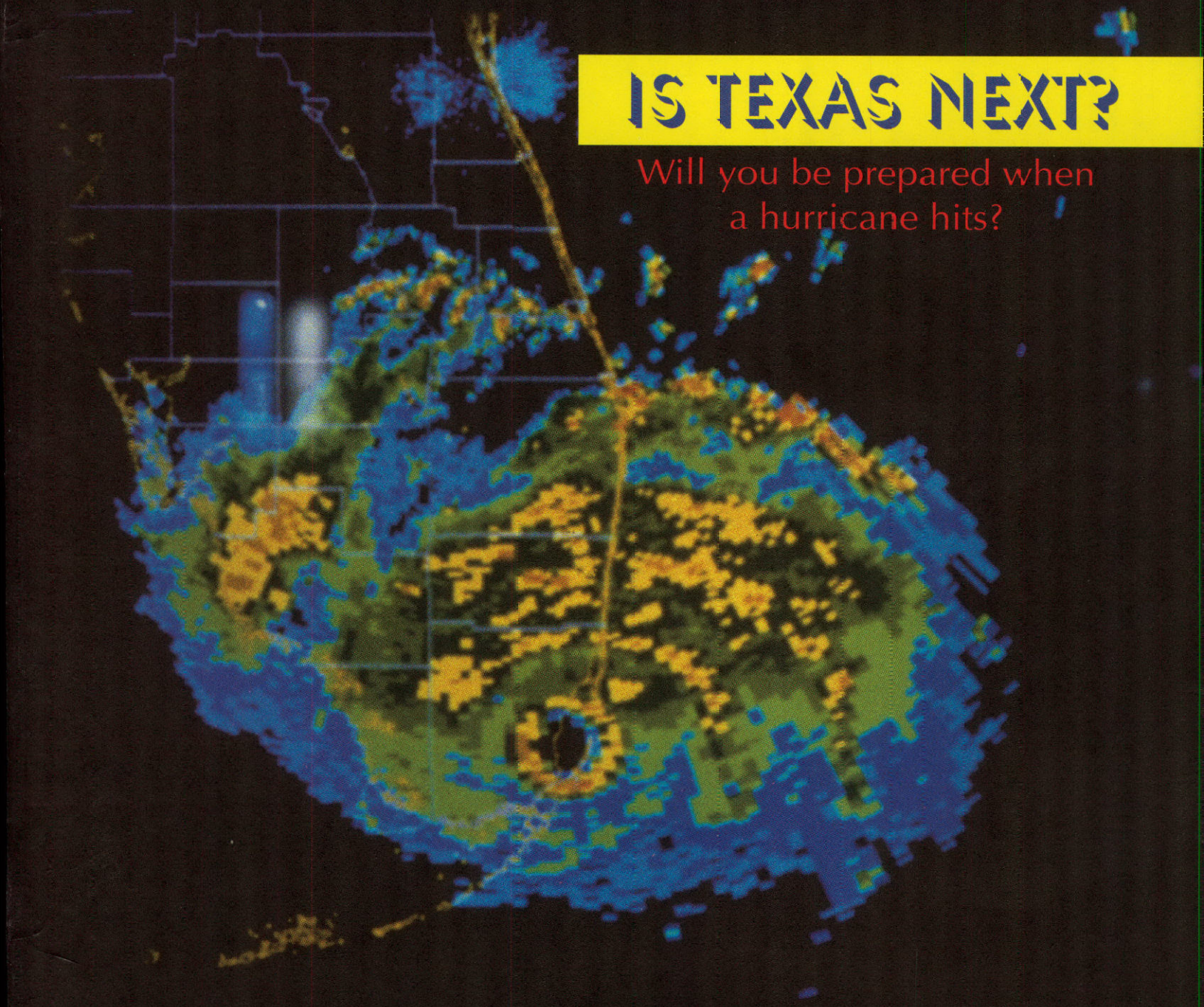
Earn 1.5 hours of CE with head injury article on page 28.

Texas EMS

Magazine

A special license plate for Texas EMS? See page 5



IS TEXAS NEXT?

Will you be prepared when a hurricane hits?

Serving Texas Emergency Care Professionals Texas Department of Health May/June 1996

Animal Attack: A veterinarian and a paramedic tell you how to respond to an animal attack—and keep yourself safe. Page 24.

Order these free materials for your community education programs.

Mail or Fax order form to:

Bureau of Emergency Management
Texas Department of Health
1100 West 49th Street
Austin, TX 78756
or Fax to (512) 834-6736

Shipping information:

Organization _____

Shipping Address _____

City/State/Zip _____

Telephone _____

Contact _____

Amount ordered	Description
_____	**"Ready Teddy" coloring book.** Twelve pages of injury prevention and EMS awareness tips by the Texas EMS mascot. English-(4-61), Spanish-(4-61A)
_____	**"When Minutes Count—A Citizen's Guide to Medical Emergencies" brochure.** A foldout first aid guide first distributed in 1988. Can be personalized by the EMS service. (EMS-014)
_____	**"Don't Guess, Call EMS" brochure.** A reprint of a Department of Transportation brochure updated with Texas photos and logo. Back panel listing of Public Health Region offices and a "for more information call" box, 1989. (EMS-013)
_____	**"EMS Lifesavers—Career Information" brochure.** Gives types of jobs, paid and volunteer, in various settings and salary ranges. (EMS-007)
_____	**"EMS questions and Answers About Citizen participation" brochure.** Answers questions about how to call, what to do, how the community can help EMS. (EMS-008)
_____	**"EMS—A System to Save a Life" brochure.** A 1970's title, 1990's text, and it has public health region office info and "for more information call" box. Explains BLS and ALS, 1989. (EMS-012)
_____	**"Ready Teddy" poster.** The Texas EMS mascot urges kids to prevent injuries. (4-60)
_____	**"Dedicated to Patient Care" poster.** EMT and elderly woman pictured; featured during 1988's EMS Week. (EMS-009)
_____	**"EMS—It's a Lifesaver" poster.** Features the scanned ambulance with an orange stripe and EMT. Our first EMS Week poster, 1985. (EMS-018)
_____	**"System to Save a Life" poster.** Companion poster to brochure, 1990. (EMS-011)
_____	**"When It's A Medical Emergency—You Need EMS" poster.** Pictures closeup of EMTs resuscitating a child, 1987. (EMS-010)
Being reprinted	**"I'm an EMS Friend" sticker.** Ready Teddy in a 2-½ inch 2-color sticker.
_____	Send information on borrowing the **Ready Teddy EMS Mascot suit**, available from Austin or the regional offices. Kids love him! And they learn to stay safe.
_____	Send a sample of all public information and education materials—**a PIE pack**.
_____	**"Accidents Don't Just Happen" poster**. Injury prevention tips featuring Dr. "Red" Duke, 1993.

(Please limit poster orders. We can only send 20 posters of each type.)

Contents

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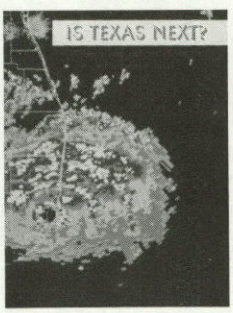
New Departments

Departments



ABOUT THE COVER: Hurricane Andrew devastated Florida when it slammed into the coast with 150 mile -per-hour winds. Photo courtesy of the National Oceanic and Atmospheric Administration.

Texas Department of Health Mission

To protect and promote the health of the people of this state.

Bureau of Emergency Management Mission

To facilitate statewide, regional, and community systems that provide emergency and health care for all individuals.

Texas EMS Magazine

May/June 1996 Vol. 17 No. 3

A bimonthly publication of

TEXAS DEPARTMENT OF HEALTH

Texas EMS Magazine

KELLY D. HARRELL — Editor

JAN M. BRIZENDINE — Art Director

RYAN DAVIS — Staff Assistant

Texas EMS Magazine (ISSN 1063-8202) is published bimonthly by the Texas Department of Health, Bureau of Emergency Management, 1100 W. 49th Street, Austin, Texas 78756-3199. The magazine embodies the mission of the Bureau: to help organizations function professionally as EMS providers, to help individuals perform lifesaving prehospital skills under stressful conditions, and to help the public get into the EMS system when they need it. It takes state and national EMS issues and answers to ECAs, EMTs and paramedics serving in every capacity across Texas.

Editor's office: (512) 834-6700, 1100 W. 49th Street, Austin, Texas 78756-3199.

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We will accept telephone and mail queries about articles and news items. Manuscript and photograph guidelines available upon request. Materials will be returned if requested.

Second Class Postage paid at Austin, Texas. POSTMASTER: Send address changes to *Texas EMS Magazine*, 1100 W. 49th Street, Austin, Texas 78756-3199.

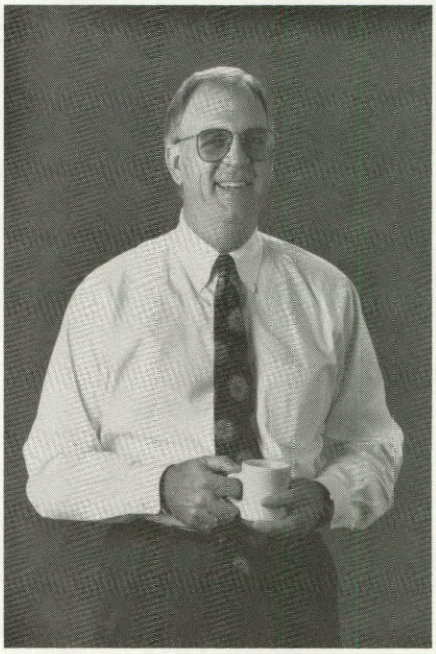
Is it time for EMS to have special license plates?

About a year ago we received a letter from Alfred Duque, a paramedic with Frio County EMS, with a suggestion that Texas needs a license plate for EMS personnel in our state. Mr. Duque explained in his letter that he believes that a distinctive EMS license plate would be an honor and a way to show the public the dedication and commitment EMS people have to the citizens of Texas. If you are interested in having such a license plate in Texas, it will take at least 1,500 people who will commit to purchase these plates once they are produced. The legislation for other special plates in use now creates a $25 fee to be used by that group as designated by the legislature. If there are enough EMS personnel in Texas interested in a distinctive EMS license plate, legislation will be necessary.

Please let us know if you would be interested in purchasing a special EMS license plate. We will use this column as an informal survey of the the demand for such a license plate. Please write me a note with your thoughts and ideas on this project. We thank Alfred Duque for his foresight with the original idea.

As all of us know, emergency medical service is still a fairly new profession. In Texas, emergency medical service has been in existence for approximately 29 years. I remind you of our young age to remind you that we need to begin now to preserve the history of EMS. A big thanks goes to Steve Diamond for having the foresight to preserve some of our EMS history. Steve has spent the last several years collecting and restoring old ambulances. He is in the process of donating the 1962 Oldsmobile, on display at our conference last year, to the Public Health Museum of Texas. We will have some pictures of Steve and the antique ambulance in future issues of our magazine.

Starting on page 10, you'll find information for Texas EMS Conference '96. In this issue, we have a general agenda and a listing of all our preconference classes. Our July/August issue will carry a detailed agenda of all our classes. As usual, we'll have three days of classes that can earn you up to 15 hours of CE credit during the regular conference and 16 hours during preconference. The big difference in preconference classes this year is that we are requiring preconference attendees to preregister. That way we can get an idea of how many people to expect. For general conference registration, you can preregister for $75; after November 1, the price rises to $90. We'll see you in November.



GENE WEATHERALL, CHIEF BUREAU OF EMERGENCY MANAGEMENT

TEXAS EMS CERTIFICATIONS AS OF MARCH 11, 1996

ECA	8,230
EMT	24,994
EMT-I	3,323
EMT-P	9,129
TOTAL	45,676
COORDINATOR	391
INSTRUCTOR	1,588
EXAMINER	1,822

By
Mike Strachan, LVN, EMT-P

Experience gives medic a different perspective on death

The last time I submitted an article was to praise Chico Volunteer Fire Department a few years ago for their quick action in starting CPR on a patient. This time, the article is about something I personally went through.

Many times during my career as a paramedic and nurse, I have seen strange things happen both in the field and in the hospital. Occasionally, when someone was close to death, strange occurrences would take place. We have all been exposed to these occurrences at one time or another but we usually don't discuss them. Personally, I was a little afraid of them, so I seldom talked about them with anyone.

Bright lights, long lighted halls, people talking, out-of-body experiences: What were these things that were happening to the patients?

Bright lights, long lighted halls, people talking, out-of-body experiences: What were these things that were happening to the patients? As medical professionals, we look for a rational explanation, such as medications, to explain these strange occurrences.

I believe I found my answer in a very dramatic way on June 29th, 1995. It was like any other day except that my wife Katie and I had to buy a present for my son who would be three on June 30th. We headed to the local Kmart. On the way, I became a little nauseated and my left arm felt strange. Since we were only three miles from the store, I felt I could make it without any problems. I drove on. As we pulled into the parking lot, I realized I was sweating profusely. Determined to get our son a present, I told my wife she would have to go in and get the gift and that I would wait in the car. Katie knew immediately I was ill. She made a comment about my color and my being soaked. She pulled me over to the passenger side of the car and sped toward the hospital where I worked. As we arrived at the ED, I remember the fear on everyone's faces when they saw me. I was getting worse. My arm was falling off from pain, I was diaphoretic and I lost all strength. I could not breathe and could not even get myself out of the car. Katie and a co-worker, Lou Brown, RN, managed to pull me into a wheelchair and get me onto a stretcher. I was rolled into the cardiac room. Dr. Mellot, whom I had worked with many times, was on duty. I was afraid. I asked Dr. Mellot not to let me die. Things were happening very fast: an IV and oxygen was started and monitors were placed, all by people I worked with on a daily basis. Some had tears in their eyes but kept on working.

I was getting worse and knew it. I told Shirley Madison, RN, that I was going out. I just could not take the pain any longer. My chest had a ton of weight on it. I continued to fight for air. I told Lou to make sure she told Katie that I loved her. I knew I was dying. After just a few minutes, I finally gave up. I closed my eyes. Suddenly the scene was in slow motion. I could see everything that they were doing to me. I saw them charging the defibrillator. Another co-worker, Ann Hash, RN, leaned over me and told me that if I died she would kill me. I remember how funny that sounded. She had tears in her eyes. I continued to see them work on me. Lou thumped my chest as hard as she could. I did not feel a thing.

After a moment, something compelled me to turn around and leave the ED. I found myself walking down a dirt path. It was warm, quiet and peaceful. So peaceful in fact, that I never wanted to leave. No pain at all. No strife. I had never felt so at peace before. Continuing down the path, I met three men wearing old dirty robes. One on the right stopped me. He reached out and touched me with his left hand. As he did, he explained that I would have to return, because it was not my time yet. I did not ask for, or need, an explanation.

The next thing I knew, I was back in the ED, and fighting to get the bag off of my face. Another co-worker, Dan Howard, was trying to ventilate me but I would not have any of it. I was able to wrestle the bag away. We settled on a mask. Ann was telling me I had crashed and burned. Dr. Mellot confirmed this. My doctor, F. Lonergan, arrived and I was rushed to the ICU where I worked. Dr. Morrison was called to consult and also arrived. He showed me the prettiest strip of Gran-Torsades I had ever seen. Mine? The only thing I had missed was when they defibrillated me. I had suffered an anterior MI that day, and have since had surgery. I don't wonder what my patients may be seeing or doing anymore. I certainly do not fear it. In fact, I do not try to interfere. Some patients have told me similar stories of near-death experiences since then and I listen intently.

I knew I was dying. After just a few minutes, I gave up. I closed my eyes.

Some of you will never believe in these occurrences, but I certainly do. They taught me to be more receptive to the spiritual needs of the patient and they removed some old fears. I no longer have to ask what the patient is seeing or hearing. I have a pretty good idea.

The Bureau of Emergency Management mourns the passing of these EMS friends

Raymond Ashcraft, 58, died of natural causes on January 20, 1996, at his home. A firefighter for his entire adult life, Ashcraft was the fire chief for City of Copperas Cove Fire Department for 20 years and had been involved in EMS since Copperas Cove Fire Department took over the ambulance service in 1981. Under his direction, Copperas Cove FD/EMS service increased its capabilities from one ambulance at the funeral home to four MICUs.

Debbie Cox, 42, died of smoke inhalation in a house fire on July 14, 1994 in Kermit. The fire also killed her husband and five-year-old niece. Results of the investigation were inconclusive. Cox had been certified as an EMT for almost one year and was a volunteer for Winkler County EMS.

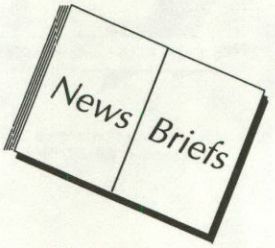
Mark W. Beck, 33, of Lubbock County EMS, was killed in the line of duty on July 24, 1991. He was an EMT-P instructor and had served as president of the volunteer service in Abernathy, Texas and as an advisor to New Deal and Lubbock EMS when they began their first responder programs. Beck was fatally injured when his head struck an I-beam while delivering a patient to a local convalescent home during a rainstorm.

Debra M. Samson, 33, of Hull-Daisetta Ambulance Service, was killed in the line of duty on May 12, 1995. Samson had been an EMT for several years in Canada and the United States and had advanced to EMT-I certification before her death. Samson suffered fatal head injuries and trauma when the ambulance she was driving was struck by a truck on I-10 in Baytown.

Mark Beck and Debra Samson, Texas EMS personnel who were killed in the line of duty, are to be inducted into the National EMS Memorial during the Fourth Annual National EMS Memorial Service to be held at Greene Memorial United Methodist Church, Roanoke, Virginia, on May 25, 1996. For more information on the EMS Memorial, call the National EMS Memorial Service at (804) 282-3311.

To submit an obituary for a medic, call Penny Workman at (512) 834-6700.

A compilation of news from around the state and the nation



LCRA plans radio system upgrade

The Lower Colorado River Authority plans major improvements in its mobile radio system that will boost its ability to serve the public, especially during weather and power emergencies. The LCRA will replace its current radio system, a conventional two-way radio system, with a "trunked" system that allows everyone in defined groups to hear what is being said. In addition, the new radios will allow users to conduct private conversations. LCRA officials say that the system will allow different agencies to communicate more effectively with each other and coordinate efforts in emergencies. LCRA's service area includes parts of 58 counties in Central Texas. Future plans include expansion over much of the state.

As a service to government, public safety and other nonprofit entities in the region, the LCRA will offer the use of the system for a fee to LCRA that covers the costs of the system. Officials estimate the monthly service fees will run between $25 and $60, while equipment costs range from $600 for simple, two-way radios to $3,000 for sophisticated units that have scrambling capacity. The plan calls for the LCRA to construct new towers, transmitters and a 900-megahertz trunked radio system at an estimated cost of $33.8 million. The LCRA plans to complete work by spring of 1998. For information, call Larry Krenek, LCRA telecommunications manager, at (512) 473-3200.

IAFC voices opposition to using fire service for riot control

At a recent of the International Association of Fire Chiefs (IAFC) board meeting, directors again voiced opposition to the use of fire and emergency personnel in crowd or riot control situations. According to the IAFC, there are safety issues for emergency personnel in those situations. The organization also believes that the using of high-pressure fire hoses on people is inhumane and dangerous.

The use of fire and emergency personnel for riot control has recently been suggested in six suburban Detroit communities, which sparked the reiteration of IAFC's 30-year-old policy. For information, call Mike Forgy, IAFC, at (703)273-0911, ext. 316.

DMAT unveils homepage on internet

Texas DMAT1, the Disaster Medical Assistance Team profiled in the January/February issue of *Texas EMS Magazine*, now has a homepage full of information available to anyone with access to the World Wide Web. Check it out with your web browser at: http://rgfn.epcc.edu/users/dmat1/dmat.html

And while you're there, look at the plug for *Texas EMS Magazine*.

Rule correction

Provider rule 157.11 does **NOT** have a $2,000 cap on firm licensure fees. That section was removed from the rule. All providers (except those with volunteer status) shall pay $100 per vehicle regardless of how many vehicles the provider operates.

Texas EMS Conference '96
November 24-27, 1996

Texas EMS Conference '96

The 11th Annual Texas EMS Conference and Exhibit Show

November 24-27, 1996

Fort Worth-Tarrant County Convention Center, Fort Worth, Texas

- *Want to hear from leaders in EMS?*
- *Looking for top-quality education?*
- *Want to see the latest in technology and patient care?*

Texas EMS Conference once again comes to the Fort Worth Tarrant County Convention Center. From November 24 through November 27, you will have your pick of quality clinical and administrative workshops, the opportunity to comparison shop equipment and teaching materials, and plenty of time to share experiences with your counterparts from across Texas and the U.S.

