Maryland
EMS
NEWS
Vol. 12 No. 7 JANUARY 1986

Ground-Breaking for New STC

(l-r) Frank Gunther, R Adams Cowley, MD, Gov. Harry Hughes, and Senator Frank Kelly lift the first shovel of dirt at the ground-breaking ceremony for the new Shock Trauma Center.

December 20, 1985 was a celebrated milestone in the history of the Shock Trauma Center. After 10 years of struggling to make the dream of a new building for the center a reality, R Adams Cowley, MD, and his supporters finally saw ground being broken for a new seven-story construction with state-of-the-art equipment. In keeping with the unanimous resolution of the board of directors of the University of Maryland Medical System (UMMS), the new building will be named after Dr. Cowley, the center's founder and director.

Speaking to the large crowd gathered at the ground-breaking ceremony, Dr. Cowley said that "it was 10 years ago that we began our work to reach this day. We made our first set of plans in 1975. . . . A lot of people have helped us get this far—among them, the state police, fire associations, EMTs, MIEMSS workers—and we thank you.

"The Shock Trauma is about saving the lives of critically injured citizens of Maryland. And this building will help us do it far more efficiently and allow us to do it for lots more people."

The Shock Trauma Center, which began as a two-bed unit in 1961, admitted more than 2000 patients last year. On the day of the ground-breaking, the center was only 54 patients shy of having admitted 20,000. Noting this, Dr. Cowley said: "I realize how far we've come and how far we have to go. For years they told us this couldn't be done. But they were wrong, and I thank you citizens of Maryland."

The new building will have approximately 100,000 more square feet than the current building. The number of resuscitation/stabilization bays will increase from 6 to 11; operating rooms

(Continued on page 2)

As a crowd gathers at the site where the new Shock Trauma building will be constructed, the ground is warmed for the official ground-breaking.

New STC Milestone Celebrated

The proposed Shock Trauma Center.

(Continued from page 1)

from 3 to 5; critical care/intensive care beds from 40 to 72; and intermediate care beds from 49 to 66. (The intermediate care beds will be located on the fourth floor of the south wing of University Hospital.) The new building will provide on-site radiologic capability and will include an organ procurement suite, all topped by a heliport.

Scheduled to be completed in 1988, the new building for the Shock Trauma Center will cost approximately $34.4 million. The Maryland General Assembly, under the leadership of Governor Harry Hughes, approved $21 million for the project during last year's legislative session. During the ground-breaking ceremonies, Governor Hughes assured the crowd that "there is another $10 million coming."

Besides the governor, numerous dignitaries from the Maryland legislature and the University of Maryland (including the Board of Regents), UMMS, MIEMSS, and the Shock Trauma Board of Visitors participated in the ground-breaking ceremony.

After the governor arrived by helicopter, he and the other dignitaries were escorted down a red carpet to the speaker's platform—the red carpet symbolizing the red line followed by all patients brought into the Shock Trauma Center.

Trowels were presented to the dignitaries and to representatives of the architects Reid and Stuhldreher.

Although a large single-handled shovel will be placed in the new building to commemorate the ground-breaking, a four-handled shovel was used in each of the two "diggings." The first group to break ground included Governor Hughes, Dr. Cowley, the Honorable Frank Kelly (state senator), and Frank Gunther (chairman, UMMS). The second group consisted of Edward Brandt, MD, PhD (chancellor, University of Maryland at Baltimore), John Dennis, MD (dean of the University of Maryland School of Medicine), Morton Rapoport, MD (president and chief executive officer, UMMS), and Allen Schwait (chairman, University of Maryland Board of Regents).

Hundreds of pink and white balloons were released following the ground-breaking—a ground-breaking that had become a milestone in the history of the Shock Trauma Center, for it meant that the center that was world-famous for its state-of-the-art trauma medicine would soon be housed in a "state-of-the-art" building and that critical patients would no longer have to be turned away because the center was grossly overcrowded and on flyby.

—Beverly Sopp

(l-r) John Ashworth (executive director, Shock Trauma Center), Elizabeth Scanlan (director, nursing, Shock Trauma Center), and R Adams Cowley, MD (director, MIEMSS)—three key people involved in planning the new building.

