Hospice Protocol Developed

Until recently, the interaction between hospice patients and the EMS community has been a source of potential conflict. While both EMS providers and hospice providers perceive themselves to be acting in the patient's best interest, there was a perceived conflict between the prehospital provider's duty to sustain life and the hospice patient's expressed wish to die naturally. Although discussions have taken place on this issue for many years, it was not until nearly a year ago that a group of hospice providers and EMS providers met to further discuss the issues, grapple with the medical and ethical issues, and work toward common guidelines. In January of 1988, a draft protocol was distributed to EMS jurisdictions, Regional EMS Advisory Councils, and the Regional Medical Directors throughout the state. Following input and modification, the protocol was approved by the Board of Medical Examiners on March 17, 1988.

Although the protocol was adopted many months ago, it was felt unwise to distribute the protocol without a firm educational program. Therefore, MIEMSS has been working with the Hospice Network of Maryland to develop educational programs to train EMS providers and hospice families and their care providers in the use of the protocol. Training programs were piloted in Frederick and Harford counties during October. Since the protocol is a short, straightforward document, EMS providers can be oriented to its use during November and December. The training will be offered both as ALS and BLS continuing education and during the 10-hour local option in the 110-hour EMT-A courses.

As an approved ALS protocol, the Hospice/EMS Palliative Care Protocol which appears on page 2, will be included in the July 1, 1989 edition of the *Maryland Medical Protocols for CRTs and EMT-Ps*. As an approved BLS update, it will also appear in the next reprinting of the *Maryland Way*. This protocol, however, will go into effect January 1, 1989, before it appears in the upcoming documents referenced above.

A key portion of the training for hospice patients and their families includes education as to the appropriate use of 911. The intent of the training is to reduce the number of 911 calls. However, a few 911 calls may still take place. In such cases, the protocol addresses the problem of identification of hospice patients by requiring a two-step procedure. The first step requires that a hospice patient or his care provider present to the responding ambulance personnel a hospice identification card (shown on page 2) which includes a brief description of the patient and other pertinent information. These cards are available only through Maryland Hospice Programs, are numbered sequentially, and are issued only by the hospice programs after the patient and the patient's family have received counseling and have explicitly selected hospice care. The card, which indicates that the patient does not wish resuscitation and does want the hospice protocol followed, is signed by the patient as well as by the patient's physician.

The second step in the process requires independent confirmation of the patient's identity by an individual present at the site of the call. This individual may be the patient himself; a doctor, nurse, hospice program provider, family member, or other care provider; or an EMS provider on the scene who knows the patient. Only after the identification is confirmed by this second step will the Hospice/EMS Palliative Care Protocol be implemented. This two-step procedure is simple and rapid and should avoid conflicts which have arisen in some past situations.

With respect to transport, it was agreed that, when feasible, hospice patients should be transported to their hospice hospital where hospice care which they have opted for can be implemented. In almost every case, this will be the nearest hospital. In the few occasions when this may not be the case, it is understood that the crew would transport to the nearest hospital if their services were needed elsewhere. In either case, the emotional welfare of the patient and family should be attended to by thoughtfully explaining the situation and where possible by trying to accommodate the patient's needs.

The Maryland Institute for Emergency Medical Services Systems wishes to acknowledge the contributions of Dr. P. Gregory Rausch of Frederick, who has been a pioneer in the development of this protocol in Maryland. Additionally, Robin Dowell, RN, of St. Agnes Home Care, and Dottie Arnold, RN, CRT, of Harford County, have devoted many hours in working with MIEMSS staff in the development of this protocol and the associated educational programs.

For additional copies of the protocol, questions about the protocol, or to schedule training opportunities, please contact your MIEMSS Regional EMS Office. Region I —(301) 895-5934; Region II — (301) 791-2366; Region III — (301) 328-3996; Region IV —(301) 822-1799; and Region V — (301) 474-1485.

— Ameen I. Ramzy, MD
State EMS Director

Maryland
EMS
NEWS

Vol. 15, No. 5, NOVEMBER 1988

Hospice/EMS Palliative Care Protocol

1. INTRODUCTION

A hospice patient is a person with a terminal illness with a life expenctancy of six months or less and who is under the care of a Hospice Program. Hospice care neither hastens nor prolongs death; it allows the dying process to occur naturally while palliating the patient to the highest degree possible. For the hospice patient, life support measures including CPR are inappropriate.

