Supporters of seat belt legislation in Maryland made their views known at UMAB on February 3. It is estimated that mandatory seat belt use would decrease the number of traffic fatalities in the state by half and would significantly reduce the number of head and spinal cord injuries resulting from traffic accidents. After passing the Maryland Senate, the seat belt bill has gone to the House Judiciary Committee, which defeated the proposal during the 1985 session.

Maryland
EMS
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Incident Command for EMS Providers

Prehospital providers can be confronted with handling major EMS incidents involving serious injuries and the potential loss of many lives. During the era of "swoop and scoop," little was known about or done to develop command procedures for the so-called "ambulance drivers," because fire suppression officers commanded the EMS incidents. With the transition from "ambulance service" to "emergency medical services," it became evident that command procedures for EMS incidents, although paralleling fire ground operations, were different. "Buzz" words that were used by fire ground commanders were not appropriate for their counterparts in EMS.

This article provides insight into command procedures as they are related to the prehospital provider. The first arriving EMT, CRT, or paramedic must understand that establishing command early in the incident has dramatic effects on the final outcome of the total incident.

An EMS command procedure is needed for several reasons:

I. It fixes responsibility for command on one individual.

II. It ensures that strong, direct, visible EMS command is established early in the incident.

III. It establishes an effective command framework through which duties and functions related to EMS operations can be carried out.

IV. It provides an orderly transfer of command as ranking officers arrive on the scene.

To develop a better understanding of EMS command procedures, let us examine each one.

I. Fixing Responsibilities

Command dictates that one person maintains the authority, responsibility, and accountability for actions taken during the incident.

II. Strong, Direct, Visible EMS Command

When assuming EMS command, the objectives are to assume an effective command position and to transmit a brief radio report to include, but not be limited to, the following:

A. *Unit identification and location,* such as "Medic 1 will be medical command and will be located at First and Main Streets."

B. *Incident description* including type of incident, number of patients, and special concerns such as extrication problems, hazardous materials, or fire conditions.

After command has been established, proceed with the following actions:

1) Size up the situation
2) Develop tactics to be used
3) Designate unit assignments
4) Provide progress reports
5) Continuously review and evaluate tactics and revise them to meet the needs of the incident. The key to the overall success of the incident will be whether the EMS commander is proactive or re-active.

III. Effective Command Framework

A. Personnel operating on the scene will know who is in charge. Upon arrival, new units report to or contact EMS command for orders. This reduces confusion and unnecessary duplication of efforts, and the incident will be managed as a single operation rather than as multiple disjointed operations.

B. Besides the designation of EMS command, consideration should be given to the following sectors: triage, treatment, transportation, and staging. The communications component should be part of the transportation sector, which has the responsibility for directing patient flow to appropriate medical facilities.

IV. Orderly Transfer of Command

As higher ranking officers arrive at the incident, an orderly transfer of information regarding the incident is required to ensure that appropriate actions will be taken. The following procedures should be followed by the officer assuming command:

A. Size up the incident.

B. Confer with the officer operating as EMS command. Determine actions taken and existing conditions.

C. Assess the incident to determine

(Continued on page 2)

EMS Command Procedures Outlined

(Continued from page 1)

the future course of action.

D. Determine objectives.

E. Assume command *if necessary* and take appropriate actions.

The first concerns when arriving at the scene of an EMS incident should be directed toward initial size-up. Size-up should be continuous, beginning at the time of dispatch with the information given regarding the incident. Upon arrival at the incident, size-up can be made on seen or known information, or on what is considered factual. There are three important questions to be considered when doing the initial size-up.

1) What needs to be done?

2) What additional equipment or personnel are needed to do the job?

3) Who is going to do it?

Consider all possibilities and probabilities that will ensure a successful outcome. A pro-active rather than a reactive size-up is the best approach to handling any incident. The EMS commander who considers all the facts and alternatives ahead of time will be capable of handling the problems confronting him, as he will already have a plan to address the problems. Being reactive to a problem sometimes results in inequities that ultimately affect the patients we are treating.

