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NEWSLETTER

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SYSCOM, EMRC Merge; Now in Dunning Hall

"Several years in planning, the new communications facility is unique in the world."

Two communications centers, SYSCOM (Systems Communications Center) and EMRC Emergency Medical Resource Center), are being merged into a single location in Dunning Hall, adjacent to the R Adams Cowley, MD, Shock Trauma Center.

SYSCOM, the link between helicopter crews and hospital personnel, moved from the fourth floor of the previous shock trauma center to the first floor of Dunning Hall in mid-February. EMRC, which handles ambulance calls between field providers and hospital personnel in the Baltimore metropolitan area, is scheduled to start operating from the new facility in two months. It had been located at Sinai Hospital since its inception in 1975.

Several years in planning, the new communications facility is unique in the world. Andy Pilarski, chief of SYSCOM/EMRC operations, explained that the consoles were designed as a collective effort of the communications department. Combining the skills of operators, technicians, and maintenance personnel, the group has created an environment tailored to the needs of their work. Mr. Pilarski commended Tom Miller, in particular, for his leadership in the design of the center.

The center has six console stations: two for SYSCOM operators, two for EMRC operators, one for the MIEMSS medical duty officer, and one for a Maryland State Police (MSP) duty officer. All consoles have the same telephone and radio communications capabilities, with the medical duty officer having the ability to assist, as needed, in both SYSCOM and EMRC operations.

The medical duty officer oversees the medical communications operation of the center, verifies that operating protocols are followed, makes shift assignments, and ensures that the

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incoming shift is briefed by the outgoing shift. This person also manages field situations that fall outside established medical protocols. If the medical duty officer feels that a superior should make a decision in such an event, the information is relayed to the MIEMSS aeromedical director or EMS director, as appropriate.

The MSP duty officer is responsible for dispatching helicopters on missions other than med-evacs and for deciding which helicopters will be dispatched on missions. Additionally, this person decides when helicopters will remain grounded (due to poor weather conditions). In the future, the MSP duty officer's station will be the central dispatch point for all med-evac and law-enforcement missions.

A coming addition to the technologic capabilities of SYSCOM is an aircraft flight-following system. This system provides electronic tracking capabilities that will allow the duty officers and SYSCOM operators to monitor the location of each Dauphin helicopter. Gene Bidun, director of MIEMSS communications, noted that this system will improve efficiency in making helicopter assignments for med-evac and law-enforcement missions. For example, if a helicopter returning to its base is near the scene of an emergency, it can be directed to the site, even though it is in an area that it does not usually serve.

The computer that controls flight following will also portray maps of the state and can zoom in on sites of emergencies. SYSCOM operators can then relay details such as street names and highway numbers to helicopter crews approaching the scene.

SYSCOM and EMRC operators were trained on the new equipment in early February. The SYSCOM operators are leaving a system consisting of three independent radios and are moving to a console with eight integrated radios. In the former operation, medical calls had to be put on hold when an operator was juggling several simultaneous communications. In the new center, operators at their consoles can provide assistance when another operator becomes swamped with incoming calls.

Similarly, the EMRC operation has been made more efficient and flexible. The previous EMRC facility contained a collection of old equipment, which played a vital role in the development of Maryland's communication system but has outlived its effectiveness. Mr. Pilarski observed that "most electronic equipment has a life expectancy of 8 to 10 years. Some of the EMRC stock is 15 years old and can no longer be repaired."

Several operators have already been cross-trained on the SYSCOM and EMRC equipment. The center's plans call for all operators to be familiarized with the use of both systems.

The new arrangement also enhances the reliability of the operation. If one console should "go down," the operator will move to another console. If the power fails in Dunning Hall, a back-up emergency power generator will supply power to SYSCOM and EMRC. As an additional precaution, a battery power supply is also in place.

Because staff members have designed the new system, they will be able to make repairs and modifications more efficiently than in the previous operations. The old equipment was installed and maintained by outside contractors.

