 to 1) of the ALS providers who responded favored the use of the term "licensure." A simple majority (8 to 7) of the BLS providers favored the term "licensure." Based on the survey, the MSFA recommended certification for BLS providers and licensure for ALS providers and endorsed the legislative proposal.

Approaching Alternative-Fueled Vehicle Crashes

EMS, law enforcement, fire, and public safety personnel who arrive on the scene of an alternative-fueled vehicle crash should be able to identify the specific type of fuel involved and secure the scene so investigative procedures and rescue work can begin. The first arriving emergency responders also need to know when to call for trained personnel equipped with proper protective gear for assistance.

Below are the key features and emergency approach procedures for five of the most common types of alternative-fueled vehicles. The information is reprinted from the publication entitled: "Identifying and Approaching Alternative-Fueled Vehicles," produced by the National Highway Traffic Safety Administration, Office of Enforcement and Emergency Services.

The first objective is to identify the specific type of alternative-fueled vehicle. Look for special fuel ports, distinctive profiles, and any written markings on the vehicle. Except for selected local areas, alternative-fueled vehicles are not required to be identified and there are no standardized placards, logos, or symbols. Several examples of identifying symbols are given for each type of alternative-fueled vehicle listed below.

LPG & CNG

• Locating the Fuel Source.

Most liquid petroleum gas (LPG) or compressed natural gas (CNG) vehicle containers will be found in the trunk area, under the side panel of a van or school bus, on the frame, or in the bed of a pick-up truck.

Expect a majority of the vehicles to be owned by a fleet service such as buses, taxi cabs, or utility companies.

• **Handling Emergency Incidents.** If the vehicle is not on fire and no



obvious leak is detected, stabilize and secure the vehicle by setting the brake, utilizing wheel chocks or other forms of cribbing as needed. Then turn off the vehicle's ignition and turn the gas cylinder valve handle to the "off" position.

If the vehicle is on fire or a leak is detected, do not approach the vehicle. Secure the scene using non-sparking markers or cones. **DO NOT USE FLARES!**

Approaching the CNG or LPG vehicle that is leaking fuel or on fire should only be attempted when wearing proper protective clothing and self-contained breathing apparatus. If you do not have the proper protective gear, equipment, and training to deal with fire or hazmat emergencies, do not approach the vehicle. Create a safe zone and contact the proper response units in your area. Remember, in most cases, an alternative-fueled vehicle in a crash should not require a hazmat response.

PROPANE/FLEET LPG

The greatest hazard of the LPG containers exposed to fire or extreme heat is BLEVE (boiling liquid/expanding vapor explosion). However, a CNG container exposed to fire can also fail, releasing dangerous amounts of fuel and/or flame. When LPG fuel containers become compromised, the fuel converts from a liquid to a vapor that could rapidly produce a sizable vapor cloud which may ignite and flash back to the fuel source.

Methanol & Ethanol

• Locating the Fuel Source.

Methanol or ethanol uses the vehicle's existing fuel tanks. Bus fleets

are common users of these two types of fuels.

• **Handling Emergency Incidents.** If there is no fire or leak, carefully approach the vehicle, turn off the dri-

POWERED BY



ver's ignition switch, and set the parking brake or use wheel chocks to secure the vehicle.

If fire is present, stay away from the vehicle, secure the area, and deny entry. **CAUTION:** A fire fueled by methanol or ethanol burns bright blue

ETHANOL POWERED

and can be difficult to see on a clear day. If there is an obvious leak, you may approach the vehicle, but use the same caution as when working around a traditional-fueled vehicle. When a leak or fire exists, call fire or hazmat services.



If you do not have the proper protective gear, equipment, and training to deal with fire or hazmat emergencies, do not approach the vehicle. Create a safe zone and contact the appropriate response units in your area. **DO NOT USE FLARES!**

Electric

• Locating the Fuel Source.

Look for an electric charging port on the side or front of the vehicle, the electric logo, a stepped-up roof line or a distinctive profile. These vehicles are powered by batteries, as high as 300 volts, usually located under the hood, in the trunk, or under the vehicle. A separate, traditional 12-volt battery is still needed to operate the vehicle's electric feature such as the radio or headlights.

• **Handling Emergency Incidents.** If there is no fire or battery liquid

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Alternative-Fueled Vehicles

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leak, carefully approach the vehicle, turn off the driver's off/on switch, and set the parking brake or use wheel chocks to secure the vehicle. If smoke is visible, no one should approach the vehicle without self-contained breathing apparatus. Toxic fumes and vapors from damaged batteries can be carried in the smoke or steam.