When arriving at the scene, EMS personnel operate in one of three modes that are similar to fire suppression's "nothing showing, fast attack, and command" modes. The EMS modes are "assessment, immediate intervention, and command." First is the assessment mode: when answering the call dispatched as a 1050 PI, sick or injured person, this is the mode in which we normally operate, requiring us to do an initial assessment before doing anything else. The second mode is the immediate intervention mode: this mode is usually used when upon arrival on the scene a patient is found who requires immediate intervention due to life-threatening problems such as cardiac arrest, multisystem trauma, shootings, and stabbings. The third mode is the command mode: when confronted with an incident that overwhelms current resources and requires escalation of the incident, such as a bus or train accident, it is imperative to establish command procedures. With the use of these "buzz" words to identify our modes of operation, we can clearly determine where the incident is heading. The incident may begin in the assessment mode and escalate rapidly to either the immediate intervention or command modes.

The EMS commander should be capable of managing people and resources, be competent in prehospital EMS procedures, and be able to make the transition from provider to supervisor. When confronted with an incident involving large numbers of casualties, prehospital providers tend to want to treat rather than command. If the prehospital provider realizes the importance of establishing command and practices the procedures discussed in this article, Maryland will continue to be recognized as a leader in prehospital emergency medical services.

—Lt. Gary Warren
Baltimore County Fire Department
—Ameen Ramzy, MD
State Medical Director
for Field Operations

Region I

On January 18, the Region I EMS Advisory Council sponsored its annual banquet to honor EMTs. Individuals and organizations who had provided outstanding rescue efforts during the November floods were recognized. Awards were given for 5, 10, and 15 years of EMT service. The 15-year EMTs are William Rafferty, D. Allen Ruby, Ralph Witt, and Charles Wood. Of special interest was the short narrative by Robert Willoughby regarding his rescue by Cpl. Ed Hanna and Tfc. Rick Anderson. In addition, Cyndi Kolbe related her thanks to Helicopter 5 and the rescue squads that responded to a pedestrian accident in which she and her son were involved.

The speaker for the banquet was William Clark, MIEMSS Director of Field Operations. Mr. Clark spoke on the changing scene of Maryland EMS.

A new ambulance has been initiated as part of the Oldtown Volunteer Fire Department. The new service began operation in late December 1985 and will provide coverage to the southeastern portion of Allegany County.

Region I's EMS Olympics will be held on March 22 at the Eastern Garrett County Volunteer Fire Department, Finzel. Al Ward, chairman for the committee, states that he hopes that the region will have a good showing this year, as a great deal of effort is going into the planning and organization for the skills competition.

—Dave Ramsey
301/895-5934

Region IV

Congratulations to the Sudlersville Fire Company, whose new ambulance was inspected in January as part of the Maryland Voluntary Ambulance Inspection Program. Passing this inspection continues the company's certification of excellence. The fire company and community should be proud of this accomplishment.

EMS providers in Kent and Queen Anne's County should be aware that the Kent and Queen Anne's Hospital has had several successful educational programs in cooperation with the Region IV office. The March program is a trauma case review. Check with your ambulance captain for the date and time.

The Memorial Hospital at Easton hosted a seminar on the respiratory system for EMS providers in the mid-shore area on January 30. The seminar was set up by Margie Callahan, RN, EMS nurse coordinator at Memorial Hospital. Gary Poole, assistant director of cardiopulmonary services at Memorial Hospital, discussed the anatomy, physiology, and assessment of the respiratory tract as well as the management of respiratory problems and the techniques of management. The Region IV office urges EMT-As in Talbot, Caroline, and Queen Anne's counties to attend as many of these local programs as possible to take advantage of the educational opportunities and to meet and work more closely with your local hospital staff.

Finally, do not forget the Region IV EMS Olympics that will be held on March 22. We hope your team is a winner!