The new center provides an improved work environment for the operators. Temperature and humidity controls are independent of those for the building. A break area with kitchen appliances has been provided for operators, as well as a private locker room and restroom facilities.

The EMSTEL (EMS Telephone) network also falls within the purview of the MIEMSS communications. This statewide telephone network, developed in 1978, is being replaced by a system of microwave links. The change will lower the cost of operation and will improve communications among medical personnel across the state.

In addition to their duties within SYSCOM and EMRC, members of MIEMSS communications division are responsible for repair of radio equipment on ALS and BLS ambulances and of monitor/defibrillators. Their duties also include design, installation, and maintenance of over 65 med-channel transmitter sites, the EMSTEL network, the microwave system, and hospital and central alarm medical consoles.

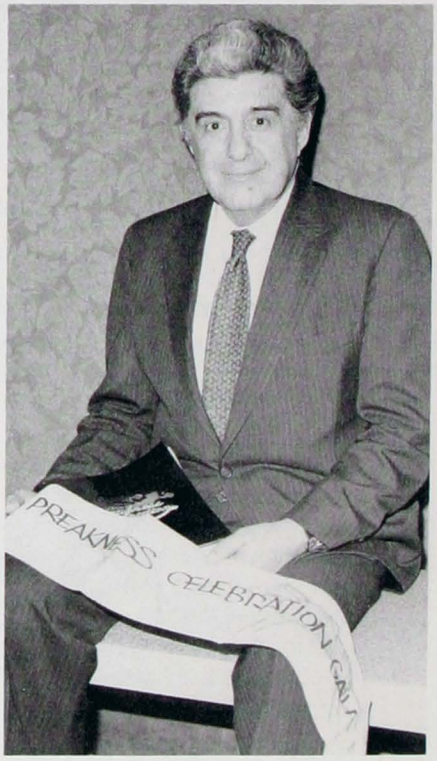
The division was recently honored with the Employee Group Recognition Award from the University of Maryland at Baltimore. It was presented to them in November by Edward Brandt, MD, PhD, chancellor of the university.

◆ *Linda Kesselring*

Preakness Celebration Gala Benefits STC

The Shock Trauma Gala, to be held May 13 at the Towson Centre of Towson State University, will become part of Preakness Week. With the support and cooperation of Frank DeFrancis, president of Laurel Racing Association, Inc., this year's annual dinner dance will be known as the Preakness Celebration Gala. Last year the charity netted $200,000 to benefit trauma research programs at the MIEMSS Shock Trauma Center as well as throughout Maryland. In addition to Mr. DeFrancis who is serving as director/coordinator, Governor William Donald Schaefer is honorary chairman, Phyllis Livingston is gala chairman, and Donald DeVries is solicitation chairman.

Tickets for the black-tie event cost $150 per person. For information, call Michelle Duquet, 301-328-8976.



Frank DeFrancis is director/coordinator of the Preakness Celebration Gala.

First Dauphin Operational April 7

We had to leave a significant number of patients behind at the scene last year who were transported to hospitals by ground ambulance, because we couldn't transport more than one person at a time in our present helicopters," says John D. Stafford, MD, MIEMSS aeromedical director. "Of the 2,400 patients we transport a year, we estimate there might be 200 flights in which two patients will be transported at one time to trauma centers."

The first new 365 N-1 Dauphin 2 helicopter, Trooper 1, becomes operational on April 7 at the Maryland State Police (MSP) Aviation Division Baltimore Section at Martin's Airport. Although the Dauphin is presently in use in 11 other programs around the country, MIEMSS improved upon it substantially with a specially designed state-of-the-art medical interior. "It can handle both on-scene rough-and-tumble conditions and interhospital flights," Dr. Stafford says.

MSP Med-Evac pilots are each receiving 20 hours of training for the new aircraft at the helicopter assembly plant in Grand Prairie, Texas, near Dallas. (The helicopter is built in France, test flown, disassembled, and reassembled in Texas.)

