Maryland
EMS
NEWS

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(Top) Southern Maryland Hospital Center (SMHC) was recently designated as the tenth areawide trauma center in Maryland. (Bottom left) Dr. Francis P. Chiaramonte, director of SMHC, and Dr. R Adams Cowley, director of MIEMSS. (Bottom right) SMHC staff Dr. Chiaramonte, Dr. William L. Joseph, emergency department director; Linda Hines, RN, head nurse of the trauma center; and Dr. Louis Perna, director of the trauma service and chairman of the department of surgery.

Trauma Center Dedicated in PG County

Southern Maryland Hospital Center (SMHC), in Clinton, Prince Georges County, was dedicated on May 13 as the tenth areawide trauma center in the Maryland EMS system. The new trauma center is the culmination of years of planning, perseverance, and hard work by the director of the hospital, Francis P. Chiaramonte, MD, and his staff.

"Trauma medicine is a highly disciplined specialty and an attitude that is not wholly understood by all of the medical profession," says Dr. Chiaramonte. "It has saved thousands of lives in the state of Maryland. We are honored to be a part of the system with Dr. [R Adams] Cowley and the MIEMSS team."

Dr. Cowley, director of MIEMSS, welcomed the new trauma center to the system, saying, "Dr. Chiaramonte tried again and again to establish this areawide trauma center. He didn't have any money, and it was an uphill battle. But he persisted until the trauma center went through all the necessary steps to reach the high standard we must have. Why do we have these standards? Consider an emergency delivery of a critically injured man who needs an operation—now. It is not enough to say that he will be treated when everyone is finished with what they are presently doing; he needs an OR available, an anesthesiologist, physicians, nurses, and blood. He can't wait; if he waits he dies. There must be a system worked out in advance. We must be selective, and be sure that the trauma centers meet our criteria."

Areawide trauma centers are evaluated according to the MIEMSS Echelons of Trauma Care, a document outlining stringent requirements that a hospital must meet to be considered as a trauma center. The specifications include staffing, facilities, equipment, and uniform treatment protocols. They also address cost containment by preventing duplication of services through the designation of trauma centers with consideration to population density and geography. The centers must agree to be evaluated biennially.

Following an extensive study of the rapidly growing area, the Region V EMS Council recommended that the SMHC be evaluated as a trauma center and designated by MIEMSS if the evaluation was positive. SMHC was surveyed by MIEMSS and designated in accordance with recommendations by the Region V EMS Advisory Council, such as the stipulation that for the first year the trauma center would receive patients by land transport only. According to Ann Kartley, RN, MSN, director of nursing and assistant administrator, SMHC has 308 beds, 26 of which are dedicated to critical care. Louis R. Perna, MD, clinical director of trauma service and chief of surgery says, "We've waited a long time for this designation; it has been our goal for years."

SMHC is a "high-tech hospital" serving Maryland's southern peninsula, Dr. Chiaramonte points out. It has special study rooms, catheterization rooms, and a CAT scanner. It has full-time

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High-Tech Services Offered by SMHC

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house staff in surgery, medicine, pediatrics, obstetrics, and anesthesiology; a neonatal intensive care unit; and critical care areas. From the beginning the hospital was designed with trauma in mind, with all the necessary components located on the same floor at ground entry level. One enters the triage/emergency room area, which is backed up by radiology, a laboratory, operating room, recovery room, and intensive care units. Step-down units are on the same level. "We have always felt that because of our strategic location we have a moral obligation to have a trauma center," Dr. Chiaramonte says. "However, we had to develop the *team* that is so critical in a trauma program."

When Dr. Chiaramonte, who is chief of the department of urology as well as director of SMHC, left the faculty of George Washington University and became chief of urology and president of what is now the Greater Southeast Community Hospital in Washington, DC, he, along with his colleagues, had to take patients from southern Maryland all the way to the District. "We were on faculties and board-certified in our respective fields, and wanted a hospital with university-level skills closer to the areas from which our patients are drawn."

The only source of funding available from 1974–76 was private funding through a HEW HUD program. (The alternative of selling bonds to finance the hospital was not an option because there was no market for bonds due to a recession at the time.) "Thank goodness we were able to obtain private financing to build the hospital, because otherwise we would probably still be waiting," Dr. Chiaramonte says. The Southern Maryland Hospital Center opened in 1977. "This is not a 'for profit' hospital; if it were, we would close down seven of our services. We deliver high quality care, and we are always full," Dr. Chiaramonte states.

