Maryland EMS NEWS

MARYLAND INSTITUTE FOR EMERGENCY MEDICAL SERVICES SYSTEMS VOL. 9 NO. 3 MARCH 1983

Caring for High-Risk Pregnancies

Guidelines have been approved establishing a formal network for referring high-risk obstetric patients to designated hospitals. The guidelines are an extension of emergency maternal transfer arrangements first implemented in 1978 by Johns Hopkins and University of Maryland hospitals.

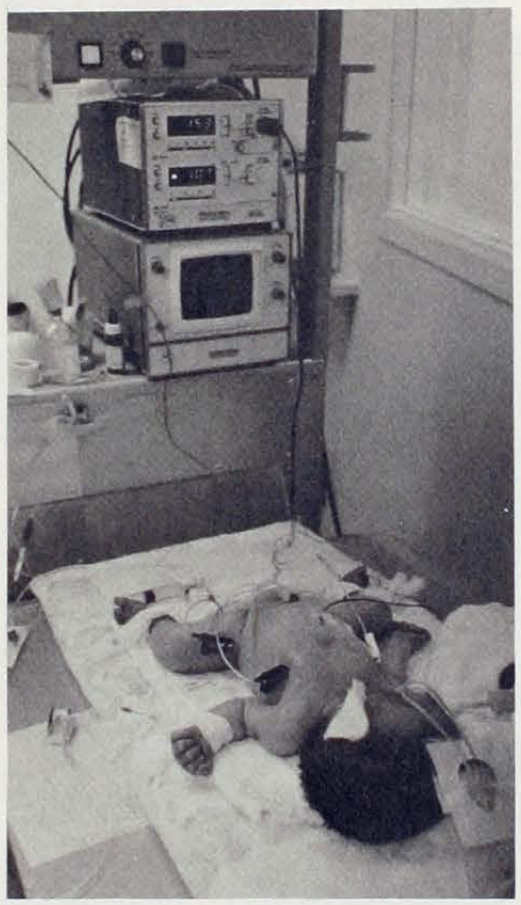
Under the new plan, high-risk obstetrics units at these two hospitals will be designated Perinatal Referral Centers, while those at Mercy, Sinai, St. Agnes, and Baltimore City hospitals will serve as backup centers. Since these six hospitals also comprise the Maryland Regional Neonatal Program, the arrangement will assure continuity of care for both mother and infant.

The number of high-risk maternal transfers has increased dramatically over the past four years, according to M. Carlyle Crenshaw, Jr., MD, chairman of the Department of Obstetrics and Gynecology at the University of Maryland Hospital and an architect of the new network. "We now have 20-25 such cases a month at the University of Maryland Hospital, and refer as many to Johns Hopkins for lack of space here," Dr. Crenshaw explained. "The neonatal intensive care unit here often is full, and we're currently planning to expand our capacity in these areas. The new guidelines should make it possible for high-risk mothers and infants throughout the state to receive the specialized care they need."

Maternal transfers may be arranged by calling EMRC at 578-8400, the same telephone number used to request neonatal transports. Both Johns Hopkins and University of Maryland hospitals will maintain current bed availability information for all hospitals in the perinatal network, and will arrange for transfers to one of the backup centers if the patient cannot be accommodated at either of the two primary centers. The Perinatal Referral Center at the University of Maryland Hospital is headed by David Nasey, MD, PhD; Jennifer Niebyl, MD, is in charge of the program at Johns Hopkins Hospital.

Improved Outcomes

Those involved in planning and implementing the new network hope that it will have an impact not only in outlying areas of Maryland (which already are using the two primary centers for transfers), but also in Baltimore City, which has one of the highest prematurity rates in the state. "Experience in other states indicates that even six minutes can make a difference to the baby delivered in a hospital with an intensive care nursery," explained Trish Payne, RN, MPH. Ms. Payne is in charge of coordinating the high-risk maternal transfer program as well as developing related educational workshops for prehospital personnel, nurses, and physicians. A clinical specialist in maternal and child health as well as a public health professional, she is employed jointly by MIEMSS and the University of Maryland Hospital.



High-risk infants are ensured specialized care as a result of the expanded perinatal program.

