A Blessing to Patients, a Lifeline to Families

By Allen & Rhonda Mayer

On Aug. 13, 2014, we got the call that begins every parent’s nightmare. The caller identified herself as a trauma social worker at Theda Clark Medical Center. There had been a motorcycle crash and they believed our son Brandon was involved.

“Do you have a son Brandon?” she asked. I could barely answer. She didn’t have any details; she knew only that he was in surgery. He was in surgery — that means he made it to the hospital. He’s alive then, right? There were so many questions. I was terrified. My husband Allen was numb. The drive to the hospital was beyond excruciating.

The social worker met us at the ER entrance and led us through the then-unfamiliar hallways of Theda Clark Medical Center to the surgical center waiting room. There, a Winnebago County sheriff’s deputy provided information: Brandon lost control of his motorcycle and struck a tree. A nearby homeowner heard the crash, came running to his aid and called 911. He was conscious at the scene and transported by ThedaStar. ThedaStar … my knees grew weaker. He must’ve been hurt pretty badly.

We paced the waiting area for an hour and 45 minutes before the doctor emerged. He identified himself as Dr. Ray Georgen, and in his calm, cool and direct manner, he began to speak — your son is a very sick boy, and if he hadn’t been wearing his helmet, we wouldn’t be having this discussion. He then began to list Brandon’s injuries from the top down: a closed head injury, a collapsed lung, a compressed vertebra at T-6, a “crack” in his spleen, multiple fractures in his pelvis, a dissection of the iliac artery and a shattered right femur. He was in a medically induced coma and was being transferred to ICU. We could see him in about an hour, at which point we’d have to provide a positive ID — they had been referring to him as “Trauma Kentucky.”

In the days and weeks that followed, we came to know Dr. Georgen very well. Despite tending to one trauma after another (he had four alone on that Wednesday night into Thursday morning), he always made time for us. He’d appear in the ICU family lounge after rounds — sometimes at 7 a.m., sometimes at 7 p.m. — usually to provide updates, often just to sit and chat. We discovered our children went to Xavier High School together, and we shared the same faith and many of the same acquaintances.

We discovered his eldest daughter attended UW–Madison with our daughter, and his younger daughter swam with one of Brandon’s best buddies. We learned his cottage is his haven, and the world became a bit smaller when Allen realized he’d been there the previous summer while on a Harley ride with mutual friends.

We derived much comfort from Dr. Georgen’s calm demeanor and came to depend on his regular visits. On the Friday following...
On two recent flights to crash scenes, the flight nurse established contact with the scene commander, who is tasked with providing information to the aircrew about the landing zone (LZ). It is the scene commander’s responsibility to inform the aircrew about the general conditions of the landing surface, wind direction, landing zone markings and obstacles. For example, the scene commander might say, “The LZ is marked by four red cones in a hay field with 12-inch stubble. There is loose cut hay, but the field has been harvested and the surface is firm. The crash scene is 100 meters north of the LZ on the east/west road with 30-foot trees on the north side of the road and wires on the south side of the road. Wind is out of the west at about 10 knots.” This basic information gives the flight crew a mental image of the landing area and alerts them to potential hazards.

While no one questions the skill of personnel who selflessly serve their communities as first responders and volunteers, experience in communicating with medical helicopters varies widely. For this reason, most EMS operators require their flight crews to make at least one orbit around the LZ before landing, to observe the landing zone, perform a risk assessment and determine the best approach, especially at night when obstacles such as wires are harder to see.

According to the FAA, there are 75 air ambulance companies that operate approximately 1,515 helicopters in the United States. Over the past 15 years or so, the FAA and the EMS air ambulance community at large have collaborated to improve the safety of the industry with positive results, but not an unblemished record. For example, 2008 proved to be the deadliest year on record, with five crashes that claimed 21 lives. Often, poor communication plays a significant role in the crash sequence.

Air Medical Resource Management (AMRM) is a concept evolved from detailed examination of aviation crashes wherein it was determined that communication failures between crew members or aircrew and ground-based (ATC) entities played a significant role. In 2005, the FAA issued guidance to operators, establishing minimum guidelines for AMRM training. The training focuses on pilots, maintenance technicians, flight nurses, flight paramedics, flight physicians, medical directors, specialty team members (such as neonatal teams), communications specialists (dispatchers), program managers, maintenance staff, operational managers, support staff, and any other air medical team members identified by specific needs (AC No. 00-64 Air Medical Resource Management). You may notice that on-scene ground personnel (scene commanders) are not on the above list, except perhaps as implied.