If the vehicle is on fire, or an obvious leak is detected, do not



approach the vehicle. Secure the scene with non-sparking markers or

cones and call the proper response unit. DO NOT USE FLARES!

When an electric vehicle has been in a severe crash and the normal safety features have been compromised, avoid approaching the vehicle when there is arcing under the hood. Never cut into the battery pack or the traction cable, even if the high voltage has been shut down, because the battery pack can remain charged.

Since there still may be toxic fumes present around the vehicle after the fire is contained, only those with proper protective gear, equipment, and training should participate in the cleanup.

Post-crash safety precautions are critical, and it is imperative that law enforcement and other emergency personnel familiarize themselves with the differences between alternative and conventional fuels.

Trauma Case Reviews

November 20, 1996
7:00 - 9:00 PM
Shock Trauma Center
Baltimore

January 18, 1997
9:00 - 11:00 AM
Johns Hopkins/Bayview
ER Conference Room
Baltimore

February 26, 1997
7:00 - 9:00 PM
Shock Trauma Center
Baltimore

RSVP: 410-706-3994

For Your Calendar

EMS Update '96

Dates: Oct. 31, Nov. 1: Preconference featuring BTLS, ACLS
Nov. 2 & 3: General Sessions featuring Bill Metcalf, Asst. Dir. of EMS for ACEP, on "The Future of EMS" and Dave Durian, WBAL-TV/Radio, on "Emergency Services and the Media"

Place: Towson State University's Student Union Building
Sponsor: Baltimore County Fire-Rescue Academy

Cost: For Balto. Co.-affiliated EMS personnel: free, plus \$5/day for meals; Non-Balto. Co.-affiliated EMS personnel: \$25, one day; \$40, both days (fees include lunch)

Credits: CEUs available through MIEMSS

Contact: Baltimore County Fire/Rescue Academy, 410-887-4890

Effective Communication & Cultural Competence in Emergency Care of the Adolescent: A Training for Emergency Medical Service Providers

Date: Dec. 5, 1996, 8:30 AM - 5 PM

Place: University of Maryland at Baltimore

Sponsors: The Adolescent Emergency Services Project of Children's National Medical Center, Washington, DC and the Center for Minority Health Research, University of Maryland at Baltimore

Cost: \$25

Credits: Continuing Education Units available for physicians, nurses, prehospital providers, and social workers
Contact: Donna Richmond, 301-650-8059

EMT-B Instructor Forum: A Summary of Experiences of Teaching EMT-B Pilots & Current Courses

Date: November 16, 1996

Place: MFRI, Berwyn Heights

Sponsor: MSFA, MFRI, MIEMSS

Contact: MFRI (1-800-543-1245) or MIEMSS (1-800-762-7157)

Trauma Orientation Workshop for Nurses & Allied Health Personnel

Dates: Dec. 10 & 11, 7:45 AM - 4:30 PM

Place: Johns Hopkins Hospital Adult Trauma Center

Sponsor: Johns Hopkins Hospital Adult Trauma Center

Cost: Free of charge to prehospital personnel

Contact: Kathy Rohrer, 410-955-5349. You may register for one or both days. Registration is limited, so please act quickly.

Spring '97 EMS Seminar at Ocean City

Dates: March 13-16, 1997

Place: Princess Royal, 91st Street, Ocean City

Sponsor: Ocean City Paramedic Foundation

Credits: 12 hours of BLS/ALS continuing education & 24-hr. EMT-B bridge session

Contact: 410-723-6616. Registration begins January 1997.

What to Do If You Suspect Child Abuse

Responding to a call and finding a child who has been abused is a particularly difficult and emotional situation for most prehospital providers. Joy Sakamoto-Wengel, JD, assistant attorney general at MIEMSS, discussed the topics of child abuse and neglect and the provider's responsibility to report them. Her lecture was part of the violence conference, "Emergency Care in an Increasingly Violent Society," presented by the Education Council of Region V and MIEMSS, last May.

In the legal definition of child abuse, the victim is less than 18 years of age and his or her health or welfare is threatened by his or her parent, a person with temporary or permanent care or custody, or a household or family member. The types of abuse include physical, mental, and sexual.

Ms. Sakamoto-Wengel described the evidence of child abuse that the prehospital provider may find when responding to an emergency call. Indications of physical abuse are injuries that are inconsistent with the child's physical development or injuries not likely to have been self-inflicted with reference to the child's developmental status. Other indications might be welts, fractures, and cigarette burns. Manifestations of mental abuse are observable mental or psychological impairment in the child (could be caused by the parent), and/or the parent threatens or denigrates the child in front of the prehospital provider. In addition, when child abuse is involved, the parent may be evasive or vague when answering the questions of the prehospital provider.

