

Helicopter 7 Base Dedicated

The opening of the seventh Med-Evac helicopter base in Maryland's EMS system was celebrated in a ceremony held at the Patuxent River Naval Air Station on July 29. The speakers at the event included Governor William Donald Schaefer; other state officials; and representatives of the U.S. Navy, MIEMSS, the Maryland State Police (MSP), and fire and rescue companies in southern Maryland.

In his address to the crowd of 250 outside a hangar on the expansive grounds of the naval air station, Governor Schaefer had high praise for the people who work in the state's EMS system. He thanked the MSP and MIEMSS personnel and made special note of the contributions of the fire and ambulance company volunteers at the local level. "These people demonstrate the pride, love, and all things necessary to save lives," he said. The governor reiterated his commitment to the concept of govern-

ment agencies and communities working together to find solutions to problems. "It's easy for public officials to say 'We'll get to it tomorrow.' But there is no 'tomorrow' [for EMS needs]. There can be no delay in saving lives. The time is now."

As an example of his administration's support of Maryland's EMS system, Governor Schaefer reported on one of the matters taken up at that morning's meeting of the state Board of Public Works. The three-member board (consisting of the Governor, State Comptroller Louis Goldstein, and State Treasurer Lucille Maurer) had voted unanimously to increase salaries for MSP helicopter pilots and increase financial allocations for the state's EMS communications system.

Bishop Robinson, Secretary of the Maryland Department of Public Safety and Correctional Services and master of
(Continued on page 2)



At the dedication ceremony of Helicopter 7, a "patient" is prepared for Med-Evac transport during a simulated accident.



At the reception following the dedication of Helicopter 7 are (l-r) Bishop Robinson, Secretary of Public Safety & Correctional Services; Delegate John F. Woods, Jr.; Capt. Stuart Fitrell, commander of the Patuxent River Naval Air Station; Louis Goldstein, Comptroller; Governor William Donald Schaefer; Senator C.B. Bernie Fowler; R Adams Cowley, MD, MIEMSS director; Sandy Kane, creator of the cake in the shape of Maryland; Delegate Samuel C. Linton; Delegate John Ashley, Jr.; and Winfield Kelly, Secretary of State.



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Med-Evac Helicopter In Southern Maryland

Helicopter 7, dedicated on July 29, actually began serving the area of Calvert, Charles, and St. Marys counties on July 1. Within its first month of operation, the Med-Evac unit was called to transport four traumatically injured people to medical facilities in the area.

This seventh helicopter in the Med-Evac fleet of the Maryland State Police (MSP) is stationed at the Patuxent River Naval Air Station in Lexington Park. The other six bases in the MSP Aviation Division are at Andrews Air Force Base (Prince Georges County), Centreville, Cumberland, Frederick, Martin Airport (Baltimore County), and Salisbury. An eighth unit is planned for Burtonsville. According to Maj. Warner Sumpter, commander of the MSP Aviation Division, this expansion of the state's Med-Evac system is an important component of the implementation of the long-range plans set by the Helicopter Advisory Committee in the mid-1970s. It also fulfills recommendations made by the Joint Legislative Committee on the Med-Evac Program, which were issued earlier this year (*Maryland EMS News*, March 1987).

The crew members of Helicopter 7 are Sgt. John Christman, section commander; Cpl. Gary Varesko, pilot; Tfc. Carl Lee, medic observer; and Tfc. Ed Syracuse, medic observer.

In accordance with state protocols, trauma victims in southern Maryland may be transported by helicopter from an accident scene to an areawide trauma center, specialty referral center, or the MIEMSS Shock Trauma Center. Sgt.
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Dedication Ceremony for Helicopter 7

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ceremonies for the dedication, called the event an "auspicious occasion." "Public safety is the foundation of freedom and order," he said. "There is no priority greater than the protection of human lives."

Leading the legislative work toward the establishment of the helicopter base was Senator C.B. Bernie Fowler, who represents Calvert County and portions of St. Marys and Anne Arundel counties in the Maryland legislature. He noted that it was a "proud moment to witness the beginning of this operation." His involvement in the efforts to bring a Med-Evac helicopter base to southern Maryland began in October 1985, when EMS personnel from the area met with elected officials to discuss the need for enhanced emergency resources.