There will always be logistical and practical considerations limiting the scope and scale of any program such as AMRM training, but air medical folks should never pass up an opportunity to communicate with our brothers and sisters on the ground to help them see things from the aircrew’s perspective. Better communication makes everyone involved more efficient, more effective and safer.
Brandon’s crash, Dr. G, as we affectionately called him, informed us he was headed to his lakeside retreat for a highly anticipated weekend of family time and relaxation.

We wished him well, doing our best to keep our emotions in check. The good doctor, no doubt, sensed our trepidation. On Saturday morning, as Brandon lay in a coma and Allen and I sat vigil in the ICU family lounge, he appeared in the doorway. My heart almost jumped out of my chest. He had driven back to check on our son, and on us I believe. It was a remarkable gesture of care and concern, and there are no words to adequately express the joy and gratitude we felt seeing him in that moment.

It was by the grace of God that Dr. Georgen was on call that fateful August night. He was the general contractor for Brandon’s care and assembled what we fondly refer to as “the dream team”: Drs. Wascher, Sears and Peebles. From the moment we met him, we knew God was working through his hands and heart. His mere presence calmed our fears and gave us hope as we rode the rollercoaster of brain swelling, storming episodes, pneumonia, a tracheostomy, the discovery of a carotid artery aneurysm and multiple aspirations.

Dr. Raymond Georgen has served as trauma medical director for the Trauma Center at Theda Clark since its inception in 1990, providing direction and leadership to the trauma program to ensure the highest level of care is provided to injured patients.

Dr. Georgen ensures all criteria are met as required for Level II trauma center verification by the American College of Surgeons (ACS). He oversees trauma performance improvement by seeing to it that quality, efficient, effective and cost-appropriate care is delivered to our patients.

Trauma rounds are held twice a week with collaborative staff, where evaluations have been overwhelmingly positive and we will continue with additional hospitals this year and next.

**Putting His Passion to Work for 25 Years**

By Pam Witt-Hillen, Flight Nurse

Over the course of 11 long weeks and multiple transfers from ICU to Neuro to Inpatient Rehab, Dr. Georgen was engaged in Brandon’s care and monitored his progress. There is no one more skilled, more compassionate or more dedicated than Dr. Ray Georgen.

He’s an asset to the medical profession and a gift to Theda Clark Medical Center, a blessing to his patients and a lifeline to their families.

Thank you, Dr. Georgen!

**Thank you to our talented course instructors**

- Mark Coenen, ThedaStar Flight RN
- Ray Georgen, Trauma Surgeon, Trauma Medical Director
- Elise Kennedy, ED RN at TC
- David Schultz, Course Director, Trauma Surgeon, ThedaStar Medical Director
- Jason Selwitzchka, ED Paramedic at TC, and EMS Coordinator for AMC/TC
- Pam Witt-Hillen, ThedaStar RN

For more information, or to request a course at your facility, please contact Tabitha Uitenbroek (920.720.7371 or tabitha.uitenbroek@thedacare.org).

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**Working Together to Save Lives**

Thanks to the Trauma Services Department at Theda Clark and the ThedaCare Foundation, the Rural Trauma Team Development Course has been shared with:

- 8 Emergency Physicians
- 23 RNs
- 8 Paramedics
- 3 CT/Radiology Techs
- 3 CNAs
- 2 Phlebotomists
- 2 Respiratory Therapists

These numbers represent three of our ThedaCare facilities (Wild Rose, Berlin and New London). Since April 2014, we’ve been able to teach these courses and have learned so much from the teams in these facilities. We’re excited to share that the course at your facility, please contact Tabitha Uitenbroek (920.720.7371 or tabitha.uitenbroek@thedacare.org).
Recovery with optimal outcome certainly is the primary goal for people who’ve experienced trauma, for their families and for their care providers. Healing means to make whole; it is the “process of the restoration of health to an unbalanced, diseased or damaged organism.”

Physicians can oftentimes predict with accuracy relative timetables for complete healing of specific injuries, barring any unforeseen event. However, for the multi-system trauma patient with a myriad of injuries, the “finish line,” or time to best recovery, seems more like a line drawn in the sand — it can easily disappear with any tidal wave of complications, including blood loss, infection, blood clots or pulmonary emboli, etc. Recovery may take weeks to over a year.