"You must remember that we're talking about a very small proportion of total births," Ms. Payne pointed out. "Community hospitals can and should continue to provide care for low-risk obstetric patients, which comprise 98 percent of all births. But the type of service we offer can make a real difference in the emergency cases."

Approximately 7 percent of the babies born in Maryland each year weigh less than 2500 grams (5 lbs., 8 oz.). In many cases premature labor accounts for these infants' low birth weight. Mothers whose membranes rupture early and those with toxemia of pregnancy are especially prone to deliver prematurely. These and other medical complications of pregnancy increase the health risk for both mother and infant, so special care must be taken during delivery and immediately afterwards.

Since 1974, the Maryland Regional Neonatal Program, which now encompasses six hospitals with neonatal intensive care nurseries, has provided specialized care for newborns with medical problems. Infants born in any Maryland hospital may be transferred to one of these hospitals. But studies show that very low birth weight babies (those weighing under 1,250 grams) have a much better chance of surviving if they are born in a hospital with an intensive care nursery. In 1980, 58 percent of these very low birth weight infants born in one of the three primary neonatal centers (Johns Hopkins, University of Maryland, and Baltimore City hospitals) lived through

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Perinatal Program Expanded

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the first year, whereas only 37 percent of those born in hospitals without intensive care facilities did.

In such high-risk patients there are several advantages to having mother and baby together, according to Dr. Crenshaw. First, the mother can be cared for by physicians who have additional expertise in premature labor and delivery. "Many obstetricians assume that such deliveries are simple, but in fact great care must be taken to avoid even minor damage to the fragile premature infant," Dr. Crenshaw explained.

"In addition," he said, "having mother and baby together promotes bonding and helps to allay the mother's fears about the baby, since she can see the infant frequently and communicate regularly with those who care for him." From a medical standpoint, he concluded, "this arrangement also makes breast feeding possible, and we recommend breast milk for most premature infants."

Support and Continuity

Emergency transfer and delivery at a strange hospital can be a confusing and frightening experience for the new mother, who often feels alone and desperately concerned about her infant. Part of Ms. Payne's role involves trying to allay such fears by visiting each mother transferred to University of Maryland Hospital. More than anything, she finds these women appreciate having a sympathetic and understanding listener.

Special care also is taken to assure continuity with those who will provide ongoing care for the mother and baby. Members of the high-risk obstetrics team at Univeristy of Maryland Hospital confer regularly with the referring obstetrician during the patient's hospital stay and, upon her discharge, provide a summary of the obstetrical course, together with recommendations about future pregnancies. Neonatologists collaborate fully with the pediatrician who will care for the infant once the critical care stage is over.

Transport, Education, and Consultation

All but a small percentage of these high-risk mothers are transferred by ambulance, according to Ms. Payne. Usually a nurse rides with the patient, but it is possible for the woman's obstetrician to accompany her to the Perinatal Referral Center and participate in the delivery. During 1981 there were 42 emergency maternal transfers by Med-Evac helicopter to University of Maryland and Johns Hopkins hospitals. The number of transfers is expected to increase as a result of the expanded network, although the majority of mothers will continue to come by ground transport.

Prehospital care will be an important facet of the perinatal network. A new obstetrics module is being included in the training program for aviation trauma technicians, and the obstetrics component of the EMT course is being expanded.

In addition, MIEMSS sponsors several nursing workshops on high-risk perinatal care. Topics include high-risk pregnancies, basic and advanced fetal monitoring, prematurity, and diabetes in pregnancy. Currently specialists from University of Maryland and Johns Hopkins hospitals offer informal seminars for hospital-based physicians. They also provide consultation and referral services on obstetric problems such as hypertension, diabetes, retarded fetal growth, genetic anomalies, infection, radiation exposure, and the effects of drugs.

For more information about the high-risk maternal transfer program, contact Trish Payne at 528-6811.

— Judie Zubin

Trauma/Disasters Conference Slated

A short course on trauma and disasters has been scheduled for April 30 and May 1 in Western Maryland. Co-sponsored by Garrett Community College, MFRI, and MIEMSS, the program will be held at the Grantsville Holiday Inn.

The two-day conference will feature nationally known speakers from across the country and cover such topics as the Air Florida disaster; small vehicle trauma; shock — the "golden hour"; field management of burn trauma; sports medicine; future directions of EMS, etc.