Earlier that year, the Region V EMS Council and local EMS groups had completed a year-long study of trauma care in the region. That study led to two recommendations: the establishment of a helicopter base station in the region and the designation of Southern Maryland Hospital Center as a trauma center (which occurred in 1986). Their findings were relayed to the Tri-County Council of Southern Maryland, which is an economic development agency established by the state legislature and which represents all of the elected officials in the three counties. The council continued to assemble data related to the need for expansion of the local emergency services and collected additional information from EMS providers; the resultant data base was used by state legislators from the area in their work toward attaining increased EMS resources.

Senator Fowler petitioned then-Governor Harry Hughes and the chairs of the budget committees of the House of Delegates and the Senate and oversaw the drafting of legislation that would provide for a helicopter base in the district. This process was interrupted by the tragic Med-Evac crash in Baltimore in January 1986, which took the lives of the pilot and medic of that flight. That event led to the creation of the Joint Legislative Committee on the Med-Evac Program. Senator Fowler and Delegate Samuel Linton (who represents Charles County) were members of that committee. Senator Fowler continued his advocacy for a Med-Evac station with Governor William Donald Schaefer, which culminated in the opening of the Patuxent River station on July 1.

An essential component in the planning for the new helicopter base was the support of the U.S. Navy. Capt. Stuart Fitrell, commander of the Patuxent River Naval Air Station, cited this project as "an example of the Navy, the state, and the county working together and sharing resources for the good of the people. The fact that lives already have been saved by Helicopter 7 in its first month of operation indicates the importance, the necessity, and the timeliness of this institution."

R Adams Cowley, MD, director of MIEMSS, was introduced as the "father of emergency medicine" by Secretary Robinson. Dr. Cowley thanked Governor Schaefer and Senator Fowler for their support of emergency medical services in Maryland. He also expressed his appreciation to prehospital care providers, hospital personnel, fire department and ambulance crew members, and the

Maryland State Police for their commitment to providing quality emergency medical care. Dr. Cowley stated that more than 35,000 severely injured people have been helped by Maryland's EMS system since 1960. In the beginning years of the system's operation, the mortality rate was 87 percent. Increasing sophistication has lowered that rate to the current level of 9 percent. "The use of the Maryland State Police helicopters enables us to get victims to the right medical people in the shortest possible time," he said. "The greatest life-saver is the helicopter system."

At the conclusion of the speakers' remarks, Helicopter 7 crew members presented a simulated Med-Evac response, which was narrated by Sgt. John Christman, section commander of the Southern Maryland Aviation Division. In addition to Helicopter 7 crew members, participants in the drill included members of the Lexington Park Rescue Squad, the St. Marys County ALS Unit, The Bay District Volunteer Fire Department, and the Maryland State Police. In the simulation, prehospital care providers came to the aid of a pedestrian who had been struck by an automobile. After determining that Med-Evac support was needed, the EMTs contacted the helicopter base via the state's communications center. The fire department personnel chose the helicopter landing site and directed the pilot to it. The pilot conducted the normal "high reconnaissance," in which the area is surveyed from the air and checked for the presence of wires or other potential hazards. The pilot then landed the craft near the accident scene, and the patient was moved to the helicopter.

The enthusiasm of the speakers on stage was echoed by local EMS providers in the audience. They see the Med-Evac helicopter base as a valuable addition to the emergency medical services they provide in their communities.

In dedicating the base, Pastor Mike Adams, chaplain of the MSP Aviation Division, expressed everyone's desire that "this be a place of safety, hope, and healing." As evidenced by the atmosphere of celebration and dedication at the ceremony on July 29, Helicopter 7 represents the commitment of the thousands of men and women in Maryland's EMS system who provide emergency medical care to people throughout the state.

—Linda Kesselring



(L-r) Governor William Donald Schaefer; Elizabeth Scanlan (MIEMSS, director of nursing); Senator C.B. Bernie Fowler; Ameen Ramzy, MD (MIEMSS, state medical director and state EMS director); Louis Goldstein, Comptroller; and R Adams Cowley, MD (MIEMSS director) at the dedication of Helicopter 7.