Quality education in luxurious surroundings at a reasonable cost has been the mission of Texas EMS Conference for 11 years. Again this year we'll give you the best educators teaching the courses you need. The convention center and our four hotels will offer outstanding Fort Worth hospitality and service at special conference rates. And the conference registration fee makes Texas EMS Conference the best bargain in the nation for CE, allowing conference registrants to earn up to 15 hours of continuing education. The registration

EXHIBITORS

TEXAS EMS CONFERENCE '96

EXHIBITOR REGISTRATION FORM

Call Jan Brizendine at (512) 834-6748 for exhibitor details

Firm Name _____

Names of _____ _____

Representatives _____ _____

(Two representatives per exhibit space are included in registration fee. Additional representatives are welcome and will be charged $50 for exhibit hall only)

Address _____

City _____ State _____ Zip _____

Type of business/products _____

_____

Phone _____ Fax _____
Area Code *Area Code*

Number of booths: 10X10 regular booths _____

20X20 vehicle booths _____

Make check to: **Texas Health Foundation**
Mail to: **Exhibitor**
Texas EMS Conference
PO Box 142694
Austin, Texas 78714-2694

(1) 10X10 booth	$475	$575 after 11/1/96
(2) 10X10 booths	$900	
(1) 20X20 vehicle booth	$550	$650 after 11/1/96
(2) 20X20 vehicle booths	$1,000	

no refund after 11/15/96 (payment should received by 11/1/96 or should be brought to the conference)

Date _____

Enclosed $ _____

Sponsored by Texas Department of Health and Texas Health Foundation

fee includes two lunches, three continental breakfasts, and snack breaks.

Make your reservations soon at one of the conference's four hotels. The Worthington, a five-star hotel seven blocks from the convention center, offers a $65 rate for one person and a $70 rate for two people, with a $6 per day charge for parking. To make reservations, call (800) 433-5677.

The Radisson Plaza offers a $55 rate for one or two people with a $6 per day parking charge, and is located across from the convention center. Call (817) 870-2100 for reservations.

The Ramada Hotel, one block from the convention center, offers a $55 rate for up to four people with no charge for parking. Call (817) 335-7000 for reservations.

The Holiday Inn Central, about two miles from the downtown convention center has a $45 rate for one to four people with no charge for parking. Call (817) 534-4801 for reservations.

Reserve your hotel room, send in your registration fee with the coupon below, and them come to Fort Worth prepared to see your favorite educators: Scott Bolleter, Don Gibson, Mark Hinson, Neil Coker, Karen Yates, Mark Warren, Joseph Coppola, and Doug Key. And as always, we'll have some new folks who will become some of your favorites. And while you're in Fort Worth, don't forget our traditional Tuesday night EMS party. Plan on some Fort Worth boot-scootin' in the cowboy capital of the Southwest.

Use these coupons to register now at the special conference rate for 1996. Call (512) 834-6700 for information about the conference.

REGISTRANT

TEXAS EMS CONFERENCE '96

REGISTRATION FORM

Call Penny Workman at (512) 834-6700 for registration details

Texas EMS Conference '96
November 24-27, 1996

Name _____

Address _____ Phone _____
Area Code

City _____ State _____ Zip _____

Level of Certification _____
(You do not have to hold an EMS certification to attend)

Do you make purchasing decisions for your firm? _____

Do you subscribe to *Texas EMS Magazine*? _____

Only $75
$90 at the door

(payment will not be accepted by mail after 11/1/96—registration fee should be brought to the conference)

Make check to: **Texas Health Foundation**
Mail to: Texas EMS Conference
PO Box 142694
Austin, Texas 78714-2694

Pre-conference workshop total $ _____

Conference registration $ _____
$75 , $90 after 11/1/96
(do not mail after 11/1/96)

Total enclosed $ _____
(no refund after 11/15/96)

Pre-conference workshop information

Workshop name: _____ Cost $ _____

Workshop name: _____ Cost $ _____

See agenda for a list and registration fees Total $ _____

Texas EMS Conference '96

Texas EMS Conference '96
November 24-27, 1996

The 11th Annual
Texas EMS Conference and Exhibit Show

November 24-27, 1996

Fort Worth-Tarrant County Convention Center
Fort Worth, Texas

Sunday, November 24, 1996

1:00	p.m. -	7:00	p.m.	Registration in the Convention Center
5:00	p.m. -	7:00	p.m.	Welcome Reception in Exhibit Hall (tentative)

Monday, November 25, 1996

7:00	a.m. -	5:00	p.m.	Registration at the Convention Center
8:30	a.m. -	9:30	a.m.	Opening Session
9:45	a.m. -	10:45	a.m.	Workshop Breakouts
10:00	a.m. -	6:00	p.m.	Exhibit Hall Open
11:00	a.m. -	12:00	p.m.	Workshop Breakouts
12:00	p.m. -	2:00	p.m.	Lunch in the Exhibit Hall
2:00	p.m. -	3:00	p.m.	Workshop Breakouts
3:15	p.m. -	4:15	p.m.	Workshop Breakouts
4:30	p.m. -	5:30	p.m.	Workshop Breakouts

Tuesday, November 25, 1996

7:00	a.m. -	5:00	p.m.	Registration at the Convention Center
8:00	a.m. -	9:00	a.m.	General Session
9:15	a.m. -	10:15	a.m.	Workshop Breakouts
10:00	a.m. -	12:00	p.m.	Exhibit Hall Open
10:30	a.m. -	11:30	a.m.	Workshop Breakouts
12:00	p.m. -	2:00	p.m.	Awards Luncheon in East Exhibit Hall
1:00	p.m. -	5:00	p.m.	Exhibit Hall Open
2:00	p.m. -	3:00	p.m.	Workshop Breakouts
3:15	p.m. -	4:15	p.m.	Workshop Breakouts
4:30	p.m. -	5:30	p.m.	Workshop Breakouts
		8:00	p.m.	Designate sober drivers for on-your-own entertainment

Wednesday, November 26, 1996

8:30	a.m -	9:30	a.m.	Workshop Breakouts
9:45	a.m. -	10:45	a.m.	Workshop Breakouts
11:00	a.m. -	12:00	p.m.	Workshop Breakouts
				Conference Adjourns

Sponsored by
Texas Department of Health and Texas Health Foundation

Preconference Classes

November 23-24, 1996

All classes at the Worthington Hotel or Radisson Plaza

Three-day classes

Saturday, Sunday and Monday

Emergency Medical Dispatch
24-hour class $100

Certify in EMD with this three-day class worth 24 hours of CE. The class follows the highly successful King County, Washington, model and is limited to 15 participants. For information, call Mike Polk at (512) 834-6700.

Two-day classes

Saturday and Sunday

Pediatric Advanced Life Support (PALS)
16-hour class $150

Get the highly-popular PALS certification in this class, which awards at least 16 CE hours. Class is limited to 48 students. Presented in conjunction with Cook Children's Medical Center. For information, call Joyce Moore at (817) 885-4170.

EMS Managing Hazardous Materials
16-hour class $35

Come see how EMS can respond to Hazmat in this hazardous materials class designed specifically for EMS responders and get 16 hours of CE. Class limited to 50 students. For information, call Louis Berry at (512) 834-6700.

One-day classes

Rural/Volunteer Track
6-hour class $20

This six hours of CE will focus on rural and volunteer issues such as funding, coverage and transport. The class is underwritten by the Local Projects program and is limited to 100 participants. Lunch will be included. For information, call Penny Workman at (512) 834-6700.

Coordinator Class
8-hour class $100

Take the training you need to become a course coordinator. This class does NOT award CE, but after taking the course, if you meet other requirments, you will be prepared to take the coordinator exam. Limited to 50 participants. For information, call Heather Godinez at (512) 834-6700.

High Angle Rescue
8-hour class $25

This popular class held on the convention center parking garage fills up fast, so hurry if you're interested. The class awards eight hours of CE and includes all necessary equipment. Strictly limited to 25 students. For information, call Rod Dennison or Mike Foegelle at (817) 778-6744.

START Triage
3-hour class $20

START Triage (Simple Triage and Rapid Treatment) is a simple, step-by-step triage and treatment method to be used by first responders to multi-casualty incidents. This class awards three hours of CE credit. For information, call Amos Hunter at (512) 834-6700.

Emergency Plans Development
4-hour class $10

One of the most difficult tasks assigned to an emergency management planner is to develop plans for health and medical response and recovery actions following a catastrophic disaster. This course will lay the groundwork for developing these plans. It does NOT award CE. For information, call Sam Wilson at (512) 834-6700.

Preconference workshop details

1. Participants MUST preregister for preconference classes. The cutoff date for sending your application AND money is October 15, 1996. The registration form is on page 11 of this issue. Be sure to write which class you're registering for on the form.

2. No refunds will be given after November 1, 1996.

3. All classes will be at the Worthington or the Radisson Plaza in downtown Fort Worth. The exact class times and locations will be published in the July/August issue. We have special hotel rates beginning Friday night at both hotels.

4. Any class that doesn't meet a minimum number will be canceled on October 20, 1996, and refunds will be issued to those who signed up.

Other preconference activities:

Valsalva Competition, Sunday and Monday. Call TAEMT at (409) 345-6352.

DWI Programs meeting, Saturday and Sunday. Call Thelma Lemley at (713) 331-8842.

Frequently Asked Questions: *Education*

By
Jeffrey L. Jarvis

I've heard that the CE Rule changed in December. What's new in it?

The CE rule was revised on December 29, 1995. Most medics will only be affected by the new content areas. The table below shows the new areas and required hours. Anyone who recertified after December 29, 1995, will report their hours in this format. If you have accumulated hours according to the more specific content areas in the old rule, you can still count them. Simply place them in the appropriate new areas.

Some of the other changes were semantic. Instructor Directed Activities were changed to Directed Activities and Individualized programs were changed to Independent Study programs. We also rewrote the section that outlined when people would be required to follow the new rule. Our previous wording was based on how many years remained in your certification when the rule went into effect. This was confusing so we now describe it based on your certification expiration date. The bottom line is still the same.

We removed several restrictions which made it difficult for rural EMS providers to attain CE. There was a 50% cap on self-study courses such as the CE articles in *JEMS, EMS* and *Texas EMS Magazine*. There was also a 15% cap on the number of hours available by publishing an article in a peer-reviewed journal. Both of these caps have been lifted.

Content Area	Paramedic Minimum	EMT - I Minimum	EMT Minimum	ECA Minimum
Preparatory (General patient assessment; shock; airway management; general pharmacology)	8	8	4	2
Trauma	10	7	4	3
Cardiovascular	8	3	2	1
Medical Emergencies	11	11	10	4
Special Patients (Geriatric; Pediatric; Neonatal; OB/GYN; Behavioral)	11	7	4	2
* Minimum Content Hours	48	36	24	12
** Additional CE Hours	32	24	16	8
Total Hours	80	60	40	20

* Minimum content hours also meet formal refresher course requirements.
** Additional CE hours may include: rescue/extrication; communications; emergency driving; docum/medical/legal; management; administration; education; and content area subject matter.

Finally, we defined a formal refresher course. It must be offered by an approved initial training program, must cover the minimal two-year CE requirements and must offer skills-proficiency verification to students.

I've heard that there are going to be RollOuts throughout the state. Do you have a schedule of these dates?

Saturday	May	4	Lubbock
Saturday	May	11	El Paso
Friday	May	17	Austin
Friday	Jun	7	Tyler
Saturday	Jun	15	Victoria
Saturday	Jul	13	Harlingen
Saturday	Jul	20	Corpus Christi

Who must attend a RollOut?

All certified coordinators must attend a RollOut. Certified instructors must either attend a RollOut or complete a computer-based training program which will be available from TDH by the end of the summer. Attendance at one of the national RollOuts is also acceptable.

I attended a RollOut and got a copy of the curriculum disk. I was able to extract all of the files but I can't seem to open the Basic curriculum. I'm using MS Word 6.0. What's wrong?

First, do not adjust your computer. The problem is with the curriculum itself. It was written using Word Perfect 5.1 and each chapter was saved as a separate document. These separate documents were then condensed into one file. WordPerfect 5.1 or later has no problem opening this file; MS Word cannot. We have tried several different means of converting the file but have so far been unsuccessful. We're contacting NHTSA to ask them to convert it from the master documents.

Up to Your Standards

By Phil Lockwood

Subscales *I understand failure of subscales will no longer cause me to fail an exam. Is test date or grade date used to make that determination?*

If your test date is on or after December 29, 1995, you will not be required to pass critical subscales.

Testing *If I don't pass my initial certification exam within 180 days of the course completion date, how long am I eligible to reattempt certification by completing a refresher course and testing [again]?*

Until one year after the original course completion date.

I was unable to complete certification within the 180 days after my course, but at that time, I was informed that I had two years to complete a refresher course and test. Does this new rule cause me to lose the second year? I turned down an earlier refresher course, thinking I had more time.

Those who completed a course before December 1, 1995 will be "grandfathered" in; that is, allowed the full two years from course completion, as allowed at the time of course completion.

Provisional Certification *I heard provisional certification is now allowable based on successful completion of an approved EMS course. How does this work?*

A licensed provider who elects to recognize it may allow such an employee or volunteer to serve as the second staff person, if someone fully certified at the same or a higher level is working with the individual. This provisional certification may continue for up to six months past course completion, but ends immediately if the individual fails the certification exam.

Certified personnel are required to present a certification identification card. What do I have to show to provide proof that I'm allowed to staff an ambulance as a 'provisional'?

A copy of the section of the applicable EMS rule, along with a copy of the course completion document will be sufficient. EMS providers choosing to implement provisional certification are encouraged to contact local enforcement personnel, such as city inspectors, to inform them of this rule revision.

Two-Year CE Report *How do I know if I have to submit a two-year report summarizing the CE hours I completed during my first two years of certification?*

Anyone whose certification expiration date is 9/30/98 or later will have to submit the report at the two year anniversary of certification, or the certificate will be suspended. Beginning February '96, we began sending notices and forms on which to report your first two years' worth of CE accrual.

What if my certificate was issued before that? Will the report I submit for recertification change?

Beginning February 1996, we will begin sending a two-part CE summary form with our 180 day recertification notices, for those whose certification expires in September 1996 or after. One of the CE summary blocks will prompt you to report on CE hours accrued in the specific content areas redefined in the revised continuing education rule (effective 12/29/95), §157.38. You should report on the preapproved CE hours you accrued after 9/1/94 on this new form, which outlines the specific content area required. The other part requires only a summary of the total hours completed during the appropriate years.

I am a volunteer with the local volunteer fire department. Since all fire departments are first responder organizations, I 'm exempt from paying a certification fee, right?

Only if the organization is currently registered with the Texas Department of Health's Bureau of Emergency Management. This two-year registration requires that the group submit an application to TDH and must be renewed accordingly. Ask to see their letter of registration acknowledgment before taking their registration or your fee exemption for granted.

Certificates *I completed EMT school and passed the certifying exam a while back, but I received only a wallet-sized certification identification card. Tell me again why I didn't get my certificate?*

Our old mainframe computer had a problem adapting to the new millennium, and could not print certificates showing the year 2000 without considerable reprogramming. A new Client/Server computer system, now on-line, enables us to more efficiently produce the certificates. We will begin sending the new, higher-quality certificates as soon as possible.

Local and Regional EMS News

Is your EMS service mentioned in Local and Regional EMS News?

It needs to be! Are you planning a fundraiser? A training class? A public education program? Do you have new people on board? Elected new officers?

Send your news to:
Texas EMS Magazine
Kelly Harrell, Editor
Bureau of Emergency Management
1100 West 49th Street
Austin, Texas 78756-3199
(512) 834-6700

We welcome letters to the editor on EMS issues, magazine articles, or other topics of interest. We print letters to the editor as we have space.

Carrollton Fire Department receives national accreditation

Carrollton Fire Department has received accreditation from the Commission on Accreditation of Ambulance Services for its compliance with national standards of excellence. Carrollton Fire Department becomes the first fire department ambulance service in the country to successfully complete the voluntary review process.

Sabinal holds DWI-awareness program

Sabinal EMS, Sabinal CISD, and TDH's Public Health Region 8 sponsored a DWI awareness program in Sabinal, staging a head-on collision in front of the Sabinal High School. Four high school students were moulaged as victims of an alcohol-related accident, one with fatal injuries. A Uvalde policeman, playing a drunk driver, got only a few moulaged scratches. The student body saw the extrication of the crash victims and then were told about the dangers of drinking and driving in a presentation given by DPS, DARE program workers, TDH, Sabinal EMS, and other agencies. Students were allowed to tour the crash scene and emergency, local government and state personnel answered questions.

Two new employees in the TDH Houston office

Kevin Veal from Beaumont recently joined the Public Health Region 6 office as an EMS Program Specialist. Veal worked in EMS for six years and is certified as a paramedic. Margaret Hernandez from Garwood is the new administrative assistant for the PHR 6 EMS office. PHR 6 covers the Houston area.

A moulaged Sabinal High School student receives medical aid from firefighters. As part of a DWI awareness program, Sabinal High School students observed emergency personnel removing four injured persons from a staged alcohol-related collision.

Local and Regional EMS News

North San Jacinto Rural EMS sponsors Open House

North San Jacinto Rural EMS, Inc., in Point Blank held an Open House in last November to celebrate the opening of a new ambulance building. Ready Teddy was on hand to give out EMS brochures.

North San Jacinto EMS recently celebrated the opening of a new building to house its ambulance. Members of Rural EMS, Inc., are, from left, Ray Agostinetti, Betty Liebert, Donnie Langley, Bob Hill, Margaret Hill, Jesse Oates, Sharon Jackson, Ready Teddy, Wanda Wright, Jack Langley, Carol Bennett, Rose Hopkins and Wayne Conley.

Wimberley EMS donates ambulance to Blue VEMS

When Wimberley EMS purchased a new ambulance, they decided to donate their other unit to Blue First Responders. Blue FR then held a benefit auction and chili supper, raising $8,000 to equip, license, insure and certify the ambulance. In March 1996, the ambulance became certified and is now transporting patients in Lee County. And Blue FR took on a new name: Blue Volunteer EMS.

Blue VEMS members stand next to the ambulance that Wimberley EMS donated to them. Standing, from left, are Kathy Wester, Tracy Mixon, Glenn Poole and Daniel Melton. Kneeling, from left, are John Wester, Travis Kuehn, Kay Kramer and David Peterson.

Trinity Peninsula Ambulance Association welcomes new members

Trinity Peninsula Ambulance Association has grown by two new members. Sharon Pitts and Sabrina Stump, certified as ECAs, now volunteer with the group.

Falls County EMS delivers New Year's baby

Falls County EMS was recognized by *The Marlin Democrat* for aiding a pregnant woman in labor. Paramedic Chuck Peterson of Falls County EMS assisted a Marlin resident giving birth to a baby boy in the Falls County EMS parking lot on New Year's Day. After the birth, the mother and child were transported to Hillcrest Memorial Hospital in Waco.

Rosebud VFD/First Responders buy beepers

Rosebud VFD/First Responders have begun to make their beeper system operational by purchasing beepers to contact personnel during emergencies. They are now raising funds to purchase a radio frequency and

to get storage space for the equipment.

High school students compete in EMS competition

High school seniors from the Academy of Science and Technology of the Ysleta ISD in El Paso competed in the Area 4 Health Occupations Students of America (HOSA) competition in Amarillo in January. The students are enrolled in an EMT-B course offered at the academy through El Paso Community College and will test for state certification in May. The following El Paso students received awards in EMS categories:

Emergency Medical Technician
- Alfred Gunter & David Molina - 1st place
- Hilda Garcia & June Duron - 3rd place
- Harmony Bingham & Fran McDaniels - 4th place

Medical Spelling
- Johanna Bopp - 1st place

First Aid/CPR
- Blanca Vasquez & Justin Davis - 5th place

Extemporaneous Health Display
- Justin Davis - 5th place

Creative Problem Solving
- Blanca Vasquez, Johanna Bopp, Alfred Gunter, & David Molina - 5th place

Fire and EMS personnel extricate EMT Joy Wolfe during a class in Palestine. Trinity EMS, Palestine EMS, Palestine Fire Department and EMT students participated in the class.

Students placing first through third place are eligible to compete in the statewide HOSA competition. The Academy of Science and Technology will be sponsoring 21 students in the state competition.

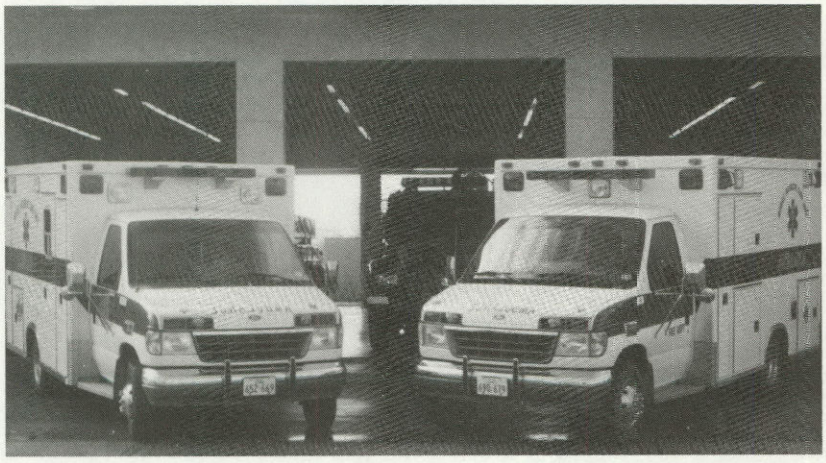
Extrication and landing zone classes held in Palestine

Members of Trinity EMS, Palestine EMS and Palestine Fire Department, and EMT and EMT-I students from Trinity Valley College attended an extrication class and a landing zone class in last December in Palestine. Instructed by EMS course coordinator David Pearse and Palestine Fire Department members, the eight-hour extrication class taught members to remove victims from wrecked automobiles without further injuring the patient. Flight crews from Mother Frances Flight For Life in Tyler instructed class members on types of scene information pertinent to the pilot, and necessary landing area dimensions.