Although the Dauphin is 8 feet longer than the helicopters now in use, loading and unloading patients will be similar but safer. The rear tail rotor is encased, so there is little danger of accidently hitting it. The main rotor blade is located higher off the ground. When the stretcher is loaded, it is engaged on a loading platform by a puck that fits into a special slot and automatically slides the stretcher into place.

Equipment for the new $450,000 Loren-C Flight-Following System will be aboard the helicopters and at SYSCOM by August.

When only the old Shock Trauma Center building was in use, helicopters had to land on top of a nearby parking lot; the patient was transferred to an ambulance and driven down the seven corkscrew levels of the garage; driven down the street; and off-loaded from the ambulance near the dumpster outside the hospital. Then the patient was pushed through the basement halls of University Hospital to the two elevators serving the entire Shock Trauma Center. In contrast, when helicopters land atop the new R Adams Cowley, MD, Shock Trauma Center, the patient will be put on a stretcher and immediately be whisked to one of three patient-dedicated elevators leading directly from the heliport to the admitting area. This will save precious minutes of the Golden Hour. Dr. Stafford exclaims happily, "The days of the dumpster are over!"

The first new 365N-1 Dauphin 2 helicopter in Maryland becomes operational on April 7.

New helicopter safety equipment at the new Shock Trauma Center includes a special lighting system for landing that will be turned on by security personnel when SYSCOM notifies them that an aircraft is approaching. The system shows the pilot a white light if the helicopter approaches high, a red light if it approaches low, and a green light if it approaches at the correct altitude. Another safety feature is a system of drains on the heliport. These drains will remove excess rain, etc., when needed. But when a helicopter approaches, the drains will be closed so that in the event of a fire, foam can cover the surface of the heliport. "In the 15 years of Med-Evac service we have never had a landing fire," says Dr. Stafford. "But we want to be prepared just in case."

It is expected that the first three helicopters will be in use by the summer and the remaining three will be in action by the end of the year.

◆ *Erna Segal*

Region IV Announces New ALS Coordinator

Sonya Crawford, RN, CEN, began her new position as EMS coordinator at the Memorial Hospital at Easton at the beginning of February. Formerly a nurse in the emergency department (ED) of that hospital, Mrs. Crawford looks forward to the challenges of coordinating ALS and developing continuing education for Memorial Hospital and the mid-shore area, primarily Talbot, Queen Annes, and Caroline counties. She will continue her ED work on a relief basis. Mrs. Crawford's husband, Tim, is an EMT-P in Anne Arundel County.

Mrs. Crawford's position was previously held by Margie Callahan, RN, who recently resigned. "It was a difficult decision to make," Mrs. Callahan says, "because I really liked working with the volunteers, the Region IV Office, and MIEMSS. It's the people who make the job enjoyable." There were only five ALS providers in the area when Mrs. Callahan began 4 years ago. She helped set up the ALS program, continuing education, and quality assurance in the mid-shore area. Mrs. Callahan will be spending more time with her family, helping her husband in his business, and nursing only part-time on a relief basis.

◆

Baby Born in New Shock Trauma Center

Another "first" took place at the new R Adams Cowley, MD, Shock Trauma Center (STC) on February 22 — a baby was born.

Heather Aspin, 8½-months pregant, was admitted to the STC at 1:51 am. She and her friend had experienced car trouble on Route 97 and were standing at the roadside when they were struck by another vehicle. Ms. Aspin was thrown onto the windshield of their car; she was taken by Anne Arundel Medic 5 to the STC. Her friend was less seriously injured and was taken to Anne Arundel General Hospital.

Upon her arrival at the STC, Ms. Aspen's injuries were treated by the trauma team led by C. Michael Dunham, MD, and Laurel Omert, MD, trauma surgery fellow. Within minutes of Ms. Aspin's arrival, Dr. Dunham called on obstetricians from the University of Maryland Medical System (UMMS) to monitor the fetus.