Joseph Colella, MD, of Prince Georges General Hospital and Medical Center (PGGHMC) and regional medical director for EMS Region V, congratulated the staff of SMHC on its achievement in being named an area-wide trauma center. He said, "Ten years ago all support for trauma came from north of here, 45 minutes away by helicopter. Today we see a tremendous change. Nine years ago Dr. Cowley had the tremendous vision to open two trauma centers to serve this area—at Suburban Hospital [in Montgomery County] and PGGHMC, and now we have grown to three. I predict that SMHC will develop and bring to its hospital patients from Calvert, Charles, and St. Marys counties who do not now have inexpensive and convenient care available to them. And as PGGHMC advances into a Level I trauma center, we hope we can assist with some patients, and develop a referral program that will be the best Maryland can provide for helping critically ill and injured patients."

Marie Warner, Region V administrator, and Brigid Krizek, Region V Council member, also offered their congratulations. Ms. Krizek said, "We hope you will continue to participate with the Region V Council in assuring the excellence of the EMS system in the 5-county area and in the state."

Chief M.H. (Jim) Estepp of the Prince Georges County Fire Department congratulated the SMHC staff and welcomed them to the system "of which we are so proud." He said there are more than 2,000 men and women in the PG fire and rescue services, 39 BLS ambulances, and 7 ALS medic units. Chief Estepp stated that an eighth ALS unit will be put into service by July 1. Dr. Cowley added, "We owe so much to the prehospital care providers who change 'victims' into 'patients.' The 30 percent increase in lifesaving is due to these people who get the patients to you in better condition. With the addition of this new trauma center, and with Prince Georges General Hospital and Medical Center becoming a Level I trauma center, service to this region will be greatly enhanced."

Ameen I. Ramzy, MD, state medical director for field operations summed up the importance of the occasion when he said, "I think the citizens of this county and of this region can genuinely count their blessings that two fine institutions designated as trauma centers serve them. We give our thanks to Chief Estepp and Dr. Colella for their leadership in EMS; to Dr. Chiaramonte and his staff; and to all the prehospital care providers who serve this area, who deliver the patients here, care for them en route, and do initial interventions that make the rest of it possible. Thanks also for those who work in the allied services, and for those whose hard work on the regional council led to the recommendation for this designation. And thanks especially on behalf of husbands, wives, and children who are glad to have their loved ones back home and functioning, and able to enjoy a sunny day such as this one." *—Erna Segal*

Revising ALS Protocols: Statewide Input Sought

The current Maryland Medical Protocols for CRTs and EMT-Paramedics have been in effect since July 1, 1985. At this time we are requesting statewide input regarding the protocols, so that a thorough review and revision process can take place with the goal of having newly revised protocols effective July 1, 1987. We would anticipate that the recently published Advanced Cardiac Life Support Standards of the American Heart Association will be evaluated and incorporated into Maryland protocols where appropriate.

Several "ground rules" will apply to the process of requesting input and implementing newly revised protocols. First, any aspect of the protocols is open for discussion—additions, deletions, or modifications. Second, implementation dates will be firm to avoid any confusion or inconsistency. Third, once the newly revised protocol is adopted, it is complete and statewide. Any regional variances will need to be considered before the implementation date, even if they had previously been approved and in effect.

To allow EMS jurisdictions to conduct orientation training for the new protocols prior to the implementation date of July 1, 1987, the new protocols will be available on February 1, 1987. To ensure sufficient time to review all the input and to draft the new protocols prior to final approval by the State Board of Medical Examiners, we are requesting that **input be submitted by September 1, 1986.** We hope that the input process will encourage discussion among prehospital providers, local program medical directors, and physicians who provide on-line consultation to prehospital providers.

Input may be submitted to your local program medical director or re-

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Sister Cities Sign Exchange Agreement

Taking part in the signing of the University of Maryland/MIEMSS medical and educational exchange agreement with Xiamen University and the City of Xiamen on June 4 are (l to r): Mr. Wang Jian Li, standing director of the Chinese People's Friendship Association with Foreign Countries; Karl Bunday, a State Department interpreter; Mr. Walter Sondheim, president of Charles Center Inner Harbor Management, Inc., who signed on behalf of Baltimore's Mayor Schaefer; the Honorable Zou Er Jun, mayor of Xiamen; Dr. Edward N. Brandt, Jr., chancellor of the University of Maryland at Baltimore; Dr. Ma Ohn Kyi, who interpreted on behalf of the university; and Dr. R Adams Cowley, director of MIEMSS.

