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How Does Increasing Violence Affect Emergency Care?

Editor's Note: "Emergency Care in an Increasingly Violent Society" was presented October 7 by the Emergency Education Council of Region V, Inc. and MIEMSS. The conference was supported through educational grants from the R Adams Cowley Shock Trauma Center and Prince George's Hospital Center.

The safety of EMS providers both in the emergency department and in the prehospital setting and the treatment of victims of violence were the main concerns of the conference.

In this issue, we focus on the safety of EMS providers, as well as the overall problem of violence in Maryland. In future issues, we will report on child abuse, elder abuse, and sexual assault, which also were covered at the conference.

The following is excerpted from the keynote address given by MIEMSS Executive Director Robert R. Bass, MD.

We begin our conference on violence as we must begin our campaign against violence--with learning ways to protect ourselves.

But as we debate bullet-proof vests and learn techniques for full body searches, we should also ask: why is an increasing amount of rage being directed at us? Are drugs, alcohol, and the breakdown of social values the only reasons? Or are we failing to recognize our patients and their families as fellow human beings who deserve courtesy, respect, and understandable information?

Do we leave the families of our patients sitting in waiting rooms for hours with no information on their loved one's condition or reason for the delay--with fear and panic building?

Do we send people home from our emergency departments with directions they cannot read?

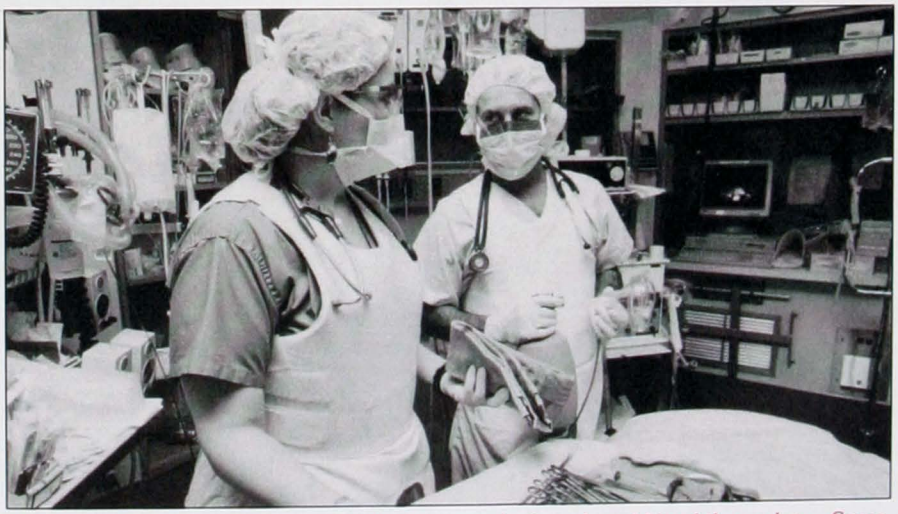
Do we have the time to notice the pain and fear in the eyes of an exhausted teenage mother and recognize her as an abused and neglected child? By helping to break that mother's cycle of ignorance and frustration, we may prevent another generation of abuse.

By noticing and reporting the neglected children huddling in the corner of a squalid apartment when we go on a call for chest pain for an alcohol-ravaged grandmother, we may break a multigenerational cycle of violence and abuse.

By providing an atmosphere of trust and support, we may encourage the victim of domestic violence to break away from that awful cycle that may kill her.

We must remember that as emergency care providers we are often the only contact with the world of authority and caring that our patients have. We cannot ignore that responsibility.

All of us as health care professionals must understand our legal and moral responsibilities to the patients we treat. We need to know not just how to treat their injuries but how to provide them access to the legal, social, and psychological services that may help them survive. We are often their only contact with those services. We cannot lose that opportunity to help.



Every day physicians, nurses, and techs are cursed, shoved, and hit while on duty. Some are critically injured or killed in their own emergency departments. Should body armor be a must for those in the ED?

EMS Survival Skills: Protecting Yourself

If you're a prehospital care provider . . . or even if you're an emergency room physician or nurse . . . your chances are steadily increasing that the next life you save may be your own or a co-worker's.

In light of the rising tide of violence in American society during the last decade, emergency medical personnel need to be as concerned about their own safety as they are about the well-being of their patients.