MPC Targets Ipecac

"Poisonings continue to be a major medical problem in Maryland," according to Gary M. Oderda, PharmD, director of the Maryland Poison Center at the University of Maryland School of Pharmacy. In 1984, the poison information specialists at the Maryland Poison Center handled 47,879 calls; of these, 28,987 were actual human exposures. Most of the poison center's calls come from the metropolitan Baltimore area; involve children under five years of age, especially two-year-olds; are accidental ingestions; and are treated in the home.

"Despite our best efforts, pediatric exposures continue to account for the majority of our calls (19,620 of 28,987)," adds Jacquie Lucy, the director of education/communications at the center. "Each year, beginning with National Poison Prevention Week, we target a behavioral objective that we want to teach. In 1984, it was poison proofing the home; in 1985, it was the Mr. Yuk stickers used as part of a poison proofing activity." For Poison Prevention Week—1986, the Maryland Poison Center is targeting syrup of ipecac. "This is a particularly difficult concept to teach because we want people to keep ipecac syrup in their homes in case of a poison emergency *but* not to use it unless we recommend it." Ms. Lucy adds that there has been a dramatic increase in the name recognition of syrup of ipecac over the past several years, but there are still many homes with small children that do not have ipecac syrup.

This year, as part of the 25th Anniversary of National Poison Prevention Week, the Maryland Poison Center is one of two poison centers in the nation that will address the national conference on its poison prevention programs. "We are trying to assemble a presentation that will show a variety of approaches to poison prevention and are eager to get any slides or materials that people have developed for community poison prevention programs," according to Ms. Lucy.

If you have any slides from programs or displays that you have developed, please send them no later than February 12 with a short description of the activity and the participants to Jacquie Lucy at the Maryland Poison Center, 20 N. Pine Street, Baltimore, MD 21201. Copies of the 1984 Annual Report are also available at that address.

Rescue Co. Opens

Ten years of planning and determination were rewarded on November 17 when the Harwood-Lothian Volunteer Fire and Rescue Company celebrated its grand opening. In the photo at the right are Herman Robinson, president of the fire company; O. James Lighthizer, Anne Arundel County executive; and Joseph M. Connell, fire administrator for the Anne Arundel County Fire Department. The Harwood-Lothian Volunteer Fire and Rescue Company is located near the Prince Georges County line on Route 2, just a half mile south of route 408, next to the Lothian Elementary School. "We're very pleased that this company will cut response time and provide greater protection for the southern part of the county," says Mr. Connell. "All personnel have at least EMT-A training, and we are reviewing locations to determine whether it is possible to move a paramedic unit to this location. Volunteers are encouraged to participate—just stop by the station and pick up an application." Company 9 received its first call six minutes after its opening when it responded to a medical box to assist Paramedic 1 and Ambulance 42.

EMS Care '86 Preconference Seminars Offered

On Friday, April 25, preconference programs on hospital-based disasters and cold-related emergencies will be offered in conjunction with EMS Care '86.

A seminar on hospital disasters such as fire and power failure, especially those requiring evacuation, will be presented at the Bethesda Marriott Hotel from 12 to 5:30 pm. The objectives are 1) to define the issues involved in hospital disasters, 2) to identify the resources and linkages necessary in planning for hospital-based disasters, and 3) to encourage interagency planning for hospital disasters.

The seminar will begin with a discussion of general principles of disaster management. Then a panel of representatives from disaster management agencies (including a public health officer, fire chief, hospital chief executive officer, emergency department director, emergency management representative, police chief, and MIEMSS representative) will discuss the roles and responsibilities of an agency such as theirs in a hospital disaster scenario. In a "lessons learned" format, Chief Gary Morris of the Phoenix Fire Department will present actual occurrences in hospital evacuations. The program will conclude with a panel discussion to define the issues and resources necessary to address hospital disasters.

This program is intended for emergency physicians, nurses, EMS managers, and others involved in disaster planning and is being cosponsored by the Maryland Chapter of the Emergency Nurses Association and the American College of Emergency Physicians.