A medical and educational exchange agreement was signed on June 4 between the University of Maryland/ MIEMSS and Xiamen (pronounced "Shahmen") University and Hospital in the city of Xiamen, Fujian Province of the People's Republic of China. Xiamen is the eighth Sister City in the program that links Baltimore with cities around the world. Formerly called Amoy, Xiamen is located on the coast of the Taiwan Strait between the East China Sea and the South China Sea. Like Baltimore, Xiamen is a port city, but the climate is more tropical.

During his visit to China, Mayor William D. Schaefer, of Baltimore, who was accompanied by Barry Burns, PhD, of MIEMSS, signed the Sister City agreement with the Honorable Mayor Zou Er Jun, of Xiamen, for exchange and cooperation in various fields including education, culture, business, trauma medicine and health, and hospitality/public relations.

Mayor Schaefer is a strong supporter of MIEMSS because it is an efficient system for saving lives. During his travels in China he observed that emergency medical services as we know them do not exist. The population of one million people in Xiamen is served by just two ambulances. They are not used for prehospital care, but only for transportation from the accident scene to the hospital. As motor vehicles have become more numerous, Xiamen officials have become more aware of the need for a higher level of trauma care. Mayor Schaefer recognized that the resources of the Shock Trauma Center gave Baltimore a unique opportunity to help its Sister City. In return, American physicians will learn more about herbal medicine, acupuncture, and reimplantation of severed limbs, areas in which Chinese physicians excel.

Reciprocating Mayor Schaefer's visit, a delegation led by Mayor Zou arrived in Baltimore on May 31. Mayor Zou was accompanied by Deputy Mayor Madame Ke Xue Qi; Mr. Zhang Zon Xu, director of the Xiamen Foreign Affairs Office; Mr. Zhou Meng Qin, deputy general manager of the Xiamen Construction and Development Corporation; Mr. Wang Jian Li, standing director of the Chinese People's Friendship Association with Foreign Countries (equivalent to the Sister Cities program in the U.S.); Miss Cai Yun Ren, English section, reception department, China International Travel Service, Xiamen Branch; and Mr. Goa Liang, interpreter of the Xiamen Foreign Affairs Office.

The delegation had a busy schedule of visits, ceremonies, and banquets. The culmination of the visit was the ceremony for signing the medical exchange agreement, which took place in Davidge Hall on the University of Maryland at Baltimore campus, followed by a tour of the Shock Trauma Center. This is the first medical exchange agreement between the U.S. and the People's Republic of China dealing specifically with emergency and trauma medicine. R Adams Cowley, MD, director of MIEMSS, will be introducing the advanced technology of the Shock Trauma concept to fully one-third of the world's population, who live in China with no such system of trauma care available. Chancellor of the University of Maryland at Baltimore, Edward N. Brandt, Jr., MD, supports the program enthusiastically and is looking forward to exchanges in many areas of medicine and education.

Members of the Health Committee representing Baltimore are: Committee Chairman Barry Burns, PhD; John K. Stene, MD, PhD; Margaret E. Trimble, RN, MA; and Carl A. Soderstrom, MD, all from MIEMSS; Kathleen F. Edwards, RN, PhD, Baltimore City Health Department; Lois Branch, RN, MEd, St. Joseph's Hospital; Lisa Miller, RN, BSN, Maryland General Hospital; and Michael L. Wiseman, DVM, and J. Alex Haller, MD, of the Johns Hopkins Medical Institutions.

Incident Command System for Disasters

"The problem with mass casualty incidents is that you can't predict them. They can come at any time. EMS personnel need to know the 'big picture' to effectively implement a disaster management plan."

Tom Schwartz, EMS director for the Central Shenandoah EMS Council in Virginia, was introducing a workshop on managing mass casualty incidents through the Maryland Mutual Aid Operational Plan. The plan has been designed to ensure full interjurisdictional cooperation between EMS, rescue, fire, and police agencies during an emergency that exhausts the resources of the public safety agencies within a single jurisdiction. It also provides integrated command for effective mitigation of the life-threatening effects of a disaster.

"The mission of the people responding to an emergency—whether it is a single car crash, an overturned bus, or a major city fire—is to *stabilize* the incident," explained Mr. Schwartz. "The ultimate responsibility for the incident rests with the city or county manager, elected officials, Board of Supervisors, etc. EMS personnel must support the stabilization strategy by their tactics and performance in the street. An individual fire fighter or rescue technician has the responsibility of locating victims and administering survival aid."