There is no charge for Maryland residents; however, enrollment will be limited with priority admission for Western Maryland EMS personnel. Those interested in registering or obtaining additional information, should contact the MIEMSS Region I Office at 895-5934 or write to P.O. Box 34, Grantsville, MD 21536.

— Dave Ramsey

MIEMSS Plans Rehab Expansion

Plans have been developed to expand the MIEMSS Trauma Rehabilitation Program at the Montebello Center from 25 to 50 beds, effective July 1, 1983. Under the proposal, the current 10 spinal cord and 15 multiple trauma beds will be expanded to 20 spinal cord, 12 closed head injury, and 18 multiple trauma beds. To accommodate the expanded program, Montebello's first-floor C wing has been assigned to the MIEMSS program. All MIEMSS patient care and therapy areas, presently located on the third floor of the Montebello Center, will be relocated to the first floor. Improvements, such as minor renovations, oxygen and suction installation, and cosmetic changes will be made to the new area.

To support the 50-bed unit, 45.5 additional staff members have been requested, increasing the number of MIEMSS/Montebello personnel from 62.5 to 108. The additional staff would include physicians, nurses, psychologists, social workers, physical therapists, occupational therapists, speech pathologists, and activity therapists. Recruitment activities to fill the additional positions have been initiated. Interested persons may call Anthony Zipp, director of administration, MIEMSS Trauma Rehabilitation, at 889-3080, X360.

It is anticipated that $50,000 for the purchase of additional equipment soon will be allocated to the program. The funds will be used primarily to support the physical therapy, occupational therapy, speech pathology, and nursing programs.

— Anthony Zipp

Shock Trauma Center Gets MHPRC Approval For New Building

Approval to construct a new building to house the MIEMSS Shock Trauma Center and its various support services has been granted by the Maryland Health Planning Resources Commission.

With some conditions, the way is now clear for MIEMSS to start the architectural planning process. The expected completion date for the new building is March 1987.

A story on the details of the commission's report will appear in a future issue of the *Maryland EMS News.*

Former Patients Participate in LEEP

On April 3, 1980, Kevin W., now age 23, was involved in a motorcycle accident in Houston, Texas — an accident which left him partially paralyzed. He tried using leg braces but developed leg spasms that would cause him to fall. To help suppress feelings of anger, frustration, and boredom he began to rely more on alcohol and valium.

Kevin came to Baltimore in June 1982, to live with his mother. During the 4th of July weekend, Kevin was partying with friends and went into a swimming pool while highly intoxicated. Nearly drowning, he had to be lifted from the bottom of the pool, resuscitated, and flown by Med-Evac helicopter to MIEMSS Shock Trauma Center.

(Above) family counseling; (below) recreation!

Four months later Kevin is a different person. After two near confrontations with death, he says he has "settled down a lot" and that his "habits have changed" considerably. He has recognized his alcoholism and is attending AA sessions. Moreover, Kevin believes he is now "at better grips" with himself, due in part to a special post-hospital rehabilitative program that has helped him take a closer look at himself.

This program is the Life Enhancement and Education Program (LEEP), an 11-week, structured, day program offered by the Center for Living, the cooperative MIEMSS/Easter Seals of Central Maryland program in Brooklyn. The center is under the direction of Marge Epperson-SeBour, director for MIEMSS psychosocial services department.

Begun in May 1982, LEEP was designed to help those with head trauma or spinal cord injuries readjust both psychologically and socially to their environment after the trauma or accident. Since clients often have cognitive deficits as a result of brain injury, skills in the areas of communication, cognition, and mobility are stressed, along with those needed for personal and psychological adjustment.

The LEEP program uses a systematic, highly structured psychosocial and behavioral approach. Each week includes activities involving psychodrama, dance and movement therapy, transitional skills, and group therapy. Sessions in substance abuse, cosmotology, and leisure skills have also been offered. Clients meet Monday through Thursday from 9:00 am until 2:30 pm for 11 weeks.

During psychodrama sessions, clients role-play situations and dramatize their feelings in a structured setting. These sessions are videotaped and then utilized in group therapy.

The purpose of dance and movement therapy in the program is to allow clients to become comfortable with their bodies. By dancing or performing sequences of movement with a ball or other prop, clients not only develop coordination and balance skills, but also increase memory recall capabilities.