—Marc Bramble, John Barto
301/822-1799

Troopers Killed in Tragic Crash

Cpl. Gregory A. May

Tfc. Carey S. Poetzman

Officials are still investigating the tragic crash of a Maryland State Police Med-Evac helicopter on January 19, which took the lives of two troopers. Cpl. Gregory A. May and Tfc. Carey S. Poetzman were killed in the early morning crash into a wooded hillside in Leakin Park in west Baltimore. They were returning to the Frederick Barracks after transporting a shooting victim from Eldersburg to the MIEMSS Shock Trauma Center. Preliminary reports cite foggy conditions and poor visibility as likely factors in the accident.

Cpl. May, pilot of the flight, graduated from the State Police Academy in 1977. Before transferring to the aviation division in 1982, he was a trooper in the Frederick Barracks. He was certified as a rotary wing pilot and an aviation trauma technician (ATT). He lived in Hagerstown with his wife Pamela May and their son.

In 1981, Tfc. Poetzman became the first woman to join the aviation division of the Maryland State Police. She graduated from the Police Academy in 1980. She was a licensed practical nurse and respiratory technician, an ATT, and a medical specialist (E-5) with the U.S. Army Reserve. Tfc. Poetzman lived in Manchester with her husband, Robert J. Simpson, a former State Police helicopter pilot who now works for a commercial medical evacuation firm near Washington.

Since its inception in 1970, the Maryland State Police Aviation Division has flown 141,708 missions, 26,710 of which were medical evacuations. Three thousand med-evac missions were completed in 1985. The fatal January crash was the first in 12½ years and the third since the division was established.

It is speculated that Cpl. May was not aware of the dense fog that had quickly enveloped Baltimore while he and Tfc. Poetzman were at the Shock Trauma Center. On the route back to Frederick, the crew was "caught" in the fog and may have been attempting to return to the MIEMSS heliport.

At a recent press conference, State Police and MIEMSS officials called for state funding for more advanced rescue helicopters. On behalf of the Maryland State Police Aviation Division, Sgt. Barnard requested "an aircraft certified for single pilot instrument flight and the appropriate instrument training for its use" to upgrade the program and achieve "state-of-the-art expertise in service to the people of Maryland."

R Adams Cowley, MD, director of MIEMSS, explained that the purchase of aircraft certified for instrument flight would help avert crashes. State Police pilots are "risking their lives to save lives," said Dr. Cowley, "and they should have the best."

—Linda Kesselring

Balt. ENA to Meet

The Baltimore chapter of the Emergency Nurses Association (ENA) will hold its 12th annual meeting, titled "The Final Diagnosis," on April 8 at the Holiday Inn in Timonium from 8 am to 4:30 pm. Discussion topics will include sudden death, SIDS, organ procurement, tissue procurement, and forensic medicine. Application has been made for continuing education units. The seminar is open to anyone in the field of emergency medicine (ENA members and nonmembers). For more information, call 301/679-5526.

Trauma Days Slated

If you haven't already marked your calendar, check off May 3 and 4 as a time to attend the Region I Trauma Days. This year, as in the past, the Trauma Days will be cosponsored by the Maryland Fire and Rescue Institute, Garrett Community College, and the MIEMSS Region I office. The topic this year will be pediatric trauma and will feature Martin Eichelberger, MD, and staff from Children's Hospital National Medical Center in Washington, DC.

The Trauma Days curriculum will include presentations on pediatric airways, oxygen administration, pediatric trauma, the child and family, and pediatric assessment. A special evening session on May 3 will feature Garry Briese, executive director of the Florida chapter of the American College of Emergency Physicians.

All those interested in attending the Region I Trauma Days should contact the Region I office (895-5934) or the Western Maryland Fire and Rescue Institute (724-4970).

This program has been extremely successful in the past and we hope to attract a large number of providers from across the state. See you in May!

—Dave Ramsey

EMS Care '86 Reminder

EMS
CARE '86

April 25-27, 1986
Bethesda Marriott Hotel

Speech Therapists Help Injured Recover

The symposium speaker came onto the stage, took off his jacket, rolled the jacket into a ball, and threw it on the floor. He crossed the stage and sat crosslegged at the edge near the audience. He talked quickly and randomly about the discussion topic, interspersing swear words. He abruptly stood and moved to the podium, wondering aloud where he had put his slides. Finally, he picked up his jacket and put it on backward.