Several hours later, Ms. Aspin's hematocrit fell, indicating a blood loss. Fetal heart monitoring displayed evidence of fetal distress. Since the fetus was relatively mature, it was decided to deliver it by cesarean section. Obstetricians Andrew Block, MD, Janice Johnson, MD, and Lindsay Alger, MD, promptly took Ms. Aspin to the MIEMSS operating room, where a healthy baby girl was born at 9:22 am.

Dr. Dunham's team then did exploratory abdominal surgery to determine the cause of the blood loss. They found that no major structures were injured; only smaller blood vessels had caused the hemorrhage.

Two days later, Jane Gerber, MSW, of MIEMSS psychosocial services, arranged for the young mother to see her baby for the first time; previous to that time, Ms. Aspin had been drifting in-and-out of consciousness.

Waiting for the baby to arrive from the UMMS nursery, Ms. Aspin said, "I'm so lucky to be alive!" Her baby, since named Laurel, was brought to her wearing a pink, green, and yellow knit cap covering her full head of hair.

As of March 1, Ms. Aspin has been moved to a step-down unit in MIEMSS; Laurel is still in the UMMS nursery.

Karen Campbell, RN, from the UMMS full-term nursery, shows Heather Aspin her new daughter Laurel who was born at the Shock Trauma Center.

National Study Center

In response to concerns voiced by EMTs, paramedics, nurses, physicians, and other first-line responders, the National Study Center (NSC) and MIEMSS cosponsored the seminar "Legal Issues in Trauma Care" on March 16 at the Stouffer Orlando Resort in Florida. Dr. Charles Wiles III, attending surgeon/ traumatologist at MIEMSS, served as course director.

Florida State EMS Director Larry Jordon moderated the morning session. During this time, "Evolution of a Lawsuit" and "Triage, Transport and Treatment: The Prehospital System" were presented by Thomas Reardon, Esq., and David Spackman, Esq., respectively, both of the Boston law firm of Gaston & Snow. William A. Bell, Esq., general counsel to the Florida Hospital Association, led a discussion on hospital administrative issues stressing the quality control factors essential to a litigation-free environment and outlining the role that hospital administrators should play in identifying and planning for the control of trauma care liability. The roles and relationships between physicians and nurses affecting issues in trauma care liability were put into perspective by both Jonathan Greenberg, MD, JD, chief of the neurotrauma service at Jackson Memorial Hospital, and Barbara Siebelt, BA, RN, health care risk Manager of RISC, Inc., in Baltimore.

The federal government is currently considering major pieces of legislation that will directly effect funding for trauma care facilities and the feasibility of transporting patients to trauma care facilities as a primary destination. Discussing the latest developments on Capitol Hill was Harry Teter, Esq., general counsel to the NSC.

During the afternoon session, the audience observed a mock trial which explained what to do when you are served with a summons, have to give a deposition, and are examined and cross-examined by plaintiff and defense lawyers.

The next NSC/MIEMSS seminar is already in the planning stages. We welcome the opportunity to address topics of concern and interest to you. Please send your comments to the NSC; 22 S. Greene St.; Baltimore, MD 21201; ATTN: Susan Kaskie or call 301-328-7231 in the Baltimore area or 1-800-872-2820 outside of Baltimore.

Susan Kaskie
Assistant to the Director, NSC

EMS Involvement In Haz Mat Calls

As EMS providers we place ourselves in danger every time we respond to a call. Often the first on the scene, we rush into the situation and do whatever is necessary to provide emergency medical care. But this "go-and-do" attitude may one day get us into trouble. We need to reeducate ourselves to stop and look before we rush into a situation—particularly when the incident might involve hazardous materials.

Hazardous materials surround us and we often take them for granted. The gasoline that powers our cars, the natural gas or oil that heats our homes, the garden chemicals in storage, and the cleaning supplies in our houses—all have the potential to harm us. Fortunately these products are in small quantities in our homes—thus reducing the risk.

As EMS providers we frequently respond to vehicle accidents when we do not know what types of vehicles are involved or what they are transporting. How often have you responded to a "man down" call in a commercial or industrial building not knowing what is in the building?