Cold-related emergencies will be the topic of the second preconference seminar, which will be held at the Montgomery County Public Services Training Academy from 8:30 am to 4:00 pm. Reduction of inner body temperature and the effects of cold on the body's periphery are important but relatively unexplored areas of emergency medicine. In this seminar, David S. Smith, PhD, of Smith Aquatic Safety Services in Missouri, will teach emergency care providers 1) to identify physical and mental reactions to cold, especially in trauma victims, 2) to apply proper field and clinical procedures for initial assessment, treatment, transportation, and clinical processing of the hypothermic patient, 3) to resuscitate victims of cold-water near-drowning as well as terrestrial hypothermic situations, 4) to distinguish between human hibernation and death, and 5) to use the most current field rewarming and transporting equipment.

The complete program for EMS Care '86 and a registration form will be published in the February issue of *Maryland EMS News*. For additional information, contact your regional administrator.

Correction

Wheaton Volunteer Rescue Squad, Inc., from Montgomery County, was inadvertently omitted from the listing of participants for the National Disaster Medical System exercise in the October issue. We regret the oversight.

MRNP Ambulance Is 'Celebration of Life'

The new neonatal ambulance was dedicated on December 3, but according to Ameen I. Ramzy, MD, state medical director for field operations, who welcomed the group gathered on the cold December day, it was not just a vehicle being dedicated, it was a celebration of life. He said that even today in many countries large families of healthy children are encouraged, to help the family harvest the crops. That's no longer true in this country, where healthy children are cherished not because of their utility, but because they are human beings to be loved. "It is a nice reflection of our sense of values," Dr. Ramzy said.

Cheryl Bowen, RN, MA, of MIEMSS, administrator of the Maryland Regional Neonatal Program (MRNP), who designed the ambulance with suggestions from neonatal transport nurses (NTNs), neonatal transport technicians (NTTs), and volunteers, introduced the speakers. Eric Fine, MD, MPH, director of the preventive medicine administration of the Maryland Department of Health and Mental Hygiene (DHMH), pointed out that 50 years ago on December 3, 1935, Title V of the Social Security Act was passed to provide funds for the first time for all states to improve the health of mothers and children. It also provided funds to identify children with handicaps and provide services for them. For the past 10 years the DHMH has provided funds to support the neonatal transport program.

Michael Newberry, age four-and-a-half, who was transported by the MRNP when he was one day old, is all set to cut the ribbon dedicating the new neonatal ambulance. (l-r) Janet E. Graeber, MD, Michael, and Cheryl Bowen, RN, MA.

Speakers at the dedication ceremony were (l-r) Ronald Gutberlet, MD; Janet E. Graeber, MD; Eric Fine, MD, MPH; Cheryl Bowen, RN, MA; and Ameen I. Ramzy, MD.

Fifty years ago, the mortality rate of infants who died in the first year of life in Maryland was 49/1,000; those who died in the first month of life had a rate of 29/1,000. In 1984, the rate of those who died in their first year was 11/1,000; those who died in the first month were 7/1,000. Dr. Fine attributes the improvement to the efforts of the neonatal intensive care units and to the resuscitation and services provided in that newborn period. He congratulated all those involved and said they are trying hard to decrease those figures even further.

The co-directors of the MRNP, Ronald Gutberlet, MD, of the University of Maryland Medical System (UMMS), and Janet E. Graeber, MD, of the Johns Hopkins Children's Center, agreed that the state has been supportive of the program. Dr. Gutberlet pointed out that about 650 babies a year are brought to Baltimore from around the state, including the Eastern Shore and western Maryland. He also thanked the American Ambulance Company and the Johns Hopkins Hospital for funds for the new ambulance and the John J. Leidy Foundation and the March of Dimes Foundation for funds for its new isolette. Dr. Graeber said that the ambulance is vital to newborns because it helps to keep them stabilized en route to the neonatal center.