Denison Fire Department/ EMS receives two ambulances

Denison Fire Department/EMS has taken delivery of two fully-equipped MICU ambulances. Texoma Medical Center in Denison purchased the ambulances for the service in a joint effort to raise the level of trauma service in the community. The

Local and Regional EMS News



Texoma Medical Center donated two fully-equipped MICU ambulances to Denison Fire Department/EMS. That brings to five the number of MICU-capable units the service operates.

first ambulance was received in spring of 1994, and the second ambulance arrived last fall. Denison now has five MICU-capable units.

Travis County departments deploy wildfire task force

Responding to a request in February from the Texas Forest Service and DPS, several Travis County area fire departments deployed a task force of firefighters with firefighting equipment to Parker County to assist in controlling a wildfire in Poolville. Fire departments who participated in the task force, C-Bar Fire Department, Cedar Park Fire Department, Hudson Bend Fire Department, Lago Vista Fire Department, Manchaca Fire Department, Oak Hill Fire Department, Austin Fire Department, Westlake Fire Department and Pflugerville Fire Department, volunteered the use of 26 personnel, one water tanker, four wildland engines/brush trucks, and five support vehicles. Austin EMS provided a paramedic, an EMT, a vehicle, equipment and supplies to provide medical support to the firefighters.

Lakehills Chapter of Bandera County EMS holds second annual CPR class

Lakehills Chapter of Bandera County EMS trained 55 citizens in CPR in the second of two annual CPR classes. The classes were held at the Lakehills EMS station and open to the pubic. Lakehills EMS Chapter sponsors two public CPR classes each year to train citizens in CPR.

EMS providers participate in Caldwell County immunization program

Luling EMS and Lockhart EMS, along with the Noon Lions Club of Lockhart, Luling Kiwanis Club, and the Edgar B. Davis Memorial Hospital Employee Advisory Committee, are participating in the "For Their Sake, Vaccinate" program. Designed to increase the percentage of correctly-immunized children under two, the program teams volunteers with parents of newborn children. Each group will follow 25 children for a six-month period, making home visits to provide information on immunizations and preventative health care, check on the immunization status of the children and answer questions. All children in Caldwell County up to age six months will be included if their parents give permission.

Henderson Memorial Hospital EMT braves cold to save couple

Despite freezing temperatures and icy conditions, EMT James Nix of Henderson Memorial Hospital EMS saved three lives by pulling a man and his pregnant wife out of a creek during an ice storm on February 1. While traveling back to their station after transporting a patient, Nix and his partner, Tom Vaught, observed a vehicle spinning off a bridge and plunging into a creek. Both individuals in the car managed to get out of the submerging vehicle and were holding onto overhead brush. Neither could

swim. EMT Nix, also a certified lifeguard, brought both to shore, where they were transported to Nan Travis Hospital in Jacksonville and released after they were found to be in good condition.

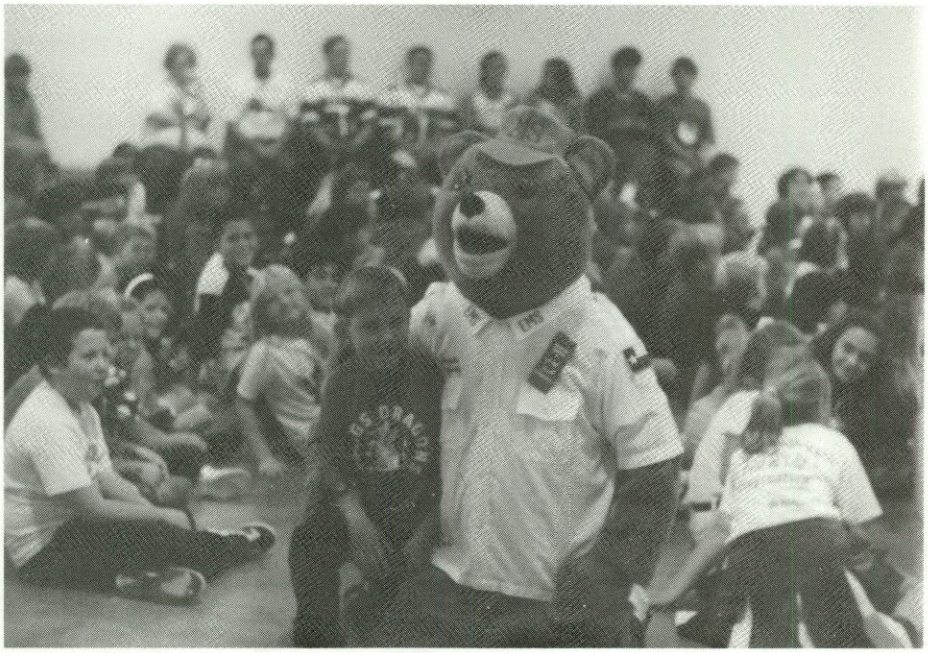
Ready Teddy and Lake Brownwood teach safety at local school

Lake Brownwood Volunteer Fire Department, Bangs Police Department and Ready Teddy recently taught fire safety, drug awareness, and how to call 9-1-1 to 600 children in a Bangs grade school assembly. They again taught injury prevention by participating in the Bangs grade school and Lake Brownwood VFD Halloween Carnival.

Having some fun at the Fire Ant Festival in Marshall are, from left, Jordan Shaw, J.R. Oden, Ready Teddy, Jessica Crooms, and Lea Baker. Marshall Jaycees donated the suit to Marshall Fire/EMS.

Marshall Fire/EMS receive a new bearamedic

The Marshall Jaycees donated a Paramedic Ready Teddy bear suit to Marshall Fire/EMS. Ready has already promoted safety at the Jaycee's Christmas Parade and the annual Fire Ant Festival, and will promote child safety and injury prevention during EMS Week.



Ready Teddy poses with a friend during an assembly at the Bangs grade school. Lake Brownwood Volunteer Fire Department and Bangs Police Department taught fire safety, drug awareness and how to call 9-1-1 to Bangs grade school students.

Local and Regional EMS News

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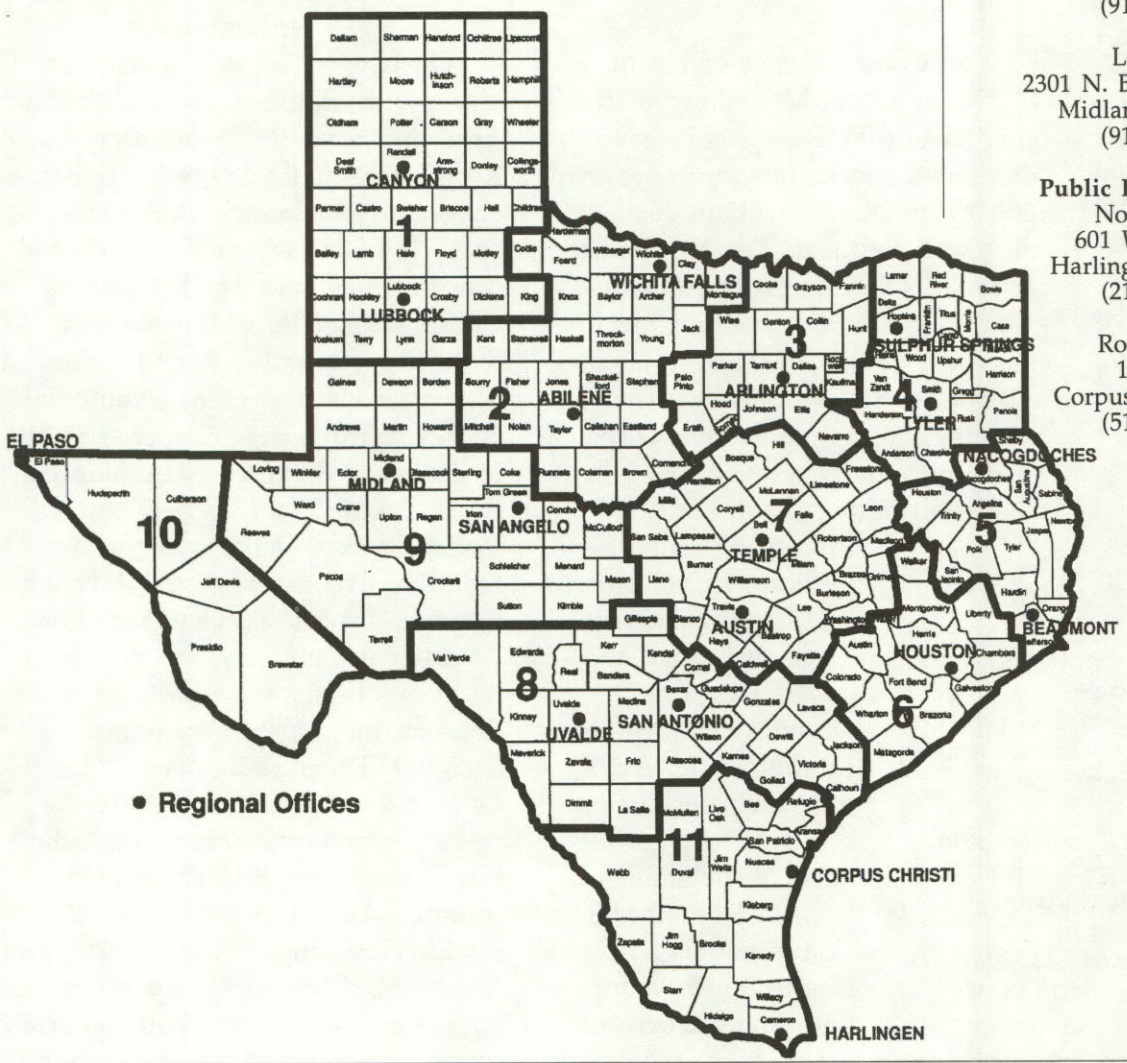


Local Projects trips deliver big (checks)

The trip to Houston brought a Level I trauma facility designation for Ben Taub General Hospital and EMS grants to 13 local organizations. From left to right are Dr. Matthew Wall, Commissioner of Health Dr. David Smith, Dr. Ken Maddox, Charles Rogers of Galena Park, Ben Taub Administrator Lois J. Moore, and heart surgeon Dr. Michael E. DeBakey.

Texas Commissioner of Health David Smith, MD, along with other TDH officials, recently gave ceremonial checks totaling more than $230,000 to 24 recipients in east, south and southeast Texas. The Local Projects Grants program awards grant monies to organizations to increase the quality of prehospital care in Texas, including improvements in training, coverage areas, response times and emergency treatment. In the 95-96 funding cycle, Local Projects awarded $1.3 million in EMS grants to 177 groups across Texas and plans to award the same amount in the coming funding cycle. Additional trips are being scheduled for other parts of the state.

On December 5, Commissioner of Health Smith, along with State Representative Pete Gallego, presented a $1,949 check in Del Rio to Val Verde Hospital; City of Marfa, Presidio EMS and Terlingua Medics were presented checks in Marfa. Later that day, Iraan EMS received $2,403 and Terrell County $25,000 at the Fort Stockton Airport. The last stop was Van Horn, where a Hudspeth County group received $25,000 to purchase an ambulance.

On January 31 in Pearsall, Smith, along with State Senator Judith Zaffirini and State Representative Tracy King, presented a $31,000 ceremonial check to Frio County EMS. On February 9, TDH Deputy Commissioner Carol Daniels and TDH Associate Commissioner Ron Mansolo met State Representative Jerry Johnson in Nacogdoches to present ceremonial checks to three organizations: $1,212 to Timpson Volunteer Ambulance Service; $2,165 to Lilbert-Looneyville Volunteer Fire Department; and $8,110 to Trauma Regional Advisory Council, Trauma Service Area H.

Later in February, Smith presented grant checks to 13 EMS organizations in the Houston area and designated Ben Taub General Hospital as a Level I trauma facility. Receiving grants that day were Aldine Fire Department, $3,900 for ECA training; Austin County EMS, $8,540 for EMT training and a CE program; Beach City EMS $3,975 for rescue equipment; Brookshire-Pattison Area

$1.3 Million Available

The Texas Department of Health will be approving approximately this amount for the funding of local EMS projects. You may obtain a copy of the Request for Proposals by writing or calling:

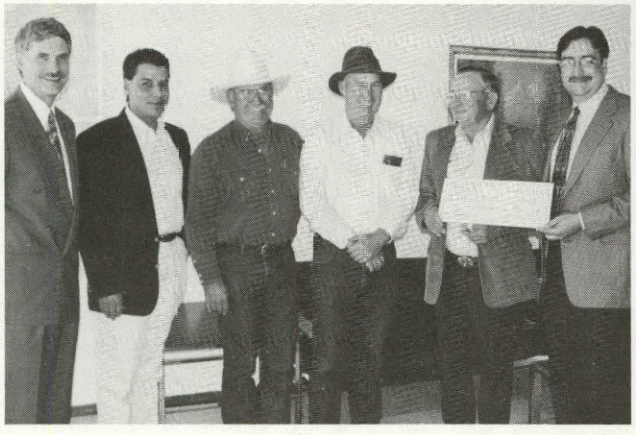
Local Projects and Grants Program
Bureau of Emergency Management
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756 or (512) 834-6700
(Be sure to furnish your address)

Bill Woodward of Frio County EMS, left, accepts a check from State Senator Judith Zaffirini, Health Commissioner Dr. David Smith and State Representative Tracy King. Frio County will use the $31,000 to help purchase an ambulance and upgrade medic skills.

Val Verde Hospital District EMS received $1,949 for computer equipment in a ceremony in Del Rio. From left are Jack Howley of Val Verde EMS, State Representative Pete Gallego, Val Verde EMS Medical Director Ramon Garcia, MD, and Nancy Perry, Chris Wheeler and Wayne Ramsey, all of Val Verde EMS.

Volunteer Emergency Ambulance Corp., $1,740 for a computer; Fairchild Volunteer Fire Department, $1,791 for training tapes and a blood pressure training kit; Galena Park Fire Department, $31,000 for an ambulance and supplies; Jersey Village Volunteer Fire Department, $4,750 for a vital signs monitor; Kingwood Area EMS, $9,890 for an AED; Matagorda Area Volunteer Fire Department, $2,012 for a computer; Medilife of Houston, a group of 13 different EMS organizations, $9,930 for medical equipment and Hepatitis B vaccine; Palacios Area EMS, Inc., $5,226 for a monitor and defibrillator; Riverside Volunteer Fire Department, $968 for oxygen units, vital signs equipment, a trauma kit and vacuum splint set; and Sargent Area Volunteer Fire Department/Rescue, $4,943 for a radio system. —*Penny Workman and Kelly Harrell*

At the Nacogdoches airport, Nacogdocies area organizations received checks. From left are Judi Brashears of Lilbert-Looneyville VFD, State Representative Jerry Johnson, and TDH Deputy Commissioner Carol Daniels. Lilbert-Looneyville VFD received $2,165 to purchase first response medical equipment.



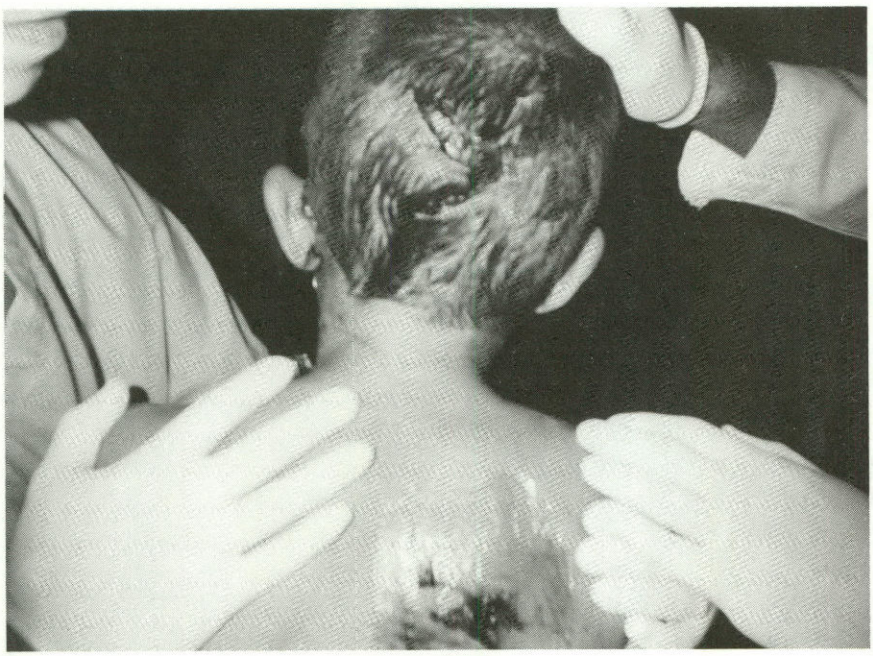
Hudspeth County Emergency Services District #1 received a grant of $25,000 to purchase an ambulance. At the ceremony were, from left, Commissioner of Health Dr. David Smith, Manny Lugan of the county judge's office, County Commissioner Larry Brewton, Kenneth Carr of Hudspeth County Emergency Services District #1, County Judge James Peace and State Representative Pete Gallego.

A veterinarian and paramedic team up to tell you how to respond to an animal bite call—and what you can do to prevent bite injuries in your community.

By
Jane Mahlow, DVM and
John Rinard, EMT-P

Animal Attack!

A 6-year-old boy was standing in the driveway of his house when the neighbor's 100-pound rottweiler mauled him. The child had large portions of his scalp torn from his skull, and one ear was detached at the back of the head. The dog inflicted deep puncture wounds to the boy's body and took large amounts of muscle tissue from his back. Following four days of hospitalization, the child still faces reconstructive surgery and months of weekly psychological counseling. Fortunately, the dog was vaccinated against rabies.



A 6-year-old Katy resident had portions of his scalp torn off by his neighbor's rottweiler in August of 1995 as he stood in the driveway of his house. Even though there is a leash law in Katy, the dog was unrestrained.

This is only one of the 1,017 reports of severe animal attacks on humans received by the Texas Department of Health between 1991 and 1994. These numbers probably reflect just the tip of the injury iceberg because they do not include all bites. The data includes only the reports which were voluntarily submitted by cities and counties in Texas and include only those bites in which the victim sought medical assistance. The reports reveal that children are more likely than adults to be victims of a severe animal bite, with more than half (55 percent) of all reported attacks occurring to youngsters less than 11 years of age. Particularly troublesome is that 82 percent of the children less than 5 years of age and 52 percent of the children 6 to 10 years of age sus-

tained injuries to the face and head, as opposed to 20 percent of the adolescent and adult victims. The difference is due in part to the height of the bite victim. Since 1980, 23 fatalities have occurred in Texas due to dog bites; 17 of the victims were less than eleven years of age.

The Role of the EMS

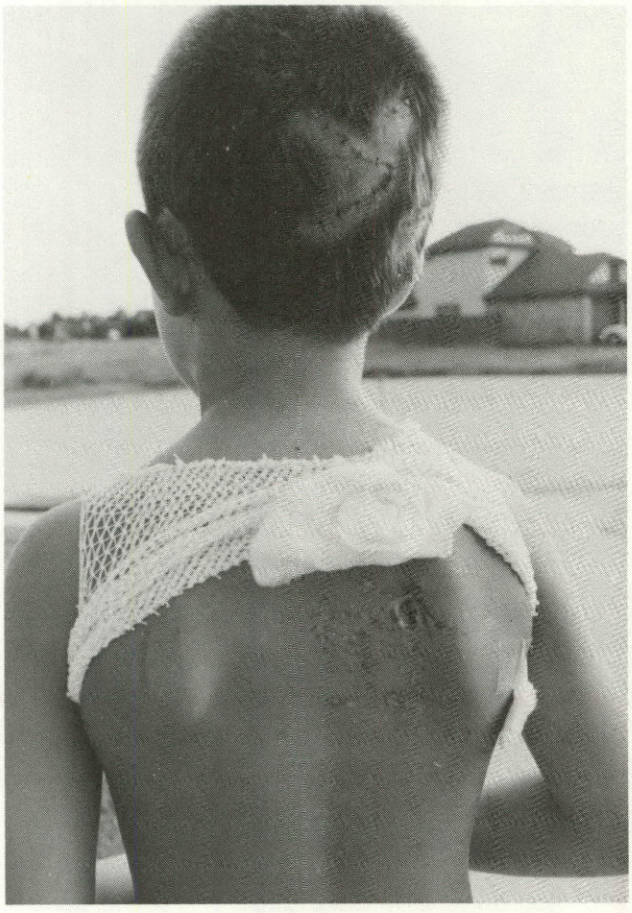
Assess the injury. The alert EMT will realize that the majority of dog bite injuries in a small child occur to the head and neck. Assessment of the airway and breathing efforts are critical; however, you should be watchful for signs of hemorrhage, particularly the jugular veins or carotid arteries. Intracranial trauma is common, due to cerebral contusions, hemorrhage, and skull fractures, and must be addressed. All head injuries should be treated according to locally-accepted protocols with additional concern and assessment techniques used to locate potential crushing skull injuries or a wound with protruding brain matter.