Transitional skills sessions focus on such topics as decision-making, assertiveness training, and interviewing and job readiness. They attempt to raise a person's self-esteem and sense of independence so that he/she will be better equipped with the personal skills needed for what is usually the next stage of rehabilitation — the vocational stage.

Cosmotology sessions also help clients feel better about themselves by working on improving their physical appearance. Substance abuse sessions are offered since many clients have been involved in accidents where they had abused alcohol or other drugs.

During the program each client, with the help of the professional staff, draws up an individual behavioral rehabilitative plan identifying his/her own personal goals.

Barbara Wallick, MS, is coordinator of the LEEP program. Elaine Rifkin, MSW, Director of Psychosocial Services for the Center for Living, does the initial psychosocial evaluation on each candidate and offers individual and family counseling for LEEP participants. Other professionals currently on the LEEP staff include: Monica Beltram, MA, movement/music therapist; Heidi Hose, cosmotologist; Dick Schreder, PhD, psychodramatist; and Lisa Reeves, MS, group therapist. LEEP clients may also utilize the services of other professionals (speech pathologist, psychometrician, counselors for therapy) at the Center for Living.

A crucial element for the success of the LEEP program is the involvement of the client's family in team meetings. Each client has a minimum of two team meetings during the 11-week program, that may be attended by family, friends, and professionals (for example, speech pathologist, Division of Vocational Rehabilitation counselor, etc.). These meetings, stressing communication and support, serve as an educational tool and model to help both the client and his/her family (and friends) continue to adapt to the trauma. As Ms. Rifkin points out, "the

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Focusing on Field Operations

The purpose of this column is to update field personnel about what is happening within MIEMSS Central Office. Several changes have been made in the last month.

EMT-A Practical Exam

I am sure that you are aware that we are trying to streamline the EMT-A practical examination process. This was proposed in December and has received considerable input from the field. Many of you were concerned about reciprocity and we are discussing that issue. There were several questions raised about the length of the course; however, this proposal should not increase the minimum number of hours.

Although all details are not finalized, we will have a practical exam conducted by the sponsoring agency at the end of the EMT-A course. We are hoping that a two- or three-station practical can be conducted with the skills for the stations being drawn at random on or prior to the day of the exam. The skills to be tested will be drawn from the skills objectives of the EMT-A course. At the beginning of the course, the EMT-A student would be able to obtain a standard textbook, a list of the course objectives, a copy of the *Maryland Way Skills Manual* to be published by late summer, and a list of the skills that might be on the practical exam at the end of the course.

MIEMSS would reserve the right to monitor the practical exam process but would not do the actual evaluation of the EMT-A during the practical. At the end of the course, the sponsoring agency would state in the verification of course completion that the EMT-A student can fulfill the skills required to become a fully certified EMT-A should he/she pass the written examination. MIEMSS would administer only the written EMT-A exam required for certification.

CRT Continuing Education

There have been several inquiries about continuing education for CRTs. We will be proposing that the recertification period for CRTs be two years instead of one year. During this two-year period, the CRT would be required to take 40 hours of continuing medical education (CME) and he/she would be able to take the ECR (written exam for the EMT refresher course). In this way, if a CRT can maintain CRT certification, he/she would automatically be recertified as an EMT-A. Field personnel have been asking for such a proposal for many months.

Maintaining CRT Certification

I also would like to remind CRTs that each of them has the responsibility to maintain his/her CRT certification. As a practicing physician, I am very cognizant of the date that my license to practice expires, and I adhere to the State Board of Medical Examiners guidelines. Obviously, I work closely with the institution where I work to ensure that I get my continuing education credits; but if I fail to meet them, it is ultimately my license at stake and therefore my responsibility to meet the requirements. Similarly it is the responsibility of all CRTs to ensure that they meet the CME guidelines in time to maintain their status.

Paramedic Program

Paramedic legislation is being introduced in Annapolis by Senator Abrams and I urge your support. Essex Community College is applying to teach a paramedic program, and hopes to have evening classes. Anyone interested in starting a paramedic program locally should contact his/her regional coordinator about possible funding through the block grant process; the EMS coordinators can also inform you about any existing paramedic program in your area.