Hospice programs will continue to include educational programs for patients and families which discourage the use of 911 for hospice patients. Occasionally, however, the EMS system is activated for these patients. This leads to a conflict between the prehospital provider's duty to sustain life and the patient's expressed wish to die naturally. The purpose of this document is to provide prehospital personnel with a medical protocol to follow when called to provide service to a clearly identified hospice patient.

2. CRITERIA FOR ACTIVATION OF THE HOSPICE/EMS PALLIATIVE CARE PROTOCOL

The Hospice/EMS Palliative Care Protocol will only be activated when official documentation of hospice status and confirmation of patient identification is available. The protocol does not apply to vehicular crash scenes or mass casualty incidents. In the absence of confirmed documentation and identification, the patient will be cared for according to standard protocols and training.

2.1 DOCUMENTATION

An official, numbered, Hospice Network of Maryland (HNM) Documentation Card must be present. It will include:

Patient Name, Age, Sex
Driver's License Number (if available)
Social Security Number
Height, Eye Color, Hair Color, Race
Next of Kin and Number
Hospice Program and Number
Physician Name and Number

2.2 IDENTIFICATION

If the HNM Card is present then independent confirmation that the patient is the person referred to in the HNM Card **must also be obtained.** Identification may be confirmed by the patient (if conscious) or at least one of the following individuals who is present at the site:

Doctor, Nurse
Hospice Program Provider
Family Member/Care Provider
OR Personal Knowledge of Prehospital Provider

(The name of the individual identifying the patient must be recorded in the runsheet.)

3. LIMITED PATIENT ASSESSMENT

3.1 Vital Signs
3.2 History of Episode
3.2.1 Identify reason aid was requested.
3.3 Pertinent Medical History
3.3.1 Medical Problems and Conditions
3.3.2 Medications
3.3.3 Allergies

4. SUPPORTIVE CARE FOR SYMPTOM CONTROL

4.1 Respiratory Distress
4.1.1 Administer oxygen at 50-100% concentration by mask without ventilatory assistance.
4.1.2 Suction as necessary.
4.1.3 Position for comfort.
4.2 Bleeding, External
4.2.1 Standard treatment (direct pressure, dressing, etc.)
4.2.2 No MAST Trousers or IV's
4.3 Fractures: Immobilize in standard fashion.
4.4 Uncontrolled Pain or Other Symptoms (e.g. severe nausea)
4.4.1 Allow patient, family, or health care providers (other than the prehospital provider) to administer patient's prescribed medications. Such health care providers administering medications will **not** have to accompany the patient to the hospital.
4.5 Existing I.V.'s: IV lines may be in place and, if so, should be monitored.

5. INAPPROPRIATE CARE FOR A CONFIRMED HOSPICE PATIENT

5.1 Cardiac Monitoring
5.2 Initiation of IV Therapy
5.3 Medications - Except 4.4.1
5.4 CPR
5.5 Intubation (EOA or Endotracheal) or Oral Pharyngeal Airway
5.6 MAST
5.7 Ventilatory Assistance

6. TRANSPORT

6.1 ALS intervention is not required; BLS transport is appropriate as needed.
6.2 Transport to patient's hospice hospital should be considered if feasible and practical.

7. COMMUNICATIONS

No consultation is required, but the receiving hospital should be notified to expect the patient and prepare accordingly.

NOTE: Please place this page in your protocol manual.

HOSPICE NETWORK OF MARYLAND #00000
DOCUMENTATION CARD

Name _____ Age ____ Sex ____
Driv. Lic # _____ SSN _____
Ht ____ Eyes ____ Hair ____ Race ____
Next of Kin _____ (_____)
Hospice _____ (_____)
Physician _____ (_____)

SEE REVERSE SIDE

This patient is enrolled in the _____ Hospice Program and does not wish to be resuscitated. If emergency hospitalization is required the patient should be transported to _____ if possible, and the Hospice/EMS Palliative Care Protocol should be followed. This identification should be independently verified.

Patient _____
(signature and date)

Physician _____
(signature and date)

Why Do I Volunteer in EMS? . . .

Volunteers . . . what would EMS do without them? A majority of more than 20,000 BLS and ALS providers across the state are volunteers, not only providing their life-saving skills free of charge but also giving up precious time with family and friends to do it. Are these EMS volunteers anachronisms in these days of tough economic times that call many to work two jobs, saving their free time for recreation and relaxation? What makes EMS volunteers willing to devote their time and effort to the system?

