

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.

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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,

employees and patients cannot be protected. Preparedness does not have to be an expensive proposition. An increasing variety of prepackaged, portable kits are available in the marketplace to assist in the proper care of contaminated patients and to protect the ED. Chemical preparedness should not be viewed as an isolated task, but optimally should be combined with a strategy of adequate preparation for the care of patients with active TB, violent patients, those requiring reverse isolation, etc.

What is important is that emergency physicians know how to recognize, evaluate, and stabilize patients, and then deliver adequate care without compromising the hospital staff or the facility. Further, every hospital should know where to send a chemically contaminated person or how to obtain necessary assistance, just like they know where to send a patient with a burn, a trauma or a psychiatric emergency. This is true, especially for high-risk parts of the country.

We recognize that there is a long list of tasks, each touted as the most important thing that ED directors should do. Despite limitations of time and funding, every professional should try to do his or her best, even with a minimum of resources. No ED will be "well-equipped" until it has in place a minimum program of medical preparedness for chemical accidents.

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