

NCEMSF NEWS

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"Our collective advancement of collegiate EMS, achievement of personal growth, and a continued commitment towards improving humanity provide the framework of Dr. Pryor's legacy"

Message from the President

Dr. George J. Koenig, Jr., NCEMSF President

Several weeks ago, Paul Meddaugh, Chief and Executive Director of Harpur's Ferry Student Volunteer Ambulance Service, extended an invitation to speak at their dedication of a memorial plaque for Dr. John Pryor. Among many notable accomplishments, Dr. Pryor was a member of the class of 1988 at Binghamton University and during his college years an active member of Harpur's Ferry Student Volunteer Ambulance Service.

This past weekend approximately 50 students gathered on a sunny, Saturday afternoon to remember the accomplishments of Dr. Pryor. When I accepted the invitation from Paul, I did not realize the significance of my participation in the dedication. Many of the members of Harpur's Ferry SVA never knew John. Perhaps they heard of him through people that attended our conference, or maybe through the media, but few ever met him. Nevertheless, they felt an inseparable bond and loss of a member of our EMS community.

I began to realize that the importance of my participation was not only to provide a glimpse into the impact that Dr. Pryor had during his life, but to provide a sense of meaning to the memorial. I knew that Dr. Pryor would have wanted me to tell them how proud he was of them and the service that they provide to their community. I also wanted to ensure that this memorial was not just an occasion to remember a great person, but rather an opportunity to reflect personally on how each one of us can make a difference and truly let his legacy live on.

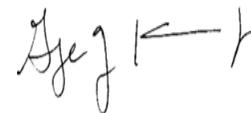
That night, I had met with several of the leaders of Harpur's Ferry. Over dinner, we discussed their future career plans. Noah Ginsberg, Deputy Chief, expressed his excitement about his summer internship at Sloan Kettering. The internship is designed to provide him with exposure for a career in hospital administration. Mike Simons, a recent alumnus, spoke of returning to school for a nursing degree with the aspirations of becoming a nurse

anesthetist. Paul Meddaugh, Chief, was trying to decide between pursuing a career in veterinary medicine or utilizing his current degree in biomedical anthropology in either the public health or environmental protection sector. It was during that conversation that each of them realized how their participation in campus EMS impacted their career choice.

Involvement in campus EMS provides an unparalleled experience for those in college. It provides an exposure to leadership, emphasizes the importance of team building, and strengthens problem solving skills. In addition to these skills that are essential to success in virtually every career, involvement in campus EMS reinforces the importance of giving back to your community. These values are what made Dr. Pryor a valuable proponent of our organization and the campus EMS community.

Our collective advancement of collegiate EMS, achievement of personal growth, and a continued commitment towards improving humanity provide the framework of a legacy that Dr. Pryor would have wanted us to remember him by. As an organization we strive to encourage these values. We hope that our commitment towards education, research, and leadership enables you to achieve your goals.

Best Wishes for a safe and relaxing summer,



George J. Koenig, Jr. DO
NCEMSF President

PADs and Home AEDs: A Review

Dr. Michael T. Hilton, NCEMSF National Coordinator

Although many assume that public access AEDs (PADs) are beneficial, this "fact" is hardly unquestionable. This is an important topic to collegiate EMS providers who may be involved with establishing or maintaining a public access AED program. AEDs' promise comes from their ease of use and their *potential* to provide a defibrillating shock early in the course of a sudden cardiac arrest. The problems associated with AED usage include cost (of the unit itself and also of preventative maintenance), liability, medical oversight, training and administrative labor, and lack of use in real-life situations by lay persons and non-medical first responders. This article will review briefly why AEDs may or may not be effective when used in public settings. Then, this article will discuss the evidence behind the use of AEDs at home and will discuss the reasons why home AEDs do not improve the survival rate from out of hospital cardiac arrests.