Should all EMS field providers wear body armor? Many people, explaining that no one knows when an emergency will be violent, answer strongly in the affirmative.

Recognizing the severity of the problem of caring for victims of violence, Capt. Dennis Krebs, of the Baltimore County Fire Department, and 1st Sgt. Mark Gabriele, of the Maryland State Police Aviation Division, have developed an 8-hour educational program for emergency medical professionals entitled, "EMS Survival Skills," and a book on the same topic. They summarized some of the main points of their program recently at the conference "Emergency Care in an Increasingly Violent Society" on October 7.

Basically, the program cautions emergency medical personnel to (1) keep their eyes pealed for signs of potential harm with the goal of preventing violence before it occurs; (2) ensure their own personal safety by knowing how to keep out of harm's way; and, (3) because trouble might arise despite their best preventative efforts, plan ahead of time how to deal with a violent incident.

Signs of Potential Harm

Only law enforcement officers are allowed to search a person, presumably for concealed weapons, notes Sgt. Gabriele. However, he says medical personnel can protect themselves by examining patients for "lumps, bumps, and deformities" first from the clothing in, and then from the skin in. And to prevent getting stuck by dirty needles or other sharp objects, never stick your hand into pockets while searching for identification, he advises. Instead, he recommends trying to identify objects by feeling their shapes from the outside of the clothing and, when uncertain about what they are, cutting the clothing open to reveal the objects.

The objects you retrieve while examining a patient may seem to be innocuous on the surface, says Capt. Krebs, but emergency personnel need to be aware that what looks like a pen may actually be a butterfly knife, that a wallet could conceal a 25-caliber gun, and that a cigarette lighter could be rigged to go off like a miniature grenade.

"It's not true that the only weapons of violence are the AK-47, the shotgun, and the 9mm handgun," as many emergency personnel believe, says Sgt. Gabriele. In fact, any sharp metal object could be used to stab someone, notes Capt. Krebs. For example, Ninja keychains, which are associated with the martial arts, have been used to wound others on more than one occasion.

Just finding such an object on a patient should be a warning sign of the type of patient you are treating, says Capt. Krebs. Actual and potential weapons can also be concealed in the orifices of the body, he adds, so emergency personnel should be aware of that and use caution.

Keep Out of Harm's Way

There are numerous techniques that emergency personnel can use to keep themselves out of harm's way. However, the idea of putting your own safety above your concern for the patient has proven to be the most difficult attitude of emergency medical personnel to break, says Sgt. Gabriele. Unless you observe your surroundings carefully, you may unexpectedly find yourself in the middle of a violent situation, he says, adding that this is often preventable.

Maryland Violence Stats

Statistics tell a gruesome story about murder in Maryland.

- In 1993, 632 murders were committed in Maryland, a 78% increase since 1984.
- The rate of murders per 100,000 population has increased from 8.1 in 1984 to 12.7 in 1993.
- Handguns were the weapons used in 68% of the murders in 1993, a 10% increase since 1992.
- In 1993, nearly one-third of the murders in Maryland were committed by people 21 years of age or younger; 13% by people under the age of 18.
- In 1993, in 30% of the murders in Maryland, the victim and murderer knew each other; in 8%, they were related.
- In 1993, there were 3,245 aggravated spousal assaults reported, a 5% increase over 1992. Of the total reported, 245 involved firearms.
- In 1993, of those brought to trauma centers in Maryland, 28% were victims of violence.

For example, Capt. Krebs maintains that a primary survey can actually be done from the front porch of somebody's house. Consider the scenario of hearing a domestic argument upon approaching a house. This tells you right away that the people inside have patent airways and that they are not likely to die soon from any wounds, he says. Do not become involved in that situation without law

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enforcement backup.

A situation in which prehospital care providers need to be especially careful is when the patient is a victim of a shooting. Capt. Krebs warns prehospital care providers never to

start an IV at the scene because the perpetrators may still be in the vicinity. Knowing that you don't administer fluids to a dead person, they may try to finish off the patient with you stuck in the middle. Instead, if you are in an area of heavy gang activity such as Los Angeles, he recommends first transporting the patient several blocks away from the scene and then pulling over to start the IV before continuing on to the hospital.

Although paramedics are not allowed to use law enforcement devices, such as handcuffs, it is sometimes effective in restraining a patient's arm to use the excuse of having to measure the radial pulse, notes Sgt. Gabriele.