Boat Equipped for Rescues on Lake

At the northern shore of Deep Creek Lake in Garrett County, Maryland, is docked an emergency vehicle that is used to aid swimmers and boaters in trouble. This fire/rescue boat, owned and maintained by the Deep Creek Volunteer Fire Department, has proved its value many times in the rescue of swimmers, the control of boat fires, the recovery of the bodies of drowning victims, and even the response to structural fires on the lakefront.

Deep Creek Lake, which has a circumference of 65 miles and covers 3,900 acres, is surrounded by the majestic mountains of western Maryland. On holiday weekends, the county population of 30,000 is doubled by the influx of vacationers. On 12 occasions last summer,

Prices of Patches For EMS Providers

Due to increased manufacturing and mailing costs, the MIEMSS office of pre-hospital training and certification is raising the prices of three embroidered emblems (patches): EMT-A, CRT, and EMT-P. The increase will be effective September 1, 1987. New prices for these patches are as follows: EMT-A, \$1.50; CRT, \$1.75; and EMT-P, \$2.25.

Other patches and EMS hats will continue to be sold at the following current prices: First Responder, \$1.00; First Responder Instructor rocker emblem (set of two), 75 cents per set; CRT Instructor rocker emblem (set of two), 50 cents; EOA/MAST emblem, 50 cents; and EMS hats, \$8.00.

Emblems are available for purchase by **Maryland-certified EMS personnel only**. All prices include packaging and shipping.

All orders placed by individuals belonging to a tax-exempt organization must be on official organization stationery. Include your name, social security number, current mailing address, and identification certification number of the person(s) for whom the purchase is being made.

Make a cashier's check or money order payable to MIEMSS Prehospital Training and Certification Program. **No personal checks will be accepted.** The order and payment should be mailed to: MIEMSS Prehospital Training and Certification, P.O. Box 22587, Baltimore, MD 21203.



Chuck Thomas operates the fire and rescue boat on Deep Creek Lake.

people involved in water recreational activities needed emergency assistance from the power boat crew.

Chuck Thomas, the assistant fire chief, is one of 18 fire department members qualified to operate the boat. He explained that the company is alerted to an emergency on the lake through Garrett County Central Alarm (911). When a call is received, the crew members go from the fire station to the dock, about 50 yards away. Because of speed and safety considerations, the optimal number of crew members for the 24-foot boat is four to six people.

The crew members have taken a two-day boat safety course sponsored by the Department of Natural Resources (DNR). Boat drivers have also completed a 30-hour class on the operation of water pumps. Two of the crew members are certified EMTs. Some members have received scuba training at the Cumberland YMCA; the fire department sometimes requests the assistance of scuba divers from the community, who are not members of the fire department.

The \$45,000 boat was purchased in 1984 with state, county, and fire department funds. It is now maintained physically and financially by the all-volunteer fire department. The boat is kept in the water from early May to late October; during the remaining months it is stored in dry dock to avoid the damage that winter weather conditions would cause.

The equipment on the Wellcraft fire/rescue boat includes a 500-gallon/minute Watrous pump, 500 feet of 2.5-inch hose, 300 feet of 1.5-inch hose, scuba gear, ropes, life preservers, and stretchers. The boat is powered by a 235-horsepower outboard engine and has a 100-gallon gasoline tank.

Rescue boat drivers have a particularly challenging task at the scene of a boat emergency. Mr. Thomas described incidents in which the crew has responded to boat fires, often on choppy water. While the other crew members operate the powerful water pump, the driver must control the movement of the rescue boat by compensating for the "pushing" forces generated by the pump.

Response times have been reduced dramatically by the availability of this water craft. After the crew has arrived at the dock and is en route, it can reach an accident scene across the lake in 7 or 8 minutes. In contrast, because of the mountainous terrain of the shore area, land vehicles require as much as 45 minutes to travel to certain sites.

Although the rapid development of summer and winter recreational facilities is a source of welcome revenue to the county, it is cause for concern among emergency medical personnel. Mr. Thomas pointed to the four ski slopes being built across the lake from the fire/rescue boat dock and to the condominiums under construction at the foot of the slopes. "Imagine a fire in one of those buildings. Add a foot of snow and hundreds of cars parked randomly along the road. Fire equipment and ambulances would have a very difficult time getting up there."

