

NCEMSF NEWS

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"The most difficult challenge that many organizations face is maintaining a competitive edge."

Message from the President

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

As we count the days until winter break, we are confronted with the hurdle of finals. We turn our focus to summarizing our academic efforts for the semester in papers and exams. In a few short days, it will be a blur as you return home for a break from academic stresses. Each year, during this temporary reprieve from other commitments, I reflect on the past year. During the semester break, I encourage each of you to take a moment and reflect on the accomplishments and challenges of your campus EMS organization. Think about creating a plan to further your organizations' accomplishments and promote sustained growth while addressing the challenges.

The most difficult challenge that many organizations face is maintaining a competitive edge. Failure to address this challenge leads to the demise of not only new organizations but also well-established organizations. A competitive edge can be defined by several broad categories with regards to campus based EMS. Similar to many businesses, the service that you provide can be at risk to competing service providers. While this is rarely the case, we must not forget that there are other providers that may be willing to offer the same service. It is essential that we continue to provide excellent care at the highest professional standards.

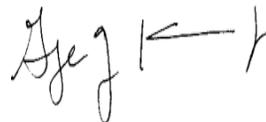
On college campuses, we find ourselves more often competing with other organizations for members. Campus based EMS requires a substantial commitment to complete training and time to provide care. Since there is a limited amount of time that people can spend on non-academic activities, we need to maintain a competitive edge by promoting the value of being involved in pre-hospital care. In addition to attracting members, maintaining a competitive edge is necessary to ensure funding within the budgetary constraints of your university. It is essential that through public relations you continue to educate your campus community about the value and worth of the services that you provide.

Maintaining a competitive edge is directly linked to sustaining the growth of your organization. Your organization can not succeed with one and not the other. Some define growth as the rate of increase in your membership. Others define growth by expanding services that you provide. However, it is important to not define your organizational growth by a single metric. Growth should be defined by compiling several indicators. Using a single indicator can be misleading and can lead to incorrect conclusions about the health of your organization.

In order to maintain your competitive edge, during the semester break, take a moment and commit to writing your organization's goals for the remainder of the year. Get input from your members and staff and rank the goals in the order of priority. Identify the resources that are needed to achieve your goals. Do you have enough resources within your organization to achieve your goals? If your answer is no, you need to go back and redefine your goals. Consistent growth is not obtained from lofty goals. It is obtained from goals that are achievable. After deciding on goals that you can accomplish within the constraints of your resources, the next step is developing an action plan. Implementing change is difficult. However, creating milestones and breaking goals into smaller tasks can help. Goals that seem impossible become achievable when implemented in steps. In addition, timelines promote accountability and help track progress. Remember goals are something to work towards to help your organization grow. They are rarely instantly achievable.

I look forward to seeing you in Philadelphia this winter so that we can continue to exchange ideas to make our organizations better.

Regards,



Cold Emergencies

Michael T. Hilton, MD, NCEMSF National Coordinator

With the weather getting colder in much of the NCEMSF world, now is a good time to review cold emergencies. Cold exposure illness can affect anyone. On college campuses, the use of drugs and alcohol puts students at direct risk. Prolonged activity in this environment can also lead to emergencies.

Normal body temperature ranges between 35 to 38.2 degrees Celsius (95 to 100.8 degrees Fahrenheit). Anything below this is called hypothermia (which is always pathologic). Body temperature is maintained by the hypothalamus, a part of the brain which acts as a thermostat. It receives sensory information from nerves in the skin and deep inside the core of the body.

At rest, your body normally produces heat in the range of 40 to 60 kcal (one kcal is one food Calorie) for every meter-square of body surface area. This is from all of the activity that occurs in your body at rest: thinking, digesting, peristalsis, breathing, heart function. At the same time, your body loses heat at rest, mostly by radiation (55-60%) and evaporation (22-40%). Conduction and convection account for about 15%.

In a cold environment, there is a behavioral response: you begin to move and fidget (which raises heat production), there is a desire to huddle with others (decreases radiant heat loss) and to seek warm environments. The body begins to shiver, with quick, fine muscle movements, increasing heat production, and your peripheral blood vessels constrict, decreasing radiant heat loss. Beyond this, there are further endocrine and biochemical responses to cold which aim to increase heat production.