If that technique doesn't work, prehospital care providers can use their emergency medical equipment, such as the long-board spinal immobilization device and the Kendrick extrication device, to restrain violent patients, says Capt. Krebs. If necessary, the head can be taped to the board. The use of such measures when the patient's injuries do not call for them should be red flags to emergency room personnel that the patient is potentially dangerous.

Emergency personnel should not carry anything on their persons that a violent patient might use as a weapon to inflict injury, such as a stethoscope which, if worn around the neck, can be yanked and used to pull one down. Other things that could be used against emergency personnel include a pin-on ID badge, loose jewelry, and pens or pencils. To lessen the likelihood of being grabbed and held, men who wear ties should use the clip-on type and women should not wear their hair in a pony tail.

NLU Study

In his recent study completed at National-Louis University (NLU) in Evanston, Illinois, entitled "An Analysis of the Application of Body Armor for Paramedics," Paramedic Donald W. Walsh recommends that all EMS field personnel wear body armor while working. Paramedic Walsh is also an EMS district commander for the Chicago Fire Department's Bureau of EMS.

The study included 251 paramedic participants in the 25 largest U.S. cities and spanned a 2-year period that ended April 1994.

Some of the statistics as reported in *JEMS* (September 1994) included:

- 92% of paramedic surveyed said they had been assaulted (hit with fists, hands, or feet; stabbed; or shot)
- 80% of major U.S. cities surveyed reported EMS personnel shot at but not hit while on duty

Although protective clothing, like Kevlar, is available to emergency personnel to wear, Sgt. Gabriele points out that this apparel, which is just made of cloth, is definitely not bullet proof. He says he is evaluating the use of lead aprons, worn by x-ray technicians, for protection against flailing limbs and even bullets.

Pre-Planning

At the institutional level, preplanning is essential to avoiding violent incidents in the emergency room and to dealing with such incidents when they erupt, according to Capt. Krebs. And the various available defense mechanisms that could be adopted have cost and risk factors that must be weighed against the expected benefit, he adds.

The first line of defense may not be the emergency room security guard, especially if that person is past the retirement age and is unarmed. If younger security guards are used and allowed to be armed, the hospital must assume responsibility for their training, as well as liability for the outcome of their actions, which often affect innocent bystanders.

As an alternative, metal detectors could be installed at the emergency room entrance. But Capt. Krebs asks, "How should security guards react when the alarm goes off?" and "What message does such a barrier send to the community?" Closed-circuit television surveillance is effective, but also costly.

The first line of defense in the emergency room may not be the security guard at all, maintains Capt. Krebs, but rather the nurse performing triage in the reception area. The triage nurse should be trained to spot trouble makers by their dress, appearance, behavior, and emotional state and to take the necessary action to prevent or stop a disruption.

Depending on the situation, he says the appropriate action might be as simple as keeping the visitors physically separated from the patient, or as urgent as signaling a coded alert that results in cordoning off a section of the building, or summoning a restraint team to subdue an unruly patient or family member, or calling in the police to free a hostage. To be

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De-escalating Potentially Violent Situations

How do EMS providers cope with increasing violence on the streets and in hospitals? Many are learning police style defensive tactics or thinking about investing in bullet-proof vests. Lt. William Hogewood adds another approach—try understanding and interacting with the individual in crisis to de-escalate potentially violent situations.

At the conference "Emergency Care in an Increasingly Violent Society," on October 7, Lt. Hogewood offered insights on how EMS providers can "connect" with the potentially violent individual and reduce anxiety so that he/she listens to reason and avoids resorting to violence.

The method described by Lt. Hogewood has been successful for the Conflict Negotiation Team of the Prince George's County Police Department, which is under Lt. Hogewood's command. This conflict negotiation team has dealt with 428 barricade situations. To date, in three situations, the violent individual was killed; another time, he was injured. No one else, including hostages, bystanders, or police, was ever injured.

Lt. Hogewood agrees that communication skill is important, but he defines it as "your recognition of people as human beings. It's not just what you say but what you receive from other people. For example, did you ever stop to think why the poor guy in the emergency department is so frustrated about his wife that he wants to punch someone out? Probably not. But take a step back and think about where he's coming from and how it feels."