The foresight and commitment of agencies such as Deep Creek Volunteer Fire Company in Region I have better prepared them to help residents and vacationers in need of emergency assistance. They continue to assess the changes that are occurring so rapidly in the area and to plan the growth of EMS services accordingly.

—Linda Kesselring

Pediatric Trauma: Treatment of Shock

Editor's Note: This is the first in a series of articles (to be published quarterly) on the care of pediatric trauma patients. Requests for articles on specific issues regarding pediatric trauma are welcome. Readers with such requests should contact Margaret Widner-Kolberg, MIEMSS pediatric nurse coordinator, at 301-328-3930.

In the United States, approximately half of all deaths occurring each year in children between the ages 1 and 14 are directly related to trauma. Automobile accidents, drownings, and burn account for nearly 70 percent of these accidental deaths. Motor-vehicle-related injuries are the single largest cause of traumatic death in childhood.

The child with multiple system trauma usually sustains life-threatening injuries to areas of the head, airway, and extremities. Immediate recognition and treatment of these injuries are essential. The assessment and management of the child are based on the severity of the injury and the stability of the vital signs. The child with multiple injuries is assessed in the same manner as the adult trauma patient and treated using the same priorities. For pediatric patients with a severe injury, the initial approach is to conduct the primary survey (airway, breathing, and circulation [ABCs]) and assess life-threatening injuries and then continue on to the secondary survey.

The circulatory component of pediatric trauma is the focus of this article. This discussion is an expansion of the procedures presented in *The Maryland Medical Protocols for Cardiac Rescue Technicians and Emergency Medical Technician-Paramedics* (MIEMSS, 1986).

Only after maintaining the airway with a chin-lift or jaw-thrust maneuver, while protecting the cervical spine with in-line traction and administering 50 to 100 percent oxygen, should the prehospital care provider continue with the primary survey and assessment of the circulatory status. Although the initial presentation of adults and children in shock may be different, evaluation of the circulatory status in both groups of patients involves the same signs and symptoms, as listed below:

Capillary Refill. This is one of the best indicators for measuring perfusion of blood to vital organs. Normal capillary refill is less than 2 seconds. In addition to blanching the nail bed, capillary refill can be checked by pressing the forehead or

lip mucosa. Delayed capillary refill indicates that the child is in shock. No capillary refill indicates severe shock.

Skin. The skin of a child who is in shock is cool, clammy, and pale.

Pulse. In shock, the pulse is weak and rapid. These signs should be evaluated against the norms for a child of a particular age, but the prehospital care provider should keep in mind that a pulse greater than 130 is a sign of shock in a child. The apical pulse and the brachial and femoral arteries are the best places to assess a pulse in an infant or small child.

Level of Consciousness. Mental status is a good indicator of shock when the child does not have a head injury. The child will become restless, anxious, agitated, or confused. If a child is lethargic without a head injury, he or she is going into deep shock.

Blood Pressure. Decreased blood pressure is a late sign of shock in a pediatric patient. Children have the ability to vasoconstrict effectively and therefore can compensate for a loss of up to 25 percent of blood volume. If a child has a decreased blood pressure, it can be assumed that 20 to 25 percent of the blood volume has been lost. To determine a child's normal systolic blood pressure, the following simple calculation is used:

$$\text{Age (in years)} \times 2 + 80$$

For example, for a 5-year-old, the normal systolic blood pressure would be

$$5 \times 2 + 80 = 90$$

The normal diastolic pressure is two-thirds the systolic, so the normal blood pressure in a 5-year-old is 90/60. Generally, if a child has a systolic blood pressure of less than 80, he or she has lost a significant amount of blood.

Upon responding to a call and finding a 7-year-old male who was struck by a car while riding his bike, the responder begins the primary survey. After stabiliz-

Signs of Shock In Injured Children

Capillary refill > 2 seconds
Pallor or mottled skin
Pulse > 130 bpm
Systolic blood pressure < 80 torr
Pulse pressure < 20 torr
Disorientation in combination
with any of the above

ing the patient's airway and breathing during the primary survey, the prehospital care provider assesses the child's circulatory status. The findings are delayed capillary refill, cool and clammy skin, a pulse of 140, and systolic blood pressure of 80. The keys to the management of hypovolemic shock in the pediatric population are early recognition, replacement of circulating blood volume, and arrest of further bleeding. The treatment for hypovolemic shock in this child is as follows:

1. Apply direct pressure to control external bleeding. Even a small blood loss in a child can result in hypovolemic shock, because a child has a small total volume. If this does not control the bleeding, the responder should proceed to the next steps for controlling bleeding: elevation and compressing the appropriate pressure point. A tourniquet should be applied as a last resort.