Rabies prevention With any animal bite, there is also concern about rabies. Immediately washing the wound effectively removes the rabies virus in many instances, thereby reducing the risk of rabies and other bacterial infections. The recommended procedure includes flushing the wound with clear water for one minute followed by cleansing with soap and water. Locally-developed protocol should address this simple, yet often overlooked, component of rabies prevention.

Promptly notify the animal control officials. As soon as a reported animal bite has been received, telecommunicatores should activate animal control officers as part of the primary response sequence. With prompt notification, animal control officers stand a much better chance of apprehending the biting dog and quarantining it for rabies observation. Otherwise, if the animal is allowed to escape, the chances increase greatly that the individual will have to undergo shots for rabies prevention. Not only is the series of five injections over a four-week period uncomfortable and time-consuming for the bite victim, the

Bite Prevention

- Never leave infants and young children unsupervised around any dog, even if it is the family pet.
- Make sure the family pet receives plenty of extra attention when a new baby is brought into the home so the pet doesn't feel jealous or that its position in the household is being threatened.
- Spay or neuter the dog. It will reduce aggression but not protectiveness. Dogs who have not been spayed or neutered can be up to three times as likely to bite as those who have been sterilized.
- Avoid breeds that have a reputation for aggression or unpredictable behavior. Local animal shelters would be happy to share this information.
- Train and socialize the puppy early in its life. Do not tolerate any aggression. Even a single nip is too much.
- Teach children basic safety around animals.
- Don't approach strange dogs.
- Avoid obviously dangerous situations such as disturbing a dog who's sleeping, eating, or caring for puppies.
- Let the animal sniff the back of your hand when being "introduced" to it.
- Realize that a slowly-wagging tail may mean fear or apprehension rather than friendliness, and that when a dog shows its teeth, it isn't smiling.
- Running from a dog may provoke attack because dogs naturally chase predators. Don't make eye contact; the dog may consider it a challenge.



Even six days after the attack, a hole remains in the boy's back where the tissue has to regenerate. Nine months after the attack, some scars remain.

average cost for the injections for an adult costs between $1,000 and $1,500. Unfortunately, many rural areas of Texas and even some towns do not have animal control departments, and the community is left to its own resources for apprehending the animal.

Notify the local rabies control authority. Although not every town or county has an animal control department, state law requires that a local rabies control authority be appointed for every location in Texas. The local rabies control authority may or may not be the same individual who is responsible for animal control. The local rabies control authority must be notified of the bite incident so that he or she can make appropriate recommendations for rabies prevention vaccinations. That decision is based on a variety of factors, including whether the animal is available for rabies quarantine or testing, the anatomic location of the bite and whether the bite was provoked, to name a few. You can get the names and telephone numbers of local rabies control authorities by calling TDH's Zoonosis Control at (512) 458-7255.

EMS in the Community

As an involved community member, the EMS provider can take a proactive injury prevention role in reducing animal bites. First, educate yourself on the laws in your community regarding leash restraints, the legality of exotic animals within your area, procedures for declaring individual dogs "dangerous" and investigation protocol for bite cases with regard to rabies assessment. If you feel the laws are inadequate, appeal to your elected city or county officials to strengthen animal control laws. Your first-hand testimony, supported by proper documentation, can have a major impact on your officials' attitudes and viewpoints.

Second, use your position in the community to get the word out. Bite prevention information can be distributed through the newspaper or local television and radio stations. Likewise, presentations to local Rotary, Kiwanis, or other civic groups will yield beneficial results. The advice listed on page 25 is particularly useful for talks to PTAs, Scouts, grade school classes and other parent or youth organizations.

Stories from other survivors

As a result of an attack on her son, Dynette Espinosa has begun a organization called Survivors of Dangerous Animals (SODA). Espinosa is asking for stories from other survivors, or others interested in the subject to contact SODA between 9 a.m. and 9 p.m. CST at (713) 492-8550, or write 20406 Blue Beech, Katy, Texas 77449, or email at soda@neosoft.com

DNR Update

Progress on DNR legislation and what it means to you

Over the past few months you may have read articles or heard rumors that legislation had passed that allowed for development and issuance of an Out-of-Hospital DNR order. Well, the rumors are true. Here is the information regarding progress on DNR and what it all means to you.

What does the legislation do? The legislation allows a terminally ill patient the option of having their physician issue an order to out-of-hospital care givers which documents wishes concerning end-of-life issues. Once a properly executed order or identification device is found, out-of-hospital providers will have the ability to withhold or withdraw CPR, artificial ventilation, intubation or other advanced airway procedures, defibrillation, transcutaneous cardiac pacing, and cardiac resuscitation medications from the patient in cardiac or respiratory arrest.

What's happened so far? An implementation committee was assembled and is addressing these issues: design of a standardized registration form, design of identification devices to be used by registered patients, drafting of a rule and procedure to govern the process, and development of educational materials to introduce the program. The committee is made up of members representing EMS, fire service, hospice organizations, professional associations, physicians and home health agencies across Texas.

What is involved in implementing the program? By statute, the Board of Health and the Board of Medical Examiners are key regulatory agencies involved in approving various components of the process. The form and rule recommended by the implementation committee will be printed in the Texas Register. Following this printing, there will be a 30-day period in which the Bureau will receive and compile public comments prior to presentation of the final product to the Board.

When will the form become available for use? The actual date of implementation will depend on ratification by the Board of Health. Following the last successful vote by Board members the form and identification devices will be available for distribution and use.

Where can I get a copy of the legislation to review? The entire bill was reprinted in the July/August 1995 issue of the *Texas EMS Magazine*.

What do I do until the Board approves the Out-of-Hospital process? The Bureau recommends that until such time as final rules and forms are adopted, EMS medical directors and EMS administrators work together to draft an internal policy to guide field crews in resuscitative efforts involving patients with existing advance directives, e.g. Living Wills, Durable Power of Attorney for Healthcare and "No Code" orders. Once drafted, this policy should be circulated and fully explained to home health agencies, long term care facilities and hospice organizations within your response area. This is necessary to ensure that all persons involved in patient treatment decisions are fully aware of what they can expect from an EMS response, and what responding crews should expect from on scene staff from these facilities.

Where do I go if I need help with this process? I've been assigned responsibility for assisting in the development of these materials. For comments or questions about the process, call me at (512)834-6700 x2359. *—John Rinard*

- What does the legislation do?
- What's happened so far?
- What is involved in implementing the program?
- When will the form become available for use?
- Where can I get a copy of the legislation to review?
- What do I do until the Board approves the Out-of-Hospital process?
- Where do I go if I need help with this process?


LIEUTENANT

By
Mark Hinson, MA, NREMT-P
Photo by Vickie Whitcomb

Continuing Education

Management of Closed Head Injury

Late last fall, a 22-year-old woman was riding her bicycle for her daily exercise. While riding along side a two-lane country road she was struck from behind by a pickup truck. The driver was intoxicated and on his way home from Octoberfest. On arrival, EMS found Sara lying beside the road responsive only to painful stimuli. The paramedics, realizing the severity of Sara's condition, rapidly loaded and transported her to the local trauma facility. Initial assessment found her respiratory rate to be eight and shallow. The paramedic attempted intubation and found that Sara was clinching her teeth. Not sure how else to control Sara's airway, they continued transporting code 3 using a BVM to assist respirations. As they reached the emergency department, she began projectile vomiting and seizing. They quickly wheeled her in to trauma room one. After evaluation, the emergency department physician determined that surgery was needed. The surgeon was called from home and arrived within one hour. Sara was then rapidly taken to surgery to evacuate an expanding hematoma. She was moved to the ICU where she spent the next seven weeks.

Three months later, Sara is alive but struggles to relearn simple tasks such as eating. Her speech is disorganized and hard to understand. With many months of rehabilitation she may begin to return to a self-reliant life-style. Her family, while thankful she is alive, remembers the young active woman that now must have constant help just to eat.

Head trauma is the leading cause of traumatic death. Every fifteen seconds head injury occurs in this country, and every twelve minutes someone dies from head injury. If these statistics do not seem dramatic enough, head injury not only carries with it a high mortality rate, but also may lead to a lifetime of psychological impairment and a need for continual medical care.

Head trauma is an area in which EMS providers can have an major impact. As with other injuries, prompt and accurate evaluation is essential for a favorable outcome. Early intervention may prevent brain hypoxia and cerebral swelling which are associated with a poor prognosis.

In the past it has been taught that to treat head trauma properly you must be able to differentiate specific areas of damage such as epidural, subdural and intracerebral hemorrhage. However, these specific diagnosis have little usefulness when treating head trauma patients in the

Objectives

After completing this article, the reader should be able to:

1. Identify the major anatomical features of the head and skull.

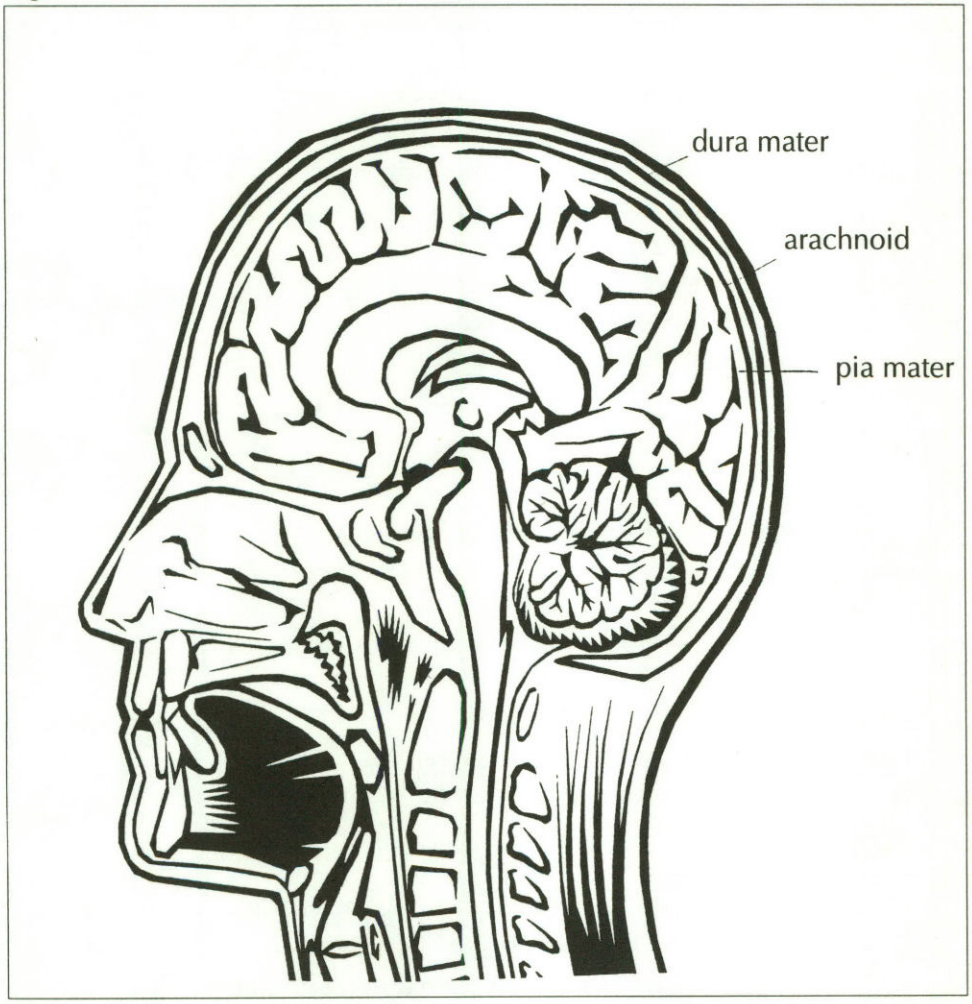
2. Identify the major physiology associated with increased intracranial pressure in head-injured patients.

3. Determine the appropriate theraputic interventions for a head-injured patient.

prehospital setting. We will therefore concentrate on treatments to alleviate the most dangerous aspects of head trauma, hypoxia and increased intracranial pressure (ICP).

Although not essential for field treatment, it is helpful to have a basic knowledge of the head and brain anatomy and physiology to understand what is causing the signs and symptoms experienced by head trauma patients. The head is composed of a rigid skull surrounding soft brain tissue. (Figure 1) The skull is composed of flat sheets of bone which provide a strong but lightweight barrier of protection from injury. The skull protects the brain but also serves as a major mechanism of brain injury. Because the skull acts like a closed box, increases in pressure and volume have little room to expand.

Figure 1



The brain is lined with several layers of protective tissues called meninges. As illustrated in figure 1, the outermost lining is the **dura mater** (tough-mother), a durable membrane which lies just superficial to the **arachnoid**. The arachnoid is a thick membrane which suspends arteries and veins; the delicate **pia mater** (tender mother) lies beneath it. Beneath these membranes, the brain floats in a bath of fluid called **cerebral spinal fluid** (CSF). This nutrient fluid is produced within the ventricles of the brain and flows around the brain to act as a shock absorber as the head moves around in the environment. The CSF is continually recycled and absorbed by the arachnoid membrane.

The brain occupies the entire cranial vault and does not have room for expansion. As the brain is traumatized, it tries to compensate by increasing blood flow to the damaged areas. In cases of cerebral swelling or bleeding within the skull, brain tissue is compressed causing the major pathophysiology associated with closed head injury (CHI).

The factors which commonly cause closed head injury are from external forces acting on the skull, not against the brain itself. These forces usually cause bruising of the brain or cause the brain to shift within the cranial vault. This may tear arteries or veins and result in intracranial bleeding. In cases of deceleration accidents, such as the head hitting the windshield in a motor vehicle collision, the skull strikes the windshield and the brain has a delayed reaction as the force is distributed through the CSF. The brain strikes the inner skull at the point of impact

then rebounds to cause damage to the opposite side of the brain. This reaction is called *coup/contrecoup*. This damage to two opposite sides of the brain can result in twice the swelling and greatly increases the pressure within the cranium.

The interior of the skull is rough and as the brain rapidly shifts within the cranium, these bony protrusions can cause various degrees of injury to brain tissue and may rupture blood vessels. The inner surface of the temporal bones of the skull have many sharp ridges and protrusions. Rapid movement of the brain against this rough area can also cause intracranial bleeding. With this in mind, a patient with an intact skull can still have significant brain injury and need intervention.

The initial response of the brain to a bruising injury is swelling. Bruising causes vasodilatation and increases blood flow to the damaged area. As blood accumulates in the damaged area it exerts pressure on the surrounding tissue. Since there is limited space within the cranium, the excess pressure causes the uninjured areas to be compressed, decreasing blood flow to the healthy tissue.

As the pressure within the cranium increases, blood pressure also must increase to pump needed oxygen and nutrients to the brain. The brain, feeling the need for oxygen, sends signals to the heart and vessels to increase the flow of blood to the brain. The heart increases its force of contraction and the vessels constrict to increase peripheral vascular resistance. This combination increases blood pressure and cerebral perfusion. As more blood is pumped into the cranium, Intracranial Pressure, or ICP, increases and the vicious cycle of head trauma spirals toward death unless ICP is controlled.

The best way to control ICP is early recognition and treatment. One of the earliest and most reliable signs of head injury is altered level of consciousness. Mental status should be monitored continuously and any changes noted. In addition, pupillary dilation, bruising around the orbits or behind the ears and any unusual drainage may also indicate head injury. Later signs of head trauma may include abnormal posturing of the extermities, projectile vomiting and seizures. Careful assessment for these signs may provide clues to the degree of head injury and the need for agressive management.

Initial management of patients with possible closed head injury is similar to any other trauma patient. A general impression of the situation should be made as you approach the patient to determine level of consciousness and mechanism of injury. Cervical spine precautions should be initiated and the airway should be

Table 1

Glasgow Coma Scale

Eye Opening	Spontaneous	4
	To Voice	3
	To Pain	2
	None	1
Verbal Response	Oriented	5
	Confused	4
	Inappropriate words	3
	Incomprehensible words	2
	None	1
Motor Response	Obeys Commands	6
	Localizes pain	5
	Withdraws (pain)	4
	Flexion (pain)	3
	Extension (pain)	2
	None	1
Glasgow Coma Score		
Total		

controlled by whatever means necessary. Assessment of breathing and control of major bleeding should be your next concern. Following this initial assessment a decision should be made as to the patient's transport priority. Altered mental status is the most common finding which should lead you to a rapid transport decision. Any patient with suspected CHI and altered mental status should be transported rapidly to a surgical facility.

An assessment tool that is widely recognized for head-injured patients is the Glasgow Coma Scale (GCS). The GCS measures mental status, motor and verbal response (Table 1). It has been closely linked to patient outcome and helps trend change in patient status. The GCS should be noted as soon as you evaluate the patient and after each intervention. Repeated GCS values are very helpful in determining patient progress. A phrase associated with the GCS can help with the decision of how to control the airway; "GCS of less than eight, intubate."

Vital signs associated with isolated head injury are unique. Blood pressure increases to perfuse the swelling brain. Decreases in blood pressure are usually preterminal signs in head injury and should typically be associated with fluid loss and not increased ICP. The respiratory patterns associated with increased ICP are variable. They can be accelerated or slow, but usually the pattern is erratic. The vagus nerve, which branches from the brain at the brain stem, is the parasympathetic nerve which innervates the heart. As increases in ICP occur, the vagus nerve releases more neurotransmitter (acetylcholine) into the heart. This increase in vagal stimulation causes bradycardia. These can be used to differentiate head injury from other forms of shock (Table 2). This set of vital signs associated with a rise in intracranial pressure is called Cushing's triad. These are not early signs of head injury and their absence should not rule out head trauma.

The most important intervention for any patient, especially those with closed head injury, is airway management. Patients with altered mental status who must be supine on a back board are at a increased risk of airway obstruction and aspiration. Therefore, good management is essential to prevent complications of aspiration and hypoxia. Proper maintenance of the airway is crucial in those patients with increased ICP. As carbon dioxide levels in the blood increase from hypoventilation, the vessels attempt to remove the excess CO_2 by dilation. This dilation in patients with head trauma may cause increased cerebral edema. Therefore, lowering carbon dioxide levels may cause vasoconstriction and reduce swelling. Insuring adequate ventilation may reduce CO_2 levels by eliminating it through the lungs. Respiratory rates of 20-24 with good tidal volume is sufficient to maintain CO_2 at acceptable levels (25-30 torr). Hyperventilation in excess of 24 breaths per minute may cause too much vasoconstriction and lead to tissue hypoxia which is a major problem in head injury.

Basic airway measures can often maintain adequate airway control; however, in the patient with altered mental status, endotracheal intubation is the definitive adjunct to control the airway. In those patients with ade-

Table 2

Vital signs	Shock	Head Injury with increased ICP
Blood Pressure	Decreased	Increased
Pulse	Increased	Decreased
Respirations	Increased	Erratic
Level of Consciousness	Decreased	Decreased

quate control of their airway 100 percent oxygen can help decrease brain hypoxia.

Endotracheal intubation in head-injured patients is a complicated procedure. These patients are often combative, which may make airway management difficult. Also, these patients need cervical motion restriction, which further hampers proper intubation. The maintenance of cervical alignment is necessary when intubating any patient with suspected head trauma. The force exerted to cause head trauma can easily cause spinal trauma as well. One person should be dedicated to stabilize the cervical spine during all intubation attempts.

In conscious patients who need airway control, there are typically two options, nasal intubation or oral intubation after chemical paralysis. Nasal intubation is a valuable tool that can often be accomplished in the conscious patient, and it does not compromise cervical spine alignment. Many patients with head trauma develop increased masseter tone. This is the contraction of the strong masseter muscle of the jaw making it impossible to insert the laryngoscope. Nasal intubation is an option for these patients as well. However, for nasal intubation to be successful, the patient must have spontaneous respirations.

In patients without spontaneous respiration or massive facial trauma, nasal tracheal intubation is not advised. Oral intubation is an alternative; however, most conscious patients will not tolerate it and those with clinched jaws will not allow it. In these cases chemical paralysis is a means of controlling the airway. Drugs called paralytics can be administer intravenously and will stop all muscle activity. This will allow passing the laryngoscope and the oral endotracheal tube. Chemical paralysis is not without concerns. Once the paralytic is administered, the patient will not breath without assistance. Therefore if you cannot successfully intubate the patient, you must have another method available to control the airway until the drug wears off. The duration of action can be from 15-90 minutes depending on the patient and the drug used. BVM ventilation is an option in this case but it is often difficult to do properly and the mask seal may not be adequate in patients with facial trauma. Surgical airway is an option but it requires much training and can be difficult to perform in a crisis. With these consequences in mind, the decision to use chemical paralysis is a difficult one.