Rarely is the full spectrum of bodily injuries identified upon admission to the ED. Vigilant assessment, along with diagnostics, continues throughout the patient’s CCU stay so that all injuries are identified. As one patient put it, “It’s like taking 10 steps forward and nine back some days. Each day I need to find my place of courage, and sink my teeth in, and put one foot in front of the other and just move forward, literally.” She suffered from a very complicated open femur fracture requiring much hardware and developed an infection in spite of antibiotic prophylaxis. She had recurring intrusive memories of her accident. She added, “Most days I need to power up my willpower!”

Yes, recovery is an individual experience. And whole healing must take into account not only the physical factors, but also the emotional and psychological ones. Some wounds that never show on the body are deeper and more hurtful than the ones that bleed.

Oftentimes the emotional effects of an accident are considered less important than the physical wounds. Wounds to flesh and bone heal through a sequential process of tissue repair and strong scar formation. In comparison, there is no predictable sequence to emotional healing. It has a very personal timeline dependent on the nature of the traumatic event suffered and how it is processed. While physical wounds progress by steadily strengthening scar tissue that replaces initial weaker repairs, psychological wounds heal with time but will require practicing new behaviors to deal with the emotional pain.

It should not be overlooked by caregivers that a large order of business for the hospitalized trauma patient is dealing with significant loss and also overcoming cognitive and psychological hurdles on the path to getting better.

Initially, they must suppress their emotions to deal with the current life-threatening crisis. Down the road of recovery, they then may become overwhelmed with upsetting emotions, frightening memories or intrusive images from replaying the horrifying event over and over.

As caregivers, we must manage more than specific trauma-affected areas. We’re all familiar with the ABCDE approach to trauma care, ensuring we don’t miss any life-threatening injuries. What about extending the “E” component of our assessment to include Empathetic care related to the disturbing unexpected event? Maybe we can impact quicker psychological healing by helping our patients process distressing feelings and feel safe from start to finish.

Post-traumatic stress disorder is much more common than talked about. Quality and empathetic care should begin on scene and continue to the finish line for injured patients. Caring is at the heart of all we do. We can help arrange the circumstances that favor whole healing and make reaching their personal finish line a “whole” lot easier!

**Managing Post-Traumatic Stress**

*By John Burke, PhD*

When people suffer serious injuries in accidents or intentional incidents, they face both physical and psychological consequences. In general, the more serious the injury, the more difficult will be the adjustment. After experiencing a life-threatening event, psychological stress may include anxiety, nightmares and flashbacks related to the trauma. I often have suggested that if a person wasn’t somewhat affected by the experience, I would wonder whether they really appreciate its severity. An exception is with those who were so severely injured, they have no memory of the trauma itself.

There are several steps to facilitate adjustment in the aftermath of trauma. One involves talking about the experience with trusted individuals. Of course, it’s important to discriminate between persons who may be helpful from those who may gossip or use the information against the individual. One must also be sensitive to any legal repercussions that can result from sharing information with others. But in general, we benefit psychologically from getting things off our chests. When we do, we gain emotional distance from the trauma so we are better able to put the event behind us. There are several formal counseling techniques that utilize that basic concept. But it also can help to simply talk with one’s spouse or partner, minister, or a trusted friend.

At the same time, it helps to take steps to face the subsequent fear head-on. I’ve often met with people after car crashes who swear they will not get back into a car. But how will they leave the hospital if they don’t accept a car ride? We know that each time they ride in a car and a crash does not happen, they decrease the degree of the association they have developed in their minds between being in a car and being in a crash.

For most people, the symptoms of post-traumatic stress either resolve or substantially decrease within a month. But for those whose symptoms include persistent flashbacks or a sense of reliving the experience, or intense distress when exposed to anything that resembles the event, I would encourage them to seek help from a counselor who specializes in trauma.
It Takes a Team

By Sheila Koch

Our son, Christopher Koch, was in a horrific car crash and flown to you the morning of March 29. He sustained head trauma, humerus and clavicle breaks, and C7 and T11 back fractures. His cranial nerves were affected, hearing was lost, teeth were broken off, and he took a hard hit to his left temporal area and upper torso. The prognosis was grave, mainly due to the head injury.