Cold emergencies come in two categories: systemic and local. The otherwise healthy person can suffer from these emergencies because of extreme cold, because of prolonged exposure, or because of factors increasing heat loss: (wet clothes increasing conductive and convection heat loss), water submersion or immersion (increase in conductive heat loss), windy environment (increased convection heat loss), and/or low humidity (increase evaporative heat loss). This is seen in hikers, mountain climbers, soldiers, but also in otherwise healthy athletes in cold environments and so may

be seen on college campuses (polar bear clubs, winter track, football, paddle tennis, recreational runners).

Cold emergencies also occur in those with underlying illness, drug exposure and those of age extremes. Because of these other factors, this type of cold emergency can be seen in minimally cool or even in normal temperature environments. Systemic illnesses that increase heat loss, decrease heat production or impair the body's response to cold environments include sepsis, diabetes, congestive heart failure, peripheral vascular disease, COPD, spinal cord injury, hypothyroidism, malnutrition, anorexia, adrenal insufficiency, eczema, burns, psoriasis, stroke, leukemia/lymphoma, among many others. Drugs that can decrease heat production and increase heat loss include anti-hypertensives, anti-depressants, anti-psychotics, anti-anxiety medications, heroin, carbon monoxide, benzodiazepines, and, most importantly, alcohol. Alcohol leads to decreased heat production, ineffective shivering and to increased heat loss (through peripheral vasodilation).

Hypothermia causes a number of changes to the body. Cardiac arrhythmias are common including tachycardia, bradycardia or even ventricular tachycardia, ventricular fibrillation and asystole. Blood pressure, initially increases, and then decreases. Respiratory rate, initially increases, and then decreases substantially. CNS function and mental status become depressed.

Hypothermic patients are cold to the touch. If you carry a thermometer, mild hypothermia is between 32 (89.2) and 35 (95) degrees. Moderate hypothermia is between 28 (82.2) and 32 (89.2) degrees. Severe is less than 28 (82.2) degrees. Initially, patients will be shivering and agitated, but will begin to display decreased mental status and respiratory rate. They will begin to act almost as if they are drunk, with staggered walking and slurred speech. Shivering will begin to decrease at less than 32 (89.2) degrees and cease at less than 30 (86) degrees.

As in all patients, your first priority is to protect yourself. Ensure that you are

protected from the elements and that you will not become trapped in the cold environment. Your next priority is the airway. Due to mental status and depressed respiratory rate, these patients may need good BLS airway control with head-tilt/chin-lift, oral or nasal airway, assisted ventilations, or other advanced airway control device. As for breathing, they should be placed on 100% oxygen, either by non-rebreather mask or, if their own breathing effort is insufficient, by assisted ventilations. These patients need 100% oxygen because hemoglobin, which carries oxygen in the blood, dysfunctions in hypothermia, and has an increased affinity for oxygen (it releases less oxygen to the body's tissues). If possible, humidify the oxygen to prevent evaporative heat loss via the lungs.

As for circulation, check the pulse. As noted, it may be slow, fast or not present. If needed for hypotension establish IV access and start a normal saline fluid bolus (hypothermic patients are volume depleted because of loss of intravascular volume from the hypothermic-injured kidneys) – however, if there is no hypotension or other indication for IV fluids, do not administer IV fluids because room temperature IV fluids can further cool the patient and cause deterioration. If the patient arrests, remember to continue BLS cardiac arrest care until the patient is “warm and dead.” Non-pulsatile patients have survived over one hour of CPR. You may need to push harder than usual for CPR to be effective – the hypothermic chest is less compressible than the chest of a normothermic patient. Do not expect any shocks delivered from the AED to be effective. The hypothermic heart is less responsive to electro-therapy due to depression of its conductive system and of the myocardium. As for ALS care, keep in mind that these patients may benefit from sodium bicarbonate as they tend to be acidemic and their own blood has lost its ability to buffer acids. ALS drugs such as epinephrine, do not bind their receptors in the hypothermic patient. As these patients rewarm, the medications that were administered when the patient was cold will hit the patient like a brick wall and you may see extreme hypertension and tachycardia. Do not terminate resuscitation in the field

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The Evolution of Change

Joshua A. Marks, MD, NCEMSF Secretary

Ever wonder why certain things are the way they are or who designed them that way? When one investigates, one discovers that whatever it is, was not necessarily envisioned in a particular way, but rather evolved over time. Each individual step was a response to the elements already in place at the time of its creation. If one were to go back to the beginning and create all of the components at once, the end product would frequently look much different and often be much more efficient.