Two families who have benefited from neonatal transport were on hand to join the festivities. Pence Potter, Jr., also known as "PJ," was born 3 months prematurely and was transported to UMMS. He had severe respiratory distress symptoms and has bronchopulmonary dysplasia. "If we hadn't had such a great team working on PJ—and I mean the doctors, nurses, and therapists—he wouldn't be where he is today," says Nancy Potter, PJ's mother. Michael Newberry, now 4½ years old, was born with transposition of the great vessels, and was transported to Johns Hopkins Hospital. Michael cut the ribbon on the ambulance as flashbulbs popped and TV cameras turned.

Neonatal centers that participate in the Maryland neonatal system include UMMS, Johns Hopkins, Francis Scott Key, St. Agnes, Mercy, and Sinai hospitals, and GBMC. *—Erna Segal*

Priority Dispatch Enhances EMS Care

Dispatcher Thomas Carr was honored for saving the second child in two years by calmly talking the mothers through appropriate life-saving techniques before emergency rescue equipment could arrive. (l-r) Mrs. Carr, Charles W. Gilchrist (Montgomery County Executive), and Thomas Carr.

The 10-month-old baby, who had been fighting a bad cold, suddenly stopped breathing. His mother called 911. The dispatcher questioned her about the baby's condition, an ambulance was dispatched, and the dispatcher carefully explained the CPR procedure to clear the air passage. The mother followed his instructions and within a minute the baby was breathing and crying normally. The dispatcher, Thomas Carr, works part-time in Montgomery County's Emergency Operating Center in Rockville, and is a full-time CRT with the Sandy Spring Fire Department. He is part of the medical priority dispatch system that helps callers take action before emergency rescue equipment can arrive. Several counties in Maryland use this system, although their procedures differ. This article focuses on the priority dispatch systems of Montgomery and Baltimore counties.

For the past ten years, Montgomery County has had a priority dispatch system that determines the level of response needed by questioning the caller. This system was expanded in April 1985 to include providing the caller with prearrival instructions. Within the first 10 days after the system was initiated, the lives of two babies were saved. Capt. Mary Beth Michos, RN, EMS officer of the Montgomery County Fire/Rescue Services, explains that the average response time for emergency rescue equipment in Montgomery County is less than five minutes. However, a person who has been unconscious and not breathing for as little as four minutes can experience irreversible brain damage.

To become an emergency medical dispatcher (EMD) in Montgomery County it is necessary to be an EMT-A or the equivalent. A 12-hour training program was developed by Sgt. Richard Long, and the course was funded by a block grant last year. (EMDs who work on the police side of the Montgomery County central alarm do not take this course; all medical emergencies are turned over to the fire/EMS dispatch staff.) The course includes CPR instruction, how to deal with hysterical callers, and the use of the prearrival instruction manual which takes callers through the various steps of life-saving techniques.

The Baltimore County call-taker/dispatcher receiving a 911 call asks pertinent questions to identify the victim's problem. Armed with a resource manual containing 27 symptom pages and 4 treatment pages, the dispatcher determines the appropriate level of medical response personnel needed, and gives prearrival instructions to the caller. Symptom pages, designed to address most routine emergency problems, are divided into sections for key questions, response determinants, and prearrival instructions. The treatment pages deal with more serious problems, such as unconsciousness, cardiac arrest, choking, childbirth, and trauma.

Many jurisdictions have CRTs or nurses available for consultation in their communications network to assist EMS call screening and to provide medical instructions in serious emergencies. Jeff Clawson, MD, fire surgeon for the Salt Lake City Fire Department, developed the first priority dispatch system specifically designed for use by nonmedically trained, civilian personnel. The system proved itself quickly.

Emergency communications technicians (ECTs) in Baltimore County do not receive field-oriented medical training. The 40-hour medical priority dispatch training program consists of CPR certification, the didactics of the first responder program, a detailed explanation of the priority dispatch book, and practical exercises. The system was developed jointly by the central communications center and the EMS division of the Baltimore County Fire Department, and initiated in 1983. Response level and prearrival instructions were determined or approved by Frank Barranco, MD, chief fire surgeon for Baltimore County. Surveys of field personnel regarding the effectiveness of medical priority dispatch indicate an almost 100 percent accuracy rate in leading the ECT to the appropriate response level. Baltimore County's medical priority dispatch system recently won an award from the National Association of Counties.