That is how Dr. Chris Hagen, a speech-language pathologist, began his presentation entitled "Linguistic-Cognitive-Communicative Impairment Secondary to Traumatic Brain Injury: Theory to Treatment," which was sponsored by the MIEMSS Speech-Communication Disorders Program. Initially, most of the audience accepted his behavior as that of a speaker who wanted to be casual during his presentation. His continuing disjointed phrases and vulgarities made some people uncomfortable. When he put his jacket on backward, it became obvious that he was demonstrating a point—the range of acceptable and unacceptable behavior—and leading into his talk on evaluating behavior, particularly communicative and cognitive-linguistic dysfunction.

At what point did Dr. Hagen's behavior become inappropriate? What defines the line between acceptable and unacceptable behavior? Speech-language pathologists and other health care professionals who rehabilitate head-injured people must routinely make those decisions about patients' behavior. They must identify the behaviors that are temporary and those that are permanent. They must determine what level of functioning is needed by patients so that they can rejoin the groups and activities in which they participated before injury. This comprehensive approach to evaluation and intervention of total communication and behavior concerns makes the speech-language pathologist a unique professional in brain injury rehabilitation.

Dr. Hagen, who is chairman of the Speech, Hearing, and Neurosensory Center of the Children's Health Center and Hospital in San Diego, emphasized the need for a team approach in the rehabilitation of head-injured patients. The members of the rehabilitation team (including physicians, physical therapists, occupational therapists, speech-language pathologists, nurses, social workers, and psychologists) concentrate on the patient's injuries that relate to their specific discipline. For example, physical therapists note movement disorders and plan treatment to correct them. Speech-language pathologists evaluate and treat communication concentration, memory thought organization, and swallowing dysfunction. It is important that the rehabilitation team members share their observations of all aspects of a patient's behavior so that the most effective and comprehensive treatment schedule can be planned. Without this approach, treatment can be fragmented, resulting in attention being given to symptoms, not necessarily to the underlying disorder.

At the time of traumatic injury to the head, a person's brain accelerates, rotates, compresses, and/or expands within the skull. The resulting injuries cause neurologic problems that manifest as disorders of physical and intellectual function, including speech and

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Brain Injury Symposium Planned

The Speech-Communication Disorders Program of MIEMSS and the Montebello Rehabilitation Hospital is actively making final arrangements for its 2nd National Traumatic Brain Injury Symposium. "The Road to Recovery: Clinical Research and Application" is a specialized interdisciplinary symposium slated for April 17 and 18 at the UMAB Medical School Teaching Facility.

In a national research forum, innovative projects concerning assessment and rehabilitation of the brain-injured patient will be discussed in 31 mini-seminars, platform sessions, and poster presentations. Nine nationally recognized speakers will provide state-of-the-art information on assessment and therapeutic procedures as they relate to medical advances, rehabilitation medicine concerns, dynamic and cognitive-linguistic interventions, swallowing dysfunctions and management, aphasia and other primary language disturbances, computer usage, and augmentative communication intervention for the traumatically brain-injured patient.

The MIEMSS Speech-Communication Disorders Program offers comprehensive diagnostic, therapeutic, consultative, and counseling services to communicatively impaired patients who have traumatic brain injuries, as part of MIEMSS' interdisciplinary rehabilitation program. Patient assessment and treatment begin between 24 and 72 hours after admission to the MIEMSS Shock Trauma Center. This early intervention enables patients to communicate their needs quickly in the rehabilitation process and enhances their ultimate recovery.

A continuity of full service delivery is provided for those patients who are admitted to the Montebello Rehabilitation Hospital for specialized head injury, spinal cord injury, multiple-system injuries, and stroke rehabilitation services.