The Maryland Mutual Aid Operational Plan was developed after evaluation of the response to the Air Florida crash and Metro derailments in January 1982. It is patterned after the response plan designed by the Greater Metropolitan Washington Council of Governments. Included in the Maryland document are criteria and procedures for requesting assistance, use and deployment of personnel, command and control, communications, and identification of functional areas and personnel. Protocols for establishing operations at the scene as well as general regional procedures are delineated.

Mr. Schwartz explained that each EMS responder is not responsible for knowing the entire plan. Each group of EMS personnel needs to know its own responsibilities in the overall structure. The incident commander or the chief officer should have the document at the scene for reference. "No one has the time or ability to memorize the entire document," advised Mr. Schwartz. "Use the plan as a resource."

Maryland's disaster plan, like other statewide plans, addresses task performance: fire, medical, community, and survival aspects. Local response plans supplement the state plan.

The concept of incident command is central to the plan. The incident commander is ultimately responsible for decision making in the emergency service response to the disaster. The type of command system that is established depends on the type of incident; for example, a police command system would be established in a police incident, with fire/rescue and EMS established as operational support services.

The incident commander is not necessarily the first person on the scene. The plan provides a mechanism for transfer of command from early responders to the plan-designated person in charge. The plan is not dependent on the arrival of any one person on the scene to take over.

The incident commander may not even be on the scene but, rather, at a command site well removed from the incident. Other officers in the system (including communications, combat, resources, and public information) feed information to the incident commander and command post to facilitate decision making.

The incident command system needs to be applicable to all situations. It must be automatic, simple to use, and established early in the incident.

Mr. Schwartz cited some of the problems that often occur during drills of the plan and in actual incidents. With appropriate planning and education, these difficulties can be avoided.

Drills of the plan should be held regularly. "You shouldn't wait for the big incident to happen. If the plan is going to work, it must be practiced," Mr. Schwartz said. He suggested that time frames be set for drills to create stress and force people to make decisions. Drills should be manageable, small, and fun. They should never be a surprise until the personnel involved are completely familiar with the disaster plan.

"The plan should be followed for small car crashes as well as large incidents and will help EMS personnel to manage the incident better. If you get a 'big one,' you will know the system and will be able to expand it to include many additional resources and personnel, including the chief officer," said Mr. Schwartz.

Emergency responders should understand that the best communication among the emergency responders is face to face. Sometimes officers will talk with each other on a portable radio when they are standing 5 feet apart. A pumper crew might use a radio to communicate with the pumper parked beside it. That creates havoc on the radio when it is important to relay vital information about the incident. Communication options other than radio are telephones, runners, ham radios, and written messages.

EMS personnel need to know their responsibilities in the plan and fulfill them. According to Mr. Schwartz, one of the biggest problems that has been experienced in implementation of the plan is "free-enterprise" decisions. Adherence to the plan is particularly important when several jurisdictions (e.g., counties or states) are involved in a response.

Responding units should be aware of the local resources that are available to assist in managing an emergency. Cranes, forklifts, and other construction equipment are needed in some emergencies. Patient transport methods are not limited to ambulances: pumpers, school buses, boats, or horses might also be used.

Poor decision making can result from not understanding the plan, protocols, and procedures. All the people involved in a response, including those relaying information from the scene and the dispatcher, need to know their roles and how they fit into the "big picture."