It's not all excitement and glory, despite the flashing lights, sirens, and uniforms. There are also routine chores, sick people, and long hours. And the Maryland EMS System has stringent requirements for certification for its EMS personnel — starting with 110 hours of training for basic EMT personnel and including over 24 hours of continuing education to be completed within 3 years of certification or recertification. But working for the EMS System seems to give volunteers more of a return than the usual volunteer job. Most EMS volunteers feel a strong sense of community and a challenge to know more and do more to help other people.

For this two-part series, we asked a few volunteers to share their feelings with us; the words heard most often were "gratifying," "accomplishing something," "satisfaction," and "I really love it." They describe personal rewards that money can't buy.

Part 1 of "EMS: Why Volunteer?" follows.

Paramedic Leona Rowe

Leona Rowe, Maryland and National Registry EMT-P

Laurel Rescue Squad

Originally a pre-med student at the University of Maryland, Ms. Rowe had to drop out because of family commitments. She joined the Laurel Rescue Squad (the only one in the area that would accept women) in 1965; she and her husband Edward, an officer and board member of the squad, met through their volunteer work. "My first title was Advanced First Aid. Then I became an EMT, CRT, EMT-P, and an EMT/CRT instructor, always broadening my knowledge base. It's been a lot of fun. It gives great satisfaction to help nice people. The job has constant variety—every call is different. There's a feeling of accomplishment in doing the right thing for the patient. And the squad also offers friendships and opportunities." From a purely volunteer beginning, Ms. Rowe built a career; she teaches for MFRI, MIEMSS, and the Prince Georges County Fire Department.

TFC Jeff Alexander, ATT, CRT

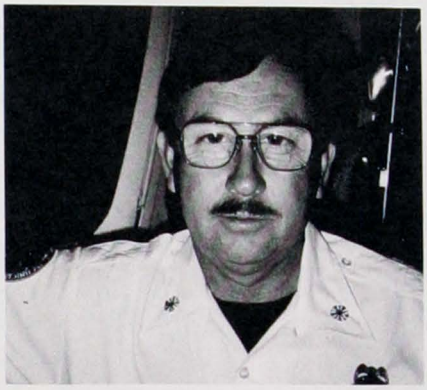
Westminster Fire Engine & Hose Company #1

TFC Alexander is stationed in Frederick with Maryland State Police (MSP) Helicopter #3 and teaches State Police to be first responders at MSP Headquarters in Pikesville. "It's tough to find time to do everything you'd like to do; sometimes you have to rearrange your social activities. Carroll County is growing so fast we need more volunteers to be firefighters and EMS providers. It requires a good bit of time, but it is interesting and rewarding." TFC Alexander's father is an active EMT with the Baltimore County Fire Department Station #2 in Pikesville.

Robert Rust, EMT-A

Chief, Kent-Queen Anne Rescue Squad, Chestertown

After 26 years of involvement in emergency services, nine of which were spent as chief of the rescue squad, Mr. Rust is now director of Civil Defense in Kent County and supervisor of the 911 system. "There is a feeling of satisfaction you get in helping others in their desperate time of need. There's a certain percentage of glory and excitement, but not too much—there are also routine calls and sick calls. But if you want to help your community, there is no better way." Kent-Queen Anne Rescue Squad is unusual in that it is not affiliated with a fire company. It is independent but responds with a fire company. "There is a benefit to the county in having a volunteer EMS system. Taxes would have to be higher to support a paid system." Mr. Rust found another fringe benefit to working with the EMS system. He and his wife Sandy met when she was a nurse working in the emergency department of Kent and Queen Annes Hospital.