We are so thankful the flight team was able to make it to the scene of the crash to fly Christopher to your facility. After Dr. Mahmoud did the head surgery (craniotomy), he was in ICU for five days. He was then transferred to the neuro stepdown/IMU for a week, then in the inpatient rehab department for a week.

I cannot begin to tell you what an amazing experience it was to be able to watch our son’s miraculous recovery. Dr. Mahmoud is an amazing neurosurgeon, and his compassion for the patient and family is above and beyond. I know we asked him the same questions repeatedly, and he patiently took the time to talk and explain things over and over. He is a great asset to your team.

Dr. Ralston, Dr. Sears and Nina took care of Christopher’s humerus and clavicle. They were amazing and compassionate. I talked to Dr. Ralston several times in the hallways, and he even said hi to a group of kids keeping vigil downstairs by the main entrance. You can tell they love their jobs.

There were several trauma doctors within the two-week stay upstairs — Dr. Brennan initially and Dr. Georgen. I saw Dr. Georgen in the halls as well, and he always took the time to chat, answer questions or just simply ask how Christopher was doing.

We had several other specialists on Christopher’s case, all of whom were kind and compassionate. Dr. Bechard took the time to go over CT scans with me and explain in detail his train of thought. The nursing staff/CTs did the brunt of Christopher’s care. The ICU nurses were amazing. They explained things over and over to us, and took excellent care of our son.

Neuro stepdown was a tough unit for Christopher. He was dealing with a lot of pain, on morphine, and had a TBI to boot. The nurses were fantastic. When we needed anything, they were helping us within minutes. Dawn (RN) on days and Amy (CT) on nights had the best rapport with Christopher. So very kind and the patience of a saint with a trying patient!

The inpatient rehab unit was amazing. Their jobs have to be quite rewarding. Christopher made leaps and bounds in progress while there. The entire staff (too many to name) are a big part of where he is today. They have our undying gratitude. They are all so positive and upbeat, and we really appreciated our stay there.

Christopher had his implant surgery done with Dr. Mahmoud on June 10. He treated us like family. So intelligent and easy to talk to, just down to earth. He treated Christopher like he was his son. Dr. Green came in to do rounds for Dr. Mahmoud one day, and he is spectacular as well, as is the nursing staff on the neuro/IMU unit. Sara and Dave (orientating) had a great rapport with Christopher — Sara, especially, as she dealt with Christopher’s shenanigans like a champ.

Christopher is doing amazingly well. He has use of his arm and fingers. His facial nerve still has room for improvement, but we are not giving up hope. He works hard in rehab and has a great attitude. He will continue outpatient rehab at Theda Clark. They do an excellent job. We were previously at Berlin and they were spectacular as well.

We are so thankful that Christopher was brought to your facility. We would like to truly thank each and every staff member that came into contact with him. He would not have made the recovery he has if not for your caring, compassionate nature and dedication to your jobs. We are blessed to have met you all.

Life is good!

A MESSAGE FROM CHRIS

On March 29, 2015, my life was forever changed.

I can only hope that during this prom and graduation season you do NOT make the same choices I made that night.

1. Don’t drink. Never get into a vehicle with a friend who has been drinking. If you find yourself in a situation where you feel you need a ride call a friend or family member to come get you. Parents will understand, they were teenagers once too.
2. Buckle up! Such an easy thing to do that could literally save your lives.
3. You are not invincible. Be sure to get enough sleep. A few seconds of closing your eyes is all it takes to have a crash.
4. Do NOT text and drive. One split second is all it takes to lose control or hit an oncoming car.
5. Drive the speed limit!!!
6. Be smart. You never think this will happen to you but I am here to tell you it can, so please be careful. Learn from my mistakes!

Thank you to everyone who has been here to support me: first responders, medical care personnel, friends, family, teachers, and community. I cannot relay how it made me feel to see the outpouring of love and support being sent to me and my family. It got my family through this. You do not ever want to put your family through something like this!

Chris’s car and message on display at school as a reminder to make good choices
Sweet Child of Mine: A Mom’s Story of Type 1 Diabetes
By Amy Zitselsberger

Dominic Houle was diagnosed with type 1 diabetes on Dec. 15, 2011, at 12½ months old. He had his first ear infection, and after finishing his antibiotic, he still didn’t seem right. I took him back to the doctor four days in a row, and they kept telling me he was fine. My mother’s intuition told me to take him in one more time after I noticed him sitting on the floor looking at a book and panting.