This recognized program at the MIEMSS Shock Trauma Center and satellite programs at the Montebello Rehabilitation Hospital have recently received a 5-year accreditation by the Professional Service Board of the American Speech-Language-Hearing Association. The accreditation indicates to the professional community the utmost importance of providing continual quality research and clinical services to all individuals with speech-language, cognitive-linguistic, and swallowing disorders.

The symposium, which represents a collaboration of the most recent advances in traumatic brain injuries, is intended for nurses, EMTs, occupational therapists, physical therapists, physicians, psychologists, psychosocial clinicians, speech-language pathologists, administrators, and other health professionals. Continuing education units will be provided for nurses, occupational therapists, physical therapists, and speech-language pathologists in accordance with their respective professional continuing education policies.

The registration fee is $125.00. Questions regarding the program content, continuing education units, and registration should be directed to Roberta Schwartz, MEd, CCC-SLP, Director, Speech-Communication Disorders Program, MIEMSS, 22 S. Greene St., Baltimore, MD 21201, 301/528-6101.

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language.

Most patients go through three stages of recovery from head trauma. In the initial phase, the patient is comatose and cannot communicate. The speech-language pathologist uses sensory stimulation, using the five basic senses, to assist the patient in becoming aware that a particular voice is that of a family member. The intermediate (agitated) phase involves a mixture of reversible and irreversible neurological impairment. The patient is aware of the environment but often responds to input in a confusing and inconsistent way. As the speech-language pathologist interacts with the patient during the intermediate phase, he or she may note different types of speech, cognitive-linguistic, or swallowing disorders. Dysfunction resulting from temporary injury may be apparent at one point during rehabilitation, but it later disappears because the underlying lesion has healed. The entire rehabilitation team should determine which problems are healing and which are remaining. Those that remain may represent irreversible neurologic impairments. During the long-term phase of rehabilitation, the extent of remaining function must be determined so that the appropriate treatment can be planned for the patient to develop and use that function to the greatest degree possible.

Patients with head injuries have difficulty organizing, structuring, and predicting their thoughts. Because of disrupted cognitive-linguistic skills (those that represent knowing, including both awareness and judgment), these people experience a breakdown in the ability to structure mental processes, choose appropriate responses, and control emotional reactions. Any interaction with a therapist or family member can help the patient organize his or her thought processes and internally structure them in a logical sequence.

Dr. Hagen defined aphasia as difficulty in understanding, internally formulating, and/or expressing language. Disorders that can be attributed to a specific lesion are "typical aphasias." They may or may not be associated with little cognitive disorganization.

For the disorders related to difficulties in abstract thinking, Dr. Hagen has introduced the term "atypical aphasias." Patients with this kind of dysfunction have a language data base but cannot use that information in

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Shootings Can Lead to PTSD

Contrary to what one might surmise from watching "shoot-em-up" movies or TV programs, injuring or killing someone in the line of duty is a devastating occurrence to a police officer. Paul R. Clavelle, PhD, chief psychologist for the Baltimore County Police Department, discussed post-shooting trauma at the Stress and Behavioral Emergencies Conference at UMBC recently.

We tend to think of a stress disorder as something that happens to a weak person, perhaps with a predisposing personality with a tendency toward depression or anxiety. Dr. Clavelle believes those factors are not always crucial in determining who will be affected by a traumatic incident; in fact, he feels they are often over-emphasized. Many police officers who were very stable before the incident and gave no indication of emotional problems suffer significantly after a shooting. EMS personnel, ED staff, social workers, and psychologists who are in contact with police officers after shootings will benefit from understanding the pressures under which the officers work and from recognizing the symptoms of stress disorders—symptoms that are not unique to police officers.

Why do officers react differently to a shooting—why will one walk away and never think about it again, and another be so severely distressed that he may retire on a disability? There are a number of factors that make the aftermath of a shooting more difficult. They can be described as situational factors, personality factors, and followup factors.

Situational factors include:

Resemblance to someone in the policeman's family—The closer in age to the officer's children, the younger the person shot, the more difficult it is for the officer to forget it.

Degree of danger and feeling of vulnerability—One way to go out on the street and face the risks every day is to deny anything can happen to you. In a shooting incident, the sense of vulnerability emerges, and the defense system collapses. Then you see post-traumatic stress disorders (PTSD).