—Linda Kesselring

Revising ALS Protocols: Statewide Input Sought

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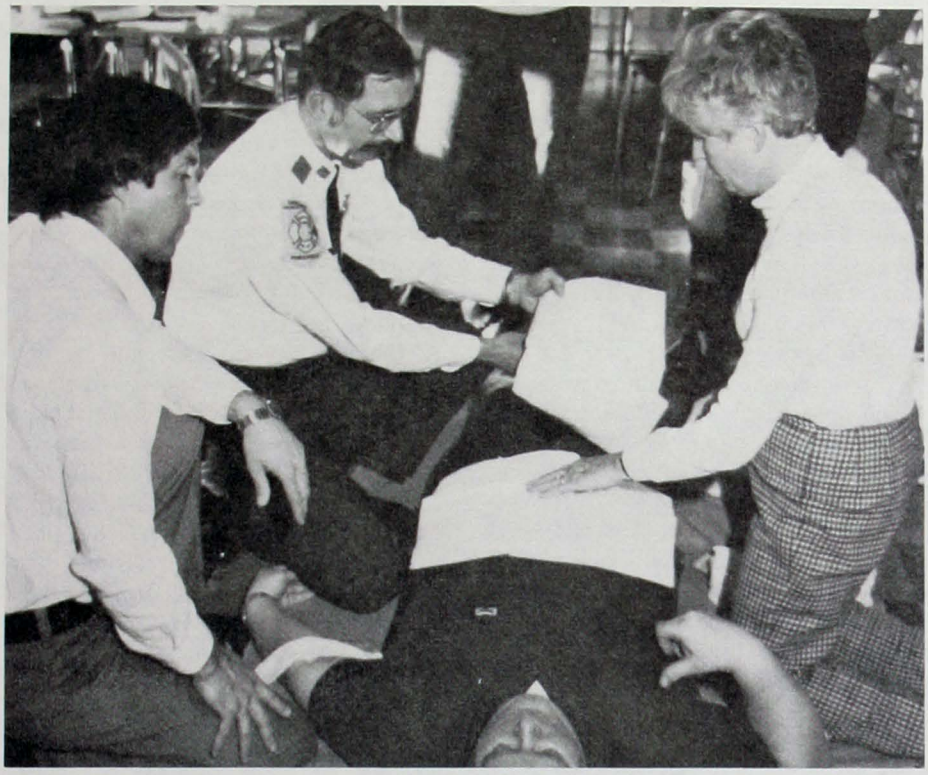
gional medical director or directly to Dr. Ameen Ramzy (State Medical Director, EMS Field Operations, MIEMSS, 22 S. Greene St., Baltimore, MD 21201). Hopefully a thorough review with full participation will assist in achieving consistent excellence in patient care.

High Schools Train First Responders



Harry Wallett teaches first responder skills to high-school teachers Richard Swomley, Janet Pabst, Kathy Freeman, and Ann Kenney. Edward Hall plays "victim."

Interested high-school seniors will be taught first responder courses in their own schools by specially trained science teachers, through a program designed by MIEMSS and the Baltimore County Public Schools. The idea grew from classes begun by the teachers.

Robert F. McNeish, coordinator of science for the Baltimore County Public Schools, contacted MIEMSS to find out whether a course called "Paramedic Biology," developed by science teachers, could gain some sort of certification outside the school system. Upon investigation, it was found that although in such areas as physiology the students were being taught even more than the requirements for first responder certification, in areas such as fracture management their material was insufficient or outdated. Cardiopulmonary resuscitation (CPR) was included in the course.

After discussions among MIEMSS and representatives of the Baltimore county school system, it was decided to raise the level of the science teachers' EMS skills to those of first responder instructors. David Gribble, MIEMSS paramedical training officer and coordinator of the first responder program, is now the MIEMSS liaison who trains the high-school teachers as first responder instructors.

Fifteen science teachers met with Mr. Gribble to arrange for the 24-hour course. The first five teachers to receive instruction and become certified by Mr. Gribble and Harry Wallett, MIEMSS EMT instructor and evaluator, are: Kathy Freeman and Anne Kenney, Owings Mills Junior-Senior High School; Edward Hall, Catsonsville Senior High School; Janet Pabst, Sparrows Point Middle-High School; and Richard Swomley, Pikesville High School. The remaining 10 teachers will take the course during the school vacation. By the end of the summer 13 high schools will have at least one certified first responder instructor.

The first responder instructor's course includes the following topics: patient assessment, bleeding and bandaging, oxygen and shock therapy, CPR, and an administrative workshop. Due to their understanding of the subject, the science teachers advanced rapidly in skills development, allowing enough time to include tours of the Shock Trauma Center and the Maryland State Police Med-Evac helicopter section at Martin's Airport. These experiences will be related to their high-school students. MIEMSS will monitor the classes to ensure that guidelines are being followed.

The new instructors are particularly interested that their students be certified as first responders so that they can attain further education and become EMTs. (Under the new EMT program, currently certified first responders can enter the 110-hour EMT course at lesson 14 if space is available in the class.) It is estimated that as many as 600 students may be certified as first responders during the first year. Another advantage to having so many students learning these skills is that in many jurisdictions there is not enough money to hire school nurses; first responders can fill that gap.

It is hoped that other school systems will implement similar programs. According to the teachers, there have been two unexpected rewards: students who see films and learn what drug abuse does to the body lose all interest in abusing those substances because they see the unpleasant consequences; and there is so much enthusiasm generated that previously poor students suddenly earn high marks. "If I had my way," says Mr. Gribble, "I would like to see every citizen in Maryland certified as a first responder. Just think how helpful it would be in public places, gym classes, or even in a family setting."