I took him to see yet another pediatrician, who ordered labs and a chest X-ray. We left the clinic with a pneumonia diagnosis. On my way home, I got a call from the doctor, who said we needed to come back. Dominic’s lung was partially collapsed (not pneumonia) and his blood glucose was 677. He was in diabetic ketoacidosis and needed to be admitted. Since that moment our lives have never been the same.

Continued on page 7

FOCUS ON SAFETY

Diabetes on the Rise
By Tracey Haag, RN, BSN, CDE

With diabetes on the rise worldwide, it is not uncommon to have a family member, friend or co-worker diagnosed with this disease. In 2012, there were 29.1 million Americans with diabetes. Of those, 1.25 million adults and children have type 1 diabetes.

There are many assumptions and misconceptions when it comes to the differences between type 1 (T1D) and type 2 diabetes (T2D). Many people think someone can cause diabetes themselves, maybe by eating too many sweets or drinking too much juice as a child. Although diet can contribute to the diagnosis of T2D, that is not the case with T1D.

With T1D, the body’s immune system destroys the cells that release insulin, eventually eliminating the production of insulin from the body altogether. Without insulin, cells cannot absorb sugar (glucose), which is needed to produce energy. A person with type 1 diabetes cannot survive without insulin. With T2D, the body is not able to use the insulin properly, which is called insulin resistance. As the T2D gets worse, the body makes less insulin, causing insulin deficiency. Someone with T2D may take one or more oral medications and/or insulin to manage diabetes.

As you can imagine, a diagnosis of T1D can be difficult on families as they learn to cope with a number of changes in their daily lives. They tend to receive advice and comments that reflect a lack of knowledge of T1D, such as, “When will she outgrow it?” or “He doesn’t look like he has diabetes.” Learning to live with diabetes can be frustrating and further compounded by common misunderstandings and misconceptions, including the belief that T1D is not a serious disease.

Diabetes is one of the most common severe chronic diseases among children.

In fact, the incidence of children with type 1 diabetes has increased in the past 20 years. In Wisconsin, children are affected at double the national rate.

CONTINUED EDUCATION

The Diabetes Program at Children’s Hospital of Wisconsin is one of the largest in the country, serving more than 1,700 children with type 1 and type 2 diabetes and their families. The staff provides top-quality, personalized, diabetes care and a full range of basic and advanced courses for caregivers. Courses are offered at the Milwaukee and Neenah locations and are recognized by the American Diabetes Association for providing quality education to patients and their families.

References: 2012 diabetes statistics retrieved from the American Diabetes Association website
Continued from page 6

He was taken by ambulance to Children’s Hospital in Milwaukee, where we spent four days. They tried to teach me everything I would need to know in order to care for Dominic once we got home. Nothing could have prepared me for the challenges we would face. His blood sugars were checked every two hours during the day, and every night I set my alarm for midnight and 3 a.m. to check him.

Dominic was still nursing at the time of diagnosis, and I was told not to take that from him as it was a security blanket during this transition. It got to the point that all he wanted to do was nurse and he would no longer eat solids.

It’s been a struggle for the past three years — he has a sensitive palate and is working with yet another a feeding group, speech therapy and occupational therapy due to sensory/texture issues. His “quirkiness,” as I call it, causes a lot of frustration.

At four years old, he is just now starting to understand he needs to make healthy choices, but that doesn’t stop him from wanting to be a “normal” kid and eat candy.

Common Myths and Facts about Diabetes
By Tracey Haag, RN, BSN, CDE

Some common myths and facts:

- **Insulin cures diabetes.**
  Insulin is needed for survival for anyone with T1D, but insulin does not cure diabetes.

- **Diabetes is caused by being overweight.**
  Obesity is known as a risk factor for T2D but does not cause T1D. Scientists still do not know the causes, but it’s believed both genetic and environmental factors are involved.

- **Managing diabetes can be “easy” by eating a strict diet and giving multiple injections of insulin daily.**
  Although you can maintain tight control by eating a healthy diet and giving multiple injections daily, there are many factors — including stress, hormonal changes, growth periods and illness — that can cause blood sugar to fluctuate. Teenagers, in particular, may be susceptible to these fluctuations as their bodies change during adolescence.