The examples of this are numerous. As I navigate the hospital maze daily, I am stupefied as to how it is laid out and what is located where. Certainly no one intentionally built it that way, but as buildings were added and parts upgraded the layout developed. In an ideal world the trauma bay, operating room, and intensive care unit would all be in immediate proximity of one another and

not on different floors in separate, albeit connected, buildings. The healthcare system as a whole has also developed in stages influenced by various special interests. Certainly no one could have intentionally designed the system we currently have in its present form. Similarly, our Foundation has grown and evolved over time responding to the specific needs of our constituents. As NCEMSF works to update our resources and improve our online presence, we are recognizing this phenomenon, Hindsight allows us all to look back and say we would have done certain things differently, however, perhaps we are able to say that only having experienced the current way first.

Faced with revamping individual pieces or restarting from the beginning, we are forced to weigh the risks and benefits of starting from scratch compared to patching what is broken. Is disruption of

service or changing what our members are used to worth it even if the new product offers some improvements?

As with most things, you need to understand your audience and strive to meet its expectations. You need to know your goals and have a clear mission. Failure is often not an option, so a well thought out plan is critical as is a willingness to change course and rework the plan when the original is not meeting the end goal. However, the process cannot be permitted to stymie forward progress or ultimate success.

With that as the introduction, several significant changes will be evident at this year's conference and the long awaited new Web site and online resources will be unveiled. We hope we meet your expectations!



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for the hypothermic cardiac arrest.

Beyond the ABCs, your treatment is to stop the cooling. Remove the patient from the cold. Place them in your ambulance (turn up the heat prior to heading out to the scene). Remove wet clothes that increase conductive heat loss. Place the patient in multiple layers of blankets (this decreases radiant, conductive and convective heat loss). These methods are called "passive rewarming."

Certain patients should also begin to receive active rewarming. Most of the methods of active rewarming are restricted to the hospital environment due to invasiveness and/or equipment needs. These include heated air blankets, peritoneal dialysis, heated irrigation (gastric lavage, colonic lavage, thoracic lavage), diathermy (heating via energy waves – microwaves and ultrasound waves), and extracorporeal blood rewarming (hemodialysis, cardiopulmonary bypass). In the prehospital environment, active rewarming can be accomplished with warm bottles or warm packs in the groin and axilla - ensure you protect the patient from burns - and with warm IV fluids.

In terms of transport decision, these patients should be brought to the nearest emergency department. Even if some of

the active rewarming methods are not available there, these patients require further stabilization prior to transfer to a more distant facility.

Local cold emergencies occur in the form of frostnip and frost bite. Frostnip is something many have experienced. It is characterized by transient numbness, tingling and mild pain in the tips of the fingers, toes, or other areas of distal blood flow, such as the nose and ears. It is caused by local vasoconstriction that decreases blood flow to the area involved. It is a superficial injury only with no actual destruction of tissue. It should be managed by passive rewarming techniques. Most importantly, get the patient out of the cold because this can progress to frostbite. Frostbite is characterized by complete numbness and severe pain. The same areas mentioned above are the most often affected. As opposed to frostnip, frostbite is characterized by actual tissue destruction. The prolonged and/or intense cold causes severe vasoconstriction leading to ischemia of the area involved. The nerve fibers begin to die, leading to numbness. Ice crystals form in the tissues that cause further physical destruction. Eventually, the severe pain is replaced by a dull ache that can persist for weeks to months. The skin can appear frozen, but more often is mottled

or waxy and is pale yellow or violet-white. The treatment for frostbite includes removing the patient from the cold. Remove wet garments. Place sterile gauze around the wound and immobilize, if possible, the area affected. Avoid movement, friction or rubbing of the extremity. This causes further physical damage because of the ice crystals present in the tissue. ALS providers should provide pain medication. It is important not to begin rewarming of the injured area in the field because further tissue damage occurs if there is only partial rewarming, if rewarming is achieved slowly or if rewarming is interrupted. Transport the patient to the nearest emergency department.

Collegiate EMS providers may not see hypothermia or frostbite often, but it is important to be able to understand, recognize and be able to care for patients experiencing these emergencies.



References:

1. Danzl, D. Frostbite (Chapter 137). Rosen's Emergency Medicine, 7th edition. Mosby Elsevier, 2010.
2. Platt, M and Vicario, S. Accidental Hypothermia (Chapter 138). Rosen's Emergency Medicine, 7th edition. Mosby Elsevier, 2010.
3. Millin, M. Heat/Cold Exposure (Chapter 18). Clinical Aspects of Prehospital Medicine. National Association of EMS Physicians, 2009.

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 near 300 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 RC.