The first communication tool is to understand how people react and why they do. According to Lt. Hogewood, it boils down to the word "crisis." People expect to be able to cope with life. But any stressor disrupts and decreases that level of coping. Depending upon the degree and number of stressors, all coping mechanisms could start to fail an individual. Common coping mechanisms include denial (for example, a hostage, with a gun pointed at his ear, thinks "this can't be happening to me"); anger; rationalization (for example, "This is no big deal"); projection (for example, "She did this to me. I didn't do anything wrong").

Most crises resolve themselves over a period of time. But some people get out of a crisis by becoming psychotically depressed. When these people reach out for help but find that their problems are brushed off, they become increasingly frustrated. When the frustration builds up and they see no solution, they often do something to get attention (for example, a worker recently laid off or fired

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If You Are Taken Hostage

Lt. William Hogewood offered the following advice if an EMS provider is taken hostage.

- Personalize yourself to let the hostage taker see you as an individual. (Example: I'm Bill. We're all upset in here. If there's anything I can do, let me know.) By personalizing yourself to the hostage taker, you are more likely to survive.
- Try to personalize the hostage taker. (Example: Is there something I can call you?) Whatever name the hostage taker prefers, use it.
- Try to get the hostage taker to talk about his feelings.
- Do not argue or discuss ideology. (Example: Do not advocate or try to explain why you are pro-choice to a hostage taker who is anti-abortion.)
- If food is delivered, eat. "Breaking bread" is a way for people to have a shared response to things.
- In a mass hostage situation, some people try to not draw attention to themselves, preferring anonymity. This is fine.
- In a mass hostage situation, talk to anyone who talks to you. Do not snub anyone. You are all in the situation together.
- In a mass hostage situation, if you are considering escaping, make sure that:

a. You are 150% certain that you can escape without becoming a victim yourself. Remember that police with guns are outside and they may not know what the hostage taker looks like except for a general description (for example, tall, white male)–a description that may also apply to you. You do not want the police to be surprised by your exit and kill you because they think you are the hostage taker trying to escape.

b. Also consider what the hostage taker may do to your fellow hostages if you escape. Can you live with the fact that they may be killed or injured because you escaped?

- If negotiators are making a connection with the hostage taker, sit back and let them do their work. Lt. Hogewood notes that he has trained more than 1,000 hostage negotiators, about half of them in Maryland. They are knowledgeable and sophisticated. He urges you to trust the process.
- Most importantly, trust the negotiation process, whether you or professional negotiators are trying to reduce the hostage taker's anxiety so that he will consciously and voluntarily do what is right–letting his hostages go and unbarricading himself.

◆ *Beverly Sopp*

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might try to jump off a bridge or take fellow workers as hostages). They become delusional in their crisis and say "if I do this, changes will be made." Unfortunately, this does not happen. But, as Lt. Hogewood points out, before you can get people to listen to reason, you have to reduce their anxiety, for high anxiety and reason cannot exist at the same time.

After recognizing the feelings of the potentially violent person, an EMS provider should refer to the last thing that he/she said (for example, "You feel angry because you don't think that we're getting to your wife in time; I understand that. But it won't be long now."). Sometimes, in order to distinguish between verbal content (words or message) and feelings (such as frustrated, angry, hostile), the EMS provider has to interpret non-verbal behavior or body language (such as clenched fists, tightened jaw, hand wringing) and the tone and inflection of the voice. Active listening by the EMS provider (for example, leaning forward) also helps the potentially violent person to calm down.

Another point to remember, according to Lt. Hogewood, is that all of us have a parent, adult, and child inside. We expect people to act like adults. But we have to remember that if we approach a person in an authoritative manner (that is, as a parent), he/she will react as a child, often refusing to do something or yelling.

But we can avoid this and further escalation of anger by practicing communication skills to calm the potentially violent person. Talk to him/her with empathy, listen and respond to the last thing said, respond to the feeling (if you know the feeling), and use eye contact. Lt. Hogewood predicts that the next thing that you will see is tension reduction. "You'll see the hardness of the body leave, the tightness of the lips decrease, the skin seem to sag and relax, the forehead unwrinkle. All that is the anxiety being reduced. And when that happens, the person can listen to reason and make a decision based on reason. This is common-sense negotiation."

Lt. Hogewood concludes with the reminder that "all you have to do is to respond to what is being said. And remember that when people are in crisis, you cannot reason with them. You have to try to soften your own words a little and help them to release their anxiety."