What are the legal implications of this type of dispatch service—for example, if the dispatcher gives CPR instruction over the phone and the patient dies? James O. Page, a nationally known attorney and EMS authority, has been quoted in *Fire Service Today* (December 1983) as saying that a person who needs CPR is pulseless and nonbreathing, clinically dead. This is the condition of the victim at the time the emergency call is made; the dispatcher does not cause the victim to be in this state. There is no way the victim can be in any worse condition. If the CPR efforts fail, the victim is no worse off than when the call was made. If the victim survives even for a brief time or in a vegetable state, he is better off than when he was clinically dead. And there can be no liability for a good faith effort that fails, or leaves a person better off than before.

The advantages of the priority dispatch system are sending out more appropriate vehicles because the dispatcher knows more accurately what is needed; consistent, documented call-screening procedures—very important in today's society, which is prone to lawsuits; prearrival instructions that can keep the victim alive until the medics can reach him; and giving the unit information about what to expect when they reach the victim.

—Erna Segal

8th National Trauma Symposium Held

Bart Chernow, MD, who delivered the Dr. T. Crawford McAslan Memorial Lecture, is shown with his wife and R Adams Cowley, MD (MIEMSS).

(l-r) The three daughters, wife, and son of the late Robert J. Ayella, MD, Yoram Ben-Menachem, MD (who delivered the Dr. Robert J. Ayella Memorial Lecture), and R Adams Cowley, MD (director, MIEMSS).

More than 600 health care professionals from the United States and Europe attended the 8th National Trauma Symposium, entitled "Making a Difference," that was sponsored by MIEMSS, November 20–22.

This was the first year that the Dr. Robert J. Ayella Memorial Lecture and the Dr. T. Crawford McAslan Memorial Lecture were presented.

Yoram Ben-Menachem, MD, professor of radiology at the Baylor College of Medicine and vascular radiologist at the Veterans Administration and Ben Taub hospitals in Houston, Texas, delivered the Dr. Robert J. Ayella Memorial Lecture. His talk was entitled "Making a Difference: The Angiographer in the Trauma Center." Dr. Ayella, chief of radiology at MIEMSS for 10 years, advanced radiologic management of the massively traumatized patient. His book on the subject has been used as a standard text for traumatologists.

Bart Chernow, MD, associate professor of medicine at the Uniformed Services University of the Health Sciences and special assistant to the commanding officers for academic affairs at the Bethesda Naval Hospital in Maryland, delivered the Dr. T. Crawford McAslan Memorial Lecture. He spoke on "Pharmacologic Agents That Make a Difference in Shock." Dr. McAslan, one of the founding members of MIEMSS, organized and streamlined resuscitation procedures and developed a system of critical care for trauma patients. His work in trauma management is the foundation of the presently accepted state-of-the-art therapy at MIEMSS. Dr. McAslan was a pioneer in medical mass spectrometry and one of the first investigators in sophisticated measurement of optimal mechanical ventilation patterns.

The general sessions of the three-day conference opened with talks by Robert J. Freeark, MD, and Ellen J. MacKenzie, PhD.

Dr. Freeark, who is the Ambrose and Gladys Bowyer Professor and chairman of the department of surgery at the Loyola University School of Medicine in Chicago, spoke on "Looking Back into the Future." He looked at the treatment of trauma in other places, specifically concentrating on "accident hospitals" in Austria and England. In discussing the differences between "accident hospitals" and trauma centers, he noted that "accident hospitals" generally admit patients with all types of injuries, including the "walking wounded"; outpatients as well as inpatients are included in the patient population; most admissions are the result of work injuries; and the primary emphasis is on physical therapy and returning the injured to work. In contrast, most trauma centers receive only the most severely injured patients; only inpatients are admitted; most admissions are the result of motor vehicle accidents and assaults; and the primary emphasis is on intensive care and saving lives.