There is one key study to be aware of that addresses the use of AEDs in public settings. There exists, essentially, no other study of decent quality or level of evidence (LOE) that addresses the question of the effectiveness on survival rates of PAD programs, and this lack of evidence may be surprising to some. This research study looks at AEDs in a specific public area and setting. It does not show that AEDs improve survival in all public areas, or, in fact, in any setting not studied. Any improvement in survival of out of hospital cardiac arrest found in the study should not be extrapolated to settings that were not studied. Valenzuela and others published a LOE 3 study with good quality. It was a prospective case series of sudden cardiac arrests in casinos and showed an impressive survival rate of discharge from hospital of 74 percent.

There are a number of limitations to using this study as evidence that public access AEDs in other settings are effective. These limitations are also the factors that limit the success of any public access AED programs. First, in this study, AEDs were located throughout the casino so that the interval between collapse of a patient to first defibrillation would be 3 minutes. It is important to note that this requires many more AEDs in a higher concentration than in most PAD programs, which usually feature one AED

per building or one every few floors of a building, or even one per golf course. Also, all security personnel were trained in the use of an AED and in CPR. Casinos have many security personnel distributed so that everyone within the casino is visible. This means that any person that collapses is immediately noticed and that a trained responder is quickly available. Again, this is unrealistic in most PAD programs where a collapse is not usually immediately noticed, and, even if it is, a trained responder is not usually within eyesight. Finally, in a casino, most cardiac arrests occur in a very confined area. This is different than, for example, an office building where cardiac arrests may occur throughout a building, in difficult to access areas.

There have been no other studies of decent quality looking at survival rate from cardiac arrest when using PAD programs. Even so, most PAD programs are not likely to be effective at improving survival rate from out of hospital cardiac arrest to any significant degree unless the factors, mentioned above, are taken into consideration. Campus-based public access AED programs are ideally located for a collegiate EMS provider, aspiring pre-medical student or pre-public health student, to perform a PAD program research study. A starting place would be to identify a faculty member or advisor with research experience who would be interested in helping you. Also, another area of campus-based EMS service involvement in PAD programs is as a training provider of CPR and AED courses to the campus population, working towards the goal of having trained responders within sight of any cardiac arrest on campus.

In an ideal world, where cost was no matter and where the risks of the insertion of an implantable cardiac defibrillator (ICD) amount to none, then all people at risk for cardiac arrest (due to previous myocardial infarction, conduction system disease, heart failure, etc.) would receive an ICD. This is, for these same reasons, not realistic. Whereas ICDs would deliver a nearly instantaneous shock after the initiation of ventricular fibrillation or tachycardia, an at-home AED could deliver a shock much earlier than EMS could. So, surely, then, AEDs, non-invasive and cheap compared to ICDs, are the next best thing and

everyone at risk for cardiac arrest should have one at home, right? In fact, the evidence shows that there is no improvement of survival of out of hospital deaths with possession of a home AED.

After an exhaustive literature search, I reviewed the only two studies that have been published that address the question of out of hospital death with a home AED vs. no AED. The first article (chronologically) was published in 1989 by Eisenberg et al is LOE 2 with a fair study quality. This trial was a 57 months study of 97 survivors of out-of-hospital ventricular fibrillation. Fifty-nine patients received AEDs for home use. Thirty-nine did not and served as a control. The primary outcome analyzed was survival of out of hospital cardiac arrest (OOHCA) during the study period. Their results included 10 incidents of OOHCA in the AED group, of which the AED was used in 6 arrests. Two of the patients in whom the AED was used were in ventricular fibrillation and 1 patient survived several months with neurologic deficits (10% of patients survived OOHCA in AED group). Comparatively, there were 4 OOHCA in the control group with only 1 long-term survivor (25% of patients survived OOHCA in control group). However, this study has numerous weaknesses not least of which is a very small sample size and so no conclusions about the effectiveness of home AEDs should be made based upon this trial.