2. Major heat losses can occur in a young child who is unclothed for even a short time. Infants and young children have a large surface area and therefore lose more heat to the environment through convection and evaporation. A drop in core temperature may interfere with metabolic processes. These changes may add further metabolic problems to a child's response to the stress of trauma. You can minimize this stress by keeping the child covered as much as possible during the evaluation process. During winter months, you can minimize this stress even greater by stabilizing the injured child in a heated ambulance.

3. Insert a short, large-bore intravenous catheter, which will facilitate rapid infusion of fluids. The best fluid for rapid volume replacement is lactated Ringer's solution. The child's weight should be estimated, and 20 ml of lactated Ringer's solution per kilogram of body weight should be given. It should be infused as quickly as possible, so use of a macro drip IV set-up is recommended. A child's blood volume is 80 ml/kg. When a child presents with a decrease in systolic blood pressure, it can be assumed that 20 to 25 percent of the blood volume has already been lost. As mentioned earlier, a child has better vasoconstriction than adults and can compensate initially for blood loss. Administering 20 ml/kg of lactated Ringer's to children with signs and symptoms of shock gives them back the volume they have lost. Most children respond rapidly to replacement fluid. If

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200 Attend Region I Trauma Days

More than 200 EMTs and CRTs from Maryland and five other states participated in Region I's Trauma Days on May 9 and 10. The event, cosponsored by the western regional office of the Maryland Fire and Rescue Institute (MFRI), Garrett Community College, and the MIEMSS Region I Office, took place at the Grantsville Holiday Inn.

Included were lectures on patient assessment and medical considerations of automobile extrications, presented by Ronald Stewart, MD, of the Pittsburgh EMS system. A workshop on trauma care was given by Ameen I. Ramzy, MD, state medical director and state EMS director. Attorney Lee N. Sachs spoke

on the legal considerations of automobile extrications; Jim Adams discussed motorcycle trauma; and Capt. Gary Warren of the Baltimore County Fire Department, who was the EMS command officer at the scene of the Amtrak train wreck in January, described the handling of that incident.

There were also lectures on motorcycle helmet removal and on extrication rescue techniques, with hands-on practicals at four skill stations. Special instructors for the practicals, from the Montgomery County MFRI, were Thomas Carr, Thomas Kavanagh, Mike Suter, Steve Wolf, and Marie Wratten.

Dave Ramsey, Region I administra-

tor, says that the conference evaluations rated the response as "good to excellent," and particularly credits the cooperation between the three sponsoring agencies. In addition, Cumberland Memorial Hospital area-wide trauma center furnished regional support by supplying loose-leaf binders to participants and by providing the services of William Hardy, prehospital care coordinator for Region I, who also serves as the medical resource person between the hospital and the region.

"Mark your calendars!" Mr. Ramsey suggests. "Trauma Days will be held on April 30–May 1 of next year."

Pediatric Trauma: Treating Shock

(Continued from page 4)

the vital signs do not stabilize and symptoms of shock persist, an additional dose of 20 ml/kg of lactated Ringer's should be repeated immediately. It is important to note that a child with a severe injury needs rapid transport. Because children's veins are small and difficult to access intravenously, it is best not to delay transport by trying to start an IV. The prehospital care provider should limit the attempts to two sticks; if these are unsuccessful, the attempts should be stopped.

Ideally, a severely injured child should be referred to a pediatric trauma center or back-up center. However, because of geography, time, and distance, this may not be initially feasible. Guidelines to clarify which children should be referred to pediatric trauma facilities are being developed.

4. Apply pediatric medical antishock trousers (MAST) to an injured child who has an absolute indicator of a systolic blood pressure of 60 or below and shock-like symptoms. A relative indicator for use of MAST is a systolic blood pressure of 80 or below and shock-like symptoms. Pediatric MAST are designed for children between 40 and 100 pounds. Inflation of the abdominal compartment can cause respiratory compromise; therefore, it should be inflated only after medical consultation has been obtained.