CRT Wayne Williams

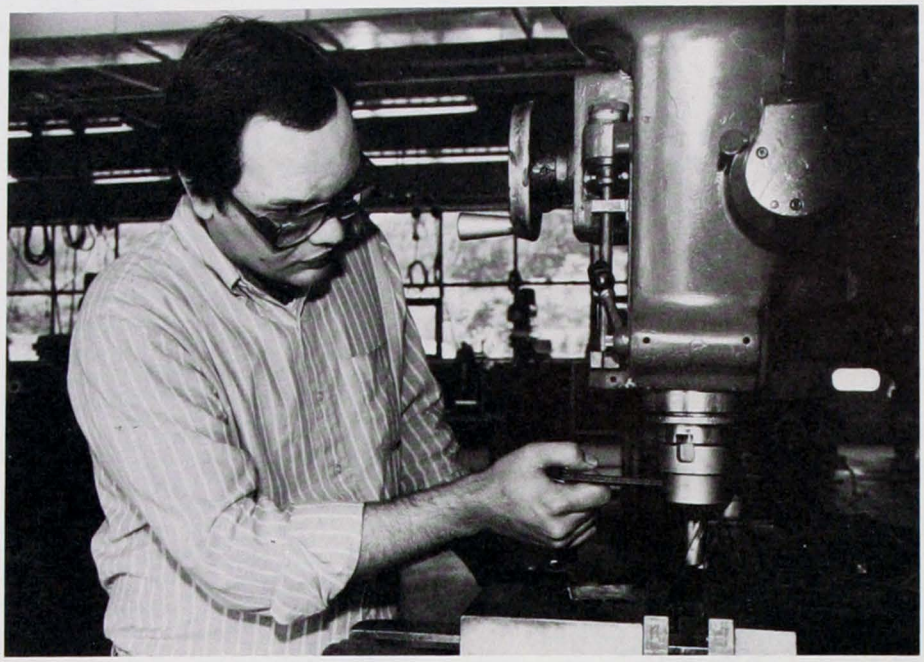
Wayne Williams, CRT

Chief, Smithsburg Emergency Medical Service

Before Smithsburg established its own EMS, it depended on volunteers from Community Rescue Service in Hagerstown for help. Now that they have a company of their own, many of the volunteers from the Smithsburg Emergency Medical Service reciprocate and give their time as volunteers for the Community Rescue Service as well as their own. Involved in EMS since 1980, Mr. Williams explains, "You have to give something back to the community, not just take." Mr. Williams volunteers at both companies and is the president of the Washington County Fire/Rescue Association. His wife helps in other ways, such as fund raising, and his daughter looks forward to becoming an EMT. "In addition to the self-satisfaction you get in helping others, young people ought to know that working in EMS can give them a start toward a medical career even before they get to college. CRTs and EMT-Ps can find a career by taking the 2-year program at Hagerstown Junior College or the bachelor's degree or master's degree programs at University of Maryland Baltimore County (UMBC). At UMBC they can choose which track they would rather follow—administration or paramedic—and go even further with a master's degree. There is a lot to offer." Mr. Williams is a salesman for the Noland Company in Frederick.

(Continued on page 7)

Center for Living Initiates Program . . .



John E. Gray, Jr., works in the machine shop at Catonsville Community College as part of the Work Readiness Program.

Twenty years ago many persons with head injuries died; others lived out their lives in nursing homes. Today's medical advances save many lives—and effective psychosocial programs and computer technology make those lives more rewarding. The Work Readiness Program begun recently by the Center for Living, a MIEMSS posthospital rehabilitation therapy center on the grounds of Montebello Rehabilitation Hospital, places head-injured people in real, rather than simulated, jobs in the mainstream work world.

The program, which is funded by a grant from the Dole Foundation for Employment of People with Disabilities, helps its clients develop the attitudes and skills they need to handle the jobs and continuously reevaluates and upgrades the skills as needed. The Work Readiness Program is a natural evolution of other Center for Living programs, such as the Life Enhancement and Education Program (LEEP), which teaches skills required for personal, social, and vocational adjustment, and the Cognitive Relearning Program (CORE), which provides remediation in cognitive, educational, and social skills.

Although clients in the Work Readiness Program range in age from 18 to 58, the average age is 26. At this time, most of the clients are male. Some of the younger clients were injured before they had much schooling or work experience; some had only the low-paying, fast-food restaurant jobs typical of young people. To prepare them for jobs that are more appropriate for their altered conditions and their future aspirations, they need realistic analysis of their capabilities and interests; counseling on how to dress, present themselves at interviews, fill out applications, and manage stress in the workplace; and skills training.

Tests are given to determine abilities and limitations. Jobs are researched on an individual basis, and on-site visits are made by Waddell Robey, coordinator of the program, who gauges what skills are needed by the worker. Mr. Robey arranges for appropriate training to make the client a suitable intern for the job.

Factors that must be considered before a client can be placed in a job include whether he/she will interact successfully with peers, will respond properly when the boss gives directions, and will be competitive with nondisabled workers. Not only do clients need to overcome difficulties caused by their injuries, they must also form positive work attitudes that might not have been part of their lives in the past. This is accomplished through counseling and group discussion.