Dr. MacKenzie holds a joint appointment as assistant professor of health policy and management in the Division of Emergency Medicine and the School of Public Health at Johns Hopkins. She discussed a prospective survey of 597 trauma patients between the ages of 16 and 45 who had been admitted to either JHH or the MIEMSS Shock Trauma Center. Those who met the study criteria were interviewed three times about changes in their lives and levels of disability following their injuries. The study focuses on the extent of recovery and the patient's ability to return to his/her previous major activity. Interestingly, the study seems to indicate that many non-health factors, such as social support, may influence whether a person returns to work, and Dr. MacKenzie mentioned that the importance of support groups needs to be examined.

Highlighting the luncheon on the first day of the conference was the presentation of a plaque to R Adams Cowley, MD. Dr. Cowley, the director of MIEMSS, was recognized for the impact of his pioneering efforts and research in shock and trauma, including the development of the concept of the "golden hour," the use of helicopters for medical evacuation, and a systems approach to EMS. The plaque was given by the many health professionals that he has trained and that have since left MIEMSS to spread his concepts of trauma care in other places.

— Beverly Sopp

Advocate for Disabled Is Helping Others

Vivacious, sociable, public-spirited, clever, pretty, enthusiastic, quadriplegic, disabled—all these words describe Karen Colvin, RN, newly elected Ms. Wheelchair Maryland 1985–1986. Although being disabled is necessarily an important part of her life, it refers to her physical condition, not her spirit.

Mrs. Colvin considers her role as the governor's representative on disability to be an opportunity for advocacy. Ms. Wheelchair Maryland can choose to what extent she would like to be visible. Mrs. Colvin plans to use her year to advance the programs with which she has been involved, such as the Spinal Cord Hotline, the Architectural Barrier subcommittee for Baltimore County, and the Howard County Disability Awareness Program, as well as other programs taking place throughout the state.

The chairwoman of the Friends of Shock Trauma and a member of the Board of Visitors of Shock Trauma, Mrs. Colvin also works for such projects as the Special Olympics. An active and involved wife and mother, she and her husband, John, have been married for 13 years. They have a daughter nine years old and a son seven years old.

Her son was four years old when a speeding car crashed into the car that Mrs. Colvin was driving, just a block from their home. "It happened so fast I didn't have a chance to say the words 'Put on your seat belt.'" Her son was thrown out of the back window and landed in bushes. Although he was unconscious, he had only minor injuries. Mrs. Colvin suffered a broken neck and injured spine. She was in traction for six weeks at the MIEMSS Shock Trauma Center before starting rehabilitation.

Karen Colvin

"When I was injured, I didn't have the answers I needed to deal with the changes in my life. That's why my husband and I wanted to establish the Spinal Cord Hotline, so other people would be able to learn what programs and facilities are available to them nationally and in their communities." (Seed money was provided by IBM and the Gorn Management Company.) "Through the kindness and wisdom of Dr. [R A.] Cowley, we've had a very successful first year. We've handled approximately 4,000 calls, and it hasn't even been publicized nationally yet." (The hotline can be reached in Maryland at 800/638-1733 or nationally at 800/526-3456.)

Until recently, people with sight, hearing, or neuromuscular problems stayed home, isolated, because it was too painful to go out. They couldn't go up and down curbs or steps, elevator buttons were too high, and architectural barriers and people's attitudes made it hard to lead a semblance of a normal life. Mrs. Colvin says there is a strong movement in this country now to help the handicapped. She feels that by educating children to be advocates of the disabled, the entire picture will improve.

"It's hard to change many older people—they think of you as 'crippled.' But my children think that is a 'cuss' word. They are fully cognizant that I am disabled, but they have no barriers with it. Education is the essence. Advocacy is the tool."

A good example of a program to educate children is the Howard County Disability Awareness Program, funded by the Howard County school system, which is geared toward pupils of all ages. School is closed for the day. Groups of instructors with various disabilities including paralysis, epilepsy, blindness, hearing impairment, cerebral palsy, and mental retardation—people who are comfortable talking about the challenges they face—educate the children.

As an advocate for the disabled, Mrs. Colvin says, "I would welcome conversations with professionals, patients, or groups, to spread the word that it's OK—we exist, and every life is precious, in no matter what form. It doesn't matter what the outside of the package looks like, it is what's inside that counts.