There are three ways an EMS provider might be involved in a HAZMAT call: First on the scene, patient transportation, and medical surveillance.

First on the Scene

Consider the guidelines below the next time you respond to a call.

- Position your vehicle so you can make a strategic withdrawal if hazardous materials are involved in the incident. "Upwind and uphill" is the best position.
- Be observant as you approach the scene. Look for unusual signs, such as discolored grass, fumes, people coughing, or warning placards.
- Be proficient in the use of self-contained breathing apparatus and protective clothing. Do not be afraid to use them.
- If a hazardous material is suspected, notify your central alarm, stay away, and await additional assistance.
- Keep bystanders away.
- If possible, identify the product—without becoming exposed to the product, fumes, or runoff.

Patient Transportation

If you encounter a patient who has been exposed to a hazardous product, self-protection and on-scene decontamination must be high priority considerations. Placing a contaminated patient into your transport vehicle will not only contaminate your vehicle and supplies but will also provide a source of contamination that might endanger you. You and your coworkers could then carry contamination back to the ambulance company and even to your homes. In addition, if on-scene decontamination is not done, the contamination might be spread throughout the emergency department, resulting in its closing.

Consultation with the Maryland Poison Control Center regarding treatment is highly encouraged. It is imperative that the receiving hospital be notified in advance to allow time to remove all unnecessary equipment from the room where the patient will be placed.

A contaminated patient should be transported with all windows in the vehicle open and with the mechanical ventilation turned on. Transportation by helicopter is not an acceptable means of transporting a contaminated patient.

After transferring the patient to the emergency department staff, the transport unit should remain out of service and return to the incident site for a final decontamination. The crew and the transport vehicle should be thoroughly decontaminated before the unit is returned to service.

Before the incident is terminated, everyone involved should be given a debriefing that includes the possible effects of the hazardous product and what to do if any of the signs or symptoms develop after the incident.

Medical Surveillance

Normally these activities are performed by a medically trained member of the HAZMAT team. The HAZMAT team standard operating procedures should include establishing a baseline physical evaluation before any team member dons protective clothing. This physical should consist of blood pressure, heart rate, respiratory rate, body temperature, baseline EKG, and body weight. A repeat physical is required for every member exiting the hot zone. Evaluation of these physicals are the determining factors in allowing HAZMAT team members to enter or reenter the hot zone. Prehydration and rehydration of HAZMAT team participants are also responsibilities of the medical team. The medical surveillance process also requires visual monitoring of team members working in hot and warm zones.

HAZMAT Training

Currently many local jurisdictions are involved in hazardous materials training. Current law requires that anyone (including EMS providers) involved in responding to a hazardous materials emergency have 24 hours of training each year. Even though you may not be part of the HAZMAT team, as an ambulance crew member you might respond to a HAZMAT emergency and thus are required to be trained. The number of hours required is being contested and may change in the near future. For additional information on available HAZMAT training, contact your county fire/rescue training office. The Maryland Fire & Rescue Institute (MFRI) has developed a series of HAZMAT classes which have been approved for EMT-A and CRT continuing education. Information on these can be obtained from your regional MFRI office.

◆ *Ken Young,*
Associate Director for Quality Assurance
Prehospital Training and Certification

Physician Focus

Pan American Trauma Society

In this newsletter, another new academic trauma society is highlighted. In contrast to the Eastern Association for the Surgery of Trauma (profiled last month), whose creation was brought about in large part by a number of Shock Trauma staff and alumni, the Pan American Trauma Society (Sociedad Panamericana de Trauma) was born due to the efforts of one Shock Trauma surgeon, Aurelio Rodriguez, MD. Dr. Rodriguez, who is from Peru, served a trauma surgery fellowship at the Shock Trauma Center during the 1976-1977 academic year. After receiving two additional years of training in thoracic surgery at Wayne State University in Detroit, he returned to join the attending surgical staff at the Shock Trauma Center.

