

To the Editor:

Allow me to express some thoughts that have been on my mind for the past several months regarding the quality of relationships existing among various human components of EMS and the degree to which each underutilizes the expertise of another. I am particularly concerned and dismayed at the apparent distrust of many of the practitioners, educators and researchers toward equipment manufacturers.

Recently, I paid my money and attended an excellent EMS conference. During one of the workshops, the facilitator called for involvement of all interested parties in a newly created forum. Since I had more than sufficient credentials, I volunteered. The facilitator thanked me for my company's past and present financial contributions, but expressed strong reservations about my participation since I represented a manufacturer. This is not an isolated case; I hear similar comments routinely.

This issue parallels many of the recent discussions, articles, and presentations calling for closer collaboration among the many EMS bodies, yet it is not always perceived the same. Is there a single group serving EMS that does not have its own agenda? Is there a single group that can't be charged with questionable motives? Professors who must publish or perish. Physicians who must conduct a study to complete residency. One medical speciality challenging the intelligence and motives of another. Federal agencies defending their actions following public outcry. Is the vested interest of an organization such as the International Fire Chiefs or the National Association of EMS Physicians any more or less credible than the Ambulance Manufacturers Association? Is a group that operates on tax dollars or as a non-profit corporation more altruistic or ethical than one which operates for profit?

Although many reputable manufacturers would meet the same criteria, let's use Ferno as an example. If we make inferior products, customers will not buy them. We are required by law to conform to Good Manufacturing Practices that are enforced by the FDA. Failure to do so may result in fines, imprisonments, loss of good will, loss of market share, liability, and litigation. We work with advisory committees to assist us in our product development. We conduct field and clinical trials and market research. We warrant our products. We offer training packages to our customers, and we demonstrate proper usage of the equipment. We support field personnel and distributors to ensure that our customers can perform their tasks well. What is it about our activities that cause worry, alarm, fear of consternation to those who believe manufacturers should not even be players in this game of providing EMS to our citizens?

We are routinely asked to support various organizations by becoming "corporate members." This means we pay money to finance their activities, which we are happy to do—but we have no vote in their decisions. We are asked to sponsor events or seminars, but are not asked to provide input. We are expected to "exhibit our wares" at hundreds of conferences each year, but we are considered outsiders and are seldom asked to participate actively in the conference.

We have been involved in prehospital emergency care since the funeral home days. We have been in the international arena for 30 years. Our products are used in 80 countries throughout the world. In many respects, we and other manufacturers like us, have a stronger command of EMS events and directions (on

a geopolitical, financial, and medical basis) than just about anyone.

Some may wonder if a manufacturer would attempt to "sell his wares" if given a voice in some of the areas I have discussed. While it is unlikely that a particular product would be promoted, you could expect the manufacturer to support a particular direction or vote for a particular cause, just as any other participant would support his belief system.

Understand that we do not expect you to embrace "salespeople" *per se*. You want knowledgeable individuals who came up through the ranks like you to sit in on these important meetings. Most manufacturers have someone in their employ who is prepared by education and years of experience to serve in such roles. Often, you will find that their perspective is considerably broader than that of many other participants.

People are genuinely worried about conflict of interest and this is a valid concern, but I question whether manufacturers pose a greater risk than any other subset of EMS. What do you think? Perhaps now is the time to create a dialogue that will lead to an understanding of appropriate involvement by all EMS groups regarding research, the future of EMS reimbursement issues, product development, and so on. Ferno and other manufacturers can contribute positively and effectively to the theoretical and accepted body of knowledge and assist in its dissemination. We can also teach organizations how to market themselves to government, other associations, and the general public. All manufacturers can be much more responsive to the EMS industry in providing the tools that are truly needed if we are included as partners in the beginning.

We really can't survive and we certainly can't forge ahead without each other. I would appreciate any response from *Prehospital and Disaster Medicine* readers on these issues.

K. Stephen Schmid, EMT-P, RN, BS
Director of Industrial Relations, Ferno

To the Editor:

I read with interest the article entitled "The Role of Health Sectors in Disaster Preparedness. Floods in Southwestern China, 1991" by Dr. Shao in the April–June 1993 *Prehospital and Disaster Medicine*.

In the credit caption at the right lower corner of both Figures 1 and 2, you had "1993 Xiaohong." On top of page 175, you also had Xiaohong. I suspect that you mistook Dr. Shao's first or given name as the last name or surname.

The Chinese always put their surnames first, followed by the first and then the middle names, as in the telephone directory, for example, Mao Tse Tung (Now spelled Mao Zedong). However, this is contrary to the Western custom in which the surname appears last, for example, Paul Dudley White. This Chinese tradition oftentimes creates a problem in English-language publications in the Western world. Just as Mao Tse Tung was sometimes referred to in the American newspaper as Mr. Tung, you mistook Xiaohong for Shao as the last name of the author of this article.

