Personal Emergency Identification—Current Crisis and Proposed Standards

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IN MEDICAL EMERGENCIES, the importance of knowing the health status of the victim which may have a significant bearing on restorative measures is self-evident. Accordingly, one might hope that current widespread efforts aimed at making information on such conditions immediately available in emergencies would be achieving this end. Unfortunately, such is not the case. Instead, the many different techniques and devices now being offered for personal emergency medical identification are threatening an avalanche of confusion both for potential bearers of identification devices and for physicians and others who provide emergency health care.

Since 1953, when the Medic-Alert program was conceived by Marion C. Collins, M.D., of Turlock, Calif., literally dozens of different devices and plans for providing personal emergency medical identification have appeared. Their scope in providing descriptions of individual health factors which might be important in an emergency varies widely. In some instances, they are designed to describe no more than a single health factor for the bearer—such as blood type or a particular disease. In other instances, provision is made for descriptions of virtually all health conditions of the bearer which might be important in an emergency. Further and wide variation exists in the devices, which include wallet cards; a sealed-in-plastic microfilm record; medallions on a neck, wrist, or ankle chain; a locket enclosing the record, to be worn about the neck or wrist; a pin-type medallion; and a belt buckle enclosing the medical record.

These differences in the scope and manner with which personal emergency medical information is provided create substantial disadvantages for both the bearers of such information and for physicians and rescue workers. For the bearers, there is the difficulty of knowing what information should be present and what type of device would serve most effectively in an emergency plus the weighing of such factors as the privacy with which information is kept during nonemergency periods and the appearance of devices worn externally on the person. For physicians and rescue workers the problem is no less complicated. As matters now stand, a physician or rescue worker attending an emergency case faces a dilemma. On the one hand, he may not be sure he is proceeding properly unless he searches the victim from neck to ankles for emergency information. On the other hand, if he conducts this search, the time required for the search may represent a critical delay for the victim. But if he foregoes the search and ministers to the victim in a manner contraindicated by information being carried by the victim, he risks both the victim's life and his own welfare.

With these risks and impracticalities, an urgent need exists for developing standards for personal emergency medical identification. This need has been recognized for some time and was reflected in the National Conference on Emergency Medical Identification sponsored by the American Medical Association on April 13 and 14, 1961. At this Conference, attended by representatives of 65 national organizations which had expressed a prior interest in the problem of medical identification in emergencies it was concluded that "the most important need . . . is to develop an area of central authority for developing uniformity of system."[1] However, despite this conclusion, an effective uni-

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formity has failed to materialize in the more than 2½ years since the Conference was held. In addition, the AMA has developed a universal emergency medical identification symbol (Fig. 1) which it is now offering to all who

Fig. 1. AMA universal medical identification symbol.

make or distribute identification cards or devises.[2]

Under these circumstances, the question of standardization is left to the market place. Conceivably, this could result in a single identification system becoming prevalent. However, even were this to occur—which seems unlikely—there is no assurance that the scope and manner of identification represented in the prevailing system would be optimum. Moreover, any such development would require time—time during which other means of identification would be present to complicate and confuse the subject. In the face of these limitations, and considering that life itself is involved, further attempts at standardization can scarcely be deferred. Accordingly, the following standards are proposed for consideration, application, and endorsement by all who procure, use, and/or are otherwise interested in personal emergency identification.

Proposed Standards for Personal Emergency Identification

Definition

The purpose and process involved in these standards is termed "Personal Emergency Identification." The word "Medical" is avoided for reasons given below under *Scope*.

Scope

The scope of personal emergency identification comprehends both personal and medical identification and provides for information now covered by the American Medical Association card titled "Emergency Medical Identification" (Fig. 2).

On this basis, all persons may be served and there is avoided the separate identification and, hence, possible stigmatization of bearers with medical conditions. Were identification to be restricted only to those who have medical conditions, some persons who should bear medical identification, particularly when an external indication of such identification is involved, would decline to do so for fear of being stigmatized.