There is another consideration when attempting advanced airway control in the head-injured patient. Any manipulation of the pharynx can cause a gag response and this response can cause an increase in ICP. And certainly placing a laryngoscope in the back of someone's throat will illicit the gag reflex. To minimize this, 1-1.5 mg/kg of lidocaine can be administered prior to an intubation attempt. Lidocaine stabilizes membrane potentials and may prevent the ICP changes associated with gagging and intubation.

Children respond differently to intubation than adults. The stimulation of the pharynx may cause significant bradycardia. This may reduce cerebral blood flow and worsen tissue hypoxia. Therefore, administering an agent to increase heart rate such as atropine may counteract this response.

With all of these drugs to consider, it is challenging to provide advanced airway management in the head-injured patient. These techniques can be life-saving but they can also lead to deteriorating outcomes with prolonged hypoxia. However, with practice and

good medical direction, these skills can be safe and effective for most prehospital providers.

Once the airway has been secured and bleeding controlled, transport should be initiated. All patients with suspected head trauma should be transported to a trauma facility so that surgical repair, if neccesary, can be done as soon as possible. Evacuation of the accumulating blood is the best definitive treatment and should be done by a neurosurgeon. Neurosurgical services are typically only readily available at a Level I trauma facility. Therfore, transport to a facility without surgical support may prolong life-saving treatments. Aeromedical transport may be a method of getting patients from rural communities to major hospitals for surgical evaluation.

A simple intervention such as raising the head of the backboard 30 degrees can help drain fluid from the head and slow down increases in ICP. Peripheral venipuncture should be initiated but should not delay transport. The fluid of choice for head trauma is normal saline. It can serve as a volume replacement fluid if needed and it is compatible with blood and other drugs used in treating head trauma. In patients with signs and symptoms of increases in ICP, treatments to help lower ICP should be considered. Mannitol is a drug which may help lower ICP. It is an osmotic diuretic, a drug that causes fluid to be removed from the head by increasing the amount of fluid that is eliminated by the kidneys. Mannitol is given intravenously and the dosage range is 0.25 - 2.0 grams/kg.

Mannitol use is controversial in the prehospital setting. It does decrease ICP by shrinking the swollen brain tissue. However, this may create more room for further bleeding and worsen the condition. Mannitol also causes a condition known as rebound. After the Mannitol has removed all of the fluid, its osmotic shifts can cause rebound increases in ICP. With these things in mind Mannitol can be used to decrease ICP in those patients with evidence of increased ICP and herniation. However, surgical support should be readily available to definitively control ICP.

Seizures are a common side effect of head trauma. They can lead to deadly hypoxia and may further increase ICP. Control of seizures in head-injured patients is similar to other types of seizure management. Protection of the airway and prevention of aspiration are important to ward off hypoxia. Initial drug therapy for the convulsions can be accomplished with one of the benzodiazapines, such as Valuim or Ativan. Once the initial seizure has been stopped, a long-acting agent such as Dilantin is usually recommended to inhibit subsequent seizures.

The management of patients with closed head trauma can be challenging. These patients rarely have isolated head injuries and we are forced to deal with multiple injuries. The most effective method to assure good treatment is first to recognize the signs and symptoms of head injury and to start treatment early. To prevent the two most harmful side effects of head injury, assure your patient is well-ventilated to prevent tissue hypoxia and to decrease ICP. We must also realize that in the prehospital setting we cannot cure head injury. The definitive treatment must be at the hospital and the sooner our patients can be evaluated and treated by a neurosurgeon, the better the outcome.

1. Which of the following is the most reliable indicator of closed head injury?

   a. Low blood pressure
   b. Tachycardia
   c. Altered mental status
   d. Blown pupils

2. The Glasgow Coma Scale evaluates?

   a. motor response, gag reflex, verbal response

   b. eye opening, motor reponse, verbal response

   c. eye opening, pupillary response, motor reponse

   d. verbal resonse, pupillary response, motor response

3. Select the correct statement regarding the Glasgow Coma Scale.

   a. A score of three is normal

   b. A score of seven represents coma

   c. A score of 12 represents brain death

   d. A score of 15 is indicative of poor prognosis

4. Cushing's triad is an early indicator of head injury.

   a. True b. False

5. Early signs of increased intracranial pressure include:

   a. nausea, vomiting, decrease in pulse and respiratory rate

   b. headache, nausea, vomiting, and altered level of consciousness

   c. widened pulse pressure, decreased pulse, altered level of consciousness

   d. increased systolic pressure, widened pulse pressure, decrease in pulse and respiratory rate

6. Descriptive terms such as "drowsy," "lethargic," and "obtunded" should be used to describe a patient's level of consciousness

   a. True b. False

7. You are called for a 24-year-old victim of a motorcycle crash. The patient was not wearing a helmet. Examination reveals blood and teeth in the mouth, an open fracture of the right femur with significant bleeding, and abrasions over the upper and lower extremities, chest, and face. Your highest priority in the management of this patient will be to:

   a. manage the patient's airway
   b. immobilize the femur fracture
   c. control bleeding from the right femur
   d. evaluate the patient for associated injuries

8. The membranes surounding the brain are called?

   a. the peritoneum
   b. meniges
   c. cranial sheaths
   d. cerebral mater

9. The mechanism of injury associated with striking the head against the windshield of an automobile, and the brain is bounced between the anterior and posterior skull is called?

a. distraction
c. coup/contrecoup
b. lateral bending
d. hyperrotation

10. Head injury patients need detailed assessment and time should taken on scene to start IV's and evaluate vital signs to assure proper diagnosis.

a. True b. False

11. A 23-year-old patient has suffered severe maxillofacial trauma with gross deformity of the structures of the midface. The most appropriate management of this patient's airway should include:

a. mouth to mouth
b. EOA
c. nasotracheal intubation
d. bag-valve-mask ventilation

12. Why is hyperventilation important in the head-injured patient?

a. hyperventilation increases the level of CO_2 resulting in cerebral vasodilation

b. hyperventilation decreases the level of CO_2 resulting in cerebral vasodilation

c. hyperventilation decreases the level of CO_2 resulting in cerebral vasoconstriction

d. hyperventilation increases the level of CO_2 resulting in cerebral vasoconstriction

13. Cushing's triad is associated with:

a. cardiac tamponade
b. massive hemothorax
c. tension pneumothorax
d. increased intracranial pressure

14. A patient who opens his eyes in response to pain, makes no verbal response, but withdraws from pain has a Glasgow Coma Score of:

a. 3
b. 5
c. 7
d. 11

15. Select the appropriate rate for ventilators in an unconscious patient with a head injury.

a. 16-18
b. 20-24
c. 26-30
d. 32-36

This answer sheet must be postmarked by June 20, 1996.

CE Answer Sheet #4 — May/June 1996 *Texas EMS Magazine*
"Management of Closed Head Injury" Pages 28–37

Name_____ SSN_____

Certification Level_____ Expiration Date_____

Organization_____ Work Phone_____ (*area code*)

Address_____ (*street*) City_____

State_____ Zip_____ Home Phone_____ (*area code*)

For TDH CE credit, mail your completed answer sheet to:

Debra Cason, RN, MS
EMS Training Coordinator
The University of Texas
Southwestern Medical Center
5323 Harry Hines Boulevard
Dallas, Texas 75235-8890

You will receive your certificate for 1.5 hours of CE about six weeks after the closing date. A grade of 70 percent is required to receive CE credit.

Answer Form

Check the appropriate box for each question.

1.	a.☐	b.☐	c.☐	d.☐
2.	a.☐	b.☐	c.☐	d.☐
3.	a.☐	b.☐	c.☐	d.☐
4.	a.☐	b.☐	c.☐	d.☐
5.	a.☐	b.☐	c.☐	d.☐
6.	a.☐	b.☐	c.☐	d.☐
7.	a.☐	b.☐	c.☐	d.☐
8.	a.☐	b.☐	c.☐	d.☐
9.	a.☐	b.☐	c.☐	d.☐
10.	a.☐	b.☐	c.☐	d.☐
11.	a.☐	b.☐	c.☐	d.☐
12.	a.☐	b.☐	c.☐	d.☐
13.	a.☐	b.☐	c.☐	d.☐
14.	a.☐	b.☐	c.☐	d.☐
15.	a.☐	b.☐	c.☐	d.☐

By Starr Eaddy

AIDS Awareness

Welcome to AIDS Awareness, a new column that will provide an open forum for EMS concerns and questions about HIV/AIDS. AIDS is unlike other health concerns because it touches the core of our beliefs and ideas. AIDS impacts our work, our relationships and our mortality; all these issues can impact the quality of care we provide.

While many readers work in rural settings and may not have not had contact with a person with AIDS, statistics indicate that will change. Between July 1993 and the end of June 1995, 476,899 American men, women and children were diagnosed with AIDS; 295,473 of those people are now dead. Texas ranks fourth nationwide in the number of AIDS cases. Dallas, Fort Worth, El Paso and Houston alone account for 22,763 cases. According to the AIDS Surveillance Report, there was at least one case of AIDS in 220 of 254 Texas counties.

I'll devote about half of each future article to answering your questions or presenting your concerns. I am an EMT and HIV/AIDS educator, advocate and counselor and currently work with people living with AIDS. There are not many questions I haven't heard. Please consider me a resource. I am often available for AIDS lectures, and have reference material on a variety of AIDS issues. Or you can write me with your questions: Starr Eaddy, PO Box 35466, Dallas, Texas 75235. I am aware of the stigma that even a question about AIDS can cause, so you can choose to remain anonymous by simply requesting that your name not be used.

Those of you who work in urban settings may have cared for many people living with AIDS; others may never have had professional contact with AIDS. To put us all on the same wavelength, I will start this series with an introduction to HIV/AIDS.

HIV (Human Immunodeficiency Virus) is the organism that causes AIDS (Acquired Immune Deficiency Syndrome), by disabling parts of the immune system. HIV attacks T-helper (T4) cells, a type of white blood cell. It is the destruction of T-helper cells that wreaks the greatest havoc on the body's ability to fight disease. T-helper cells coordinate the immune response by giving instructions to other types of white blood cells. T-helper cells are like coaches telling the team what to do, matching a player's strength with each position on the team. HIV is the player from the opposing team who is trying to break through the defenses. HIV is tricky because it steals one of our team uniforms and gums up the works by pretending to be one of us, while trying to score points for its own team.

Viruses reproduce by hijacking a cell, in this case T-helper cells, and injecting genetic material into the host cell. The infected cell is then forced to make copies of the virus. The new viruses then repeat the cycle by infecting other host cells. The initial infection stimulates an im-

Starr Eddy is an EMT and HIV educctor living in the Dallas area.

mune response against the virus. Unfortunately, HIV uses the cells sent to fight it as its hosts.

One of the reasons HIV/AIDS is so dangerous to health care providers is that it takes a long time for symptoms to develop. People infected with the virus can be healthy for several years, unknowingly spreading the disease. When an individual is infected with HIV, called seroconversion, they can spread HIV immediately, even though they may not have any symptoms or even know they've been infected. Once HIV enters the bloodstream, the immune system goes into action and antibodies are formed immediately, although the level of antibodies will not be high enough to be detected for three months. This period between infection and detectable antibody levels is called the window period.

If a person is tested for HIV during the window period, his or her results would not accurately reflect true HIV status. Testing during the window period is the major cause of false negative and indeterminate results.

Most individuals remain healthy for one to eight years after they become infected. They may be completely unaware they have HIV. This period is especially important in prevention efforts. It is very difficult to convince people that they may feel perfectly healthy and still be infected with HIV. Minor symptoms may occur between three and eight years, and symptomatic HIV or AIDS may take between eight and fifteen years to develop. AIDS is diagnosed when the number of T-helper cells falls below 200 or when the person develops an AIDS-defining illness, commonly known as an opportunistic infection, or OI. Opportunistic infections occur because the immune system has been damaged to the point that organisms are taking advantage of the immune system's weakness.

It is increasingly important for people to get tested for HIV. There are now many medications that can help prevent or fight opportunistic infections. Studies have shown that the earlier treatment is begun, the more effective it is and the longer the person stays healthy.

Do you have more questions about what HIV is or any other topic related to HIV/AIDS? I hope this column will provide a safe arena for discussion. I welcome your comments.

Write Starr Eaddy with your HIV/AIDS questions:

Starr Eaddy
P.O. Box 35466
Dallas, TX 75235

You may remain anonymous by requesting that your name not be used.

Questions? Concerns? Call TDH's AIDSLINE

Texas Department of Health has a toll-free, bilingual information and referral line for HIV, AIDS and related concerns: AIDSLINE at (800) 299-2437. Callers have the option of speaking to a health educator and/or listening to one of four educational tapes. The tapes include general HIV information as well as information on risks, testing, signs and symptoms for HIV. AIDSLINE staff can provide callers with referrals to 294 testing sites and 256 HIV service organizations statewide. Health educators are on staff from 8 a.m. to 5 p.m. Monday through Friday, and the informational tapes are available 24 hours every day. Got questions? Give them a call. —Sylvia Watson, CHES, *Texas HIV/STD Update*

Is Texas

By Sam Wilson

Sand, sun and surf: living on the Texas Gulf Coast has a special appeal. The lure of life on the beach has caused the population along the Texas coast to swell in recent years. Many residents are new to beach life and have never had to think about preparing for a hurricane. Texas has been extremely fortunate over the past few years in that we have not had any major hurricanes. The last major (category 3 or higher) hurricane that hit the Texas coast was almost 30 years ago, when Beulah came ashore in 1967. That makes us overdue for a major storm. And all of the forecasters, prognosticators, seers and wizards are predicting an increase in both the number and intensity of storms over the next decade. The bottom line? Make your plans for *when* a storm will hit, not *if* it hits.

The long season The hurricane season begins June 1st and runs through the end of November. Texas' 621-mile-long coastline borders 21 counties and encompasses about a quarter to a third of the state's population, depending on the time of the year. Any of those 621 miles are subject to hurricane force winds (greater than 75 mph), torrential rains, lightning, and flooding. That's like taking a straight line from Brownsville to Wichita Falls and making that entire distance under the threat of a major catastrophe five months of each year.

Hurricane-strength winds can generate incredible pressure forces on structures and cause tremendous damage. Of greater concern, though, is flooding. Storm surge flooding may inundate areas adjacent to the coast with up to 20 feet of water, enough to cover an average single-story house up to the roof peak. The 1900 storm that devastated Galveston, killing more than 6,000 people, had maximum sustained winds of 115 mph - a low category 3 storm. Most of the fatalities in Galveston were the result of storm surge flooding.

Are you prepared for a major hurricane? Even those living far into the state will

The relatively shallow depth of the Gulf of Mexico, especially near the coast, results in an immense storm surge wherever the storm hits. So keep this in mind: the long hurricane season brings the potential for many kinds of problems from one storm.

Paramedic Sam Wilson helps emergency services agencies plan for disasters as part of the Bureau's Emergency Preparedness team.

In 1970, Hurricane Celia hit Corpus with 130-mile-an-hour winds, with peak gusts near Aransas Pass topping 180 miles-per-hour.

next?

be affected by a hurricane that makes a direct hit on or near the Texas coast.

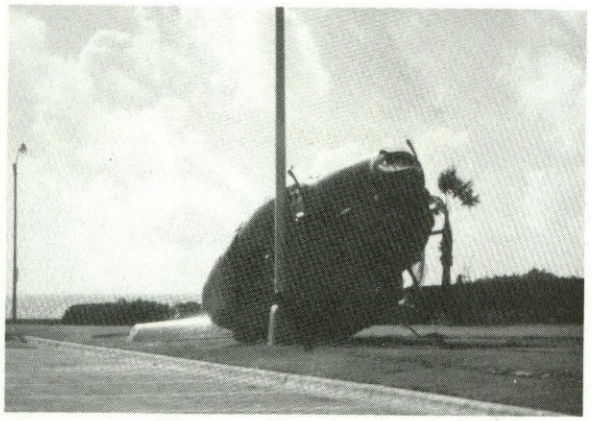
What EMS can do EMS systems providing service to the population along the coast face unique and difficult challenges in preparing for a hurricane. Not only will call volume increase, there is an additional responsibility for providing evacuation assistance to those individuals unable to move themselves.

EMS providers can educate people living on the coast about making preparations for the inevitable storm. These preparations include maintaining a supply of food and water, medications, clothing, radios and flashlights (and batteries!), blankets and bedding materials, and anything they'll need for survival.

Of course, the best possible protection from a major storm is to not be there when the storm makes landfall. Make preparations for evacuation before it becomes necessary. Know evacuation routes and make it part of your public education program. Evacuate early and encourage people to have at least two designated relocation points outside of the hurricane impact area. Residents also need to let friends and family know where they are and where they are going. If they use Red Cross or other public shelters, arrangements for pets and other animals must be made beforehand; most shelters will not allow animals inside.

The EMS system may be involved in evacuation of area hospitals, long-term care facilities, and other residential medical or treatment facilities. Those with special needs (e.g. mobility impairment, medical equipment needs, maintenance medications and/or procedures) must make specific arrangements to meet those needs prior to evacuation. Many shelters will not admit persons who will require anything more than food and a place to sleep because most shelters have neither the staff nor the equipment to address special needs. Local emergency management personnel will usually designate one or two shelters in the area for persons with special needs. Find out where they are and how to access them.

You may also want to educate people about access to emergency services during a storm. Citizens in the area may expect to be able to pick up a phone, dial the local emergency number and receive service in a timely manner. A primary responsibility of the local planner is



Even large helicopters were no match for Hurricane Celia, which blew into Corpus Christi on August 3, 1970. Hurricane Celia caused millions of dollars in property damage in the Corpus Christi area.

to educate the public on some of the changes in expectations that will follow a disaster. For example, triage protocols will often be altered when a disaster plan is put into effect. Relatively minor problems may be either denied service or referred to an alternate agency. The public needs to be aware of this fact prior to the storm.

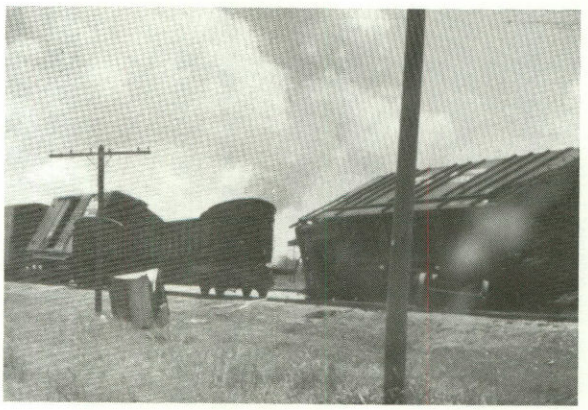
What EMS should remember As a member of the community, an EMS providers bears an obligation to that community to lend assistance during times of crisis. This obligation does not mean that they must place their personnel in jeopardy. Most providers in the hurricane impact area will cease operations when the wind speed reaches 65 mph, due to instability of the high profile vehicles. The residents of the service area must be made aware of this consideration, and realize that EMS may not be available during the worst part of the storm.

Also, emergency service providers will often be among the victims of a disaster, especially in the advent of a major hurricane landfall. Flooded storage facilities, stations damaged by high winds and/or flood waters, loss of radio communications, vehicles unable to operate due to flooded or debris-blocked roadways, lack of uncontaminated fuel and tire shortages will all result in a less-than-optimal response capability. Local hospitals that are still operational will be overwhelmed with people injured as a result of the storm.

No area immune to the effects Although hurricane preparation is mainly directed to EMS providers along the coast, those elsewhere in the state are not immune from the effects of a major storm. A hurricane landfall can have an impact many hundreds of miles inland. For example, Hurricane Allen, a relatively weak storm, came up the Rio Grande Valley in 1981. Many private airplane owners in the coastal area, in an effort to protect their aircraft, flew them to Austin, out of the storm's reach. Unfortunately, the tornados spawned by the hurricane destroyed many of the private aircraft at the Austin Airport, including many that had been evacuated from the coast. As this example illustrates, preparedness is an issue that is not limited to the hurricane impact area along the coast.

Better to be prepared Last season was a record year for the number of hurricanes that formed in the Atlantic and Gulf of Mexico. Once again, Texas avoided any direct impact of a major storm. We cannot continue to count on good luck. Preparedness is the key to survival. EMS can prepare, and help citizens prepare, by educating them about what they need, and what they can expect from emergency services during—and after—a hurricane. For additional information on this or other emergency preparedness issues, contact your local TDH office or the Emergency Preparedness Team in Austin at (512) 834-6700.

Wind gusts from Hurricane Celia were measured at 161 miles per hour at the Corpus Christi National Weather Service Office, enough to topple trains. The storm spawned tornadoes and flash flooding statewide and caused millions in damages, including $7.6 million of flood damage in Dallas County.



Tires???

Why all the concern about tires for ambulances? Think about it. Once the major debris is cleared off the streets, finally allowing for vehicle traffic, what's left? All the stuff that pokes holes in tires, that's what. And that's assuming you can use the road! Cross-country travel in a Type III ambulance is an adventure itself, not counting what is out there for you to run over. One of the major problems encountered over and over in a post-landfall environment is a shortage of tires for ambulances. Without making allowances for that, most EMS units will be out of service following their first run or two. So, add this to your list of things to do: Make sure you have access to enough tires to allow you to operate after the storm passes.