A number of years ago, Dr. Rodriguez began to receive invitations to speak throughout Latin America. It was during a lunch break at a conference at the Central Hospital of the Mexican Red Cross (El Hospital Central de la Cruz Roja) in Mexico City that the idea for the Pan American Trauma Society was conceived. Dr. Rodriguez's colleagues at lunch, who included Dr. Baquerio and Dr. Grife, both surgeons from Mexico, discussed the need for a trauma society for the Americas. At that time, the only academic trauma society on this continent was the American Association for the Surgery of Trauma. That association, which was mid-way through its fifth decade of life, was and is targeted to the North American health care community.

Dr. Rodriguez began to "test the waters" of the luncheon suggestion (which he credits to his Mexican colleagues) in his subsequent visits to other South and Central American countries. In his visits to Peru, Ecuador, Colombia, Venezuela, Panama, Uruguay, Chile, Argentina, and even Spain and Portugal, he found his clinical colleagues echoed the need for the new trauma society. The society was founded in the fall of 1986 when trauma surgeons from the Americas met during a conference in Bogotá, Colombia. Those in attendance included Dr. Jose' Félix Patiño (Colombia), Dr. Alberto Villazon (Mexico), Dr. Charles Lucas (Detroit), and Dr. David Mulder (Canada).

The main goal of the Pan American Trauma Society is to serve as a forum for presentation and dissemination of experiences in the care of the injured patient in the Western Hemisphere. The ultimate result of that interchange will be to improve the prehospital and intrahospital care of trauma patients. The potential to learn much from Society member experiences is great. North Americans will particularly benefit from the experiences of trauma that are indigenous to their southern neighbors, such as earthquakes, volcanic eruptions, guerrilla warfare, and large volumes of penetrating trauma associated with drug trafficking. Our Latin American colleagues stand to learn much from the trauma center/system experiences of the past two decades in the United States.

The Clinical Congress of the Sociedad Panamericana de Trauma took place in October 1988 in San Juan, Puerto Rico. Dr. Rodriguez presided at that meeting. Approximately 250 members attended the meeting, at which the keynote speaker was R Adams Cowley, MD. For his pioneering work in trauma care and the development of trauma systems, Dr. Cowley was awarded honorary presidency of the society. Curiously, the most discussed paper came from Japan. The principal author of that paper, which examined the role of endoscopic retrograde pancreatography in the management of blunt duodenal trauma, was Dr. Kazuhiko Maekawa, a former Shock Trauma trauma fellow and attending surgeon.

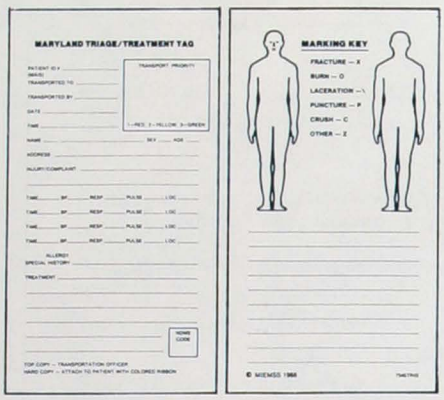
Dr. Rodriguez will relinquish his presidency at the third clinical congress in 1990 to Dr. Francisco Holguin from Bogotá. That meeting will be held in São Paulo, Brazil. Dr. Holguin was a fellow in surgery and traumatology at the Shock Trauma Center during the academic year 1977-1978.

In a short period, the Pan American Trauma Society can boast the following accomplishments: *Panamerican Trauma*, a quarterly journal, is slated to begin publication in September 1989. Papers from the first meeting of the Society will be featured in the bilingual *Journal/Revista*. Topics and authors for a textbook in trauma care have been formalized. The World Congress of Surgery has invited the Pan American Trauma Society to participate in its upcoming congress in Toronto, Canada, in August of this year. The membership ranks have grown to 500. Recognizing the importance of teamwork in trauma care, the Society has had the foresight to accept critical care/trauma nurses as associate members.