A much stronger and more recent study, considered to be a landmark study, is the HAT trial performed by Bardy and others and published in 2008. This study is LOE 1 with a good study design. This was an international (7 countries), multicenter (178 sites) trial that enrolled patients between Jan. 23, 2003 and Oct. 20, 2005. Patients were followed through Sep. 2007. This was a prospective, randomized control trial that enrolled patients in stable condition with history of anterior wall MI and a companion at home willing to call 911, perform CPR and use an AED. Patients were excluded if they were ICD candidates, already own an AED, or were DNR status. They enrolled 3506 into the control group. The protocol for this group was that after a sudden cardiac arrest of the patient, the companion would call 911 and then start CPR. They enrolled 3495 patients into

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the intervention group who followed this protocol: after a sudden cardiac arrest of the patient, apply and use the supplied AED, then call 911, and finally perform CPR. The primary outcome was death from any cause.

They found that a total of 450 patients died. Of these, 228 (6.5%) were in the control group and 222 (6.4%) were in the AED group. This means that the AED group had a death rate that was not statistically different from the death rate of the control group. The primary outcome did not differ among any pre-specified subgroups and secondary outcomes did not differ between AED vs. control. In summary, compared to having no AED at home, home AEDs had no effect on the death rate in a population at risk for out of hospital sudden cardiac death.

This can be explained by looking at the AED group more closely. The first reason that home AEDs are not effective is that only a small percentage of out of hospital deaths were due to tachyarrhythmia sudden cardiac arrests that were witnessed at home. A home AED is useless if the SCA occurs outside of the home, if the SCA is unwitnessed and if the death is not due to tachyarrhythmia sudden cardiac arrest. In the HAT trial, 169 deaths (37.6% of total) were from sudden cardiac arrest (SCA) due to tachyarrhythmia (ventricular tachycardia or fibrillation) – the deaths that theoretically could be treated with an AED. But, in the study, the AEDs were at home. So, how many of the tachyarrhythmia SCAs were at home? It turns out that 117 of these were at home, so only 70% of all tachyarrhythmia SCAs were at home. How many of the at home tachyarrhythmia SCAs were witnessed? Only 58, so only 50% of all at home tachyarrhythmia SCAs were witnessed. When looking at all tachyarrhythmia SCAs in the AED group, only 34.3% of them occurred at home and were witnessed. When looking at all deaths in the AED group, only 13% of these were tachyarrhythmia SCA, occurring at home and witnessed. We have now defined the deaths where an AED could possibly have been used, and it is very much less than the total number of deaths in the AED group.

The second reason that home AEDs are not effective is because available home

AEDs are used only about half of the time that they could be used. In HAT, a home AED was used in a witnessed at home tachyarrhythmia SCA only 32 times. So, a home AED was used in only 55% of witnessed at home tachyarrhythmia SCA deaths. Stated another way, a home AED that was ready and available for use in a witnessed at home tachyarrhythmia SCA was not used 45% of the time. Imagine how effective CPR would be if you used it in only half of the patients you respond to who are suffering from cardiac arrest – a treatment is simply not effective if it is available and not used half of the time.

The final reason that home AEDs are not effective is because AEDs (along with ACLS, emergency department care and intensive care unit care) are limited in their ability to affect death rates from cardiac arrest. Of all out-of-hospital cardiac arrests that EMS providers respond to, only an average of 4.4% survive to hospital discharge. In HAT, there were only 4 survivors of SCA after AED use.

To summarize, possession of home AEDs does not decrease death from all causes (LOE 1; Bardy 2008) or improve survival of out of hospital cardiac arrest (LOE 2; Eisenberg 1989). There is no evidence for improvement of survival with possession of a home AED.

Because of the dearth of available research, the use of public access AEDs and home AEDs is an exciting area for further research. If you are interested in this area, you should find a faculty mentor or advisor who can help you begin or join a project. If you would like further guidance on how to become involved in research, please email me without hesitation at nc@ncemf.org.



1. Valenzuela TD, Roe DJ, Nichol G, et al. Outcomes of rapid defibrillation by security officers after cardiac arrest in casinos. *N Engl J Med.* 2000 Oct 26;343(17):1206-1209.

2. Eisenberg MS, Moore J, Cummins RO, et al. Use of the automatic external defibrillator in homes of survivors of out-of-hospital ventricular fibrillation. *Am J Cardiol.* 1989 Feb 15;63(7):443-6.