Proposed Legislation

Also new on the legislative front is the introduction of a bill by Delegate Mooney which would add an extra fee to moving traffic violations so that the people who cause most of the accidents would help pay for the EMS system that saves their victims' lives. Although the bill does not stand much chance this year, hopefully its introduction will initiate study of possible funding of the program.

I thank you for your continued support.

— Alasdair Conn, MD
Program Director of Field Operations

Region 1

Meetings with the ambulance services in Region I to explain the land and Med-Evac transport protocols were held during February. Co-sponsored by the Maryland State Police and the MIEMSS Region I Office, the meetings briefed the ambulance personnel on the regional patient classification system and when Med-Evacs should be called. The issue of which hospital should receive which patients (classified by clinical nature of injuries and priority level of treatment needed) was also reviewed.

Representatives from Cumberland Memorial Hospital also updated squads on the activities of the areawide trauma center and medical command. The importance of accurate patient triage and ambulance/hospital communication was stressed.

Five meetings were conducted throughout the region with over 30 fire and ambulance companies in attendance from Maryland, Pennsylvania, and West Virginia.

— Dave Ramsey

Region 2

At 7 am on Monday, February 7, 1983, Washington County Hospital opened its new emergency department. Ambulances will be able to drive up the new ramp from Baltimore Street, next to King Street, and unload at one of three vehicle bays. The central nurses' station is just inside the doors so that every vehicle arriving can be seen. Patients can be transported immediately into the trauma operating rooms in the emergency department, or to the trauma operating suite on the second floor of the hospital via an elevator. This elevator also connects with the helicopter landing pad on the roof of the new building for Med-Evac flights to and from the hospital. Lesser injured patients who arrive by ambulance will be triaged at the nurses' station and then transported to the appropriate station. Walk-in patients for the emergency room will come in through the new front entrance of the hospital.

Other sections of the hospital, including the intensive care, progressive care, and cardiac care units, will be opened in March. This multi-million dollar building represents a giant step in providing efficient care in the areawide trauma center. Hospital staff members have been conducting tours of the new building for physicians, nurses, and hospital administrators both from Region II and neighboring states.

– Mike Smith

Region 3

Since the last newsletter, we have received several questions concerning the Region III Emergency Medical Services Advisory Council. The membership of the council represents all aspects of EMS, including consumers, government, field providers, hospitals, planning agencies, and medical specialties. The council advises the director of MIEMSS, R Adams Cowley, MD, on matters concerning EMS in Region III and participates in the Regional Emergency Medical Services Advisory Council (REMSAC). REMSAC consists of representatives from the five regional advisory councils and advises Dr. Cowley on matters of statewide concern. The representatives for the prehospital providers to the Region III Advisory Council are: Chief Roger Simonds, Anne Arundel County; Chief Michael Jachelski, Baltimore City; Capt. Reggie Shephard, Baltimore County; Capt. James Dwyer, Carroll County; Capt. Richard Enfield, Harford County; and Capt. Donald Howell, Howard County.

EMT-Ps are not yet permitted to practice in Maryland. However, plans are being made in anticipation that they soon will be granted certification. Senate Bill 403, which will allow EMT-Ps to practice in this state, is being introduced in the Maryland General Assembly. The chance of it being passed is favorable at this time.

One EMT-P program has already graduated 25 paramedics and another is nearing the end of its formal approval process. Anne Arundel Community College, in cooperation with the Anne Arundel County Fire Department, has had its program in place for three semesters. Essex Community College, in cooperation with the Baltimore County Fire Department, has developed an EMT-P program that has been approved by the State Board of Community Colleges. The program still needs to be approved by the State Board of Higher Education. The college hopes to begin offering the curriculum in the fall 1983 semester. Persons who want further information on either program should call Valerie Deverse, Anne Arundel Community College, at 269-7385, or Rhoda Levin, Essex Community College, at 522-1328.

To address the major concerns of field personnel regarding medical screening and dispatch, the Baltimore County EMS division and the communications staff, following extensive research and preparation, have developed a new method of medical call screening. As part of this Medical Prioritization Program, incoming calls will be screened by 911, based on a preestablished "symptom" card file. The file contains key questions, appropriate equipment response, and, when indicated, prearrival instructions to be administered by our operators while medical personnel are responding to the call. This program has been successful in several cities in the country, including Salt Lake City, Phoenix, and Seattle. While Baltimore County's prioritization program is still in the planning/training phase, it should be on-line by midsummer of this year.