"I owe my well-being to being a graduate of the Shock Trauma program. I wouldn't be what I am now, either physically or psychologically, if not for the excellent staff. They are responsible for the accolades I've received. At MIEMSS and the hotline, our job is to help people get back to their maximum capabilities, and to let them know that they can carry on. There are worthwhile things they can do to make the most of their lives." —*Erna Segal*

EMS Clearinghouse Created by NASEMSD

The National EMS Clearinghouse, a resource bank of EMS information, has been created by the National Association of State EMS Directors (NASEMSD). By collecting data and publications from state EMS directors and by using its own information resources, NASEMSD can now provide additional services to its members as well as to nonmembers.

The clearinghouse staff can assist requestors with the preparation of surveys, proposals, or research reports. They can conduct research on EMS historical issues, current EMS practices, or more technical matters. The Council of State Governments, which manages the clearinghouse, specializes in comparative state studies on EMS procedures.

The *1985 National EMS Data Summary* has been compiled from a survey of all state EMS offices. It is available from the clearinghouse as a complete report or in the following sections: state EMS transportation systems; training of state EMS personnel; state EMS communications systems and level of preparedness for disasters; state EMS facilities and regulatory control; state EMS information and public education systems; and administrative structure, function, and budget sources of state EMS offices.

The charges for these services differ for NASEMSD members and nonmembers. For more information, contact the National EMS Clearinghouse, the Council of State Governments, P.O. Box 11910, Iron Works Pike, Lexington, KY 40578, 606/252-2291.

Maryland EMS NEWS

Published monthly by the
Maryland Institute
for
Emergency Medical Services Systems

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

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

Address Correction Requested
MIEMSS, Maryland EMS News,
22 S. Greene St., Baltimore, MD 21201-1595

Field Notes

By William E. Clark, State EMS Director

We all know it, and we hear it repeatedly—trauma is a surgical disease. And half of all trauma deaths occur within a few minutes of the accident.

The overwhelming majority of this tragic and unnecessary loss of life results from motor vehicle crashes. The real tragedy is the fact that so many of these deaths and injuries could be prevented by the use of occupant protection devices that currently exist, such as safety belts and motorcycle helmets.

Despite years of availability and huge campaigns to promote voluntary use of safety belts, fewer than 10 percent of those involved in serious crashes are wearing belts. The Maryland State Police consistently report that approximately half of the persons killed in traffic accidents who were riding inside of motor vehicles would have probably lived if they had been buckled up.

Belts, like helmets, have been repeatedly referred to as a freedom of choice issue and everyone knows the resulting cost to society is enormous because of the lack of utilization of occupant protection devices.

Some time in the future I believe we will see automatic protective devices in all motor vehicles. In the meantime, the carnage on our nation's highways continues.

Let's consider this freedom of choice issue. Should there be a choice? I don't believe so because if this point of view is valid then why do we have such things as speed limits, traffic lights, driver's licenses, and so forth?

Nationally, the trend is toward mandatory use laws that require the occupants of motor vehicles to buckle up. Here in Maryland, previous attempts to enact such legislation have met stiff resistance.

This year, Senate Bill 15 has been prefiled with the General Assembly calling for the enactment of mandatory seat belt usage. Senator Barbara A. Hoffman (D, 42nd, Baltimore City), who is the principal sponsor of SB15, said that "motor vehicle trauma is second only to cancer in economic burden to society." Senator Hoffman is also quick to point out that "as tragic as these motor vehicle deaths are, they constitute the smaller part of the problem in terms of lost productivity, medical and rehabilitation costs, and overall societal burden when compared to nonfatal trauma."

SB15 has passed Committee and will now go to the floor of the Senate. However, observers of the Annapolis scene predict that resistance will come from the House side, specifically the House Judiciary Committee.

Now is the time to let your voice be heard on this vital issue. As a Maryland citizen, I ask you all to take pen and paper in hand and write to Delegate Elmer F. Hagner, Room 212, House Office Building, Annapolis, MD 21401.

Please, don't delay. Your voice is important. Let's not be passive about this issue, because the tragedy we see every day *can be prevented*. Don't be among the silent majority. Speak out today to help save human life.