Canada

University of Windsor Emergency Response Team (UWERT) once again had a fantastic EMS Week, conducting various public relation activities including visiting a grade school and conducting a 9-1-1 information session, holding a health fair, and offering public free CPR awareness for CPR day. UWERT also received a new special event golf cart for site responses, and continues to experience success with its new orientation and training program. A new addition in the winter will be a revamped continuing education lineup including external guest speakers.

Under new leadership *Brock University Aid (Brock Aid)* has started to make motions towards a serious expansion in training and level of service. In the past Brock Aid was only event coverage at the CPR/First Aid level; however, it is now pushing the university towards on-call status with an Emergency Medical Responder training program. The group is working very closely with NCEMSF to accomplish its goals.

Ryerson University Student Emergency Response Team (RyeSERT) has ceased operations of its off-campus special event team and has focused its resources on expanding its on-call service to hopefully be 24/7 for the entire campus. It also ran a PR booth for EMS Week.

Massachusetts

Brandeis Emergency Medical Corps (BEMCo) has been getting good publicity lately: three stories have been published in various Brandeis newspapers about the group, its mission, and about the six new AEDs Brandeis received this year. BEMCo's major project was to train the community on the use of these new AEDs, which the group accomplished during EMS Week.

Tufts EMS has acquired a new emergency response vehicle – a Ford Explorer completely outfitted with state-of-the-art sirens, LED lights, and Scotchlite reflectivity. This vehicle replaces a prior

model, and TEMS is very excited to use the new truck.

Boston College EMS set out for a very productive EMS Week, teaching CPR principles on Monday and handing out emergency preparedness information throughout the rest of the week. Members continue to promote their group on the campus, and help organize continuing education opportunities for surrounding schools.

Midwest

Case Western Reserve University EMS (CaseEMS) has made several significant accomplishments this semester. It has instituted new protocols with a wider scope of practice (still BLS though). It also planned and executed the largest mass casualty drill in CaseEMS' history, including 70 volunteer patients and responders from University Hospitals Medevac, Cleveland EMS, Cleveland Fire Department, Cleveland Heights Fire Department, and of course, CaseEMS. The drill also transported several patients to University Hospitals Emergency Room for further simulated treatment. In addition, CaseEMS now has several AHA CPR instructors within the organization who have begun teaching CPR to the Case Western community. Finally, the group has responded to more calls this semester than any semester in the past and is looking at acquiring an ambulance to better serve the campus.

This semester *John Carroll University EMS (JCUEMS)* established a bi-weekly continuing education program for its members, complete with a run review with the Medical Director. The group also completely changed its application process to be accepted as a member into the department to include an essay as well as a standardized interview. The biggest accomplishment has been getting a CPR initiative off the ground, which included getting over 50 members of the group's members community CPR certified this semester.

North Central

The University of Wisconsin Police Department First Responders celebrated National Collegiate EMS Week by hosting an open house to showcase its new facilities. Visitors were able to see equipment and hear about the services

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offered by the UWPD First Responders. A great turn out included the Dean of Students, Chief of Police, and several other prominent community members. The First Responders also taught Compression-Only CPR (CCR) during the Open House. The UWPD First Responders plan to make this an annual event.

Northeast

TCNJ Lions EMS held a CPR/AED certification class at the end of Collegiate EMS week. The organization hoped to spread awareness within the community while simultaneously advertising its EMT class.

University of Rhode Island EMS has launched an initiative to start a fire rehabilitation team that will be utilized regionally and county-wide. It will be a special response team with equipment such as a tent, water coolers, Gatorade, extremity-cooling chairs (which research has shown to be effective), a pulse CO-oximeter (vs a standard pulse oximeter—this can detect differences between CO levels vs. O2 levels), etc. The volunteer team members will be trained in fire rehab according to the latest NFPA standard.

Pennsylvania

On December 4th, 2010, DeSales University EMS hosted one of the nation's leading EMS law firms, Page, Wolfberg and Wirth, LLC, for a day of learning.

Regional Coordinator Network

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West

A senior capstone group has taken an interest in the volunteer services of Santa Clara University EMS and has decided to engage in a fundraisers that will benefit the squad. SCU EMS intends to use the extra funds to update their carts and provide financial assistance for the certification/re-certification process.

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.