If you have any questions on any of the above items, please call us at 528-3996.

— Kerry Smith, John Donohue

Region 5

Ellen Hewitt, RN, one of the founders of the EMS system in Region V, resigned last month as St. Marys County EMS Coordinator and County EMS Advisory Council Chairperson. Mrs. Hewitt's withdrawal from active participation in the EMS system will leave many gaps in the regional program since she served the system in so many capacities.

An EMT instructor, an American Heart Association CRP instructor, and a newly certified CRT, Mrs. Hewitt was also a member of the Region V EMS Advisory Council and an alternate to the Regional EMS Advisory Council (REMSAC). A former emergency department nurse, and inservice education director at St. Marys Hospital, she is also active in the Maryland Nurses Association and the Emergency Department Nurses Association.

Long a positive force in the ongoing development of EMS, Mrs. Hewitt's withdrawal from active participation in the system comes only after her dream of bringing ALS services to rural St. Marys County has come true. The county recently finished its second CRT class. Medic 10, a fitting monument to Mrs. Hewitt's years of dedication and service, will go into service later this year.

At its January meeting the Region V EMS Advisory Council recognized Mrs. Hewitt for her dedication. This is not the first time she has been so honored. In 1980, she was honored as the "St. Marys County EMS Provider of the Year" and received a certificate of appreciation from MIEMSS and the Regional Council.

— Marie Warner

Hazardous Materials

A hazardous materials seminar, sponsored by the Montgomery County Department of Fire/Rescue Services, will be held May 13 – 15 at the Fire/Rescue Services Training Academy in Rockville.

The seminar will feature "hands on" workshops dealing with the management of hazardous materials accidents, sessions on the development and operation of hazardous materials teams, and case study presentations.

For more information, or to register for the seminar, please call Capt. Mary Beth Michos at 251-2114, or write to her at the Montgomery County Department of Fire/Rescue Services, 101 Monroe Street, Rockville, MD 20850.

Regional Coordinators

Region I — Appalachia
David Ramsey
895-5934

Region II — Mid-Maryland
Michael Smith
791-2366

Region III — Metropolitan Baltimore
Kerry Smith
John Donohue (associate coordinator)
528-3996

Region IV — Eastern Shore
Marcus Bramble
John Barto (associate coordinator)
822-1799

Region V – Metropolitan Washington
Marie Warner
Ed Lucey (associate coordinator)
773-7970

Groups Urge Child Restraint Laws

Despite the facts that accidents rank as the major cause of death among children under the age of 14 and that 51 percent of those fatalities involve automobiles, Maryland has no mandatory restraint law for children riding in motor vehicles.

Statistics show that "75 – 90 percent of child passenger deaths are preventable through the regular and appropriate use of child passenger restraints," says James A. Holroyd, MD, FAAP, chairman of the American Academy of Pediatrics' (AAP's) committee on Accident and Poison Prevention. Yet Maryland legislators consistently have defeated proposed child restraint bills.

According to MIEMSS Pediatric Nurse Coordinator Margaret Widner, spokesperson for MIEMSS on the subject of pediatric trauma, legislators defend such defeats in the face of overwhelmingly supportive statistics by citing such reasons as "word ambiguity," "too large of an age range" as stated within the bill, fears of "increased governmental regulation and interference" in the private sector, parental "inconvenience," child "dislike," and "excessive cost" to consumers.

MIEMSS and other agencies throughout the state, such as the Maryland chapters of the American Trauma Society (ATS) and of the AAP and the Maryland Department of Transportation (MDOT) have established information distribution and consumer awareness programs to attack the last three "reasons" directly and the first three indirectly through legislative pressure exerted by an informed public.

Ms. Widner has implemented a dual approach to pediatric trauma education: programs designed specifically for health care personnel and consultation and information services for the general public.

In addition to giving lectures to in-house personnel at hospitals and medical centers around the state, Ms. Widner has designed a nursing workshop on prevention of pediatric trauma. This one-day workshop acquaints community health nurses with sources of preventative measures for major pediatric accidents and with treatment protocols for those accidents that do occur.