How can EMS providers along the coast, as well as those across the state, be better prepared? Here are some questions that may help with preparation efforts:

1. Do you have a hurricane disaster plan?
2. Is your plan coordinated with the city/county Emergency Management Coordinator?
3. Have you identified and trained staff to respond and implement the disaster plan?
4. Have arrangements been made to care for the families of staff involved in the response effort?
5. Have you identified locations for evacuation?
6. Have you made arrangements for medical supplies, equipment and mutual aid?
7. Are you encouraging families in your jurisdiction to do their own planning? Family Protection Planning will ease the burden on emergency responders by reducing the number of people who require immediate assistance.
8. Have you considered some means of stress management for emergency responders? Critical Incident Stress Management can help emergency workers involved in disasters and other critical emergencies.

Texas Department of Health
Health and Medical
Community Hurricane Evacuation Planning Guidelines

The following are some simple guidelines for developing a plan for a successful evacuation:

1. The management of each health and medical facility has the responsibility to develop an effective plan to evacuate its patients to a safe environment. What facilities? Hospitals, nursing homes, even home health care agencies must have a plan. Each plan must be detailed, accurate, realistic, and coordinated, and therefore "workable."

2. Develop your plan in coordination with other affected organizations within your community and provide a copy of your plan to your local jurisdiction's emergency management director or coordinator for review and coordination. Example: Hospital and nursing home administrators should talk with EMS providers about ambulance support and with local emergency management personnel for warning procedures and evacuation routes. If your plan requires some firm or agency to do a particular job, ensure that they are prepared to do so!

3. Administrators of hospitals and nursing homes, and guardians of other home patients with special needs should determine early, before a hurricane, a safe location or locations where their resident patients can receive satisfactory medical care. What is a safe environment? A safe environment is a comparable facility located well inland from coastal areas that are at risk from the effects of hurricanes. You may need to make contingency agreements with several different facilities in order to house all of your patients. Get agreements in writing.

4. Successful transportation of residents involves coordinated and planned use of the transportation assets of the entire community. What are these assets? Private transportation providers should be the first place to call. Public resources are next; they include transit buses, school buses, church vans, community center vans and others. Keep in mind that during a hurricane evacuation, many different facilities may be evacuating simultaneously and may need assistance. You cannot necessarily count on exclusive use of public resources; advance planning can help ensure that you will have what you need to evacuate when you need it.

5. Ambulances and EMS personnel are scarce assets used to evacuate only patients whose medical condition requires lifesaving care en route to a safe haven. Priorities: 1. Hospitals 2. Nursing Homes 3. Other. To avoid overcommitting, EMS providers should develop written agreements of their commitments and document these agreements in their plans.

6. Prepare "medical packs" (medicines/medical records/hygiene items) to accompany your patients. The list and responsible individuals can be determined beforehand. Identify (and contract for when necessary) sources for special equipment that may be needed to accompany the patient. Example: oxygen for emphysema patients.

7. After resources of commercial providers and the local jurisdiction have been planned for use, identify those residents (if any) that cannot be evacuated. The chief elected official of local government may request state assistance when local resources have been exhausted.

Predicting hurricanes

The Tropical Prediction Center (TPC), part of the National Centers for Environmental Prediction (NCEP), evolved from the National Hurricane Center. Housed on the Tamiami campus of Florida International University in Miami, TPC assists the National Weather Service to protect lives and property from tropical weather hazards. TPC prepares and distributes tropical weather products, conducts training courses for disaster response officials and meteorologists, and educates public officials and the media on tropical weather hazards. During major events, such as the threat of a severe hurricane, TPC personnel provide products and services to all levels of government, private industry, the media, and the general public by providing satellite-based analysis, reconnaissance aircraft data analysis and model guidance. — *Penny Workman*

Hazmat training is available

EMS personnel are required to participate in various levels of hazardous materials training before performing patient care on individuals involved in and possibly contaminated by hazardous materials released at an accident. The level of training required is based on the function to be performed by the EMS responder.

The Texas Department of Health (TDH) in cooperation with the Federal Emergency Management Agency and several host cities will present a 16-hour "EMS Managing Hazardous Materials" course developed by the Agency on Toxic Substances and Disease Registry.

The course is designed to meet SARA and OSHA requirements and NFPA Standards for EMS level 1 competencies. The course is approved for continuing education credit by TDH, EMS Division. EMS personnel attending the course should have already completed Hazmat awareness training.

Courses are currently scheduled in:

McAllen	May 21-23
Eagle Pass	June *
El Paso	July *
Waco	July *
Austin	August*
Port Aransas	August *

* Actual dates of courses not finalized

For more information on this and other training opportunities, contact Louis Berry, Texas Department of Health, Emergency Preparedness Program, 1100 West 49th Street, Austin, Texas 78756-3199 or (512) 834-6740.

—Louis Berry

Saffir/Simpson Hurricane Scale

Scale number (category)	Central Pressure		OR	Winds (mph)	OR	Surge (feet)	Damage
	Millibars	Inches					
1	≥ 980	≥ 28.94		74-95		4-5	Minimal
2	965-979	28.50-28.91		96-110		6-8	Moderate
3	945-964	27.91-28.47		111-130		9-12	Extensive
4	920-944	27.17-27.88		131-155		13-18	Extreme
5	< 920	< 27.17		> 155		> 18	Catastrophic

"Where do you get those questions?"

EMT-Basic exam blueprint outlines how exam questions are chosen

TDH IS IN THE PROCESS OF REVISING THE EMT-Basic exam to reflect the changes in the curriculum. Those changes make it necessary to revise our EMT exam blueprint. Here's the method we used to build the blueprint.

The National Registry of EMTs funded and administered a practice analysis for EMT-Basics and paramedics to determine the frequency and criticality of slightly over 100 tasks. The registry devised a survey and distributed it to EMTs and Paramedics in every state and summarized the results.

Each task was weighted based on a formula of three times the frequency value plus six times the criticality value. This formula assured that infrequently performed tasks which make a critical difference in the outcome of patients when they did occur were evenly weighted in the overall analysis. These tasks were then distributed within the modules defined in the DOT EMT-Basic National Standard Curriculum and averaged.

The number of questions to be asked from each subscale on the Texas certification exam was based on 100 (the total number of active questions on the exam) times the average module weight divided by the sum of all module weights. This formula gave us a range of 13 to 16 questions in each module and reflects the relative balance of material included in the curriculum.

The current EMT-Basic exam databank will need to be rewritten to reflect the assessment-based nature of the new curriculum. This process will involve item-writing groups comprised of practicing EMTs throughout the state. Each item will then be reviewed, revised and pilot-tested to determine its validity. —*Jeffrey L. Jarvis*

EMT-Basic Exam Blueprint

Exam Modules

1.	Preparatory	
	Average weight from practice analysis:	25.00
	Number of questions:	14
2.	Airway	
	Average weight from practice analysis:	28.95
	Number of questions:	16
3.	Patient Assessment	
	Average weight from practice analysis:	26.88
	Number of questions:	15
4.	Medical	
	Average weight from practice analysis:	24.06
	Number of questions:	13
5.	Trauma	
	Average weight from practice analysis:	25.77
	Number of questions:	15
6.	Infants and children	
	Average weight from practice analysis:	23.51
	Number of questions:	13
7.	Operations	
	Average weight from practice analysis:	25.44
	Number of questions:	14
	Total number of questions:	100

Doing the right thing

The older patient who needs to be hospitalized but refuses transport: How far can friends and family go?

By
Jan Brizendine
and
Jeff Rubin

When Dorothy Jamar finally retired, she had been working for Gulf Oil Company in Venezuela for 17 years. She bought a beautiful home in Spain overlooking the Mediterranean Sea. Fourteen years later, Dorothy moved to Austin, Texas, where she had her family and friends.

Dorothy lived alone in a large home on beautiful Shoal Creek and had a great love for her big yard, where she could feed the many birds, squirrels, neighborhood cats and raccoons that came up from the creek.

With such a big yard, Dorothy needed help with all the necessary landscaping. Her dearest friend was Randy Robbins, the man who helped her with her yard for more than ten years. Randy would sit and talk with her for hours after he finished working on her yard. He was almost like a son to her.

In early 1995, Randy noticed Dorothy had begun to lose weight. When he asked her about it, she explained that she needed to lose a few pounds anyway. Each week Randy saw Dorothy and it was obvious that she was losing more weight. He encouraged her to see a doctor. She did not think she needed to see a doctor—a doctor might want to run a bunch of tests and it would all take so much of her time and energy. And, at 81 years old, her energy was in short supply. Randy became so worried, he asked her next-door neighbors if they thought she needed help. They didn't want to interfere but they did think she needed help. By this time Dorothy was so thin that Randy would make up an excuse to stop by to see her. He had begun to check on her almost every day.

Randy persuaded his wife to call and talk with Dorothy's sisters. The sisters knew Dorothy would not listen to them.

They said Randy was the only person that Dorothy would listen to.

Randy asked his wife to call the local EMS. Her question to the dispatcher: "If you send an ambulance to pick up an 81-year-old to take to the hospital and she refuses to go, what happens then?" The answer: "If she is able to answer some standard questions and seems to be okay, we will not take her against her will."

So, Randy had his wife call the Department of Human Services. An official took down careful notes about what had been going on over the last few months with Dorothy Jamar, and dispatched two social workers within 24 hours to see her. They reported that Dorothy was extremely thin and seemed to tire very easily, but she was very alert and her intellectual capability was superior. They could do nothing.

By this time, Dorothy was so weak she was unable to walk very far and was refusing all food. She would only drink a small amount of Sprite. Randy knew he was helpless to do anything, but was checking on her twice a day by this time. She was still refusing any medical treatment.

A few days later Dorothy was so weak she could not move from one chair to another without help. Randy carried Dorothy to her backyard and put her in a comfortable chair under the shade of a huge pecan tree. Although she was still refusing to go to the hospital, Randy decided he couldn't wait any longer and had his wife call 9-1-1.

Randy said a prayer as he walked to the backyard. He hoped he was doing the right thing and at the right time—he was confused. What about her rights? Do you completely ignore someone's wishes? Dorothy was a helpless, lonely little figure looking at her big yard on the creek for what turned out to be the last time.

Randy was not fully prepared for what the 9-1-1 call would set in motion. Within two minutes the wail of a siren could be heard in the distance. In another minute, two big firetrucks pulled to the curb in front of Dorothy's house—men spilled off the trucks in loose-fitting yellow outfits. Two police cars also pulled up. Randy had mixed feelings as he observed the huge group descend on Dorothy's yard—he felt relief and fear. He hurried to talk to some of the firefighters and then went quickly to Dorothy so she wouldn't be afraid. The ambulance was backing into her driveway.

Randy stood quietly by and observed the firefighters, police, and EMS at work. It was a hot August day and they were all in uniform. They all stood patiently while one of the paramedics spoke in a quiet professional conversation with Dorothy Jamar. They had all quickly and efficiently evaluated the situation. Everyone acted as though at that moment in Austin, Texas, the most important thing going on was the well-being of Dorothy Jamar.

—*Jan Brizendine, Texas Department of Health*

On Sunday, August 20, 1995, I was working on Aid 8 with my partner, Barbara Kniffin. We had started our 24-hour shift at 0900. At approximately 1945 we responded to general weakness; the Austin Fire Department, providing medical first response in Austin, was

Jan Brizendine, an employee of Texas Department of Health's Bureau of Emergency Management, is Randy Robbins' wife and cherishes her memories of their friendship with Dorothy Jamar.

Jeff Rubin has been a FF/EMT with Travis County Fire Control/ ESD#4 since 1987 and an EMT with Austin EMS since 1993.

requested as well. Upon our arrival we found an 81-year-old female, Dorothy Jamar, with a minor complaint of weakness, but alert and oriented. EMS had been called by some close friends of Ms. Jamar, without her knowledge. Her friends informed us that she "had not been eating, and had lost a lot of weight." They felt she needed to be evaluated in an emergency room. Ms. Jamar adamantly refused assessment, treatment and transport. Although our further assessment of Ms. Jamar suggested that she might have been suffering from altered mentation, she clearly was in sufficient possession of her faculties to refuse our services. Inspection of her residence yielded the following conclusions: 1) she had spent the previous night in her car, in her garage, possibly because she hadn't been able to get inside the house; 2) her house was disorganized; 3) she appeared unable to provide for her own needs; 4) she possibly presented a hazard not only to herself, but to her neighbors as well, due to potential fire danger. As Barb, along with the family friends, tried to talk Ms. Jamar into voluntary transport, Ms. Jamar became progressively more insistent upon staying, although she did permit limited assessment (blood sugar and vital signs, which were all within normal limits).

Barb Kniffin and Jeff Rubin were in the same EMT class in 1987. Barb has been an EMT with Austin EMS since 1989.

At this point Michael Ramsey, one of four Austin police officers who had responded to the call, entered the discussion and, playing off my partner, began trying to persuade Ms. Jamar to think about getting into the ambulance. Officer Ramsey used gentle persuasion and his attitude showed genuine concern for Ms. Jamar's health and safety. After several attempts, we finally were able to persuade Ms. Jamar to sit on the stretcher and be taken to the Emergency Room at Seton Hospital. Our on-scene time was 35 minutes, almost entirely spent trying to talk our patient into transport.

Upon our arrival at Seton, Ms. Jamar was reexamined. Tests over the next several hours revealed possible malignant masses in her abdomen and brain. More significantly for her short-term health, she was malnourished and dehydrated. After two days of nourishment and hydration, Ms. Jamar became fully alert and comfortable. It was the consensus of Ms. Jamar's friends, her neighbors, her doctors, as well as my partner and me, that Ms. Jamar needed to go to the hospital. It was our opinion that Officer Ramsey's efforts tipped the scales in favor of her agreeing to transport.

This call raised some ethical and, I suppose, legal, questions. At what point is a patient no longer capable to make an informed refusal? To what lengths can or should we go to provide treatment and

Officer Michael Ramsey says his "heart went out to Mrs. Jamar—something had to be done to help her." Officer Ramsey has been with the Austin Police Department for seven years and has a brother who is also a police officer.

transport for a patient who needs care but is adamantly refusing? Ms. Jamar represented the type of patient that we will be seeing more of in the future: non-emergent but still in need of our services. Although we didn't consider a Code 3 response necessary, and a Code 3 transport wasn't even considered, Ms. Jamar needed EMS. In the looming world of managed care, managed cost and ever-growing reduction of services, patients like Ms. Jamar will be the easiest to allow to slip through the cracks. It's up to all of us to see that this doesn't happen. —JEFF RUBIN, AUSTIN EMERGENCY MEDICAL SERVICES, AUSTIN, TEXAS.

Dorothy Jamar lived 12 days after Austin EMS transported her to the hospital. Randy Robbins visited her every day while she was there and says, "I hope I did the right thing. I always respected Dorothy's wishes, but getting Dorothy medical help seemed very important and the only right thing to do at the time."

Age-related health problems

The Washington, D.C.–based Nutrition Screening Initiative has come up with an acronym—DETERMINE—to help providers remember older patients' nutritional risks.

- Disease Any disease, illness, or chronic condition that changes the way a patients eats.
- Eating poorly Eating poorly, both in quantity and quality.
- Tooth loss/mouth pain Missing, loose or rotten teeth-as well as dentures that fit poorly or cause mouth sores—make it hard to eat.
- Economic hardship As many as 40 percent of older Americans have incomes of less than $6,000 per year.
- Reduced social contact One-third of all older people live alone. Being with people daily has a positive effect on well-being, morale and eating.
- Multiple medications The more medicines taken, the greater the chance for side effects like increased or decreased appetite, change in taste, constipation, weakness, drowsiness, diarrhea and nausea.
- Involuntary weight loss/gain Losing or gaining weight without a conscious attempt to do so.
- Needs assistance in self-care Although most older people are able to eat, one in five has trouble walking, shopping, buying and cooking food.
- Elder years above 80 As age increases, the risk of frailty and health problems increases.

—Nutrition Screening Initiative, 2626 Pennsylvania Avenue NW, Ste. 301, Washington, DC, 20037.

What's happening with the Trauma Registry?

By
Gene Willard,
Gulnur Scott
and Jennifer
Hunteman

In 1989, the Texas Legislature passed a bill which led to establishment of the Texas Trauma Registry. Since then, guidelines have been finalized for transmission of prehospital and hospital data to the Texas Trauma Registry:

- Prehospital EMS/Trauma Reporting Guidelines
- Hospital Trauma Reporting Guidelines

These guidelines define how prehospital providers, hospitals and the Texas Trauma Registry can interact to facilitate and improve trauma data collection efforts in Texas.

Additional developments include:

For those prehospital providers interested in entering only the essential data items, there is now a version of TEXEMS computer software in which the essential data items are placed on the first three data entry screens. The desirable data items are also included, but they are placed on subsequent data entry screens. This version of TEXEMS may be obtained by contacting Gulnur Scott at (512) 458-7266.

The Texas Trauma Registry now has two computers for receiving electronic data. They are set to receive data at either 2400 bits per second (bps) or 9600 bps and should be available 24 hours a day, seven days a week.

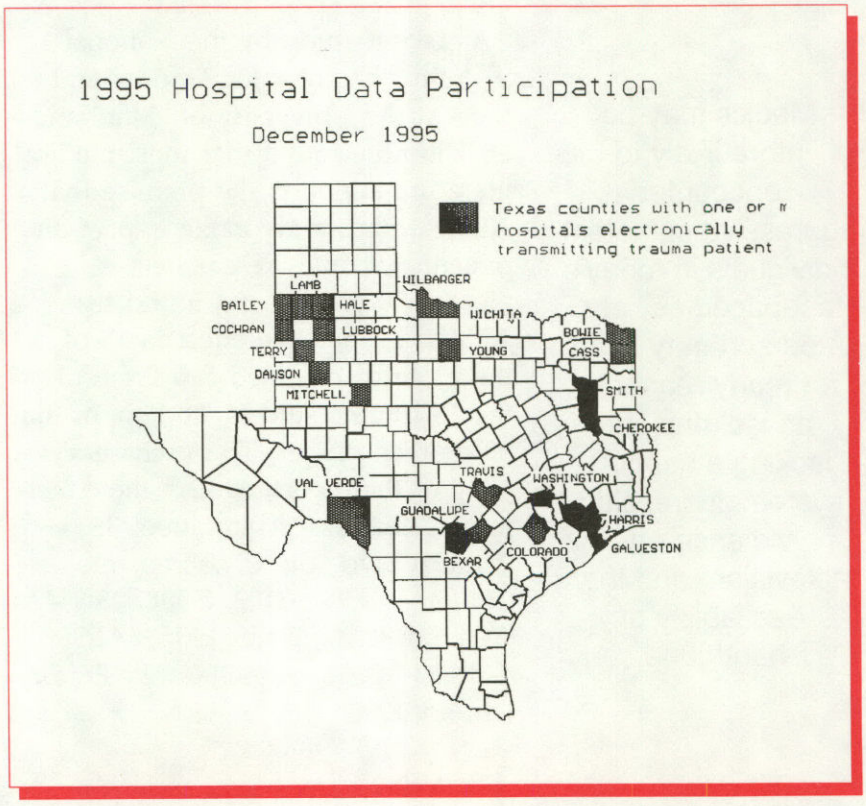
Prehospital and hospital reports based on received trauma data are being placed on electronic bulletin boards at the Texas Department of Health (TDH). A computer communications program called TEXCOM 1995 has been developed to make it easier to access TDH electronic bulletin boards and EPIGRAM software for

Developing a trauma registry for a state the size of Texas is an enormous undertaking. Current rules require quarterly submission of EMS data starting August 31, 1996. Photo by Joni Parr.

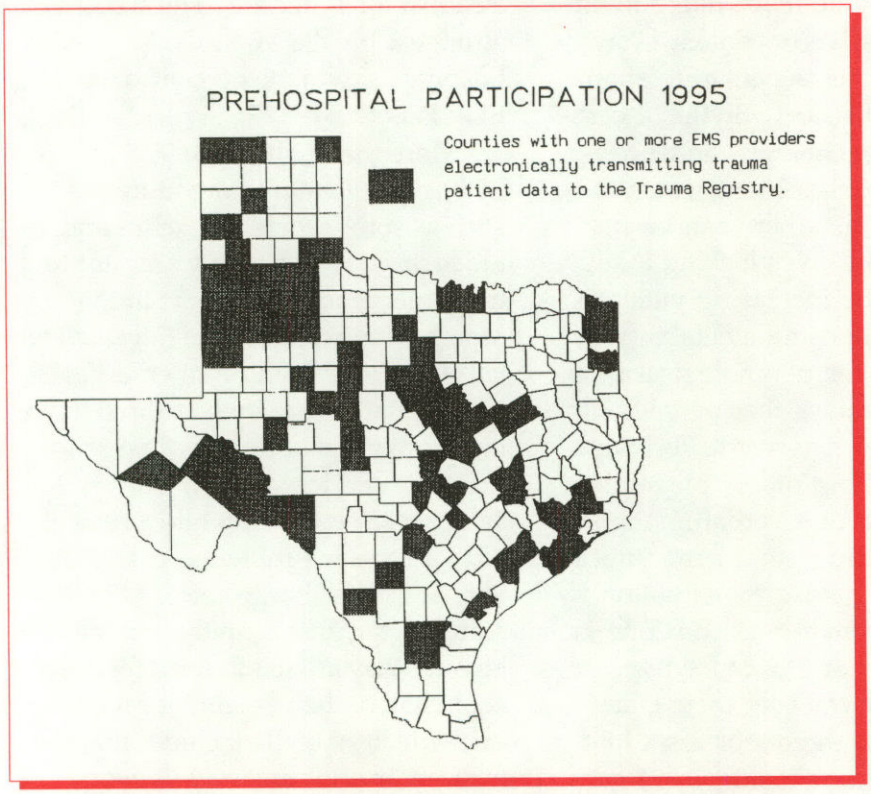
analyzing mortality and population data. TEXCOM 1995 is free software and if you would like a copy, contact Gulnur Scott at (512) 458-7266.