3. Bardy GH, Lee KL, Mark DB, et al. Home use of automated external defibrillators for sudden cardiac arrest. *N Engl J Med.* 2008 Apr 24;358(17):1793-804. Epub 2008 Apr 1.

4. Nichol G, Thomas E, Callaway CW, et al. Regional variation in out-of-hospital cardiac arrest incidence and outcome. *JAMA* 2008 Sept 24; 300(12):1423-31.

Benefits of Membership

Karolina Schabbes,
NCEMSF Membership Coordinator

Do you wonder what benefits your NCEMSF membership provides? In addition to making a continued commitment to the advancement of existing collegiate emergency medical services and the development of new response groups, your membership provides financial support to promote Collegiate EMS Week, help support our annual conference, produce publications, honor outstanding collegiate EMS organizations and personnel through our awards program and advocate for collegiate EMS throughout the country.

Your NCEMSF membership also entitles you to a host of member discounts. These offers and discounts are detailed on our Web site and are available only to members of NCEMSF. Skyscape is the leading provider of medical references for PDAs, carrying hundreds of different titles across multiple specialties that are all cross-linked with each other. Skyscape, in collaboration with NCEMSF, offers you a 20% discount on the purchase of these references. Savelives.com / Common Cents EMS Supply, offers a 10% discount to NCEMSF members on many of its great products. Emergency Training Associates / The NCEMSF Store, offers up to a 26% discount for EMS texts and NCEMSF apparel. Purchases through the NCEMSF store also supports the Foundation. *JEMS* offers discount subscription to members. *Emergency Medical Services Magazine* is available to personal NCEMSF members free of charge. Newly introduced for us in 2009, watch for information about AllMed's VAP program that allows institutional members to save on hundreds of commonly-used EMS supplies.

Your NCEMSF membership adds to the collective strength of hundreds of members throughout the nation - those participating in and advocating for collegiate EMS. Renewing your NCEMSF membership in June for the 2009-2010 academic year shows your continuing commitment to collegiate EMS. Don't let your enthusiasm for collegiate EMS diminish just because your college graduation is imminent. NCEMSF offers life memberships which keep you in touch with the world of collegiate EMS. More information about our membership categories and rates can be found online at www.ncemf.org/membership.



Regional Roundup

News from Around the NCEMSF Regions

From the National Coordinator

The Regional Coordinator (RC) network exists to facilitate communication between NCEMSF and its greater than 250 constituents. It is through the Regional Coordinators that NCEMSF is best able to accomplish its mission of advocating and supporting campus based EMS. The Regional Coordinators are equipped to assist each squad with the day-to-day issues it faces and to help publicize squad achievements. There are few issues that the NCEMSF leadership has not seen before and for which it is not equipped to offer advice and guidance. If you are a CBEMS leader and have not met your Regional Coordinator, please contact me (Michael Hilton, NCEMSF National Coordinator) and I will gladly connect you with your regional coordinator.

Massachusetts

Christian Erhardt spoke to a group of EMTs and administrators from around Boston on April 2. The talk was sponsored by **Boston College**. The talk, "Experience, Judgment, and Professionalism", similar to the one presented at this year's NCEMSF conference, was well received and sparked inter-group discussions. In addition, Eagle EMS is expanding its service successfully, and aims to continue the work they are currently doing.

Boston University is running many EMT classes with over a hundred students total. They are excited about the enthusiasm and are looking forward to continuing their many training programs.

Brandeis Emergency Medical Corps (BEMCo) is re-evaluating its operating procedures and official status with OEMS to provide the best care to its community. They report that their numbers are strong and they have ambitious plans for future trainings.

Smith College EMS had to make small adjustments to its hours of operation in response to member numbers, but it is looking to stay connected with nearby colleges for group trainings and other support.

UMass Amherst is working to upgrade its service from event standby to QRS.

They have made their first big step in becoming an official BLS service, and are currently finalizing a proposal for getting a response vehicle.