The successful management of a major injury in a child is a great challenge to us all. Appropriate assessment and treatment will positively affect the long-term survival of these children.

—Margaret Widner-Kolberg, RN, MA



(Top) Extrication rescue techniques are demonstrated during Region I's Trauma Days. (Bottom) Jim Adams discusses motorcycle safety.



MIEMSS staff Howard Belzberg, MD (critical care) and John Siegel, MD (deputy director and director of clinical center) show Dr. and Mrs. Samuel Penchas around the Shock Trauma Center.

STC Used as Model for Israeli Hospital

A leading Israeli doctor says Maryland's Shock Trauma Center will be used as the model for a new emergency medical facility to be established in his country. Dr. Samuel Penchas, director general of the Hadassah Medical Organization, discussed plans for the new facility during a recent tour of the MIEMSS Shock Trauma Center.

Dr. Penchas said that concern over the large volume of severely injured traffic victims has sparked plans for a shock trauma facility in Israel. He said that although the Israel military has developed its own system of emergency medicine, the civilian trauma teams have not made parallel strides. Civilian trauma victims are often taken to the nearest

hospital rather than the hospital best equipped to treat their injuries.

To help plan the adoption of MIEMSS procedures for Israel, Dr. Avraham Rivkind, a faculty member of Hadassah University Hospital, is studying emergency medical techniques at Shock Trauma under a two-year fellowship.

—Ruth Pollack

Med-Evac Helicopter In Southern Maryland

(Continued from page 1)

Christman noted that locating a helicopter base station in southern Maryland has decreased patient transport time to well within the Golden Hour. The average flight time for Helicopter 7 to reach the site of an accident in southern Maryland is 10 minutes compared with 25 minutes for Helicopter 2 to come from Andrews Air Force Base. Both crews would require the same amount of time at the scene and the same amount of time to fly to a medical facility (about 25 minutes). The saving of 15 minutes in the response time is significant for patients in need of immediate medical attention.

Helicopter 7 will operate seven days a week between 5 pm and 1 am. Major Sumpter explained that a study of Med-Evac use in southern Maryland has indicated that the majority of requests for helicopter transport are received during those hours. During the hours when Helicopter 7 is not on-call, Med-Evac coverage is supplied by the crews and rotorcraft at Andrews Air Force Base. As part of the planned growth of the entire Med-Evac system, the hours of operation of Helicopter 7 will be extended as more pilots are recruited and the system expands.

—Linda Kesselring

New ALS Protocol Manual Distributed Throughout State

New protocols for ALS providers in Maryland went into effect on July 1, 1987, and are presented in a 160-page document called *Maryland Medical Protocols for Cardiac Rescue Technicians and Emergency Medical Technician-Paramedics*. The manual is useful for EMS work in the field as well as for a study guide for ALS students.

The new protocols manual is an enhancement of the shorter document previously used in Maryland. It offers more detailed instructions for the care of ill and injured patients and is consistent with the new protocols for CPR and emergency cardiac care that were adopted by the American Heart Association in June 1986. The section on the care of pediatric patients has been expanded extensively. The 1987 document covers prehospital care procedures for victims of stroke, heat-related emergencies, hypertensive crises, and pesticide (anticholinesterase) poisoning, which were not included in the previous protocols document.

An earlier version of the new document was distributed in 1984. Input from field providers, hospitals, regional medical directors, and local ALS program directors led to the refinement and clarification of the protocols.

In conjunction with the publication of this document, MIEMSS has issued specific directions for EMS instructors so that students in all parts of the state are trained in the same basic principles. The specialized needs of local protocols and of individual variations among instructors are acknowledged. In February, an orientation session was held by Ameen Ramzy, MD, state medical director and state EMS director, to review changes in the revised protocols.

Copies of the protocols manual have been distributed to ALS program directors for distribution to all ALS providers within their jurisdictions. ALS providers who have not received a copy should contact their local ALS coordinator. These copies are available at no cost to the Maryland provider; however, a \$7.50 charge applies to replacement or duplicate copies.

ALS providers who have questions about the protocols described in the manual should contact their local ALS coordinator.