Developing a trauma registry for a state the size of Texas is an enormous undertaking. If you have any comments or suggestions for improving the process, please give the Texas Trauma Registry a call (512) 458-7266.

1995 Hospital Data Participation



1995 Prehospital Participation



Did you read...

By Kelly Harrell

Medics may be more likely to encounter aggressive or violent individuals in today's fast-paced society. A person may snap for many reasons: an isolated life lacking a support system, increasing violence on television, and the availability of handguns.

A recent study by the National Study Center for Trauma and EMS at the University of Maryland at Baltimore found that most medical literature supports the premise that ALS care has a favorable impact on patient outcome. Researchers reviewed 70 articles and found that ALS had a positive effect in 18 of the 21 cardiac-related cases, ten of the 15 trauma studies, and six of the nine other studies. To purchase a copy of the report, contact the American Ambulance Association, 3800 Auburn Blvd., Ste C, Sacramento, California 95821-2102; (800) 523-4447.

From *JEMS*, Inside EMS, "ALS Works," Marion Angell Garza, Editor, January 1996

In today's fast-paced society, medics may be more likely to encounter aggressive or violent individuals. What causes a person to snap? According to Bruce T. Blythe, a certified clinical psychologist and president/CEO of Crisis Management International, Inc., there can be many reasons: isolated lives lacking a support system, the increasing violence on television, and the availability of handguns. As for psychological motivations, Blythe says that people with low self-esteem may try to feel superior by controlling others physically, sexually or through verbal manipulation. Medics using good communication skills can defuse the situation by showing the person that someone is listening to his or her concerns. However, they can't let their guard down. Give the aggressor a six-foot radius. Blythe says if they can't get to you, they're less likely to be as violent. If you can't stay six feet away, try to keep something between the two of you or stand next to an escape route. When you talk to people, have your hands open and palms up, which indicates that you don't want to fight, and have nothing in your hands.

From *Emergency Medical Services*, "Losing It," by Nancy Perry, March 1996.

More than half of the 90.5 million ED visits a year are for conditions such as sore throats, ear aches and ankle sprains, which rarely amount to true emergencies.

For the first time in a decade, emergency room visits at hospitals around the U.S. are falling, and experts expect the trend to continue as managed care increases its domination. According to the American Hospital Association, ED visits fell 2.4 percent in 1994 after rising steadily for a decade. The trend was strongest on the West Coast, where hospitals saw a 14 percent drop in ED visits.

More than half of the 90.5 million ED visits a year are for conditions such as sore throats, ear aches and ankle sprains, which rarely amount to true emergencies. A report in the March 7 issue of the *New England Journal of Medicine* found that emergency rooms charges are two to three times higher than what doctors charge for the same services in their offices. Researchers found that while a typical bill for routine problems costs about $62, hospitals charge about $124. Researchers say that hospitals charge more because they are reimbursed for only about half of their emergency room care, which typically includes many uninsured or underinsured patients.

From TDH's News Clips, *The Wall Street Journal*, "HMOs See Emergency-Room Visits Drop," by Ron Winslow, March 7, 1996.

In Nashua, New Hampshire, one dog recently saved an owner's life by dialing 9-1-1 when the owner's oxygen mask became unplugged. Judi Bayly's Irish setter, Lyric, is trained to hit a programmed button and bark into the receiver when the oxygen supply alarm sounds. Bayly, an EMT, takes oxygen for asthma.

From TDH's News Clips, *USA Today*, "Dog telephones 9-1-1 to save owner," March 13, 1996.

Women alcoholics are more likely to suffer from cardiomyopathy, a weakening of the heart muscle, than alcoholic men, according to a study in the *Journal of the American Medical Association*. The study involved 50 alcoholic women, 100 alcoholic men and 50 non-alcoholic women, all of whom had no other complicating factors such as drug addiction. The study found that although the men consumed more alcohol than the women, the women suffered equal heart damage. Researchers say that a woman's heart is more sensitive to alcohol than a man's.

From TDH's News Clips, the *Houston Chronicle*, "Alcoholic women hit harder with weakened heart muscle," March 10, 1996.

The federal government has been investigating one of the most popular car safety seats for children after reports that it can break loose from its base during a crash. The Century 590, a rear-facing infant seat, has been the subject of questions since it flunked a test by *Consumer Reports* magazine eight months ago. Century Products, Inc., the manufacturer, has said that there it nothing wrong with the seat. More than 2.6 million seats have been sold over the last five years and so far seven children have been injured when the seat failed in the manner described by the magazine.

From TDH's News Clips, *Austin American-Statesman*, "Kids' safety seats under scrutiny," March 24, 1996.

If you've ever responded to a car wreck and found a cellular phone in the car, you might have suspected that it contributed in some way. Now you have proof. The March issue of *Accident Analysis and Prevention*, a British journal, says that people with a cellular phone in the car run a 34 percent higher risk of having a wreck. The danger increases when they use the phone frequently or while doing something else, such as drinking coffee or lighting a cigarette. Most often, it seems, motorists engrossed in a phone conversations run red lights and get into collisions at busy intersections. The Cellular Telecommunications Industry Association dismissed the survey as limited and flawed. About one in ten motorists in the U.S. owns a car phone, with about 28,000 more subscribers a day signing up for cell phone service.

From TDH's News Clips, the *Houston Chronicle*, "Is your brain in gear?" by Ben Dobbin, March 19, 1996.

A new study shows that the arteries of people exposed to passive smoke thicken at a faster rate than those of people not exposed. Researchers studied 8,415 men ages 45 to 60 using ultrasound techniques to measure the progression of thicken-

People with cellular phones in their cars run a 34 percent higher risk of having a wreck and the danger increases when they are doing something else, such as drinking coffee or lighting a cigarette. 28,000 subscribers a day are signing up for cell phone service.

A dog recently saved his owner's life by dialing 9-1-1 when the owner's oxygen mask became unplugged. The setter is trained to hit a programmed button and bark into the receiver when the oxygen supply alarm sounds.

Allergic reactions to foods could be on the rise, thanks to genetically engineered food—researchers said they have solid evidence that transferred genes can cause allergic reactions.

ing of the carotid arteries. Carotid artery thickening is a major cause of stroke. Among nonsmokers who had never been exposed to second-hand smoke, arteries thickened 40 micrometers over three years. In nonsmokers exposed to second-hand smoke ten hours a week, arteries thickened about 45 micrometers. Former smokers not exposed had arteries thicken at 50 micrometers, while former smokers exposed to smoke thickened at the rate of 55 micrometers. Current smokers' arteries thickened by 60 micrometers over three years. Researchers said that on the average, exposure to smoke caused about a ten percent increase in the rate of progression towards atherosclerosis.

From TDH's News Clips, *USA Today*, "Artery thickening and passive smoke," by Tim Friend, March 19, 1996.

Do you see products that are unsafe and wish you could do something? Now you can contact the Consumer Product Safety Commission directly with your concerns. The commission requests the following information:

- Description of incident sequence
- Treatment date and date of incident
- Description of injuries incurred
- Type of consumer product involved
- City and state where the incident occurred
- Manufacturer, model, brand and serial number
- Availability of product for the inspection
- Contract information for anyone who investigated the incident
- Your name, address and phone number

Write the Consumer Products Safety Commission at Division of Hazard and Injury Data Systems, EPDS, Washington, DC 20207; or by phone at (800) 638-8095, FAX (800) 809-0924; or email at amcdonal@cspc.gov

Allergic reactions to foods could be on the rise, thanks to genetically engineered food. Researchers announced in March that they had solid evidence that proteins that can cause potentially serious allergic reactions could be transferred through genetic engineering. Scientists at the University of Nebraska proved that soybeans modified with genes from Brazil nuts caused allergic reactions in people sensitive to Brazil nuts. The substance, created to enhance animal feed, was not marketed because of fears that the substance would make its way into human food supplies. Genetic food engineers mix a wide array of species, and researchers say that other genetically engineered food may cause similar problems. About two percent of adults and eight percent of children report food allergies. Critics claim that the industry needs tighter regulation, while the industry wants to continue with the current system of mostly voluntary reporting.

From TDH's News Clips, the *Houston Chronicle*, "Scientists genetically transfer allergens from one food to another," by Warren E. Leary, March 14, 1996.

Long after the initial effects of a child's head injury have faded, problems in learning and behavior can surface, according to a new study. Using brain-imaging techniques, researchers at the University of Texas at Dallas found that dam-

age to brain tissue can worsen months after the initial injury, and learning and social problems can appear years later. The implications are significant because almost one in 30 newborns in the U.S. will sustain a head injury before age 16.

Each of the 250 children in the study had a magnetic resonance image, or MRI, done three months after the injury and again three years later. Most had lesions in the frontal lobe. Researchers found that some lesions persist, and some new lesions appear as well. This could be because cells in the brain connected to the injured ones may deteriorate as time goes on. Further research may determine whether the related regions are actually causing the problems. Many of the children who recovered initially didn't maintain the recovery and fell behind after a few years. The next question to be answered, researchers say, is how to help head-injured kids do better in school and social situations.

From TDH's News Clips, *The Dallas Morning News*, "Long-term effects of children's head injuries studied," by Sue Goetinck, February 19, 1996.

Having trouble remembering things? Relax. It's not always a sign of Alzheimer's, the devastating brain disease that destroys memory. Scientists says that such memory lapses are natural, especially as you get older. Forgetting is nature's defense against too much information. Adults remember little that happened to them before age 5; when they reach their 30s, they typically begin to experience a drop in memory ability. A steeper decline begins in the 60s and gets worse in the 70s and 80s. Researchers give several reasons for the memory loss: aging nerve cells, interference from more recent memories and sheer information overload.

From TDH's News Clips, the *Houston Chronicle*, "Relax, memory loss a natural part of aging," by Robert S. Boyd, February 27, 1996.

Having trouble remembering things? It's not always a sign of Alzheimer's, the devastating brain disease that destroys memory. Scientists say that such memory lapses are natural—forgetting is nature's defense against too much information.

Request for Triage Tags

$19/bundle 100 tags/bundle

Number of bundles: _____

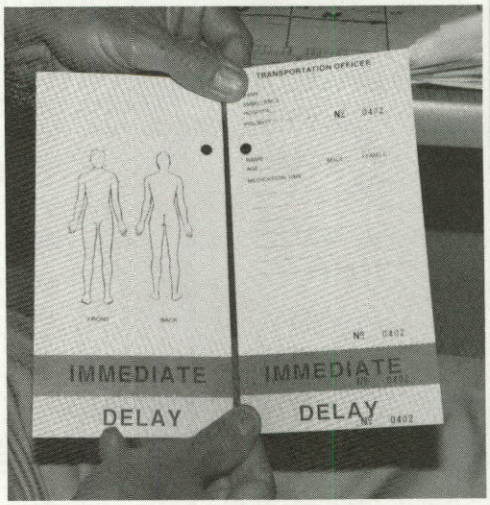
Amount enclosed $ _____

2A281 – Fund 001

Make check or money order for $19 payable to Texas Department of Health

Enclose payment and send with this request form to:

Remittance Enclosed
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199



Name _____

Organization _____

Street Address _____

City _____ State _____ Zip _____ Phone _____
area code

EHCAC Recap

Emergency Health Care Advisory Committee Members

R. Donovan Butter, DO
San Antonio

Gary D. Cheek, RN, EMT
Abilene

Barbara Curtis
Humble

James "Red" Duke, MD
Houston

Leticia Goodrich
Amarillo

Lance Gutierrez
Tyler

Allan Helberg
Texarkana

John Holtermann
San Marcos

Jorie Klein, RN
Dallas

Ray Mason
Lubbock

William Moore, MD
Tyler

Ronald Redus, DDS
Amarillo

Joan Shook, MD
Houston

Clint Vardeman
Carrollton

EHCAC Meeting Dates

All meetings are in the Texas Board of Health Boardroom, Room M-737, Moreton Building, Texas Department of Health, 1100 W. 49th in Austin.

- May 9, 1996
- September 13, 1996
- December 6, 1996

At left, Clint Vardeman, corporate vice president of Rural Metro Ambulance, and Amarillo oral surgeon Ronald Redus, right, joined other EHCAC members in drafting EHCAC's mission statement and goals at the February meeting.

The Emergency Health Care Advisory Committee met on February 9, 1996, at the Texas Department of Health.

All 14 the members of the committee were present. Ray Mason of Lubbock was elected chair; William Moore, MD, of Tyler was elected assistant presiding officer; and Leticia Goodrich of Amarillo was elected parliamentarian.

Chairs for each of three standing subcommittees were recommended by the nominating committee: R. Donovan Butter, DO, will chair the EMS; Joan Shook, MD, will chair EMS for Children; and Jorie Klein, RN, will chair Trauma.

Terms of office for each member were established by drawing lots. Drawing two-year terms were John Holterman; Ronald Redus, DDS; Leticia Goodrich; and Barbara Curtis. Drawing four-year terms were James "Red" Duke, MD; Ray Mason; Clint Vardeman; Allan Helberg, EMT-P; and Gary D. Cheek, RN, EMT. Drawing six-year terms were R. Donovan Butter, DO; Joan Shook, MD; Jorie Klein, RN; Lance Gutierrez, RN; and William Moore, MD.

The committee also discussed and finalized a mission statement and goals.

Mission The EHCAC will proceed to fulfill charges by addressing three primary areas: (1) Injury Prevention through professional and public education; (2) Assessing the individual and collective elements that must be in place to minimize morbidity and mortality associated with acute illness and injury throughout the State of Texas; and (3) encouraging and supporting individual regions to attain maximal reasonable quality service delivery by educated professionals.

Goals To develop a strategic plan for a statewide educational program that includes injury prevention directed at each appropriate age group and professional education. To develop a task force to determine educational priorities and facilitate the implementation of this plan.

To develop a comprehensive plan for the most expeditious care for acutely ill and injured persons with consideration given to individual geographic constraints and requirements through the integration of the efforts of the following standing subcommittees: (1) EMS (2) Pediatrics and (3)Trauma.

To develop a comprehensive series of strategies to generate adequate funding at both the local and statewide level to successfully achieve the evolving goals of reducing injury occurrence and minimizing morbidity and mortality associated with acute illness and injury. To develop a task force that examines funding requirements and explores mechanisms for generating required support to meet the identified goals.

To develop a series of strategies that clearly quantifies the impact of the presence or absence of comprehensive total care delivery systems in the event of acute illness or injury.

For a complete copy of the meeting minutes, call Debby Hilliard at (512) 834-6700, or email her at dhilliard@ems.tdh.state.tx.us —*Kelly Harrell*

1996 Texas EMS Photography Contest

Entry Form

Photographer's Name _____

Address _____

City _____ State _____ Zip _____

Phone (home) _____ (work) _____

Mail to: EMS Photos, Texas Department of Health
1100 W. 49th Street, Austin, Texas 78756.

Deadline for entering: October 15, 1996

Tape this form to the back of the photo.
For more information call Jan Brizendine at 512/834-6748.

Photo Contest Rules

- Anyone is eligible; no entry fee is required.
- Entries must be received **no later than October 15, 1996.** Winners will be announced at the Texas EMS Conference, November 24-27, 1996.
- Unmatted prints **8x10 inches** or **5x7 inches** may be submitted, in color or black and white. Fill out the entry form on this page, tape it to the back of your photograph, and mail your entry to: Jan Brizendine, Texas Department of Health, 1100 W. 49th Street, Austin, Texas 78756-3199.
- The Texas Department of Health will keep all photo entries and will have the right to publish entries in TDH publications. Photographer's name will be printed along with the photo. Ownership of the negative will remain with the photographer.
- Two grand prize winners will be chosen—a color photo category and also a black and white photo category. Each winner will receive $100 and a plaque. One first place winner will receive $75 and a plaque. One second place winner will receive $50 and a ribbon, one third place will receive $25 and a ribbon. One honorable mention winner will receive a ribbon and $15. Judges will select winning photographs based on artistic composition, originality, visual appeal, and good patient care.

Want a 10th anniversary conference bag?

Texas EMS Conference '95 attendees loved these big red bags. They are heavy-duty nylon bags and have sturdy navy blue straps, three pockets and three zippers. They are imprinted with the 10th anniversary conference logo. You will use these bags for years. Send this form and your $10 check or money order to the address below.

Send $10 for each bag to the address below.

Make checks to: Texas Health Foundation
Mail to: EMS Bags
PO Box 142694
Austin, Texas 78714-2694

Number of bags	
Total	$

Name _____

Street Address _____

City, State, Zip _____

Texas Association of EMTs
1996 State Skills Competition Championship &
1996 World Valsalva Bowl Competition Championship

Sunday, November 24, 1996
8:00–5:00 pm
The Radisson Plaza Fort Worth, Texas

Skills

Team Composition
3 Members + 1 Alternate

ALS Team	ALS Competition	BLS Team	BLS Competition
EMT/P & EMT/I	Written exam	ECA & EMT	Written exam
May have 1 BLS member	Medical call (megacode)	All BLS	Medical call
	Trauma call		Trauma call
	Fun event (2)		Fun event (2)

Awards

Best ALS exam score
Best ALS medical call
Best ALS trauma call

Best BLS exam score
Best BLS medical call
Best BLS trauma call

Best fun event scores

ALS State Champion

BLS State Champion

Entry Fees

Teams of all TAEMT members $50.00
Teams of non TAEMT members $75.00

Valsalva Bowl World Championship Competition

Preliminaries run concurrently with Skills Competition

Championship Rounds at TAEMT Awards Meeting
Monday Night, November 25, 1996

Team Composition

3 Members + 1 Alternate
All members must have Texas EMS Certification
May be any combination of ECA, EMT, EMT/I, EMT/P

Entry Fees

Teams of all TAEMT members $15.00
Teams of non TAEMT members $25.00

For rules and entry package:
Texas Association of EMTs, 202 South Columbia Drive, West Columbia, TX, 77486 or (409) 345-6352

Calling all authors

KELLY HARRELL, EDITOR
TEXAS EMS MAGAZINE

To paraphrase a proverb I once read: I reach the stars only because I stand on the shoulders of others. As many of you know, Alana Mallard, longtime editor of *Texas EMS Magazine*, left last year to take a promotion to TDH's communications division. Now I've been given the honor of continuing to build on the excellent foundation that she laid in her 25 years with EMS. Many of you know me as associate editor of this magazine, a position I've held for the last four years. In the many articles I've written about Texas EMS in those years, I had the opportunity to visit many services across the state, and even to ride out with a few of you. Those who attend the conference might know me as that woman in tennis shoes with the radio stuck to her ear. However you know me, I'd love to hear from you. Please call or drop a line anytime.

One of the ways I'll continue the excellence is to publish a continuing education article in each magazine. So I'm calling all authors to send me their ideas for CE articles. I'll be happy to send out the requirements for submission, and to talk to you about any ideas you have. Please call me before you begin working on any article, though, so you won't duplicate anything already in the works. And remember, you can earn CE credit by writing articles.

Although there has been no charge for the CE in the past, we may have to begin charging. We have thus far relied on staff at Southwestern Medical Center to grade and send out CE certificates, but we can't continue that arrangement indefinitely. So the future may bring a small charge—$5 or so—with each CE answer sheet sent in to be graded. And while we're on the subject, we should really give a pat on the back to Southwestern's Debra Cason, Cynthia Ramirez, Karen Murdock and Dr. James Atkins. These folks really supported the program and made it possible for Texas EMS to get better access to CE.

Another big item for us this year is to gauge the interest in an EMS license plate. See Gene Weatherall's article on page 5 for more details. As he says, a minimum of 1,500 people need to express an interest and say that they would be willing to pay the extra $25 before the legislature will consider it. Write Gene with your comments.

I look forward to meeting you at the conference, in our offices or while I'm out on the road. Call me at (512) 834-6700 if you have any questions, or just want to chat.

You can write letters to the editor to:

Kelly Harrell, Editor
Texas EMS Magazine
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199

THE INFORMATION IN THIS SECTION IS INTENDED TO PROVIDE PUBLIC NOTICE OF DISCIPLINARY ACTION BY THE TEXAS DEPARTMENT OF HEALTH AND THE BUREAU OF EMERGENCY MANAGEMENT AND IS NOT INTENDED TO REFLECT THE SPECIFIC FINDINGS OF EITHER ENTITY.