An overall theme for all schools is a desire to work together to solve administrative problems, conduct joint trainings, share resources, and have a good time. Several schools in the greater Boston area aim to make this a permanent fixture – I will be in touch with all of you in the near future, and if you have a planned event that you would like to open to other schools, please email me at ma-rc@ncemsf.org.

Mid-Atlantic

Virginia Tech Rescue Squad has received a truck which will serve as a technical rescue vehicle for the Squad's growing Special Operations Division. The Ford F-350 will house hydraulic tools, ropes, confined space, and other technical rescue equipment. VTRS has also recently taken delivery of a Chevrolet Suburban to be converted to an interoperable command unit. The vehicle will be equipped with eight mobile radios capable of communicating over multiple frequency bands to assist in alleviating a lack of interoperable communications in the region. In November, VTRS wrote a grant for a strategic radio cache and was recently awarded \$850,000 through Montgomery County. VTRS is coordinating the purchase of 150 portable radios, an interoperable gateway system, portable repeaters, and deployable cellular phones for use throughout Virginia and anywhere in the country if requested. The cache will provide rapidly deployable communications for first responders where interoperability is required and existing communications are damaged or insufficient. The Virginia Tech Rescue Squad is proud to be celebrating its 40th anniversary in May.

Midwest

Case Western Reserve University EMS (CaseEMS) sent five delegates to the NCEMSF conference in Washington D.C. Their shared experiences have helped energize the organization. They have also realized the need to help make collegiate EMS a family. They have planned their annual barbecue with the police department as well as informal social gatherings throughout the

summer. The NCEMSF conference also lead CaseEMS to meet the founders of the University of Toledo start-up group. The UT-EMS founders are planning on visiting CaseEMS in the hopes of learning from some of the same start-up issues CaseEMS faced when it was starting in 2004.

Efforts are underway by a group of highly dedicated students to try and start an on-campus EMS squad at the **University of Toledo**. After attending this year's NCEMSF conference for the first time and gaining lots of great ideas and contacts, the cofounders are now planning to take a trip to Cleveland to visit CaseEMS and see how their organization runs. They are also meeting with their campus Chief of Police and administrators in the hopes of having all of the groundwork laid down to start operations sometime next year.

Pennsylvania

Bucknell University SERV has been focusing their energy on expanding and developing their membership through informal social events, athletic team-based competitions, and EMS-based informational training events. They were just approved to move from their current on-campus house to another one approximately twice its size starting in the fall '09 semester. The bigger house will allow them many much needed amenities and resources, including a bunk room, in-house computer, medical supply storage, in-house laundry facilities, full size kitchen, and brand new common room elements including a flat-panel TV with presentation capability, as well as brand new couches. The organization recently completed its annual Mock MVA "Dying to Drink" which was held at 1:00pm on April 19th, 2009. They really stepped up their efforts this year in advertising for and promoting the event in order to get maximum campus exposure and it was a huge success.

DeSales University EMS worked with the IT department and was added to the DeSales University website. It worked with the University Card Office to issue ID tags to each of its members. As a result of the discussion at the NCEMSF Conference Regional Roundtable, it also switched from monthly organizational meetings to weekly organizational

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meetings. DeSales EMS will be selling t-shirts to the university as a fundraiser within the coming weeks.

Temple University EMS teamed up with Temple University Police Department and conducted the International Police Mountain Bike Association (IPMBA) EMS Cyclist course over spring break. They were also pleased to welcome aboard their newest 7 members. Additionally, a number of undergraduate students took the First Responder course. Also, improvements to the EMS headquarters are ongoing. Most recently, internet was installed. In the next few weeks TUEMS will be gearing up for Spring Fling and Graduation Day.

Do you have news about your squad you'd like to share? Contact your regional coordinator and look for it in the next issue of NCEMSF News.