The next meeting of the Pan American Trauma Society will take place in San Juan, Puerto Rico, September 18-21, 1989. Physicians are invited to submit abstracts by July 1 to Dr. Rafael A. Toro Nazario, Executive Director, SPT, G.P.O. Box 4847, San Juan, PR 00936-4847. Nurses should send abstracts to Connie A. Walleck, RN, MS, Associate Director of Nursing, MIEMSS, 22 S. Greene St., Baltimore, MD 21201-1595. For information about joining the society, contact Dr. Rodriguez at 301-328-3055.

"Buena Suerte" to the Pan American Trauma Society.

◆ *Carl A. Soderstrom, MD*



Triage Tags Now Used In All EMS Responses

A revised protocol for the use of triage tags in daily operations and mass casualty incidents will be issued in early 1989 by MIEMSS Testing and Certification Office. Ken Young, associate director of that office, explained that the procedure is being changed to enhance preparedness for mass casualty incidents.

Reviews of the responses to actual mass casualty events and to drills reveal that the aspects of EMS disaster operations done best are those that are used daily and thus are most familiar to EMS providers. Previously employed only in response to incidents involving many victims, triage/treatment tags are now to be used on every EMS response in which a patient is evaluated. In daily use, the new two-part tag serves as a patient assessment form. The top copy can be handed to a staff member at the receiving facility as a quick report on the patient's status; the duplicate copy is kept by the EMS provider for referral when completing the Maryland Ambulance Information System runsheet.

For triage of victims after a mass casualty incident, the tags are used during a second-level triage, after patients have been surveyed rapidly and organized in treatment areas according to urgency for medical attention. (This article presents only the basic components of portions of the process. The treatment/triage protocol should be consulted for details of the operation.)

The first unit to arrive at the scene of a mass casualty incident is responsible for initial triage. Only basic lifesaving techniques such as establishing an airway and controlling life-threatening bleeding are administered. Patients are "flagged" with colored plastic ribbons to indicate their treatment priority. Red ribbon is tied to Priority 1 patients — those who require immediate attention. Priority 2 patients, those with emergent medical conditions that require attention but do not immediately endanger the patient's life, are identified with yellow ribbons.

As these victims are moved to separate treatment/holding areas, the Priority 3 patients (those who require medical treatment but not on an emergency basis) are tagged with green ribbons.

Second-level triage is conducted in the treatment/holding areas. When medical treatment is given and before the patient is taken to the transport sector, a triage/treatment tag is prepared. The transportation officer retains one copy of the tag to monitor the number of patients transported and their severity of injury. The other portion of the tag goes with the patient to the receiving hospital.

A videotape program describing the revised protocol is in production. Copies of the program will be distributed to the regional administrators, who will then have them available for fire/ambulance companies to borrow for training. New treatment/triage tags, instruction booklets, and an initial supply of colored ribbons will be distributed at no cost to Maryland companies.

◆ *Linda Kesslering*

Federal Legislation

The major EMS bill (SB10) introduced into Congress last year was reintroduced this year. Renumbered this year, SB15 was introduced by Senator Alan Cranston (D-CA); its companion bill, HB436, was introduced by Congressman Jim Bates (D-CA). Both bills are similar to last year's bill, with some exceptions.

According to Harry Teter, Jr., Esq., highlights of the bills include:

- A program to be administered by the secretary of health and human services to conduct research, training, and demonstration projects and to provide technical assistance to the states
- Establishment of an EMS/Trauma Clearinghouse to collect and disseminate information on trauma (this is not in the House bill)
- Grant programs to the states for: (a) not less than 35 percent of funds to plan, implement, and monitor trauma systems; (b) not less then 35 percent of funds to reimburse trauma centers for uncompensated care. This is a big issue in many states where trauma centers are stopping services due to uncompensated care.
- Yearly reports must be made giving the secretary of health and human services data on EMS systems and status of rural EMS. State EMS trauma plans must include components on designation of trauma centers following American College of Surgeon standards; rehabilitation services; no patient dumping; systems implementation standards; triage standards; evaluation of trauma center standards; and establishment of statewide central data and reporting on trauma patients. There must also be provisions for public education and interstate cooperation.
- A 3:1 state/federal match in each year in-kind contributions was authorized; the House bill calls for a 1:1 state/federal match the first year and 1:3 thereafter.
- Studies were mandated on reimbursements, long-term economic effects of trauma, and FCC channel allocation.
- The House bill also calls for a Council on Trauma to advise the secretary of health and human services and for the notification of prehospital care personnel regarding exposure to infectious disease.
- Authorization by the Senate was $75 million, with a floor to each state of $250,000; the House bill calls for $45 million with a floor of $500,000.