◆ *Beverly Sopp*

EMS Survival Skills

(*Continued from page 3*)
effective, these kinds of interventions require carefully thought out protocols and strategies that can be implemented expeditiously, right down to which member of the restraining team is responsible for controlling which of the violent person's appendages.

"You don't have to reinvent the wheel" when trying to formulate response plans to violent situations, says Sgt. Gabriele. He recommends seeking the advice of cell entry teams from correctional facilities and of psychiatric hospital workers who are responsible for patient control. The Secret Service might even be willing to conduct a security survey on an emergency room under the presumption that the hospital administration is concerned about its ability to deal with a sudden presidential visit, suggests Sgt. Gabriele.

Finally, the design and construction of the emergency room and its surroundings can incorporate passive defenses. For example, Duke University Hospital installed bullet-proof glass and erected masonry and glass block walls in its emergency room following a gang-related shooting on the premises, says Sgt. Gabriele. At the Los Angeles hospital where three physicians were gunned down during a drive-by shooting, planters have been set up in the parking lot to prevent a recurrence of that unfortunate incident, adds Capt. Krebs. He also notes that salley ports protect ambulance crews from outside attack while transferring patients from the vehicle to the emergency room.

Developing a defense against violent acts may soon become a legal requirement, if the nation follows the examples being set in Illinois and California. According to Capt. Krebs, OSHA, in an effort to target workplace violence, recently fined a Chicago psychiatric hospital for not training its employees to protect themselves from violent incidents, which have become routine at that institution. And California is requiring all hospital personnel to receive street and hospital survival training by 1995, says Sgt. Gabriele.

◆ *Dick Grauel*

December Case Review

A MIEMSS Prehospital Case Review Program will be held Wednesday, December 14 at the R Adams Cowley Shock Trauma Auditorium in Baltimore. From 7 to 8 pm, case reviews will be presented by the Poison Center; from 8 to 9 pm, by the Shock Trauma Center.

Two hours of B credits for ALS providers and two hours of T credits for BLS providers will be offered.

To register, call the MIEMSS Educational Support Services Office at 410-706-3994.

Injury Prevention

Toys: How Can They Be Hazardous for Children?

Editor's Note: As the holiday season approaches, we focus on toys and holiday decorations that are potentially dangerous to children. If you take a few extra minutes in selecting toys and a few precautions inside and outside the home, holiday celebrations can be both safe and happy. EMS providers can post the following article or duplicate and distribute it in their own public education efforts.

EMS professionals have an essential role in injury control, which has two components. The first is prevention. Providing the community with information about developmentally appropriate toys and activities can help to prevent 9-1-1 calls for respiratory distress, electrical and thermal burns, suffocation, and strangulation. The second component of injury control involves the rapid identification of a potentially life-threatening situation and the possible mechanism of injury. When the dispatch information involves a child in distress, a calm and logical approach will guide the assessment and treatment of injuries in children.

Airway Obstruction

Some commercial and handmade toys are potentially hazardous if they have small parts that can be pulled or bitten off during play and swallowed by an infant or young child. Buttons, small pom-poms, bells, small squeakers, and plastic eyes are examples of foreign bodies that can be inhaled or swallowed. A good rule of thumb is that children under three should not be given toys with detachable parts that are smaller than 1 1/2 inches in width by 2 1/4 inches in length. The Consumer Product Safety Commission has used a testing tube that simulates the young child's throat and can be used to determine if small parts or toys could pose a choking danger to children under three years of age. This "No-Choke Testing Tube" is available in safety displays at retail stores and in some safety and toy catalogs (for example, Toys to Grow On, P.O. Box 17, Long Beach, CA 90801).

A careful physical assessment for respiratory distress and an accurate history from the parent or care provider are key to recognizing foreign body aspirations in children. Toys, as well as food, are common causes of incomplete or complete airway obstructions in children under 3 years of age. The presence of stridor, choking, hoarseness, or drooling in a child with respiratory distress should be a red flag. Ask the parent or caregiver when the symptoms of respiratory distress began. If the onset of symptoms was sudden and rapid while the child was eating or playing, suspect airway obstruction by a foreign body. Infections that cause respiratory distress have a longer onset over a period of hours or days.

Management for an airway obstruction in an infant or young child should follow the American Heart Association BLS guidelines for Foreign Body Airway Obstruction in a conscious and unconscious patient based upon the age of the child.