Regional Coordinator Network

Region	Name	E-mail Address
National Coordinator	Michael T. Hilton	nc@ncemsf.org
Canada	Jeffrey J. Bilyk	canada-rc@ncemsf.org
Central	Amy Berenbaum	central-rc@ncemsf.org
Massachusetts	Kathryn Kinzel	ma-rc@ncemsf.org
Mid Atlantic	David Weand	midatl-rc@ncemsf.org
Midwest	Joseph Grover	midwest-rc@ncemsf.org
New York	Eric Pohl	ny-rc@ncemsf.org
North Central	AVAILABLE	northcentral-rc@ncemsf.org
Northeast	Yoni Litwok	northeast-rc@ncemsf.org
Northern New England	AVAILABLE	nne-rc@ncemsf.org
Pennsylvania	Les Polk	pa-rc@ncemsf.org
Southeast	Noah H. Prince	southeast-rc@ncemsf.org
West	Dan Stepan	west-rc@ncemsf.org

Technology Advancements for NCEMSF

Scott C. Savett, PhD, Chief Technology Officer

NCEMSF is a schedule-oriented organization. We move through the academic year publishing four quarterly newsletters, promoting Collegiate EMS Week in the fall, and planning for our annual conference for the late winter. With such an unforgiving schedule, it's tough to take a breather and tackle things that aren't within our normal calendar. That doesn't mean that we aren't looking to improve our current resources and add new things to the mix, as evidenced by what's contained in this article.

As the Foundation's Chief Technology Officer, I'm pleased to announce two service improvements that should directly impact all NCEMSF members. First, we have changed the way our announcement-only e-mail distribution lists are maintained. We previously used a listserv program called Majordomo. While Majordomo in various incarnations served us dutifully for over a decade, it imposed limitations that were recently growing bothersome. As a result, we have replaced Majordomo with an e-mail list management program called dada. From your standpoint, announcement messages will continue to come to your e-mailbox in the same way. However, The Foundation will now be able to better manage bounced messages and archive messages. Dada also allows us to offer our announcements as an RSS feed.

The second change I'm happy to announce is the rebirth of the NCEMSF discussion forums as www.NCEMSForum.org. The NCEMSForum will be replacing the GENERAL-L e-discussion list. With more than 100 members already signed up on NCEMSForum.org, it's a lively place for collegiate EMS discussion. If you have not already visited, I would encourage you to register (free, quick, and easy) and start browsing the posts and participating in the discussions. Forum administrators Austin and Matt from SUNY Cortland EMS are sure to give you a warm welcome.

There are other technological changes on the horizon at NCEMSF. A brand new server is being prepared to be placed in service. With the new server our storage capacity will be significantly increased. With that new space at our disposal, we will be looking at ways to allow member squads to upload documents into an online repository. SOPs and bylaws are by far the most commonly requested documents. We currently link from a group's NCEMSF Web profile to its online SOPs. Under the new system, we would have a copy of the SOPs on our server instead of relying on them existing externally on your school's Web server. This new method will be the start of a great reference library.

Before signing off, I'd like to make you aware of two newer resources on the NCEMSF Web site. Did you know there is a pin map of all North American collegiate EMS organizations on our Web site? Visit: <http://www.ncemsf.org/resources/database/> and click on the link entitled "Show all groups on a map." Additionally, did you know there is a library of example patient care report forms (PCRs) on the NCEMSF Web site? Check it out at: <http://www.ncemsf.org/resources/pcr/>

We're always looking for ideas of how NCEMSF could better serve our membership using our computing resources. If you have a suggestion, please contact me at vp@ncemsf.org. We really do listen – just ask Austin and Matt on NCEMSForum.org.



"No matter what level of service you currently offer, there is something that you should be striving to achieve...your organization's leadership should have a stated list of achievements for both the near-term and long-term."

About This Publication

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Making Your Collegiate EMS Group REAL

Scott C. Savett, PhD, NCEMSF Vice President

Having been involved with NCEMSF since its humble beginnings in the early 1990s, I have witnessed several member organizations come and go over the years. In the early years, we usually didn't have a good handle on why a group disappeared. This was before e-mail communication was widespread, so we couldn't send a quick e-mail asking what happened. Long-distance calling was expensive at 25 cents per minute and the Foundation had no budget for such communication. It also pre-dated our regional coordinator (RC) system. So, when a group stopped coming to the annual conference and dropped out of sight, it became an enigma. In many cases all it took was a new group of motivated students a few years later to reinvigorate an organization and they would reappear on our radar screen.