Single Bearer Source

All requisite information is provided for in one source on the bearer's person. This avoids

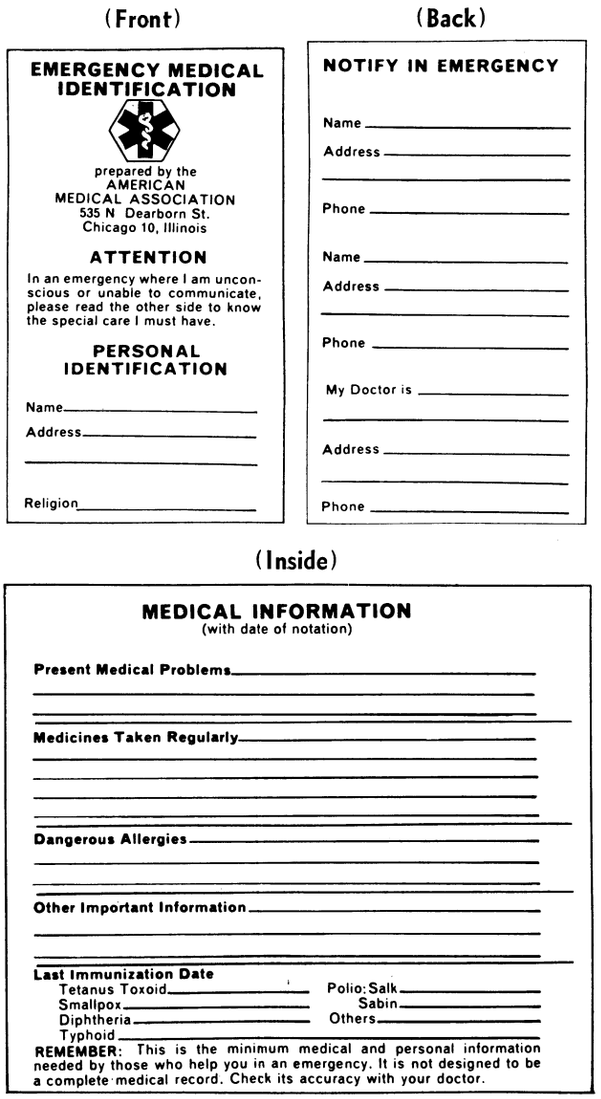

Fig. 2. AMA emergency medical identification card.

difficulties involved in providing and/or seeking information at more than one location on the bearer's person. It also permits emergency identification to be independent of a requirement that information be kept on file away from the bearer and out of his control—a practice which both adds to the cost of providing identification and deters participation because of the unwillingness of some persons to reveal personal particulars in other than emergency circumstances.

Location on Bearer

Identification is carried externally to the bearer's person and clothing at either or both of two locations where it is readily apparent and quickly available in emergencies. These locations are the wrist and the front beltline.

Designation of these two locations, while desirably limiting the number of places in which information is to be sought in emergencies, still permits high acceptability by bearers of either sex.

Information Record

Identification information is clearly printed (not written in longhand) with indelible ink on a record form which is indelibly inscribed on material resistant to deterioration from aging, fire, water, and other common sources of damage.

Record Enclosure

For insuring the privacy and safety of the information record during nonemergency periods, yet still permitting economical updating of information, the record is retained within two enclosures.

The inner enclosure, a sealed but nonresealable opaque plastic or other waterproof and dustproof envelope, is inscribed with the words "Emergency Identification Information." Inner enclosures, once unsealed, must be resealed if the record enclosed is to be considered usable.

The outer enclosure, a durable fire-resistant device, is so constructed as to be readily opened and closed but, when closed, to be so securely fastened as to minimize the possibility of accidental opening. Additionally, the outer enclosure provides projections or other means for retaining the inner enclosure when the outer enclosure is open. On the surface of the outer enclosure most external to the person bearing it, there is durably inscribed the emergency medical identification symbol now authorized by the American Medical Association.

Attachment

The outer enclosure for emergency identification information is securely attached to the bearer's person (in the case of wrist devices) or to another article which is securely attached to the bearer. Attachment of the outer enclosure to an expansion watchband or expansion bracelet, or simple pinning the enclosure to clothing is not sufficient.

While these standards suggest that outer enclosures designed as belt buckles or as lockets attached to fixed-length bracelets and watchbands can qualify as satisfactory devices, it is not intended that outer enclosures necessarily be limited to such devices. Other enclosures, such as might be incorporated in belts away from the buckle or in the waist area of swim apparel may also qualify. Especially not to be overlooked is the desirability of having belts and fixed-length bracelets and watchbands in general possess the means to incorporate a standard-size enclosure device, in addition to their being able to be used independently of such device. Permitting the device to be used at either of two locations would appear to advance the utility, economy, and acceptability of personal emergency identification and promote its use.

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References

1. Conference on Medical Identification in Emergency Situations. *J.A.M.A. 176:*29, 1961.
2. *Emergency Medical Identification Symbol.* American Medical Association pamphlet.