Degree of responsibility—Especially if other people were injured, particularly if they were police officers.

Environmental aspects—Nighttime and indoor shootings seem to be more difficult emotionally for officers. Dr. Clavelle's personal observation is that it has something to do with the sense of uncertainty, surprise, vulnerability, and that things are happening very quickly under uncertain circumstances.

Amount of time the officer has to react—The less time, the more doubt is usually planted in his mind as to whether he overreacted.

Degree of helplessness—An officer might say, "When I shot and hit the suspect, he kept coming—that's not supposed to happen. Your gun is supposed to protect you, and it didn't."

Predisposing personality factors are important precursors of PTSD—for example, emotional difficulties or prior involvement in shootings. "There is a myth in the military that the troops you want to take into battle are the war-hardened vets who have been slugging it out for three or four years, and have seen everything," Dr. Clavelle observes. "Actually, military psychiatry statistics indicate that this is the *last* group of soldiers that should be chosen. During World War II, it was found the longer the soldier was in combat, the higher the probability of his suffering 'combat fatigue' or 'shell shock' or PTSD. *It is not true that you get hardened.*" Police officers who have been in previous shooting incidences are at a much higher risk of developing severe post-shooting trauma.

Another factor is the degree of depression-proneness. The important questions here are, to what extent is the officer primed for a severe loss reaction, and to what extent have his past losses not been resolved appropriately? After a shooting, officers sometimes have persistent nightmares that have nothing to do with the shooting incident. Instead, they have to do with past losses they had experienced. "Why am I dreaming about my father's death when what I went through last week was the killing of my fellow officer?" Mr. Clavelle explains, "It doesn't make sense to him, but that's a pattern. He has made the link between emotions. Loss of self-esteem and loss of invulnerability can also lead to depression. The shooting is a trigger for a variety of experiences. It is the precipitating event."

There are followup factors that the police psychologist or mental health

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Program Teaches Children About EMS

Prehospital providers in Region IV help their communities not only by delivering emergency medical services, but also by teaching public school children how to deal with emergencies. They stress that fire and rescue personnel are there to help, and they explain their equipment to make it seem less frightening.

In the town of Sudlersville, in the northeast section of Queen Anne's County at the intersection of routes 300 and 313, an EMS educational program has been conducted at the elementary school since 1980. Held especially for the fourth grade, the highest grade in the school, the program stresses emergency first aid techniques, fire safety, and accident prevention. The children rotate to seven learning stations: CPR and choking, burns and heat exposure, bleeding and bandaging, poisons, allergies, seizures, and shock. A variety of learning aids are used, including Resusci-Annie, hands-on demonstrations, and films.

The program was originated by Mrs. Karen Van Wyck, the fourth grade teacher, and 1/Lt. Madeline Coursey of the Sudlersville Volunteer Fire Department, who is media aide at the school. This extracurricular activity is planned in conjunction with two programs used in the Queen Anne's County school system, the "Project Basic" program and the "Learn Not to Burn" program. Mrs. Van Wyck and Lt. Coursey explain that rural communities differ from urban settings in that the nearest neighbor may be either a short distance away or several miles away, so help from a neighbor cannot be assumed. In the majority of homes today both parents work, and in many areas children nine or ten years of age are encouraged to be independent and to assume responsibility for younger schoolmates or siblings for an hour or two. Woodstoves and hazardous materials are readily available. This program answers a specific need, to help children learn what to do—and what not to do—in case of emergency.

The children are given an intensive course in fire prevention, practice "stop, drop, and role" techniques, and discuss a fire escape plan with their parents before the day the volunteers come. A firetruck is brought to the school; its operation and fire safety rules are explained by the firefighters. Jo Ann Adams, a CPR instructor for the Sudlersville Volunteer Fire Department, says, "Children particularly need to know how to avoid danger by keeping curtains or loose materials away from woodstoves, to avoid smoke inhalation in the event of a fire, and to practice exit procedures before a fire occurs." An ambulance is also brought to the school and is made available for the children to examine, and they have their blood pressure and pulse rates taken. Phil Hurlock, supervisor of Queen Anne's County Emergency Operations Center, uses training telephones to teach the children what information they need to know if they must make a call during an emergency. (In rural areas few houses have street numbers; a child must know how to describe specific roads and landmarks to direct emergency vehicles to his location.)