—Erna Segal

Region I

The Northern and Southern Garrett County Rescue Squads received good news from the 1986 Maryland legislative session. House Bill 826, establishing a special funding source for the squads, received favorable review in the Senate and House. This bill, which was introduced by Delegate George Edwards, guarantees the squads an amount equivalent to 2 cents per hundred dollars on the assessable property base in Garrett County.

As a means of showing their appreciation for the service provided by EMTs, the Region I EMS council has minted special EMT 5-, 10-, and 15-year service pins. These attractive pins are available to other regions of the state. For additional information, contact the Region I office. *—Dave Ramsey 301/895-5934*

Hearing for Behaviorally Disturbed Patients

Editor's Note: The Psychiatric Evaluation is part 3 of a three-part series on the process by which it is determined whether a person should be committed to a psychiatric facility.

Ideally the mentally disturbed patient was brought into the emergency department (ED) of a hospital by a police officer, medic, family member, or other interested party with a properly executed petition and was examined by two physicians or a physician and a psychologist to ascertain whether his difficulties were due to organic or psychiatric causes. The physicians or psychologist determined through tests that he had a psychiatric disorder needing inpatient treatment; they each signed a certificate of commitment, and one wrote a note detailing the grounds on which he concluded the patient needed hospitalization. The patient has been in a holding bed in the ED for several hours awaiting transport. How does the commitment process proceed?

Speaking at the Legal Aspects of Behavioral Emergencies Conference held at Sinai Hospital, Dennis Grote, associate director of the Greater Baltimore Medical Center and an EMT-IVT with the Rosedale Volunteer Fire Company, said that the guiding principle in a commitment procedure is whether the patient is able to make an informed decision. He said, "If so, respect it. If not, make sure that the laws and policies are implemented in such a way as to do no harm to that patient."

Transport is arranged from the ED to the inpatient psychiatric facility to which the patient will be taken for observation. If the patient is violent in the ED, a nurse or physician may order the use of restraints for the trip. If he becomes violent en route and no restraints have been ordered, the police officer escorting him may use restraints at his discretion, but must obtain a restraint order within two hours of the transport.

The patient will remain in the psychiatric facility from 5 to 10 days for observation; at the end of that period a hearing will be held to determine whether the five criteria for commitment were met. (Those criteria are the presence of a mental disorder; a need for inpatient care or treatment; presenting a danger to the life and safety of himself or others; unwillingness or inability to be admitted voluntarily; and the absence of less restrictive forms of intervention consistent with the patient's welfare and safety.)

A hearing consists of the hearing examiner, who is an attorney appointed by the state; the patient; the patient's attorney, who can be a public defender or private lawyer; and representatives from the hospital, the treating psychiatrist, and the social worker. The social worker reads the certificates, notes, and any accompanying material. The family is allowed to be present if they wish to be; it is up to the patient whether they

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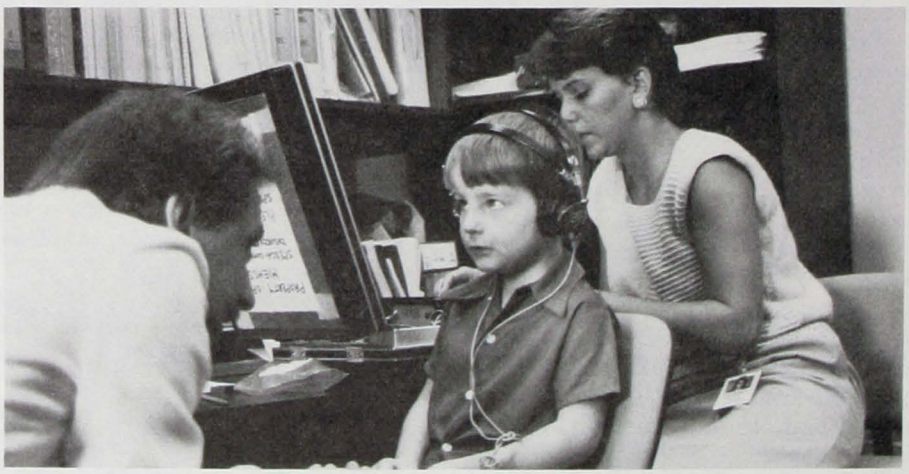
Hundreds Helped by Hearing Screenings

More than 240 people participated in the free hearing screenings performed by the speech-communication disorders program of MIEMSS Shock Trauma Center and Montebello Rehabilitation Hospital. The screenings were offered in May, which was designated as "Better Speech and Hearing Month" by the American Speech-Language-Hearing Association and the Maryland Speech-Language-Hearing Association, in order to bring speech and hearing to the attention of the public and the medical community.