To consolidate the efforts of various state and local community groups, such as the General Federation of Women's Clubs, the Maryland Fire and Rescue Institute (MFRI), the AAP, and the MDOT, Ms. Widner initiated and established the Baltimore Metropolitan Area chapter of the national Child Passenger Safety Association. This association translates a "common concern for the health and safety of children" into coordinated activities and programs for maximum community and legislative impact. The new Baltimore chapter has instituted "SOC" (Save Our Children) as its official campaign slogan and plans to create a state chapter in the near future by electing officers and adopting the national bylaws. The state chapter then will help establish additional local chapters.

The above poster was distributed in conjunction with two public service announcements (PSAs) produced by MIEMSS. The 20- and 30-second PSAs began airing in the Maryland and D.C. areas in March. The slogan "Kids in Cars Need Buckles" concludes the PSA which stresses that traffic accidents are the chief killer of children and that 9 out of 10 children that die on the highways could escape injury or death by buckling in.

The AAP has created a two-part safety program. The first part, "First Ride . . . Safe Ride," stresses the special need of newborns for protection in automobiles because they are the most vulnerable; the rate of occupant death and injury for newborns is triple that of older children. The second part of the program, ". . . And Every Ride Thereafter," addresses vehicular problems of the older child, such as school bus safety, safety and restraint of handicapped children, alcohol and driving, and teenage drivers.

The MDOT has funded a statewide "Kids in Safety Seats" (KISS) program to teach community groups how to initiate and maintain child-safety-seat loaner programs. KISS supplies the first 10 safety seats free to a community group which then rents them to people ordinarily unable to afford such devices. Community members are encouraged to donate new or used safety seats to continue the loaner program successfully. KISS also supplies consumer information on selecting an appropriate seat and on installing and using it properly. This program directly addresses the charge of "too expensive" leveled at proposed legislation.

The major goals of all these programs, according to Ms. Widner, are "to increase community awareness" of the problem and its potential solutions and "to campaign for state passage of a mandatory child restraint law."

The MIEMSS, ATS, MDOT, and AAP programs inform the public, provide immediate safety assistance for children, and serve as important statewide and national links for coordinating testimony and unifying the effort to achieve legal passage and public acceptance of child safety measures. But since such organizations cannot lobby officially at the state level, concerned consumers (parents, educators, health officials) must coordinate and direct the drive.

— Elaine Rice

Proper Helmet Removal Essential

The fitness trend that has been sweeping the nation has dramatically increased the number of weekend athletes, including those participating in sports that require the use of helmets.

Unfortunately, this dramatic rise in the number of bikers, kayakers, lacrosse players, and other helmeted athletes who are generally trying to improve their physical health, has ironically led to an unprecedented rise in the number of related injuries. For field ambulance personnel, this has necessitated skills in removing all types of helmets from these victims, for unless the first attendants at the scene can remove the helmet properly, injury can be greatly magnified.

Lou Jordan, associate director of prehospital care at MIEMSS, has observed that there are now equal numbers of victims wearing helmets for athletics as for motorcycling. "It is urgent that our field people be well trained in removing all kinds of helmets, since we can treat better in the field with immobilization of the spine," he noted. "Also, our trained technicians at the site of an event can assess the peculiarities of the accident right at the scene, and determine how to best handle the patient to assure the greatest chance of full recovery. Often, on location, trainers, coaches and others familiar with the specific helmet can assist rescuers in successful removal."

Prompt, proper removal is essential since the helmet may make rapid airway establishment, assessment, or maintenance difficult. It can also preclude patient evaluation for head, brain, or face injuries; contact lenses or neck injuries; and use of the extrication collar for cervical support. The helmet also makes spineboard use difficult due to its design.

Thus, all Maryland field personnel are carefully instructed to remove the helmet while still at the scene, whenever its presence interferes with patient assessment; the patient is unable to remove his own helmet; or if the patient's condition indicates the use of a spineboard. The only times personnel are advised against removal are when the helmet is entangled with associated head injuries, or if the patient is already dead.

The American College of Surgeon's Committee on Trauma suggests that the helmet be maneuvered over the nose and ears while the head and neck are held rigid. Inline traction must be carefully applied from above, then transferred below with pressure on the jaw and occiput, and later reestablished from above.

Mr. Jordan noted the advantage of having the well-trained field person remove the helmet rather than waiting until the patient gets to the hospital, where the patient may wind up having the helmet removed by an untrained technician who simply pulls the helmet off without regard to established removal procedures. Improper removal can lead to further injury.