Clients must also adjust to leaving the supportive environment that has surrounded them since their injury, where they had professionals and family members responsive to their needs. In contrast, the work world—even in the most caring environment—seems impersonal. Head-injured persons are sensitive and tend to take criticism personally.

"Another fact of life they learn to face is that in the outside world there are people who will be uncomfortable, unfriendly, or downright rude to a disabled person," Mr. Robey says. "Some people make snide remarks; clients are taught to disregard them and to think of all the people who are their friends and wish them well. By interacting with their peers at the Center for Living, they can express their feelings and discuss them. Peer support helps them make the adjustment."

If a head-injured person makes a mistake on the job, it is assumed that it was due to his/her injury. However, even noninjured workers make mistakes due to stress, phone interruptions, or other distractions. Supervisors and peers must be educated in that regard. The client's anxiety over his memory might cause him even more stress. "We teach our clients that if they have problems, they should be open about them," Mr. Robey says. "Most people would be understanding if another person says, 'I'm a little nervous about this; could you give me a little more time.' Or, 'Would you mind saying that more slowly, so I can write it down?' Most people would say, 'Sure!' This eliminates 90 percent of the stress. The client knows that although he might appear slow, people know where he is coming from. Then he can be far more effective. Clients receive group and individual counseling about how anxiety is expressed, how they can deal with it, and how to recognize what makes them anxious. Pretty soon mutual respect develops, anxiety disappears, and there is an irreplaceable self-initiated support system."

After job placement, clients return to the Center for Living for training in whatever areas are needed for successful job retention, which might include additional memory, speech-communication, or work skills, or psychosocial counseling. Employers are provided with educational resources and consultation with staff if they see difficulties arising and may refer clients back for additional training or counseling if necessary.

Since the Work Readiness Program began in January, 15 persons have been enrolled; some are in training, others are

(Continued on page 5)

. . . Focused on Job Skills, Retention

(Continued from page 4)

already working in creative and effective placements. In many cases, computers substitute for the physical deficits of the clients—computers have very good memories and lots of patience and never get frustrated from repetition.

Mr. Robey works closely with the Catonsville Community College Occupational Training Center, which individualizes courses for head-injured clients. Instead of taking three courses at a time, clients might take only one; or perhaps courses are scheduled at an earlier time to accommodate persons without a lot of physical stamina.

All of the clients' jobs give them self-respect, fulfillment, and a feeling of well-being. They are usually highly motivated workers. One young man with hemiparesis, including limited use of his right hand, is studying to be a machinist with the help of computers. Another client, who is an artist, is learning to express her art through state-of-the-art computer desktop publishing. A client is working as a docent for the Smithsonian Institution in Washington, DC. At present, they are not making their living at these jobs; they are interns. It is hoped that in the future they will be paid on a competitive basis.

Plans are being made for clients with cognitive or memory impairments to be placed in jobs by using the services of job coaches who will help them develop the skills needed, be their advocate, and be a buffer between the client and the employer. Simple, repetitive tasks, such as taking horticultural cuttings, could be handled by this clientele with the help of the job coach.

For further information about the Work Readiness Program, contact Waddell Robey at 301-243-2800.

— *Erna Segal*

Claudius Allen takes computer training at Catonsville Community College as part of the Work Readiness Program.

EMS Providers
are invited to tour the new
R Adams Cowley, MD, Shock Trauma Center
on December 13
from 7 to 8:30 pm
or December 14
from 10 to 11:30 am
Reservations must be made by calling your regional administrator.

Training Programs from ARC

Three new training programs in CPR and first aid, developed by the American Red Cross (ARC), have received high praise for their quality and content from EMS instructors in Maryland. The programs are titled "BLS for the Professional Rescuer," "Community CPR", and "Standard First Aid."

Ron Schaefer, NREMT-P, director of MIEMSS' prehospital training and certification office, stated: "These are quality productions that I hope will be used throughout the EMS program. The educationally sound presentation of the steps involved in CPR and first aid combined with a systems approach to EMS make these programs excellent instructional resources. These programs will be approved for continuing education credits for BLS and ALS providers."

"BLS for the Professional Rescuer" is a supplement for teaching professional rescuer skills. Two courses are available: "Learning Professional Rescuer Skills" is intended for use during initial instruction; a second course, a skills review, was developed for ARC recertification in CPR.