Times have changed significantly. NCEMSF RCs are now our front-line representatives charged with fostering open communication with the 250+ campus-based EMS groups throughout North America. Free-flowing e-mail and unlimited long-distance calling are the accepted norms. As a result, RCs have a much better handle on the challenges that each group within their region is facing and the accomplishments they have realized.

In this article I'd like to discuss why certain groups thrive and others just scrape by or disappear altogether. I've discussed this topic in previous articles over the years, but it recently dawned on me that the ideals could be distilled down to a short acronym: REAL. We all know how much EMS personnel love acronyms (DCAP BTLS, anyone?).

R stands for responsibility. In a recent discussion with members from DeSales University EMS and Muhlenberg College EMS, it was very clear that these folks understood the gravity of the responsibility with which they had been charged. At both DeSales and Muhlenberg, the campus EMS organization is an extension of the campus public safety department. Just as a public safety officer is ultimately responsible for the safety and welfare of students, staff, and faculty, a campus EMS group is responsible for the emergent medical needs of the same population. And just as a public safety officer can't blow off a shift due to other personal commitments (they'd likely get fired), a campus EMT can't pull a "no show" for a shift. In our discussion, it boiled down to this: while campus EMS is generally considered a student activity, it is unlike any other activity. If a member of the jazz choir doesn't show up for

practice, nobody dies. If a flag football player decides to take the day off to see a concert instead, it doesn't have any large repercussions. But if a campus EMT is irresponsible and misses a shift and doesn't arrange for coverage, there is a possibility (admittedly remote) that somebody on campus will die. At a minimum, you should recognize and respect the level of trust and responsibility that campus administrators have bestowed upon you and your organization.

E stands for education. Being at an institution of higher learning, your connection to education is multi-faceted. First, every campus EMS member must realize that your number one priority in attending college is to gain an education yourself. Dedication to a campus squad should never trump academic needs. In other words, your GPA should not suffer appreciably because you are saving lives on campus. Having said that, I will posit there is more than just classroom-based education for campus-based EMS providers. Through on-scene experiences as well as interacting with others in the campus community, campus-based EMS personnel learn resource management, leadership, and inter-personal skills among other things.

Secondly, education is also a key to ensuring the campus community understands campus EMS' role. How do people get in touch with you if there is an injury or illness on campus? What should they expect will happen once they call you? What is your scope of practice (put in layman's terms)? When I say "campus community" I mean everybody who is regularly on campus – the cafeteria staff, public safety officers, professors, secretarial staff, fellow students, athletic trainers, maintenance personnel, etc. By publicizing how you are activated and what types of situations you are equipped to handle, you'll minimize surprises for everyone involved.

There is a third aspect of education that all squads should embrace: continuing education of your members. Regular formal and informal training and education should be offered. All members should be mandated to attend at least a stated minimum number of training sessions.

A stands for achievement. Your organization and every member within it should strive to achieve greatness. Rather than be a wall flower, the organization should be a prominent and visible component of the campus community and the greater EMS community.

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There are wonderful examples of this such as Harpur's Ferry Ambulance (Binghamton University), which was named Emergency Medical Services Agency of the Year by the New York State EMS Council. Syracuse University Ambulance received the same award the year before Harpur's Ferry. It's no surprise that these organizations received such a prestigious award since the groups continually strive to innovate.

No matter what level of service you currently offer, there is something that you should be striving to achieve. For example, if your group is BLS/QRS that responds on foot, perhaps you should look to obtain a vehicle. If you currently offer evening-only or weekend-only service, the next logical step may be to increase your hours of operation. If you are currently running with limited personnel, you should be examining ways to bolster your roster with new members. In other words, your organization's leadership should have a stated list of achievements for both the near-term and long-term. These achievements can be both proactive and reactive.