"We have been able to control the way helmets are removed with our people by intensive training through the basic training program, the refresher course, and inservice [drill manual] programs," Mr. Jordan said. "Each helmet has specific guidelines for removal. Despite some controversy, I believe that it is essential that well-trained personnel remove the helmet as soon as possible, to assess injury and prevent further damage. If the helmet is not removed properly, a patient with minimal or no spinal damage can wind up a quadriplegic or even dead," he added.

Despite the problems that can result from improper removal of the helmet, Mr. Jordan stressed the importance of wearing the proper helmet for the sport being played. "The helmet is an absolute must," he said, "as it prevents head and brain injury and even death, and it just takes a little extra caution to be removed properly. For safety measures, a helmet should always be worn." — *Rochelle Cohen*

Calendar

DATE	EVENT	PLACE	CONTACT
Apr. 14 – 15	ATLS Provider Course	MIEMSS	528-2919
Apr. 18 – 20	National Medevac Helicopter Conference	Crystal City Hyatt Regency Arlington, VA	Pat McAllister 528-3160
Apr. 27	Triage for Mass Casualty Situations	Medical School Teaching Facility University of MD at Baltimore	528-3931
Apr. 30 – May 1	Trauma and Disaster Course	Holiday Inn Grantsville, MD	Dave Ramsey 895-5934
May 1	Dedication, Washington County Hospital's New Facility	Hagerstown, MD	Jane DiGirolamo 824-8663
May 6 – 12	Maryland Nurses Week		
May 12 – 13	ATLS Provider Course	MIEMSS	528-2919
May 13 – 15	Hazardous Materials Seminar	Fire/Rescue Services Training Academy Rockville, MD	Capt. Mary Beth Michos, RN 251-2114
June 9 – 10	ATLS Provider Course	MIEMSS	528-2919
July 14 – 15	ATLS Provider Course	MIEMSS	528-2919
Aug. 19 – 21	Para Scope '83	Marriott Hotel Bethesda, MD	Capt. Mary Beth Michos, RN 251-2114

LEEP Emphasizes Psychosocial Rehab

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beauty of the program with this kind of team approach is that it takes the burden of blame off the client and stresses the cooperation of all."

A person interested in participating in the LEEP program is first interviewed and given a psychodiagnostic evaluation. Then the prospective client's family and significant others are brought in to gain insights into how the prospective client relates socially and how all are emotionally handling the trauma. At this point, depending upon the needs of the individual, a person may be recommended for the LEEP program — or, if not, then for some other services offered either by the Center for Living (that is, psychotherapy, cognitive retraining, speech and language program, and/or the open social activities center) or by other outside rehabilitative agencies. Those who decide to participate in the LEEP program then make a contract to attend the sessions, while more data on the client are gathered from MIEMSS or the particular rehab center. Cost for the 11-week program is $110 a week, with many clients charged on a sliding scale.

What happens after a client completes the program? LEEP staff continue to remain active with each client on an individual basis until that person is firmly situated. Since the LEEP program focuses primarily on the psychosocial phase in the client's total rehabilitative plan, clients usually are prepared to make a transition into the educational/vocational phase. Some, like Kevin, make plans to spend time at a rehab center to be evaluated for aptitude and to receive training in vocational skills. Hopefully, those completing the program all leave better prepared to realize their personal goals. — *Denise Calabrese*

Washington Co. Hospital Dedication

Washington County Hospital in Hagerstown, the areawide trauma center in Region II, will hold a dedication ceremony for a new addition to the building at 2 pm, Sunday, May 1 in front of the hospital's main entrance.

The $28.9 million structure, which will be in full operation by the time of the dedication, will house the hospital's new emergency department, operating suite, intensive care and coronary care units, and facilities to meet the needs of trauma patients at various stages of recovery. A heliport is situated atop the new building to permit the Med-Evac transport of patients.

The dedication ceremony will kick off two weeks of special activities for the communities served by Washington County Hospital. Guided tours of the new building will be conducted, supplemented by a videotape of restricted areas. In conjunction with the Washington County Health Fair, which will be held concurrently, the hospital will sponsor various medically related activities, such as health problem screenings and lectures on health topics. — *Dick Grauel*

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