Results of the hearing screenings showed that 69 percent of those tested failed and required further evaluation. Referrals were made to the ENT Department of the University of Maryland Medical System as well as to other community centers.

Due to the overwhelming response to the screening, extended hours are planned for next year's screening. "The speech-communication disorders program is proud to provide this valuable service to the community," remarked Roberta Schwartz, director of the speech-communication disorders program at the Shock Trauma Center and Montebello Rehabilitation Hospital.



More than 240 people participated in the free hearing screenings performed by the speech-communication disorders program.

Correction

In the article on EMS legislation passed by the Maryland General Assembly that appeared in the May issue of the newsletter, an explanation of SB 582 (HB 1013) appeared. According to this law, if a paid or volunteer firefighter or EMT treats or transports an ill or injured patient who is later diagnosed as having an infectious disease, the attending physician or physician's designee must notify the firefighter or EMT and his employer of the individual's exposure to the patient. Eight infectious diseases were mistakenly noted in the article as required to be reported. The law, as signed by the governor, lists the following: mononucleosis, hepatitis, meningitis, rabies, tuberculosis, and malaria. We regret the error.

Commitment Hearing

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will be present during the reading of his medical record. If they are excluded, they are allowed to return later to testify. The patient may have anyone he wishes testify for him. If the hearing examiner determines that based on the evidence presented the five criteria are not met—and this is decided by the letter of the law, regardless of the patient's condition—the patient is released, or may sign voluntary commitment forms.

When a person is found to have been inappropriately committed, upon discharge there are safeguards against disclosure. The observation period records are sealed and kept away from other treatment records. If the patient is admitted, the observation period records will be included with other records. If it is determined that the commitment was valid, there will be a retention hearing every six months that the patient is in the psychiatric facility. He can be discharged sooner if his doctors feel he is well enough.

Patients have a right to look at their hospital records. If the physician believes it will cause medical injury to have the patient see his records, disclosure may be prohibited. However, if the patient asks for a summary the hospital is obliged to give it to him in written form. According to Robert Fontaine, of the attorney general's office, if after the hearing the patient feels he is being held improperly, he does not go back before the hearing officer but petitions the circuit court for a writ of habeas corpus.

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Field Notes

By William E. Clark, State EMS Director

During the fiscal year that just ended, there was tremendous progress for the emergency services organizations in Maryland. Many times we tend to focus on what needs to be improved. But let's reflect for a few minutes on some of the important highlights of the past year.

In July, four important events occurred: Senate Bill 508 provided direct state assistance to local jurisdictions for the first time; Maryland-certified paramedics began providing care for the first time; Helicopter 6 began providing service for the upper Eastern Shore; and 9-1-1 became statewide in Maryland.

In August, a terrible bus accident near Frederick ultimately claimed the lives of 6 persons and left 11 others injured. Frederick County volunteers did a magnificent job in rescuing the injured and exhibited the highest level of professionalism in managing the mass casualty incident.

In September, the National Disaster Medical System exercise at BWI Airport and Andrews AFB provided us with a splendid opportunity to treat and manage 600 mock casualties.

Shortly after the exercise, Hurricane Gloria roared up the coast, causing widespread evacuations and taxing the emergency services personnel throughout the state. You all did a great job.

During the first week in October, we paused to recognize the important job of the EMS system providers during EMS week.

And just before Christmas, we celebrated another milestone with the ground-breaking ceremony for the new Shock Trauma Center in Baltimore.

In January, tragedy struck when Corporal Greg May and TFC Carey Poetzman lost their lives when Helicopter 2 crashed in Baltimore following a Med-Evac mission.

A mandatory seat belt use law was passed during the 1986 session of the Maryland General Assembly. It is hoped that this legislation will cut down on some of the needless deaths and injuries that are caused by motor vehicle accidents.

Because of legislative inquiry into the needs of the Med-Evac program, a consultant study of that program was requested; the consultants have started to gather the information for their report. In March, a special report was prepared by Leonard King (president of the Maryland State Firemen's Association [MSFA]), George Brosan (state police superintendent), and R Adams Cowley, MD (director of MIEMSS), outlining the development of our EMS system and making recommendations as to the needs of the system.