The program "Community CPR" is actually three courses: adult CPR, infant/child CPR, and community CPR (including instruction in resuscitation of adults, children, and infants). In dramatic portrayals of medical emergencies in common settings, the videotape illustrates how a trained bystander can take charge of the situation and provide effective care.

"Standard First Aid" covers CPR, rescue breathing, first aid for choking, and other basic first aid skills. It was designed to teach citizens about the support that can be given to an injured person before EMS personnel arrive at the scene. The program is also useful as a skills review for professional rescuers.

Each program "package" consists of a videotape, a detailed workbook, and an instructor's manual. By organizing the tapes into blocks of information, the ARC has provided a structure that allows instructors to stop the film to provide supplemental information to students or enable them to practice at skills stations.

In the early 1970s, the ARC initiated its well-known training programs in first aid and CPR for the lay public. The decision to concentrate on that audience was based on an assessment of the organization's resources and the most pressing needs at the time. Now the organization has expanded the focus of its training programs to include professional rescuers—people whose jobs or volunteer activities carry a duty to respond to a medical emergency. In addition to prehospital personnel, the intended audience encompasses allied health professionals, police officers, lifeguards, security guards, and members of search and

(Continued on page 8)

MBB Honors Maryland Pilot, Medic

Two members of the Maryland State Police (MSP) Aviation Division are the recipients of the 1988 MBB Flight Crew Extraordinair Award. Sergeant Harold Baker and TFC James Collins, Jr., pilot and medic, respectively, were honored at the national conference of the Association of Air Medical Services (formerly ASHBEAMS) on September 21. Initiated in 1983 by Messerschmitt, Bölkow, and Blohm (MBB), a German helicopter manufacturing firm, the award recognizes medical helicopter personnel who have distinguished themselves by exceptional performance and is the highest award given by the organization.

Sgt. Baker and TFC Collins, stationed at the Helicopter 4 base station in Centreville, were involved in the medical evacuation of TFC Eric Monk, a fellow officer who had been struck by a car while issuing a citation for speeding near Princess Anne in April. The injured trooper had sustained very severe multi-system trauma. Despite the life-saving efforts of many troopers and medical personnel, the officer died 4 days later.

Sgt. Baker and TFC Collins were selected to receive the award for their exemplary performance in this difficult situation, emotionally compounded by their friendship with the critically injured officer. It was the first time in the award's 5-year history that helicopter crew members from Maryland were chosen as recipients.

Sgt. Baker has been with the MSP Aviation Division since 1983, being stationed at the Baltimore Section, at the Salisbury Section, and now at the Centreville Section, where he is section commander. Following his graduation from the MSP academy in 1982, he was assigned to the Waldorf Barrack and then, after being promoted to corporal in 1978, to the College Park Barrack. He worked as the shift supervisor at the Forestville Barrack until he transferred to the Aviation Division. Prior to his employment with the state police, Sgt. Baker served as an E-4 in the US Navy, on an LST operating in the May Kong Delta of South Vietnam. He completed his 6 years of military service as a staff sergeant, Company A, 5th Battalion, 20th Special Forces Battalion, 1st Special Forces Group (Abn).

TFC Collins joined the Maryland State Police in 1983 following 2 years of service in the US Marine Corps and completion of an Associate of Arts degree in law enforcement. Following graduation from the state police academy, he was assigned to Leonardtown Barrack and was then transferred to the Centreville Barrack, where he was recognized for his criminal investigation abilities.

TFC Collins attained an EMT-A rating while he was in high school, which he maintained until his transfer to the MSP Aviation Division in 1987. He currently is certified as a CRT and an ATT and is attending the EMT-P program at Essex Community College.

In recommending the Maryland troopers for the MBB award, Major Warner Sumpter, commander of the aviation division, wrote, "Although the incident [in which the men were involved] . . . recalls a great deal of emotion and sadness, [it is] . . . the story of a crew that I feel conducted themselves with the utmost professionalism and competency, making all who are associated with the aero-medical field proud."

(L-r) Andy Aastad, vice-president of MBB, TFC James Collins, Jr., (MSP medic), Sgt. Harold Baker (MSP pilot), Maj. W.I. Sumpter (commander, MSP aviation division), and Capt. F.E. Meeks (assistant commander, MSP aviation division) following the presentation of the 1988 MBB Flight Crew Extraordinair award.