- **People with diabetes need to eat special “diabetic foods.”**
  A healthy meal plan is recommended for anyone, with or without diabetes. Diabetic foods or “sugar-free” foods generally do not offer any special benefit. Most are expensive, still raise the blood sugar and can have a laxative effect if they contain sugar alcohols.

- **Diabetes is not a serious disease.**
  Those who properly manage diabetes can prevent or delay complications. However, diabetes causes more deaths in a year than breast cancer and AIDS combined. Two out of three people with diabetes die from heart disease or stroke.

- **People with diabetes cannot eat sweets or anything with sugar.**
  Limiting sweets will help people with diabetes keep blood sugar under control, but sweets can fit into meal plans under the direction of doctors and dietitians. At times, sweets are needed to raise dangerously low blood sugar to a safe range.

- **Kids don’t get type 2 diabetes.**
  Although T2D is more common in adults, increased obesity and other factors have led to a growing number of children under 10 and young adults being diagnosed with T2D.

- **Only kids get type 1 diabetes.**
  T1D was formerly known as juvenile diabetes, as it was often diagnosed in children, teenagers or young adults. However, people can develop T1D at any age.

- **People with diabetes can’t participate in sports.**
  Physical exercise is important for everyone’s health, and especially important for people with diabetes. Regular exercise can help insulin work better and keep sugar in a safe range.

His blood sugars are an everyday struggle; I can check at the same time two days in a row and get completely different results. Dominic has since had 20 ear infections, two sets of tubes and adenoids removed. The ear infections/antibiotics constantly created blood sugar spikes.

This has also caused a lot of elevated A1Cs at his endocrine appointments. It’s hard to keep good blood sugars working with all of these issues, and it makes me feel like a bad mom a lot of the time.

Now, Dominic’s blood sugars get checked every two hours during the day, and he gets insulin six to eight times per day. It’s second nature to him; he doesn’t know anything different. I have raised him to know that we do what we have to do and it is for his own good. He started day care in September 2014, which created high blood sugars for three months because of his anxiety, as well as questions about why he is “different” from the other kids.

He asks me why his pancreas doesn’t work, and it breaks my heart to tell him I don’t know. That’s just the way God made him. God knows he is tough enough to handle it, and he definitely is.

He’s never once cried from a finger prick or injection. Dominic is a happy, funny, extremely smart and well-adjusted kid.

He loves Case IH tractors, reading books, playing with his kitten Rose, and spending time with his friends and family.

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• **Congratulations** to Dr. John Burke, PhD, who recently retired from ThedaCare after serving on the staff at Theda Clark in Rehabilitation Psychology from 1988 until June 2015. He impacted countless lives by helping patients maximize their independence, health and welfare during recovery while dealing with stressors and disabilities from injury and illness. Dr. Burke obtained a PhD in Counseling Psychology from Texas A&M University. We will truly miss his contributions.

• **Congratulations** to Dr. Raymond Georgen for serving as trauma medical director for the Trauma Center at Theda Clark for the past 25 years. We are thankful for his extraordinary commitment to excellence in trauma care.

• **Congratulations** to Kirk Vandenberg, BSN, CCRN, and manager of ThedaStar since December 2014. He joined ThedaStar in 2011 as a lead flight RN with 13 years of critical ground and rotor wing experience. He also served as safety manager and managed a critical care transport ground base. He is constantly looking for ways to improve our service and works with all agencies to ensure transport needs are met. Kirk is easygoing, considerate and aspires to set the highest standards of quality for critical care during patient transport. Feel free to contact him at kirk.vandenberg@thedacare.org.

• **Congratulations** to Tabitha Uitenbroek, RN, BSN manager of the Trauma Center at Theda Clark. She was trauma coordinator for two and a half years prior and a ThedaCare employee for eight years. Tabitha graduated from nursing school in Chicago and relocated to the Fox Valley. She wanted to work for a hospital known for trauma care, came to Theda Clark and has “felt at home here since day one.” Tabitha is excellent at valuing and integrating feedback and feels honored to build relationships with other hospitals and EMS agencies. She loves being able to not only support, but also impact, quality care for injured patients in our community. You can contact her at tabitha.uitenbroek@thedacare.org.
Seymour Rescue Squad Active in the Community

Established in 1974 by charter members Chub Garsow and Bob Coenen, Seymour Rescue Squad is an advanced EMT ambulance service that serves the City of Seymour, Town of Osborn and Town of Seymour. Seymour Rescue has two fully equipped ambulances and is staffed with six EMT-Bs and 10 AEMTs. In addition to its EMTs, the squad is supported by first responders of the Town of Seymour and Town of Osborn.