—Linda Kesselring

New Mailing Address

The mailing address of the Region V Office has changed. (The office is at the same location but the building has been renumbered.) The new address is:

MIEMSS REGION V OFFICE
5111 Berwyn Road
College Park, Maryland 20740

Nucci Joins Staff

Barbara Friend Nucci, RN, MS, recently became the new administrative assistant to State EMS Director Ameen I. Ramzy, MD. Mrs. Nucci's experience includes nine years as a nurse in the Shock Trauma Center in the admitting and critical care areas; associate director of a trauma service in San Diego, California; and trauma coordinator in the adult trauma service at Johns Hopkins Hospital. Mrs. Nucci earned her BSN and MS in nursing administration at the University of Maryland.

Trauma Support Groups Aid Patients

Trauma patients, in the recovery process from catastrophic illness or injury, may face changes in their lives due to cognitive impairment, psychological changes, or irreversible body damage. They tend to feel "different" from other people and believe that no one else can understand what they are going through. The reality of living with long-term disabilities can be depressing to both recoverees and their families, sometimes leading to thoughts of suicide. Trauma support groups, or self-help peer groups, are making a difference in their lives.

Some of the goals of trauma support groups are to reduce feelings of isolation, promote friendship, and encourage the hope of a better life in the future through contact with others who have surmounted the same obstacles. Sharing with others who have had the same experience helps put things into perspective.

There are several trauma support groups available around the state; some are affiliated with the Maryland Head Injury Foundation. Each group has a sponsoring organization and a consultant or facilitator who gives form to the meetings and keeps them "on track." Most groups are open-ended; they can be attended as often as desired on an ongoing basis. Descriptions of these groups follow.

Trauma Recovery Inc.: The first trauma support group to be organized in the state, it began in 1979 in response to the needs of a recoveree from the MIEMSS Shock Trauma Center. Jeffrey Levesque, MSW, LCSW, then part of family services (now director of social work at Montebello Rehabilitation Hospital), and Ann Scanlon-Schilpp, RN, a former nurse at the Shock Trauma Center who is now at Johns Hopkins Hospital, recognized that one of their patients needed peer support and help to cope with the emotional, social, and financial stresses brought on by trauma. It was originally thought that the group would continue for about six sessions — but it has been running ever since.

Tom Dockery, vice-president of Trauma Recovery Inc., is in charge while president Linda Wolfe is on maternity leave. Approximately 20 people usually attend the meetings, and the group encourages friendship by holding dinners and picnics that include members of their respective families. Meetings take place on the second and fourth Thursdays of

each month from 7 to 9 pm at Easter Seals, 3700 Fourth Street, Brooklyn, MD 21225. Mr. Levesque is usually the facilitator. For further information call Tom Dockery, 301-551-5345.

Easter Seals Family Support Group: This group began about 1½ years ago to help family members and "significant others" of trauma recoverees. Three areas of interest are offered: education, support, and guidance. Sometimes families think that when the visible injuries are healed the problems should be over. They need help to understand what to expect from the recoverees' cognitive losses, memory impairments, and frustrations. Louis Barnett, MSW, LCSW, who facilitates the meetings, explains, "The former patient may look the same but really may be a different person as far as personality or cognitive function is concerned. We have seen family members who were on the verge of leaving the recoveree learn to deal with their problems after an interchange of ideas at a meeting. This is very rewarding work — helping very nice people with problems that could happen to anyone." Meetings take place on the third Wednesday of the month from 7 to 8:30 pm, at Easter Seals, 3700 Fourth Street, Brooklyn, MD 21225. For further information call Louis Barnett, 301-355-0100.

Suburban Hospital of Bethesda: Brain-injured recoverees and families combine for a general meeting and then disperse to three small groups, one of which is for the recoverees. It is particularly helpful for new recoverees to learn how other people handle similar social, emotional, and financial problems. Various rehabilitation hospitals are discussed and site visits are encouraged. Approximately 30–40 people attend meetings, which are held at nearby St. Mark's Presbyterian Church at Old Georgetown Road and Route 270, on the first and third Mondays of the month from 7:30 to 9 pm. Co-facilitators are Anna Holton, RN, Susan Wallace, MSW, and Anne Kuzas, RN. For further information call Anna Holton, 301-530-3030.