Evidence of sexual abuse may be presented as blood in the underpants of the child; the child may have a sexually transmitted disease, may be uncomfortable sitting or walking, or may exhibit unusual knowledge about sex or sexual practices. In these

cases, exploration or molestation of the child for the sexual gratification of an adult may have occurred.

Another form of child abuse is neglect. This is when the child is not receiving proper care and attention. Neglect is also evident if the child's health or welfare is endangered, or the child does not receive proper food, clothing, shelter, medical care, nurturance, guidance, or supervision. The prehospital provider must report child neglect, as well as physical, mental, or sexual abuse.

Both child abuse and neglect must be verbally reported immediately. Abuse must be reported immediately to the Department of Social Services and to the local law enforcement agency. Neglect must be reported immediately to the Department of Social Services. Within 48 hours, the prehospital provider must also send a written report on evidence of child abuse to the Department of Social Services and to the local law enforcement agency. In addition, a written report on child neglect must be sent to the Department of Social Services within 48 hours.

Ms. Sakamoto-Wengel discussed how to document a possible child abuse or neglect call. The provider must get the following information to put on the report:

- The child's name, age, and home address
- the name of the parent or guardian
- the whereabouts of the child
- the nature and extent of the abuse/neglect
- previous abuse or neglect of the child
- the possible cause of the abuse or neglect
- the identity of the abuser
- the names and ages of other children in the home

The prehospital provider has immunity from civil or criminal penal-

ties for reporting suspected child abuse and/or neglect. However, there ARE penalties for NOT reporting suspected child abuse or neglect. For paramedics and CRTs, these penalties may include being reprimanded, suspended, or being refused recertification. EMT-As, as well as paramedics and CRTs, may be subject to civil liability as a result of not reporting suspected child abuse and/or neglect. It is important for the health care provider to remember that child abuse and/or neglect that goes unreported only increases, possibly putting the child's life in danger. The laws concerning the reporting of suspected child abuse or neglect mandate the health care provider to take action against child abuse and neglect by reporting it, and to allay his or her fears of civil liability in the unlikely case of a mistake on the part of the provider.

- ◆ *Kimberly S. Weinkam, EMT-A*
Ms. Weinkam works in both a private and a volunteer ambulance company.

Region IV Office Moves

The MIEMSS Region IV Office has relocated. The new office mailing address is 301 Bay Street Plaza, Suite 404, Easton, Maryland 21601. The phone and fax numbers remain the same: 410-822-1799 (phone) and 410-822-0861 (fax).

In Memoriam

Richey D. Adams, a member of SEMSAC and Life Member of the Bethesda Chevy-Chase Rescue Squad, died on October 29, 1996. Maryland's EMS community has suffered a great loss by his passing.

Telemedicine in Trauma

With more than 300,000 pre-hospital responses per year, the Maryland EMS System is a model for many other systems.

Teleconsulting between the field care provider and the trauma physician has occurred in Maryland for many years. For example, the Emergency Medical Resources Center (EMRC) of MIEMSS directs calls from the prehospital care provider to the appropriate hospital, including patching connections with the trauma attending in the R Adams Cowley Shock Trauma Center. However, in the next few months the Anesthesiology Department at the Shock Trauma Center is beginning a new initiative to broaden the scope of telemedicine in trauma. The following article is written by Colin F. Mackenzie, MD, who is the Interim Director of the National Study Center for Trauma and Emergency Medical Systems and Professor and Chief of Anesthesiology at the Shock Trauma Center, University of Maryland School of Medicine.

Express Care Pilot Project

In October 1996, the first field trials of telemedicine by the Shock Trauma Center occurred in the Maryland Express Care ambulance service. This commercial service completes 3,500 transports of critically ill patients per year to the University of Maryland. In these trials we are using digital cell-phone technology to gradually upgrade the information transmitted. We are examining the added value of real-time vital signs transmission during ambulance transport. We also intermittently transmit a still patient image via cell-phone. As a further addition to the currently available audio communication, we will transmit video images. The utilization of this technology in a real-life mobile transmission "test bed" will be evaluated by the Express Care transport care providers, emergency medicine physicians in Express Care, and human factors engineers.

Do such improved telecommunications change patient outcome, alter interventions made en route, or improve the receiving hospital's perception of patient diagnoses and needs? These and other evaluations will determine the usefulness of such enhanced telecommunications for Express Care. Development of these telecommunication upgrades can also serve as a model for testing in trauma field care.