NCEMSF Awards Capture the Spirit of Collegiate EMS

NCEMSF recognizes outstanding efforts made by individuals and organizations through our awards program. Instituted in 1997, the program currently has nine different awards:

- Striving for Excellence
- Richard W. Vomacka Student Speaker Competition
- Collegiate EMS Week Celebration of the Year
- Collegiate EMS Video of the Year
- Collegiate EMS Web Site of the Year
- Collegiate EMS Advisor of the Year
- Collegiate EMS Provider of the Year
- Collegiate EMS Organization of the Year
- George J. Koenig, Jr. DO Service Award

NCEMSF also recognizes 5-year milestone anniversaries.

The NCEMSF awards committee reviews all nominations. Awards are presented each February during the Annual National Conference. Nominations RECEIVED BY the Friday two weeks prior to the start of the conference will be considered for that year's award (Deadline this year is February 11).

Only current year dues paying institutional members are eligible to receive NCEMSF recognition. Individuals nominated for individual awards need not be dues paying members to win, however, their institution must be up-to-date with its dues. With the exception of Striving for Excellence, no nomination form or application exists. Nominations should consist of a formal nominating letter making the case for the nominee and highlighting unique attributes that distinguish the nominee. Any appropriate

supporting documentation should also be provided. See each individual award description on the NCEMSF Web site for additional specifics as well as the current conference year's Web site. An organization may submit and win multiple awards. Self-nominating is permitted; however, supporting documentation is required. Submitted materials may be featured in future NCEMSF published media.

All nominations and supporting material should be sent to the e-mail (preferred), fax, or postal address below:

awards@ncemsf.org

(208) 728-7342
NCEMSF
PO Box 93
West Sand Lake, NY 12196

The Benefits of Membership

Karolina A. Schabses, MPH, 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 including *NCEMSF News*, honor outstanding collegiate EMS organizations and personnel through our awards program, and advocate for collegiate EMS throughout the country.

Membership benefits include great member discounts and offers, consulting services, reduced conference fees, eligibility for annual awards and membership cards. Check out our latest offers online from a variety of vendors including EMS equipment and supply companies (Gall, Common Cents EMS, AllMed), trade text books (EMSBooks.com), software (SkyScape and journals (EMS Magazine, JEMS) as well as a number of other companies. Discounts range from 10-60% off applicable merchandise. EMS Magazine subscription is free with NCEMSF membership. Discount codes, where applicable, may be found on the NCEMSF Web.

Purchases through Galls and EMSBooks help support the Foundation as a percentage of all sales are donated to NCEMSF.

We appreciate your ongoing support! Information about our membership categories and rates can be found online at www.ncemsf.org/membership.



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THE JOURNAL OF EMERGENCY CARE, RESCUE AND TRANSPORTATION



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Alumni Corner

Joshua E. Glick, NCEMSF Alumni Coordinator

After gathering suggestions from various collegiate organizations, plans for the new NCEMSF Alumni Network are quickly moving forward. Development of the improved network will continue on through the winter months, and the new online system should ultimately be available for senior collegiate EMS members who will be graduating this upcoming spring. The new network will provide recent graduates with connections to professionals around the country, ultimately assisting in career development.

I would like to encourage all collegiate organizations to reach out to alumni and extend an invitation to the national conference next February. In addition to hosting a reception catered specifically to alumni of NCEMSF, the conference offers a great opportunity for alumni to reunite with old friends and colleagues. We are expecting a high turnout of alumni this year and hope to see every squad well represented.



How were Collegiate EMS Week and CPR Day celebrated on your campus???

NCEMSF wants to hear, please email stories, photos, videos, press releases and local press coverage to: emsweek@ncemsf.org

"No matter how obvious they may be, we don't always heed the warning signs presented to us..."

About This Publication

NCEMSF NEWS is an official publication of the National Collegiate Emergency Medical Services Foundation (NCEMSF). This newsletter is published as a service to the Foundation's members and the national EMS community.

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E-mail articles to be considered for publication to in-

Heeding Warning Signs

Scott C. Savett, PhD, NCEMSF Vice President

Warning signs for all sorts of things surround us in daily life. A stench when you uncap the milk jug suggests that you should pick something else to accompany your breakfast. A score of 60% on a biology quiz might be a wakeup call that more time should be spent cracking the books instead of browsing Facebook or running EMS calls. And that "Check Engine" light on your car's dashboard would seem to indicate that a visit to the mechanic may be in your near future.