Prince Georges Hospital Center: Recoverees and families begin with a general meeting and then break up into smaller discussion groups. Facilitator Carol Cox, RN, says, "People learn from one another and develop understanding and strength. Support and friendship emerge, and feelings of isolation and

being different or handicapped are reduced." Meetings take place on the second and fourth Tuesdays of the month from 7:30 to 9 pm in the Gladys Noone Spellman Nursing Care Center, Hospital Drive, Cheverly, MD 20785. For further information call Carol Cox, 301-341-2010.

Washington County Hospital Association "Headway": This Hagerstown trauma recovery group includes both recoverees and their families in meetings that include speakers, programs, and general discussions. Meetings take place on the third Tuesday of the month at 10 am and on the first Wednesday of the month at 7 pm, on the sixth floor, Room A, at 251 E. Antietam St., Hagerstown, MD 21740. For information call Kelsey Wilkes, MSW, LCSW, 301-824-8150.

When the first trauma support group was established, it was not known how long a recovery period was to be expected — six months, two years, or longer. From experience it became apparent that recoverees still continue to grow, to learn to cope, and to adapt after five or six years or more. —Erna Segal

Hardy Coordinates Prehospital Care



William Hardy, Region I's prehospital care coordinator, began his position in October 1986 after eight years of experience as a paramedic in the Florida EMS system. Mr. Hardy provides services to prehospital ALS providers in the region; sets up and teaches continuing education courses; acts as a clearinghouse for EMT and CRT paperwork in regard to certification; staffs the Region I Medical Advisory Committee; and is active in the quality assurance program.

The prehospital care coordinator position is funded by Cumberland Memorial Hospital, Region I's areawide trauma center.

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EMS WEEK '87

"The Maryland EMS System: Caring Is What We Do Best" is the theme for Maryland EMS Week, September 20-26. Activities and demonstrations are being scheduled in each of the state's five regions. For information, call your regional administrator.

The statewide awards luncheon honoring EMS providers will be held September 23.

Performance to Benefit Poison Center

Tickets for the opening night performance of "Arsenic and Old Lace" at Baltimore's Morris Mechanic Theater, on October 27, are available from the Maryland Poison Center (MPC). A portion of the proceeds from these ticket sales will benefit the MPC.

Tickets for this classic comedy, starring Jean Stapleton, Marion Ross, James MacArthur, Larry Storch, and Jonathan Frid, can be reserved as follows: \$50, orchestra; \$40, first mezzanine.

The MPC is also hosting a special reception after the show at the Lord Baltimore Clarion Hotel. Tickets for this party to which the cast has been invited

Effects of Seat-Belt Law Compliance

Preliminary Maryland State Police (MSP) data indicate that nearly half the drivers and passengers killed on Maryland highways between January 1 and June 30, 1987, might have survived had they been wearing their seat belts.

Among the fatalities, 54 were belted, 153 were not. At least 33 persons were ejected from their vehicles, making it likely that they were unbelted. (Persons involved in rollover crashes are particularly at risk if ejected; the car can roll over the ejected person.)

According to MSP statistics, 70 per-

cent of the fatal crashes were alcohol-related; 137 were speed-related; and 267 involved driver errors.

During this same 6-month period, compliance with the seat-belt law improved. A MSP survey indicates that in motor vehicles 59 percent of the drivers and 56 percent of the passengers wear their seat belts; the figure was less than 20 percent before the law went into effect July 1, 1986. More than 36,180 tickets or warnings were issued for seat-belt violations as of June 6, although in Maryland it is mandated that a car cannot be stopped for a seat-belt violation alone.

TFC Greg Shipley, MSP spokesman, says: "If we had statistics on the numbers of injuries that were prevented or lessened, the results would probably be phenomenal. I've seen two women get out of a car that had rolled over several times and their worst complaint was that the seat-belt buckle was a bit hard to disconnect. They had no injuries. Some people are afraid to fasten their belts for fear that they might be trapped in the car if it should catch fire. But this kind of accident is rare — fire is likely to happen in less than one percent of accidents."

TFC Shipley emphasizes that seat-belt surveys and law enforcement will continue, to increase public awareness and to keep compliance up.