Video Laryngoscope Test Project

Among 4,350 recent new patient admissions to the STC, 240 (5.5%) had tracheal intubation by the field care provider, and 513 (11.8%) required tracheal intubation during resuscitation. Yet 528 (70.1%) of these intubated patients did not require surgery in the first six hours of injury. These data indicate the importance of advanced airway management in the early phase of resuscitation and suggest great potential benefit from implementing tracheal intubation teleconsulting in the field.

In November 1996, we will set up a teleconsulting "test bed" in the Shock Trauma Center. We will use a video laryngoscope to assist trainees learning or refreshing intubating skills. The image of the larynx (seen from the tip of the laryngoscope) will be used by a remotely situated anesthesia care provider to talk the trainee through placing the tracheal tube between the vocal cords. An ear-piece in the trainee's ear and a microphone attached to the trainee will be used for audio communication between the anesthesia care provider and the trainee laryngoscopist.

Once we have developed expertise in teleconsulting for airway management (the anesthesia care providers have to learn this), we intend to test this in selected field situations. The video image of the larynx will be transmitted from the field to the anesthesia care providers in Shock Trauma. This teleconsulting will be available 24 hours a day, 7 days a week. We are interested in

having field care providers participate in this study, both when they are visiting the Shock Trauma Center to refresh their airway skills and when they are intubating trauma patients in the field. The proposed teleconsulting would allow participating field providers to review the video with the consulting anesthesiologist if the patient is transported to the R Adams Cowley Shock Trauma Center at the University of Maryland Medical System.

As a comparison to teleconsulting, we will develop an improved airway management simulator which uses the airway and torso of the full-mission anesthesia simulators made by CAE-Link and LORAL. Advantages include the ability to make the tongue swell, to create laryngospasm, to put the C-spine in traction, and to produce a "cannot intubate, cannot ventilate scenario." The simulator has a pulse oximeter (with audio signals), arterial blood pressure waveform, and electrocardiogram. The signals from these are controlled by the simulator operator to reflect the events (e.g., with O₂ desaturation the pulse oximeter goes from a steady "BEEP, BEEP, BEEP" to "BEEP, BOEP, BOOP, BOUP, BUUP" as desaturation occurs).

What Does All This Mean to the Field Care Provider?

- We will be cabling the Shock Trauma Center to enable on-line data acquisitions from all the trauma resuscitation unit (TRU) bays and operating rooms to a central telemedicine control room.
- We will be requesting your participation in viewing resuscitations from the control room and giving us a verbal summary of the field care. We will audio tape this while you are watching the resuscitation.
- On October 1, 1996 we began implementing a two-minute silence for you to give your summary of the history and physical to the trauma team in the TRU. During this time, the trauma team will apply patient monitors, take measurements, and listen to your report. We believe the field care providers admitting patients to Shock Trauma are part of the

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Governor Parris N. Glendening

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DATED MATERIAL

Telemedicine in Trauma

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trauma team and should present their findings once to the entire resuscitation group, rather than multiple times to individuals.

- As a temporary measure, to enable all the equipment for the central telemedicine control room to be installed, we will relocate the room currently used by the field care providers admitting patients to Shock Trauma. The field care providers' new space will be adjacent to the area they presently occupy on the TRU floor of the Shock Trauma Center. We appreciate your willingness to put up with this inconvenience while space in the TRU area is being redesigned.

For Information

If you have any questions or comments, please call 410- 328-2628 or E-mail Dr. Mackenzie (Colin@trauma.ab.umd.edu). If you are interested in seeing more of our work, publications are on our World Wide Web page <http://www.anesthlab.ab.umd.edu/HF>.

New FDA Equipment Reporting

New FDA (Food and Drug Administration) regulations on the reporting of problems with medical devices became effective July 31, 1996. The regulations, which fulfill a requirement of the Safe Medical Devices Act of 1990, specifically apply to ambulance providers and rescue squads.

Both medical device manufacturers and health care provider organizations are now required to create new medical device reporting procedures, as well as to maintain files containing information about "adverse events and product problems," copies of all forms submitted, and documentation of all defibrillations and decisions relative to the event. Providers must maintain these files for two years, and the FDA is allowed to access and copy these records at any time.

Medical device problems must be reported on the FDA's MEDWATCH Form 3500A. The form and more than 50 pages of instructions are available by automated FAX from the

FDA. Use a touch-tone telephone to call 800-899-0381, then depress 1 at the first voice prompt, then depress 853# for the instructions, and 854# for the form.

Please have your FAX number available when you make the above call.

In addition to MEDWATCH Form 3500A for individual reports of "adverse events," FDA Form 3419 is required for semiannual reports. However, Form 3419 is not required unless a Form 3500A has been used previously during the preceding 6-month period.

Forms are also available on the Internet at <http://www.fda.gov> as well as from the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161.