This completely volunteer service, which is funded by the City of Seymour, responds to approximately 300 calls each year.

Throughout the year, its EMTs participate in several community service events, including Seymour Safety Day, Hamburger Days, the Outagamie County Fair, athletic events and presentations to community organizations.

According to director Mary Greuel, who has been on the squad for more than 15 years, “The people I work with in EMS are my second family. We need each other to survive the tough calls and to celebrate our successes. We come from all walks of life to join together for a common goal: providing quality care to those we serve.”

Public Safety Awareness Event in Weyauwega a Success

On May 18, in conjunction with Emergency Medical Services Week, the Weyauwega Fire Department conducted a training drill simulating a multi-vehicle crash scene. Other emergency services involved included Gold Cross Ambulance Service, ThedaStar, Weyauwega Police Department and the Waupaca County Sheriff’s Department. Community members also attended this great public safety awareness event, learning about the roles of various departments roles in a mass casualty situation.

ThedaStar has had the privilege of participating in this collaborative event since its inception in 1998. This training exercise has been successfully organized each year by Robert Ehrenberg, Weyauwega Fire Department deputy chief and training officer. Bob has been with the department since 1976.

Simulated victims in the vehicles provided optimal training realism for this drill, which consisted of vehicle extrication and victim removal from vehicles by fire department and EMS personnel. Training with ThedaStar consisted of communication procedures, landing zones, proper safety procedures with the aircraft, and patient loading. The Weyauwega Police Department and Waupaca County Sheriff’s Department concentrated on scene safety and accident investigation during this longstanding, valuable event.
The Shock of a Lifetime
By Pam Witt-Hillen, Flight Nurse

What started out as a holiday get-together turned quickly into a test of poise and competency for one Dane County sheriff’s deputy vacationing with his family.

On May 25, the ThedaStar air medical crew was called to a campground in Marquette County for a patient who suffered sudden cardiac arrest (SCA). Each year in the United States, more than 500,000 people suffer cardiac arrest and fewer than 15 percent survive. But because of the quick and thoughtful actions of Curtis Laffin on that day at Lake of the Woods Campground, Jeffrey Berkely survived a pulse-less, non-breathing state and beat the odds.

All of us in EMS health care know the chain of survival for SCA. Deputy Laffin assumed charge of the incident when his father-in-law suddenly collapsed. He did everything right, from having nearby campers call 911 to the emergency response system, to starting CPR and sending someone to retrieve the campground’s AED. He began CPR on his father-in-law, knowing early-bystander CPR with high-quality compressions until the AED arrives often saves lives.

Correct operation of the AED and delivering two shocks as directed saved Mr. Berkely’s life. Early defibrillation in SCA’s directly related to improved survival rates in out-of-hospital arrests.

Longer times to defibrillation negatively impact survival. Deputy Laffin’s training and instincts, along with rapid treatment, prevented any long-term side effects that commonly are caused by SCA.

Mr. Berkley had a palpable pulse and return of spontaneous circulation when Waushara County EMS arrived on scene.

ThedaStar was activated by Waushara County EMS. Impacting the patient’s good outcome was early advanced life support followed by post-resuscitation care.

In my experience, this entire incident was a perfect storm of positive events, initiated by Deputy Laffin. Having the wherewithal to work on his family member is heroic in itself, and we can attribute this amazing success story directly to his professional training and brave actions.

Our accolades also go to the campground for having an AED on the premises, and for the swift and decisive actions of the EMS crew who responded. Jeffrey Berkley has expressed his sincere gratitude to all involved in this successful resuscitation.

While on scene we only met Deputy Laffin’s father. I hugged him and said your son saved a man’s life today and that he should feel proud. This is the real paycheck for the jobs we do. It was a privilege to meet Mr. Berkley and his family members that fateful day, and this kind of call makes our crew feel good for a long time.

Mark Twain said, “The two most important dates in a person’s life: the day he was born and the day he found out why he was born.” Perhaps Deputy Laffin just found out his second most important date: saving his father-in-law’s life.