Recently Elected . . .

Ameen Ramzy, MD, state EMS director, was elected to the executive committee of the National Association of State EMS Directors at its annual meeting in October.

John Stafford, MD, MIEMSS state aeromedical director, was elected to the board of directors of the Association of Air Medical Services (AAMS) at its annual meeting in September. Dr. Stafford will represent ALS providers in the organization.

AAMS (formerly the American Society of Hospital - Based Emergency Air Medical Services) currently has a membership of 250 medical air evacuation services nationally and internationally. According to Dr. Stafford, AAMS is in the process of developing standards for quality assurance and for evaluating the safety features of helicopter programs, as well as creating training standards for medical flight crew members.

Ron Schaefer, director of prehospital training and certification, was elected to serve a second term as secretary of the National Council of State EMS Training Coordinators.

Trauma Case Reviews Conducted for EMTs

Prince Georges Hospital Center in Cheverly is offering monthly trauma case review sessions for EMTs. Presented by traumatologists and other specialists from the hospital center, the case reviews are open to all EMTs and will be held the third Tuesday of every month at 7 pm in the center's auditorium. Maryland continuing education credits are available. For further information, contact George Linnell at the hospital (301-341-3300) during the evening.

Why Do I Volunteer in EMS? . . .

CRT Terry Shook

(Continued from page 3)

Terry Shook, CRT

President, Thurmont Community Ambulance Service

Chief Hospital Corpsman Terry Shook had his first ride on an ambulance when he was 2 years old; his father helped start the ambulance service in Thurmont. "I was born and raised in the company, and joined as a volunteer in 1967 as a teenager. There's a special feeling when a call turns out real well and you can be there when people need help." Chief Shook also passes on his knowledge in his work as an EMT instructor and evaluator for MIEMSS. "I tell people that if they're going into EMS for money, thanks, or pats on the back they'll be disappointed. But if they are going in to give help and can put aside their own priorities for the good of the community they will enjoy it." The community must agree with him—out of a population of 3,000, there are 42 EMTs, 1 CRT (in addition to Chief Shook), and 50 associate members of the service who raise funds and help in other ways. The Thurmont Community Ambulance Service acts as a back-up unit to Camp David's medical personnel and had the unique experience of transporting President Jimmy Carter when he had heat exhaustion after a run through the mountains. Two problems that Chief Shook wishes the public understood more is that EMS depends on volunteers outside of the big cities because small communities cannot afford paid workers; and the county gives a small allotment for equipment and supplies, but the ambulance services rely on donations for the rest. "To deliver the quality of care we want, we must have public support in money and time."

John Hockheimer, EMT-A

Cambridge Rescue Fire Department

"It is satisfying to see the results of something I've done when I help people through EMS work. There is a great deal of self-fulfillment in it. People who move in from larger communities that have paid EMS personnel don't understand the importance of being a volunteer. This kind of service is not affordable any other way. You must take part in your community." Mr. Hockheimer is on the Region IV EMS Advisory Council and is the regional representative to REMSAC. Mr. Hockheimer says that as an engineer with the University of Maryland Cooperative Extension Service he is fortunate that his job offers time flexibility. EMS needs lots of help in this small community with busy Route 50 nearby.

CRT Fran Pope (top) shown with co-workers EMT Barb Swiger (left), EMT Phil Rook (bottom), and EMT Rayma Weeks (right). (Photo by Craig Phillips)

Fran Pope, CRT

Southern Garrett County Rescue Squad

"Working as an EMS volunteer is different than other volunteer work because we take the time and make the effort to have the skills and learn protocols to stay certified. We are professionals—this is life-saving work, not filing or putting books on shelves. It's not the glitz or glamour; there is a lot of work involved." Ms. Pope originally became an EMT in 1976 because she wanted to prepare for the emergencies that might occur in raising her small children. Even though she is a nurse (BSN), she felt that EMS made her skills child-proof. "It requires a commitment. In our travels we have seen other places and how they cope with emergencies; Maryland has a system that makes the others pale by comparison. We can be proud of it." A Region I EMS Advisory Council member, Ms. Pope is thinking of taking the EMT-P course.