THIS INFORMATION MAY NOT REFLECT ANY NUMBER OF FACTORS INCLUDING, BUT NOT LIMITED TO, THE SEVERITY OF HARM TO A PATIENT, ANY MITIGATING FACTORS, OR A CERTIFICANT'S DISCIPLINARY HISTORY. THIS LISTING IS NOT INTENDED AS A GUIDE TO THE LEVEL OF SANCTIONS APPROPRIATE FOR A PARTICULAR ACT OF MISCONDUCT.

FOR INFORMATION, CONTACT THE BUREAU'S CHIEF INVESTIGATOR, VIC DWYER, AT (512) 834-6700.

A.C.S. Ambulance Services, Inc., of Houston, Texas. Agreed to administrative penalty of $2000. Chapter 773, Health and Safety Code, 773.050, failure to have two certified attendants when in service.

* **A.S.A. P. Ambulance**, Deer Park, Texas. Administrative penalty of $250.00. EMS Rule 157.11 (m)(11) failure to notify department of change in medical director.

City of Azle E.V.A.C. Azle, Texas. Agreed to eighteen months probation of provider license from March 1, 1995, to October 1, 1996. EMS rule 157.11 (a) (I) failure to have a medical director for the advanced level service.

Barcheers, William A., Hemphill, Texas. Twelve months probation of EMT-Paramedic certification through July 10, 1996. EMS rule 157.51 (2)(Y), jeopardizes health or safety of a patient.

Bertin, Randal P., Spring, Texas. Agreed to twelve months probation of EMS Coordinator Certification from September 25, 1995, to September 25, 1996. EMS rule 157.64 (a)(7) Coordinator compromise of examination process and (8) fail to maintain integrity of the course.

* **Calder, Yulonda Lynn**, Kemp Texas. Twelve months probation of EMT certification through January 8, 1997. EMS Rules 157.44(b)(1) and (c), and 157.53, misdemeanor conviction.

Christian, Aaron Louis, Beaumont, Texas. Two years probation of EMT certification through October 19, 1997. EMS rules 157.44(b)(1) and (c), and 157.53, felony conviction and misdemeanor convictions.

Corbeil, Louis Adrein, Brownsville, Texas. Five years probation of EMT-Intermediate certification through May 3, 2000. EMS rule 157.44 (b)(1) and (c), and 157.53, felony conviction.

Dunn, Jeffery D., Trinidad, Texas. Emergency suspension of EMT certification. EMS Rule 157.51 (a)(1)(A) imminent threat to health and safety, felony conviction while certified.

* **EM-CARE Ambulance Inc.**, Edinburg, Texas. Administrative Penalty of $4,000.00. EMS Rule 157.11(a)(1)(F) Certificate of insurance not in force for provider.

* **Guerrero, Reynaldo, aka Guerra, Reynaldo**, Dallas, Texas. Decertification of EMT certification. EMS Rule 157.51(2)(P), (Z), falsification of an application for certification, failure to report felony conviction.

* **Hagar, Kathleen**, Girard, Texas. Twelve months suspension of EMT certification starting February 13, 1996, to February 13, 1997. EMS Rule 157.51 (2)(A), (B), (H), under the influence of alcohol which affects certificant's ability to render aid according to accepted procedures or protocol.

Haxton, Ricky Joe, Tyler, Texas. Twelve month probation of EMT-Paramedic recertification from October 19, 1995, to October 19, 1996. EMS rules 157.44(b)(1) and (c), and 157.51(b)(16), misdemeanor conviction while currently certified.

* **Highland Village VFD**, Highland Village, Texas. Administrative penalty of $100.00. EMS Rule 157.16 Subscription service operation without department notification.

Jackson, Benjamin John, Plano, Texas. Two years probation of EMT certification through February 8, 1997. EMS rule 157.44 (b)(1) and (c), and 157.53, felony conviction.

Jonas, Kolin Max, Kendalia, Texas. Twelve month probation of EMT-Paramedic certification from October 19, 1995, to October 19, 1996. EMS rules 157.44(b)(1) and (c), and 157.51(b)(16), misdemeanor conviction while currently certified.

* **Lewis, William Andrew Jr.**, Killeen,Texas. Twelve months probation of EMT certification through September 20, 1996. EMS Rules 157.44(c) and 157.53, misdemeanor conviction.

* **Lucero, Jaime Joseph**, Amarillo, Texas. Twelve months probation of EMT certification through February 13, 1997. EMS Rule 157.51(b)(26), falsification of an application for certification.

Madison, Edith Ann, Bay City, Texas. One year probation of EMT certification through June 15, 1996. EMS rule 157.51 (2)(Z), falsification of application for certification.

Madison, James Monroe, Bay City, Texas. One year probation of EMT certification through June 15, 1996. EMS rule 157.51 (2)(Z), falsification of application for certification.

* **Mason, Ronald Alan**, Tyler, Texas. 24 months probation of EMT-Paramedic recertification through January 11, 1998. EMS Rules 157.44(c), 157.53 and 157.51(b)(16), misdemeanor conviction while currently certified.

Massegee, Tommy Doyle, Grand Prairie, Texas. Four years probation of EMS certification through March 12, 1999. EMS rule 157.44 (b)(1) and (c), and 157.53, felony conviction.

* **McClain, William Keith**, Stephenville, Texas. Twelve months probation of EMT-Intermediate through October 19, 1996. EMS Rules 157.44(c), 157.53 and 157.51(b)(16), misdemeanor conviction while currently certified.

Paducah Ambulance Service, Paducah, Texas. Agreed to twelve months probation from September 25, 1995 to September 25, 1996. EMS rule 157.19 (c)(1)(U) violation of any rule or standard that would jeopardize the health or safety of a patient.

* THESE LISTINGS ARE NEW THIS ISSUE. DENIALS AND REVOCATIONS WILL BE PRINTED IN THREE CONSECUTIVE ISSUES. SUSPENSIONS AND PROBATED SUSPENSIONS WILL BE PRINTED UNTIL SUSPENSION OR PROBATION EXPIRES.

Attention Paramedics

The Texas Department of Health wants to employ an outstanding Texas paramedic. They must have strong people skills as they will represent the state of Texas as a role model for EMS personnel statewide in TDH's state-of-the-art ambulance. Job duties will include: interacting with local EMS providers to coordinate educational displays and programs about EMS; designing and developing model standards for EMS personnel and services; providing technical assistance to and serving as a resource for EMS organizations; and conducting research as directed.

We're looking for a person with the right stuff—good paramedic and people skills, with an in-depth knowledge of EMS operations and current issues, willing to seek and learn about new technology and bring innovative ideas to the job.

Salary: $33,792 with state benefits including health insurance and paid annual and sick leave. Statewide travel 25 percent of the time. For a copy of the full job description or a state application, call your regional office or TDH Human Resources in Austin at (512) 458-7302. No resumes accepted.

Plumlee, Robert Michael, Saginaw, Texas. Twenty-four months probation of EMT certification through February 17, 1997. EMS rule 157.44 (b)(1) and (c), and 157.53, misdemeanor convictions.

* **Rhame, Steven Wayne**, Arp, Texas. Twelve months probation of EMT-Intermediate certification through November 17, 1996. EMS Rules 157.44(b)(1) and (c), and 157.53, misdemeanor conviction.

* **Ruiz, Eric Charles**, San Antonio, Texas. Twelve months probation of EMT certification through January 8, 1997. EMS Rules 157.44(b)(1) and (c), and 157.53, misdemeanor conviction.

Slaughter, Robert E., Fort Worth, Texas. Decertification of EMT certification. EMS rule 157.51 (V) obtaining any benefit not otherwise entitled by ...fraud while... in the course and scope of duties as an EMS certificant.

Smallwood, Derek, Richmond, Houston, Texas. One year probation of EMT certification through May 12, 1996. EMS rule 157.44 (b)(1) and (c), and 175.53, felony conviction.

Speirs, Gary II, Fort Worth, Texas. Denial of EMS recertification through August 31, 1996. EMS rule 157.53 (2), previous conduct of applicant relating to the duties of EMS personnel contrary to accepted standards.

Thompson, Jack W., Anson, Texas. Agreed to 12 month probationof EMT-Paramedic certification from December 21, 1995 to December 21, 1996. EMS rule 157.51 (b)(3) failure to maintain confidentiality of patient information obtained in the course of professional work.

Turnbow, Brandon L., Snyder, Texas. Agreed to 24 month misdemeanor probation and $500 fine. Chapter 773, Health and Safety Code, 773.063, misrepresentation as certified to be an Emergency Medical Technician.

Urdialez, John Martinez, San Antonio, Texas. Decertification of EMT certification effective December 8, 1995. EMS rule 157(2)(P), felony conviction.

Vonief, Kyle A., Houston, Texas. Emergency suspension of EMT certification. EMS Rule 157.51 (a)(1)(B) failure to complete biennial continuing education (CE requirements as stated in 157.38). Also 157.51 (b)(15) obtains recertification by fraud, forgery, deception, misrepresentation or subterfuge.

* **Wagener, Marvin Joseph**, College Station, Texas. Twelve months probation of EMT-Paramedic recertification through November 29, 1996. EMS Rules 157.44(c), 157.53 and 157.51(b)(16), misdemeanor conviction while currently certified.

Weinheimer, Rex Joseph, Stonewall, Texas. Four years probation of Emergency Care Attendant certification through September 30, 1999. EMS rule 157.44(b)(1) and (c), and 157.53, misdemeanor convictions.

EMS Standards

You can still contact us by E-mail at our same address: EMSCert@ems.tdh.state.tx.us

When contacting us by phone at 512 834-6700, you'll get the right processor and faster service if you use key words such as certification verification, deficiencies to be cleared, crime history evaluations, address changes, duplicate certificates, complaint investigation, coordinator, instructor or examiner certification; or miscellaneous provider license information.

Fax us at 512 834-6736. We encourage you to submit letters, address and name updates, requests for information, etc. by fax, but documents that require original signatures should be sent by regular mail. —*Phil Lockwood*

Calendar

Meetings

May 16-17, 1996. **Basic CISD Course**. $35, 16 hours. Wichita Falls General Hospital, Gaines Education Pavillion. Contact Betty Bowles 817/761-8536.

June 14-15, 1996. **Basic CISD Course**. $35, 16 hours. Lake Jackson, Brazosport College. Contact David Filipp 409/266-3000.

June 15, 1996. **Vertical Rescue Problems Course**. $110. Prerequisite: MCC Advanced Vertical Rescue course. McLennan Community College, Waco, TX.

June 15, 1996. **Advanced Burn Life Support for Paramedics**. $120. Held at Shriners Burns Institute, Galveston, TX. Contact Ginger Stuart at 409/770-6780.

June 21, 1996. **Street Gang Dynamics**. $45. Texarkana College, Texarkana, TX. Contact Kathy Jordan 903/838-4541, ext. 277.

July 9-10, 1996. **Basic CISD Course**. $35, 16 hours. Waco, Hillcrest Baptist Medical Center. Contact Donna George 817/756-8476.

August 2-4, 1996. **Idaho Statewide EMS Conference**. For more information call 208/334-4000.

August 5-10, 1996. **Wilderness EMT**. $360. Texas Tech University Health Sciences Center, Lubbock. Call 806/743-3218.

August 12-16, 1996. **EMT Refresher**. $150. Bryan, TX. Texas A&M University Emergency Medical Education Programs. Call 1-800-423-8433.

August 19, 1996. **EMT Refresher Courses**. Texarkana College, Texarkana, TX. Contact Kathy Jordan 903/838-4541, ext. 277.

August 24-25, 1996. **Basic CISD Course**. $35, 16 hours. Groves Fire Department. Contact Bradley W. Corley 409/962-4471.

November 24-27, 1996. **Texas EMS Conference '96**. Registration fee $75, $90 at the door. Fort Worth, TX. Call 512/834-6700 for more information.

Paramedic Ready Teddy. Don't forget to use Texas' furry EMS mascot to help you with these local activities: **National Bike Month** May, **Buckle Up America Week**, May 20-27, **National EMS Week**, May 19-25, **Safe Kids Week** May 4-11, **National Sage Boating Campaign** May 18-24, **National Safety Week** June 28, **Safe America Month** June (ends July 4), **National Farm Safety Week** September 15-21, **National Fire Prevention Week** October 6-12, **National School Bus Safety Week** October 20-26, **National Drunk and Drugged Driving Awareness Month** December.

Call 512/834-6700 to schedule the Ready Teddy costume or request activity packets.

For a free conference listing or ad send a fax to *Texas EMS Magazine*, 512/834-6736.

Jobs

EMTs and Paramedics: Needed immediately for West Texas service. No experience necessary. Management positions available. Send resume to: Texas West Ambulance, PO Box 50542, Midland, TX 79703 or for information call 915/570-4892.*

EMT-Paramedic: Full-time position open on MICU 9-1-1/transfer service. Serves Winkler County. Full county benefits package. Please call Mike Dorris at 915/586-5864.*

EMS Employment Opportunities: Looking for qualified EMS personnel seeking employment/relocation opportunities. Nationwide positions available. Send $3 for more information to: EMS Network, PO Box 3202, Tonopah, NV 89049-3202.*

Work Wanted: National-registered, Texas-certified firefighter with over 10 years experience. ACLS, BTLS, CISD, Rescue, and Haz-Mat-trained. Seeking EMS director/supervisor position and/or fire chief position in city, rural, hospital-base or private service. Resume upon request. Mail to: Fire/EMS Inquiry, 603 N. Main, Rockdale, TX 76567 or call 512/446-6701 or Fax 512/446-7679.*

Public relations: Medical Training Company. Must have experience in customer relations field or health training. Resume: Earl Woolbright, Metroplex Medical Training Services, 2429 E. Hwy 80, #101, Mesquite, TX, 75150.+

Paramedics: Full time positions. MICU service for 9-1-1 city/county emergency calls and transfer services for local hospital in Alpine, TX. Call Mike Scudder at 915/837-3028 or send resume to: WTAS-Alpine EMS, PO Box 338, Alpine, TX 79831.+

EMTs: Needed for new paramedic company home office in San Antonio to do medical exams. Must be able to record medical history. Call Lori at 210/699-6280 or fax a resume to: 210/699-6281.+

Volunteers: The oldest EMS in the state needs volunteers. ECAs, EMTs and paramedics for one or more shifts per month. Harris Co. Emergency Corps makes 12,000 calls per year and is affiliated with Hermann Hospital MedCon. Low cost training and an opportunity to gain additional 9-1-1 experience while helping individuals through a non-profit agency. For information call Barbara Sampey or Dr. J.P. Price at 713/875-8000.*

Calendar

For Sale

Billing and collection service: Available for electronic billing for Medicare, Medicaid and private insurance, as well as reporting to TDH Trauma Registry. Call Tom Van Wyngarden at 800/568-7004.*

For Sale: Motorola Maxtrac 300 16-channel UHF programmable scanning radio with speaker and antenna. Programmed with all Med channels. Like new, $400 OBO. Call 512/776-2955.*

For Sale: Sweet Computer Services. Full line of software solutions. Contact Dave Doerscher at 800/537-3927.*

For Sale: 1986 Ford Type I ambulance, 70,000 miles on rebuilt diesel engine, with lights/siren $11,900. 1984 Chevrolet Type I with 454 gas engine, with light/siren $8,500. Scott Stevens, Life Rescue Ambulance 409/787-4086.*

For Sale: Rocker patches for Instructor/Examiner, now available for your uniform or jacket, fits directly below your TDH patch. $2.75 each plus $.50 postage. Contact S. Carson, 4044 Staghorn Circle, Fort Worth, TX 76137 or call 817/847-5106.*

For Sale: 3 used monitor II pagers and chargers. Low band 37.180. Excellent condition, $125 each. Contact Calvin Wright. 210/981-4912.*

For Sale: 1985 Wheeled Coach/Ford Diesel, Type I ambulance with stretcher and light bars. 38,000 miles. Extra clean inside and out. Sealed bids will be opened on May 16 at 2:00 pm. Contact Chief Hutchens, Jersey Village Fire Dept. 713/466-2131.*

For Sale: EMS training supplies for EMT basic and intermediate classes. List available on request. Call 817/562-5970, leave message.+

For Sale: Six Motorola Miniter pagers with chargers. Four NEC pagers with chargers. One Motorola encoder. $1,000 for complete package. Contact Eddie Martin, Rotan Volunteer Fire Department, home 915/735-2669 or work 915/548-9075, ext. 301.+

For Sale: CPR manikins, Skillmeter Resusci Anne with printer. Resusci Junior, Resusci Baby with lights. All in very good condition with extra lungs. 409/267-3080.+

Announcements

1962 Equipment Needed: The Bureau of Emergency Management is trying to get 1940s, 1950s and early 1960s equipment for our 1962 equipment ambulance. Remember, it did not take much back then—a first aid kit and a traction splint. Check in the old ambulance barn, local funeral home or volunteer services. Contact Harold Broadbent at 512/834-6700 or write him at Texas Department of Health/MAB, 1100 West 49th, Austin, TX 78756-3199.

Study Participants: Participants needed for a PASG (pneumatic anti-shock garment) study. If interested contact First Flight Helicopter Service, contact Ken or Lee at 800/670-1002.*

CPR manikin rentals and supplies Contact Steve Cutler at Metroplex Medical Training 214/270-0857.

Rescue diver certification courses available. For more information contact Brett Shayler at Bluewater Tours. 214/317-7234 or 800/440-7234.

CPR Instructor training courses conducted throughout the year at Brookhaven College. Call 214/620-4715.

Fundraising Opportunities: Call today to learn how our continuous income program can benefit your organization. B.E.I. 800/774-3011.

\+ This listing is new to this issue.

* Last issue to run.

Placing an ad? Moving? Renewing your subscription?

Texas EMS Magazine, 1100 West 49th,
Austin, TX 78756-3199. Fax: 512/834-6736

Placing an ad? To place an ad in the calendar section, write the ad (keep the words to a minimum, please) and fax to *Texas EMS Magazine*, 512/834-6736 or send to the address above. Ads will run in two issues and then be removed.

Moving? Let us know your new address—the post office may not forward this magazine to your new address. You may use the subscription form in this magazine to change your address, just mark the change of address box and mail it to us or fax your new address to 512/834-6736. We don't want you to miss an issue.!

Renewing your subscription? Paid subscriptions have a 4-digit number on the mailing label. Example: 9610 means the subscription expires with the October of 1996 issue. Use the subscription form in this magazine to renew your subscription and mark the renewal box.

For circulation and ad information contact Jan Brizendine at 512/834-6700.

The Back Page profile features a different EMS organization each issue.
*EMS Director **Cheryl Watson** of Lockhart EMS submitted this profile.*

EMS Profile: *Lockhart EMS*

City of Lockhart EMS paramedics are, from left, Mary Schuelke, Donna Schuster, Melanie Tucker, Carol Duesterheft, Cheryl Watson, Pat Craigmile, Koren Vogel, Patrick Bass and Mark Jackson. In front is James Koch. Not pictured is Medical Director Dr. C. Lawrence.

Name of Service
Lockhart EMS

Number of Personnel
Ten full-time personnel—nine field paramedics and an EMS Coordinator who is also a paramedic—assisted by the Caldwell County Medical Assist Team First Responders and Lockhart Fire Department.

Years in Service Lockhart EMS was originally a part of the fire department and became a separate city service in November 1987.

Number of units and capabilities We have three BLS/MICU-capable units: One staffed with two full-time paramedics and a second unit staffed with one paramedic and supplemented by a CCMAT or firefighter/EMT. The third ambulance is a backup unit used for transfers and standby.

Number of calls last year 1540

What is your favorite injury prevention activity? Our favorite is the new DWI program that we obtained with funds from TDH Local Projects grants and with the money raised through CPR, EMT and paramedic courses. The DWI program is patterned after the Starflight DWI program and has been presented to the schools and a church group in San Antonio. We also teach a community CPR class every month, and we teach CPR and First Aid to the day care centers, businesses, and even the private prison in Lockhart. Other programs that are schoolchildren favorites are Ready Teddy and Andy Ambulance.

Current projects We are still planning our newest project, "EMS Kudos." While EMS is around town, we want to hand out "EMS Kudos" to people who are being safe, such as wearing their bicycle helmet, having everyone in the car buckled up, or even walking on the right side of the street. These "kudos" will be redeemed at a few of the local businesses for movie rentals, etc.

What is unusual about your service? Lockhart does not have a community hospital, so many of our patients are seeking medical advice or some minor treatment because they have no other place to obtain medical assistance. Patients are taken to San Marcos, Austin or Luling. In general, the medics are in contact with their patients for as long as an hour before they arrive at a medical facility. At least half of the medics work part-time in an emergency room, which allows them to attend to the non-emergent emergencies using better judgment and with more confidence. What really makes us special is our paramedics, who go beyond their normal duties by helping with special projects, and teaching the EMT and paramedic courses and community training courses. They genuinely care about their patients and each other. Lockhart EMS also gets outstanding support from the Lockhart City Council.

Bureau of Emergency Management
Texas Department of Health
1100 West 49th Street
Austin, Texas 78756-3199

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