I point this out to you so that you will not make the mistake of listing Dr. Shao under Xiaohong in the Author's Index. This has happened in several other journals.^{1–3} Moreover, in many national and international medical meetings which several of

my Chinese colleagues were known to attend, I always had a difficult time locating them in the program or directory of the meetings, because frequently they were listed in the index under their first or middle names instead of their last names.

References

1. Cheng TO: The Chinese last name. *J Thorac Cardiovasc Surg* 1988;96:832.
2. Cheng TO: What's in a name—The Chinese name? *Angiology* 1989;40:324.
3. Cheng TO: Word order: Oriental or occidental? *Texas Heart Institute Journal* 1989;16:121.

Cheng Tsung O
Professor of Medicine
George Washington University
Washington, D.C., USA

Editor's Reply:

This was a regrettable oversight by the publisher who creates the running heads for the journal in its final production, and it was missed in the final proofreading for that issue. We have apologized to Dr. Shao for this oversight, and his article will be properly attributed and indexed by his surname. Thank you for finding this error and please be aware that we meant no disrespect in identifying the author incorrectly. Also, we have informed the publisher that the Chinese surname always is listed first, so that in the future running heads and copyright information shall be attributed properly. In our eight volumes, we always have attempted to be certain that our author's names have been spelled correctly. We regret this error.

Also Professor Shao was identified incorrectly as the President of the Chinese Academy of Medical Sciences. Dr. Shao is the President of the Chinese Association of Emergency Medicine. Please accept our apologies for any confusion or inconvenience that this error may have involved.

To the Editor:

In his editorial response to the article "SARA three years later: Emergency physician's knowledge, beliefs, and actions" (Jan-Mar 1993, page 39-44), James Page conveyed a frustration commonly experienced by emergency physicians. Administrative physicians have many responsibilities and few emergency department (ED) Directors have the time or resources to address all the issues requiring attention. But, preparing for chemical accidents should not be overlooked because of competing priorities.

As noted by Mr. Page, emergency departments may only have to care for a rare patient who has had significant exposure to hazardous materials and adequate preparation for this possibility may not appear to be worth the effort. However, another important issue is involved. That is the safety of your ED staff and other patients. At a minimum, emergency departments need to provide basic care to chemically contaminated patients, protect staff from dangerous exposures, protect the ED from possible shut-down due to spread of toxic materials, and shield the hospital from potential litigation and financial liability.

Protection of employees in the workplace, including those engaged in the process of caring for patients, is a major responsibility. The Occupational Safety and Health Agency (OSHA) regulation (29CFR 1910.1030), for instance, requires

that employers protect their workers from exposure to blood-borne pathogens. Procedures are being implemented to protect ED staff from the resurgence of active tuberculosis. Similar occupational safeguards should be established to protect employees from exposure to hazardous materials when they are caring for patients.

A case experience at Bronx Municipal Hospital Center in New York City a few years ago highlights this point:

A middle-aged male was working on a ladder over an open wash tank at a silver plating plant. He fell from a fifteen-foot height, striking his occiput on a pipe during the fall and landing, unconscious, in three feet of fluid containing multiple chemicals. A co-worker heard the fall, pulled the unconscious patient from the bottom of the tank, dragged him to another room, and notified 9-1-1.

A Basic Life Support unit found the patient awake, with a large occipital scalp laceration, neck pain, soaking wet with unknown chemical fluid and complaining of a severe sore throat and difficulty breathing. He was immobilized immediately and transported on a backboard to the ED of Bronx Municipal Hospital. Because of the short transport time, no notification was received by the ED. The patient arrived in wet clothing on a soaked wooden backboard, anxious and restless with *severe* shortness of breath. He required immediate intubation for upper airway edema and acute respiratory distress syndrome (ARDS). Despite aggressive critical care over the ensuing two hours, the patient succumbed to overwhelming aspiration injury.

No information was immediately available as to the chemicals involved and the patient's critical status upon arrival prevented decontamination prior to entry into the patient care area of the ED. During the period of treatment, a mildly noxious odor became evident as the fluid evaporated and several of the staff treating the patient developed headaches. The ED was required to institute a significant period of EMS diversion status until the trauma area was decontaminated.

Fortunately, the chemicals involved were not severely toxic to staff. However, the case clearly demonstrates that all chemically contaminated patients will not be adequately decontaminated prior to reaching the ED. The incident prompted the development of a system in which similar patients can receive critical care while protecting other patients and staff.

The American College of Emergency Physicians (ACEP) Section on Disaster Medicine, understands the dilemma. They are trying to develop standards for a "reasonable protocol" for treating patients exposed to hazardous materials. The questions are what is a minimal standard and where does one draw the line on preparedness?

Before we can come to a consensus on a standard of preparedness, we must understand that without a minimal plan,