The president of the PTA at Sudlersville Elementary School, Mary Ann Massagli, expressed the PTA's appreciation of the fire safety and first aid program. She said, "...there is no greater personal call to safety than [to see] a motivated child mapping out a fire escape route or demonstrating how to assist a choking victim. I believe a program such as yours could benefit all children in the school system. Thank you for your hard work."

In another part of Region IV, the Kent County Board of Education encourages countywide awareness of EMS by projects such as the sixth grade contest to originate the best slogan to be used for EMS Week. Chestertown students won with the slogan, "Safety First, Together We Can Save Lives." Their reward was to have their representatives present at the courthouse when the county commissioners signed the proclamation honoring the EMTs, CRTs, paramedics, and aviation trauma tech-

(Continued on page 7)

Sudlersville volunteers conduct an annual program for fourth grade students that stresses emergency first aid techniques, fire safety, and accident prevention. Rescue vehicles are brought to the school for the children to examine.

Region IV EMTs Offer School Programs

(Continued from page 6)

nicians in Maryland. The children were given a copy of the proclamation to take back to their school.

Kent County fire and rescue squads visited seven elementary and middle schools during EMS Week. The film "The Vital Link" was shown in the middle schools, followed by a discussion of what students could do to help if they should come upon an accident. Elementary school students were given bags containing information about 911, seatbelts, and Project KISS; middle school students were given the three basic responder checkpoints.

Two prehospital providers from the Betterton Volunteer Fire Department work at the Worton Elementary School. EMT Lydia Parent, who is manager of the school cafeteria, drew pictures of "Smurfette" wearing a safety belt and saying "Buckle Up." The drawing was duplicated and given to the children to color. Sue Copper, the school secretary, who is captain of the EMTs at Betterton and served as county chairman of EMS Week, describes community reactions to the programs in Kent County. She says, "I have received many positive statements from school representatives that show that all of our volunteer companies did a great job!"

—Erna Segal

Identifying Speech Disorders

(Continued from page 5)

changing linguistic demands of a situation—they cannot logically arrange incoming data or their own thought processes to communicate effectively.

A language disorder is an overt expression of the interplay among linguistic and nonlinguistic processes. The treatment of patients with these disorders must include therapy for the nonlinguistic cognitive proceses. The therapist must determine the patient's thresholds in terms of rate, amount, duration, and complexity of tasks. Many tests and exercises are available to identify the head trauma victim's residual skills and to develop them to the greatest extent possible. The speech-language pathologist actively involves the patient in achieving a functional goal of life—the ability to communicate and interact effectively with the environment to the extent of his or her recovery potential.

—Linda Kesselring

Stress Disorders Noted After Shooting Incidents

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worker who has contact with the police department should know. We can change the way people respond *after* the shooting. *How does the department respond to the officer after the shooting?*

In many police departments, a shooting is investigated by the internal affairs office. Even if there is complete agreement that it was an in-policy shooting, there is an aura of wrong-doing associated with internal affairs. The investigation might take a year, and the stress builds up for the officer. Baltimore County established a policy that an officer involved in a shooting will be investigated differently—by homicide, for the criminal aspects, and by his commanding officer. Their reports must reach the Firearms Discharge Review Board within 10 days, and within 10 days after that the board's report and recommendations must be on the chief's desk. It should all be resolved in less than a 30-day time span, a significant change.

Another innovation in Baltimore County is to ask the officer whether there is someone he would like to have with him immediately afterward; this reduces the probability of anger and alienation setting in. "When a police department doesn't focus on an officer's emotional reaction, they end up with people leaving police work because of the way they were handled," Dr. Clavelle maintains.