Also of importance during the legislative session was the recognition of the need for a seventh helicopter section to serve southern Maryland.

Talbot County came on line with Easton Volunteer Fire Department providing ALS services. Pilot EMT-defibrillation programs were started in Calvert and Prince Georges counties. This means that 19 of the 24 local jurisdictions are providing ALS care on a regular basis. Several other jurisdictions are now working at coming on line later this year. The Southern Maryland Hospital Center was designated as an areawide trauma center.

The new EMT-A training program has been carefully developed and will be implemented this summer statewide. Personnel from the Maryland Fire and Rescue Institute and MIEMSS worked together to implement the recommendations of the EMT-A Task Force.

We also hope the new reentry program for former Maryland EMT-As will bring back many former providers who, for one reason or another, let their certifications lapse.

Leonard King just completed an outstanding year as president of the MSFA and brought many organizations and people together during his term of office. We look forward to continuing this momentum under the leadership of Clarence Carpenter.

So you can see by these highlights that we have had a very productive year here in Maryland. But it has not been without its price. Let us not forget those who paid the supreme sacrifice in the service of mankind.

The future is in our hands. Let us go forward together in the pursuit of excellence.

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Commitment Hearing

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Should the hearing officer release someone who goes out and harms somebody, the hearing officer is not liable if he acted in good faith. The issue is the constitutional right to be free, Mr. Fontaine says, and that right can be taken away only when certain things are shown to indicate that the person is imminently dangerous. Elizabeth Eckhardt, an attorney and hearing examiner says, "Each moment that a person is in the hospital he is deprived of his liberties and freedom. In many cases the diagnosis should be 'pain-in-the-neck' instead of a psychiatric diagnosis, because the patient and his family do not follow through with treatment when he is out of the hospital. The family is glad to see him in the hospital." The psychiatric facility can certify a voluntary patient who submits a 72-hour notice to leave, provided the physician thinks he meets the criteria. Five days later the patient has a hearing based upon the certificates and hospital records. When a certified patient leaves the hospital without permission, the facility can notify police that he is at large.

Mr. Grote explains why there are so many safeguards to protect the disturbed individual. "If he is not able to fend for himself, the system must defend him. We must guarantee a humane course of treatment acceptable to reasonable men and women in a just society. This is what the public expects of us."

—Erna Segal

EMT-D Pilot Program Tested

Until recently, defibrillation in the prehospital phase of care was performed only by certified ALS providers. However, in some parts of the country with long response times and few ALS units, the question arose as to whether BLS providers could perform this skill with an automatic defibrillator that would read the patient's cardiac rhythm and apply a defibrillatory shock only if the machine interpreted the patient's rhythm to be ventricular fibrillation. Such a concept developed into the EMT-D (defibrillation) program, which has been applied in some parts of the country.

EMT-D is being evaluated in Maryland. Under the leadership of Joseph Colella, MD, a pilot program was approved by the State Board of Medical Examiners for implementation in Region V. (The review process for a pilot program in Maryland includes the local program medical director, the regional medical director, the regional medical directors as a group, and finally the state medical director who performs the final review before submitting the proposal to the Board of Medical Examiners, as this group has ultimate authority for the practice of medicine in Maryland.)

In the case of the EMT-D pilot program, following approval by the Board of Medical Examiners, extensive training began in Prince Georges County for the individuals who would be involved in the EMT-D program. Later, additional approval was given to implement such a program for units in Calvert County. At the present time, it is felt that there are sufficient units involved with the evaluation of EMT-D as a pilot program, so that no further pilot programs will be approved in Maryland. Following completion of the EMT-D pilot program in Region V, the data will be analyzed and evaluated to see whether this is a skill which should be incorporated into Maryland EMS. It is essential that a thorough analysis be performed, so that a number of local programs would not spend a great deal of money on automatic defibrillators, only to find later that such a device would not be utilized on a long-term basis.

Hopefully the current pilot programs will provide meaningful results as to whether EMT-D is a useful program to establish on an ongoing basis. At the present time, only certified ALS providers or individuals functioning within an approved pilot program can perform defibrillation in the prehospital phase of care in Maryland. Anyone functioning outside of these two situations would be engaging in the unauthorized practice of medicine and could be considered in violation of the law.

We are hopeful that this article has provided some information regarding the status of EMT-D in Maryland, as well as policies regarding pilot programs.

—Ameen Ramzy, MD
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