L stands for legacy. I'd urge you to consider organizational stewardship in all aspects of your group's planning and operations. In other words, in the back of your mind you should be asking, "What are the long-term implications for what I'm doing for the squad right now?"

Sometimes there is a disconnect between what is good for a campus EMS organization in the short-term and long-term. Is it a morale boost to have an off-campus end-of-year party for your organization? Certainly. Is it OK to serve alcohol and have a YouTube video surface with your under-aged members drinking at the party? Absolutely not. Such an example is extreme but very real – there is recent precedent for this situation.

This isn't to say that the social aspects of collegiate EMS are unimportant – they certainly are meaningful and I have written about that in past issues of *NCEMSF News*. I would say that part of an organization's legacy is developing and maintaining a list of alumni. The reason is simple: since alumni probably won't be actively running calls with your group, it's important to include them

appropriately in social events. The simple act of including alumni in the loop may lead to real benefits such as gift-in-kind or monetary donations to your organization. If nothing else, some of your alumni have undoubtedly continued in the medical field and might be useful resources for continuing education.

In summary, none of the ideas I have presented here are new. Over the years NCEMSF's leaders have been espousing them, though perhaps not in such a concentrated manner. Making your group REAL just sets the stage for success. Just as staring at a treadmill won't help improve your cardiovascular health, reading this article and doing nothing in response to it won't improve your organization's health. I'd encourage you to get REAL to ensure your group's health and longevity.



Early April, NCEMSF sent all members an email calling for nominations for its six executive officer positions. Interested parties were asked to submit a letter of intent along with a copy of their curriculum vitae and position statement to the nominations committee. Having received no nominations by the posted deadline, the secretary casted one vote for each incumbent.

Congratulations to the six incumbent officers on their unanimous reelection!

President:	George J. Koenig, Jr, DO
Vice President:	Scott C. Savett, PhD
Secretary:	Joshua A. Marks, MD
Treasurer:	Michael S. Wiederhold, MD, MPH
Director:	Mark E. Milliron, MS, MPA
Director:	Eric MaryEa, NREMT-P

Interested in becoming more involved, send us your ideas for programs/projects and how you see yourself working with the NCEMSF Board. There are multiple opportunities to get involved with various committees and initiatives.

NCEMSF Executive Officers
President
George J. Koenig, Jr., DO

Vice-President
Scott C. Savett, PhD

Secretary
Joshua A. Marks, MD

Treasurer
Michael S. Wiederhold, MD, MPH

Directors-at-Large
Mark E. Milliron, MS, MPA
Eric MaryEa, NREMT-P

Division Chairs
Membership Coordinator
Karolina A. Schabses, MPH

National Coordinator
Michael T. Hilton, MD

Startup Coordinator
Andrew S. Mener

Alumni Coordinator
Daren T. Spinelle

EMS Week Coordinator
Timothy J. McMichael, NREMT-P

Contact Information:
PO Box 93
West Sand Lake, NY 12196
Phone / Fax: 208-728-7342
Email: info@ncemsf.org
Web: <http://www.ncemsf.org>



Interested in starting a new collegiate EMS organization?

Contact the startup coordinator at startup@ncemsf.org and ask for the new "NCEMSF Guide to Starting a Collegiate EMS Organization."

National Collegiate EMS Foundation
PO Box 93
West Sand Lake, NY 12196-0093

Note: personal NCEMSF membership follows the academic calendar and will expire on May 31, 2009. Please visit the Membership section of the NCEMSF Web site to renew your membership and update your contact information.

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Indicate your support of NCEMSF on your organization's home page!



We have updated the graphic, which may be downloaded from:
<http://www.ncemsf.org/logos/>

MARK YOUR CALENDARS!

The NCEMSF Board of Directors is excited to announce

The 17th Annual NCEMSF Conference will be held February 26-28, 2010 in the Heart of Charm City's Inner Harbor

**The Hyatt Regency Baltimore
300 Light Street, Baltimore, Maryland 21202**

Further Details in the coming months at www.NCEMSF.org