Peer response is very important to the officer involved. Fellow officers pump for information, curious to know the details. That is counterproductive. The appropriate reaction is to say, "I'm here if you need me. If you want to talk about it, fine." It is not appropriate to let humor go too far, calling him "killer."

Commonalities of post-shooting trauma were explained by Eric Neilsen, from the Salt Lake City police department. The impact phase comes first, lasting from two hours to 10 days. The person is still in shock, and not ready for in-depth counseling. If you go too fast, there will be denial and resistance. But it is important for the counselor to show up promptly, to build rapport for future counseling.

The recoil phase is next. Defenses are lowered, and the stress disorder can be seen. It usually surfaces in an oblique way—"My wife's having problems." The officer does not connect the stress with the shooting incident that happened two or three weeks before. He is more amenable to psychological counseling, and this is the time most progress can be made. Police officers, by the nature of the job, are very controlled people. A stress disorder makes them feel out of control and frightened. It is especially important to discuss anxiety attacks and flashbacks.

The post-traumatic phase follows, when the officer makes the connection and integrates the distress of the shooting incident with other losses he has suffered. Family reaction to the stress is an overlooked dimension to post-shooting trauma; there is so much focus on the officer, one tends to neglect what the family is going through.

Problems the officer might encounter include anxiety; digestive upsets; fatigue; headaches; rashes; constipation; temporary impotence; concentration problems; attitude changes (becoming more cautious or more reckless); and other symptoms of stress. The officer who becomes more reckless may think he has something to prove, and start doing stupid things like grabbing a loaded gun. He can be dangerous.

The rule-of-thumb for shooting incidents is that roughly one-third of officers involved will have a mild or no post-traumatic reaction; one-third will have a moderate reaction (for several weeks they will be thrown out of kilter, but they can go on with their lives). The other third will have a severe reaction and require longer term treatment; a small percentage of these will retire from the force.

—Erna Segal

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Field Notes

By William E. Clark, State EMS Director

The evening of January 18, 1986, began like any other for Cpl. Gregory May and Tfc. Carey Poetzman. Working night patrol on a Saturday night in Frederick usually meant Med-Evacs to the MIEMSS Shock Trauma Center, perhaps a call to assist ground units of the State Police with any one of the numerous police duties requiring the assistance of a helicopter, or just passing the evening—quietly catching up on paperwork. When the call came for a Med-Evac to Shock Trauma, the two troopers responded as they had so many times in the past. A life was at stake and the two troopers responded instinctively, relying on their experience, training, and dedication to see them through.

The troopers responded in Helicopter 3 to Eldersburg and transported a gunshot victim to Baltimore's Shock Trauma Center. When the bubbly voice of Carey Poetzman radioed the Systems Communications Center that the helicopter was returning to Frederick, no one knew that within several minutes tragedy would strike. As one State Police spokesman said, "The troopers made the ultimate sacrifice, they gave their lives for their profession."

Emergency services work, whether it is police, fire, or rescue, comes with inherent risk factors. We know the dangers of our work and we live with that fact each minute we are on duty. Many times it is easy to take for granted the helicopter that lifts off from the accident scene. Pilots are highly trained and aircraft are sound. But as any pilot will tell you, you are never so alone as when you are airborne and trouble occurs.

Oddly enough, it usually takes a tragedy to raise the public consciousness level to a point where it begins to reflect on the risks involved with emergency services. Senator Frank Kelly has introduced legislation to provide for the critical needs of the EMS system and the Med-Evac program. Although there is controversy over how the money should be raised, both the Governor and key members of the General Assembly are highly supportive of the program. I feel confident that things will work out for the best.

It is sad when one of our own gives his or her life to save the life of another. A void now exists that can never be filled, the void created when we lost Greg May and Carey Poetzman. If there is a degree of comfort, it should be found in the thought that out of night comes day. The State Police Med-Evac program will recover and continue to assert its rightful place as the best and most dedicated Med-Evac program in the country today. May God be with these two dedicated individuals who gave their all for their fellow man.