Many states will be challenged to meet all the requirements in the trauma plans of both bills, Mr. Teter says. Some states may need state legislation before they can establish a trauma center designation procedure and a central data bank. It would appear that as long as the states are working toward these goals and have a plan for implementation, they will be able to qualify for the grant dollars.

◆

DATED MATERIAL

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Legislature Considers Helmet Laws

State legislators again were asked to reinstitute mandatory use of helmets by motorcycle drivers and passengers during the 1989 session. The House Judiciary Committee held a hearing on the proposed legislation on February 1. Ameen Ramzy, MD, director of prehospital care, testified on behalf of MIEMSS. (The three House bills received unfavorable reports from the Judiciary Committee on February 20. When this newsletter went to press, the Senate bill was still under consideration by the Judicial Proceedings Committee.)

Several bills regarding the use of motorcycle helmets were considered by the House Judiciary Committee. House Bill (HB) 170 and Senate Bill 579 would have required the use of protective headgear when operating or riding a motorcycle. Non-use would have been a primary offense. These bills had MIEMSS' strongest support.

State law did require helmet use at one time, but that statute was overturned 10 years ago. Under that law, failure to wear a helmet resulted in conviction on a misdemeanor, which carried a penalty of not more than $500.

"Compromise" legislation was embodied in HB 193. This bill was similar to Maryland's seat belt law: helmet use would not be required, but a motorcycle driver not wearing a helmet would be cited with a secondary offense when stopped by a police officer for another violation. The penalty would be a $25 fine.

Although the third bill, HB 660, would have required helmet use, it also would have allowed people being licensed as motorcycle drivers to opt out of the requirement by paying a $100 fee at the time of licensure. That money would have been set aside for health care costs incurred by uninsured motorcycle riders hurt in crashes. MIEMSS opposed this bill because it weakened mandatory use and because the amount of money in the fund would have made little progress toward defraying the medical costs associated with recovering from head injury.

Information about motorcycle crashes has been compiled by MIEMSS statisticians in cooperation with acute care hospitals throughout the state. Their study reveals that, between July 1987 and June 1988, the acute care cost for unhelmeted drivers totaled $2,519,131. That is 10 times the cost for helmeted drivers. The average acute care hospital cost for unhelmeted drivers ($7,500) is more than twice the average for helmeted drivers ($3,400).

Unhelmeted drivers are more likely than helmeted drivers to be uninsured (40 percent and 25 percent, respectively). Of the excess cost due to non-use of helmets, the Maryland public pays $1.2 million annually and the rest is paid by the insurance industry.

Ten years ago, when motorcycle helmets were required in Maryland, 98 percent of motorcyclists wore them. After the law was repealed, the percentage of helmet users dropped to 53 percent in 1982 and then to 37 percent in 1988.

According to MIEMSS' study, non-helmeted motorcycle riders are more likely than helmeted riders to be killed in crashes, to be hospitalized, and to have a head injury only (rather than multiple system injuries).

Dr. Ramzy stated in his testimony, "Dollars and cold statistics do not tell the story of head injuries and suffering. Since the repeal of mandatory helmet use, too many people have needlessly died and too many families needlessly suffered."

In 1988, a bill requiring the use of helmets failed to pass out of the House Judiciary Committee by one vote. HB 170 also failed by one vote during this year's session.

◆ *Linda Kesselring*