EMT Ken May

Ken May, EMT-A

LaVale Volunteer Rescue Squad

"There is great satisfaction in helping someone who really needs help and making it possible for that person to survive. I just can't sit at home when the call is sounded—it would tear me up inside if I couldn't answer it. I hope I'm never on the cot in need of help. Having traveled to see other EMS systems, I can appreciate the statewide one we have in Maryland." Mr. May's entire family is active in the Maryland EMS system, including his wife Betty, his three children, his son-in-law, and his daughter-in-law. Mr. May became active in emergency services at the age of 14, when the manpower shortage in 1942 made volunteers of any age welcome. He switched from the fire to ambulance service about 12 years ago. Mr. May is manager of construction for the telephone company in Cumberland; he says they encourage community service and he never has trouble getting the time he needs.

Frank Muller, CRT Instructor

EMS Coordinator, Cecil County

"Mr. ALS of Cecil County" was a Deputy First Class with the Harford County Sheriff's Office and a volunteer CRT at the Singerly Fire Department when he helped establish the Deputy EMT/CRT program, in which law enforcement officers, who are often first on the scene of an accident, provide care until the ambulance arrives. When the county saw it was necessary to establish a more extensive program to suit the needs of the burgeoning population, Mr. Muller became the EMS coordinator. "It's the feeling of helping the community that keeps me involved," he says. "There's no

(Continued on page 8)

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Why Do I Volunteer in EMS? . . .

(Continued from page 7)
question that it takes time and training and it's tough on family life to do the job right, but it's an important job that must be done by someone." Mr. Muller has been active in EMS since 1972.

Alan Bradley, CRT
Federalsburg Volunteer Fire Company

"It was not fair for the residents of Caroline County to be denied the highest level of care because of their location, so a group of us decided to establish the Caroline County ALS Services, Inc., which went on-line on June 1 of this year. It's not possible to have 24-hour coverage yet, with the one paid person from 7-5 and the 14 other people running the unit, but we haven't missed a call yet. We have exceeded our expectations. We care about our community and it's gratifying to pitch in and see results." This lower Eastern Shore county got its ALS service (of which Mr. Bradley is president) through the cooperation of the volunteers; the county commissioners, who gave them start-up funds, the county-paid employee, the vehicle, and the equipment; MIEMSS, which gave the monitor/ defibrillator; and the MIEMSS Region IV office. Mr. Bradley's wife Debra recently became certified as an EMT, but her newborn son is temporarily keeping her out of action.

Judy Mills-Hinch, NREMT-P
Ambulance Captain, Aberdeen Volunteer Fire Department, Inc.

"Harford County is very special," Capt. Mills-Hinch says. "People here are devoted to EMS, fire, and rescue services—dedication is normal here. It becomes part of your life; you put it ahead of your social life or such things as eating and sleeping—you know that certain nights are devoted to your unit." Capt. Mills-Hinch married one of the volunteer firefighters in the unit, Fire Capt. Steven C. Hinch, who in his paid job is with the Department of the Army Aberdeen Proving Ground Fire Department, Edgewood Area. Capt. Mills-Hinch teaches firefighter first responder courses for MFRI and EOA/MAST courses for MIEMSS.

(To be continued)

EMS Care '89 . . . EMS Care '89 . . .EMS Care '89 . . .

EMS Care '89 returns to Region V on April 28, 29, and 30, 1989, with an exciting program at the Colony South Hotel in Clinton, Maryland. Daylong pre-conference programs will be held on the management of a volunteer company and haz-mat level 1 training. Saturday and Sunday offerings will include a wide range of presentations on timely medical and trauma topics as well as an expanded number of "hands-on" workshops, including helmet removal and spinal immobilization.

Another exciting addition to the program will be a panel discussion of legal and ethical issues in EMS. A panel of legal and medical experts, field providers, psychologists, and the clergy will discuss topics of interest and concern to field providers. Questions and topics for the panel to address are currently being solicited. Please send your suggestions to the Region V EMS Advisory Council, c/o Marie Warner-Crosson, Region V Office, 5111 Berwyn Rd., College Park, MD 20740. Remember that we are looking for questions that will evoke a lively exchange of ideas.

Red Cross Videotapes

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rescue teams.

These training programs are presented in community courses offered by the ARC. Arrangements can be made for an ARC instructor to give a group presentation at a site that is convenient for the requestor. Since each Red Cross chapter publishes its own schedule of courses, interested persons should contact their local chapter for more information. Details about continuing education credits for prehospital personnel in Maryland can be obtained by calling the MIEMSS prehospital training and certification office at 301-328-3666.

— Linda Kesselring