No matter how obvious they may be, we don't always heed the warning signs presented to us. There are many examples in recent history where disastrous consequences ensued when experienced people did not heed warning signs. Scientists reviewing the circumstances behind the disaster at BP's Deepwater Horizon rig in the Gulf of Mexico noted that critical alarms aboard the drilling rig were purposefully disabled. To make matters worse, workers disregarded what they considered to be anomalous readings from their other instruments and continued to work in spite of them. In the end, a cascade of critical errors and omissions led to the loss of life and a huge environmental disaster.

Turn the clock back to a frigid morning in Cape Canaveral, Florida in January 1986. A Space Shuttle had never been launched in such chilly conditions. Several engineers expressed their concern about the effect of the temperature on the resilience of the rubber O-rings that sealed the joints of the solid rocket boosters. Those engineers were ultimately overruled by their managers and NASA officials who demanded to be shown that it was *not* safe to launch despite the lack of performance data at such low temperatures. At 73 seconds into the flight, Space Shuttle Challenger began to break up in flight, ultimately killing all seven crew members aboard. The subsequent investigation found "...failures in communication that resulted in a decision to launch [Challenger] based on incomplete and sometimes misleading information, a conflict between engineering data and management judgments, and a NASA management structure that permitted internal flight safety problems to bypass key Shuttle managers."

In summary, bad things tend to happen when people don't understand the information provided to them or just patently ignore it: airplanes fall out of the sky (Air Florida Flight 90; ValuJet Flight 592), nuclear power plants melt down (Three Mile Island; Chernobyl), and hydro-electric generating stations explode (Sayano-Shushenskaya).

We have all seen clueless drivers ignore the lights and siren of an approaching ambulance, police car, or fire truck. New drivers are taught it's the law to "drive to the right-hand curb or edge of the road and stop completely and remain stopped until the emergency vehicle has passed." Blaring sirens, throaty air horns that sound like a freight train, wig-wag headlights, and enough flashing red and white LEDs to illuminate a small city apparently do not work well enough. How is it that so many people fail to heed the call to action?

Now imagine that *you* are the oblivious driver who refuses to pull over and stop for the ambulance in your rear view mirror. Or, better yet, imagine that you are an oblivious officer of a campus EMS squad that has had difficulty recruiting and retaining members for the last three years. A steadily decreasing number of active members in an organization should be like a shrill siren calling you to action.

The easy way out is to hit the "alarm silence" button without actually doing anything about the underlying problem. Unfortunately, over the years the NCEMSF leadership has seen a number of campus EMS groups do that – and slowly slip away just as the Titanic quietly slipped beneath the surface of the North Atlantic after hitting an iceberg. No matter how unsinkable you think your campus EMS group may be, you should always be on the lookout for icebergs.

What can you do today to ensure the continued existence of your campus EMS squad in the future? Careful observation and proactive communication are keys. Try to spot trends as they develop rather than after they have already been established. For example, you could track the number of members who attend your regular meetings. If the number is steadily decreasing, it may be time to examine how the meetings are run or the content of the meetings. If your call volume is decreasing, it may be that people do not know about your service and it is time to have a PR blitz around campus. These are just two examples of how a proactive approach can turn the tide and mitigate larger potential problems in the future.

The NCEMSF leadership is here to help your organization avoid pitfalls. There are few situations that we have not previously come across. Please reach out to your regional coordinator or other NCEMSF leader if your group is hitting a wall.



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*Check out the
NCEMSF Resource
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a summary of all
available NCEMSF
administrative
resources:*

*[www.ncemsf.org/
resources](http://www.ncemsf.org/resources)*

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Please visit the Membership section of the NCEMSF Web site to update your contact information.

The NCEMSF Database of Collegiate EMS Providers is an excellent resource in the event of natural disaster or other public health emergency, so please keep your information up-to-date so that should the situation arise, we can contact you and collectively as campus based EMS answer the call to act!

The 18th Annual NCEMSF Conference will be held February 25-27, 2011 in the Center City Philadelphia

**The Loews Philadelphia Hotel
1200 Market Street, Philadelphia, PA**

Why attend?

- 3 days of conference activities—Starting Friday at 4pm
- Over 50 expert lectures in up to 9 concurrent tracks
- Multiple moderated roundtable discussions
- Several hands-on skills labs
- Vomacka Student speaker competition
- Two keynote addresses
- Revamped EMS skills competition
- Annual NCEMSF Awards ceremony
- Industry tradeshow
- Lowest cost conference of its kind in the country
- NETWORK with 900+ of your peers from nearly 100 schools

Further Details including Fees, Travel, Lodging

www.NCEMSF.org/conf2011

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**The NCEMSF Board of Directors
Looks Forward to Greeting You Later this Winter!**