Electrical Burns

Toys that are electrically operated are not recommended for children under the age of six. All children initially require adult supervision when using a new electric toy. Toys should be checked regularly for broken parts, frayed cords, and damage to compartments. Cords should be placed out of the reach of children. Electrical burns in a child can be caused by wires and cords that the child places in his/her mouth. The risk for injury from the electrical energy continues over a period of days. Any child with a burn to the mouth must be transported rapidly and observed for signs of respiratory distress.

Suffocation and Strangulation

Children are also at risk for suffocation and strangulation from everyday items within the home. Wrapping paper and ribbons from presents, decorations, and certain clothing with strings and ties offer a potential danger for children. Plastic bags from the grocery, dry cleaners, and newspapers, as well as balloons, are also potential hazards. Extension cords, venetian blind cords, necklaces, and ribbons should be kept out of the reach of infants and toddlers. Preschool and school age children should be taught--and reminded--not to place strings or cords around anyone's neck, including their own.

Toy Safety Guidelines

- Read the developmental age guidelines on the toy box or package.
- Teach older children to keep their toys out of the sight and reach of younger children.
- Toys with small parts should be kept in containers with lids.
- Teach children that toys with flying parts or parts that shoot can cause eye injuries.
- Painted toys should be nontoxic and paint must be lead free.
- Wooden toys should not have screws, nails, or metal brackets that can come loose.
- Stuffed animals and dolls should not have strings or elastic bands that could strangle a child.
- Dispose of wrapping paper and ribbons immediately because they may be poisonous if chewed or cause choking if swallowed.

Toys should match a child's developmental level. Suggestions for specific ages appear in many magazines for parents. In addition, toys should meet the voluntary safety standards of the Toy Manufacturers of America and the requirements of the U.S. Consumer Product Safety Commission. Further information can be obtained from the U.S. Consumer Product Safety Commission (1-800-638-CPSC).

◆ *Cynthia J. Wright-Johnson, MSN*
Pediatric Nurse Coordinator

A Personal Tragedy . . .

Recently a tragedy struck our family when a motor vehicle accident took the life of my 3-year-old granddaughter, Dana Hutchinson. She was securely fastened in a child safety seat with a lap belt that is designed to lock on impact. After her head struck the dashboard, she succumbed to fatal head and neck injuries and a cardiac arrest at the scene.

We then learned that the factory-installed lap belt buckle was incompatible with a child safety seat and needed to be supplemented by a second buckle installed by the dealer (free of charge). This fact is buried in the owner's manual and independent questioning of service managers reveals that many of them neither know about the supplemental lap belt nor have ever installed one.

The DANA Foundation (Drivers' Appeal for National Awareness), a non-profit organization, has been created to educate the public about the seat belt systems that are incompatible with infant and child restraints and to encourage people to make the necessary modifications *now*. DANA's ultimate objective is to achieve simplified and effective seat belt systems that are compatible with child safety restraints in all automobiles.

For additional information, contact the DANA Foundation by fax 301-601-9228 or write PO Box 1050, Germantown, MD 20785.

◆ *Joseph J. Colella, Jr., MD*
EMS Region V Medical Director

What You May Not Know About Child Safety Seat Use

The Maryland Child Passenger Restraint Law requires all children under the age of four or 40 pounds to ride in a federally approved child safety seat; it has been called the Law of Love. As increasing numbers of people use child safety seats, the problem of misuse has grown significantly. Nationally the estimate of misuse ranges from 50% to 80%. Parents, grandparents, and other care providers who are placing children in child restraint systems need to recognize that using a child safety seat currently is not as simple as it may appear. The directions in both car seat manuals and vehicle owner's manuals are complex and often difficult to interpret. The "car seat" may also be referred to as a child safety seat (CSS) or a child restraint system (CRS). Unfortunately the reality of car safety systems today is that they can differ for each seating position, depending upon the car make and model.

IMPORTANT KEY FACTS Concerning Child Safety Seats from the DANA Foundation and national safety resources include the following:

1. Read the *owner's manual for the infant or child safety seat* to be sure the child is positioned correctly in the seat based upon age and weight; the harness is secured correctly based upon weight and height; and the seat is correctly placed in the car.

2. Read the *owner's vehicle manual* to determine which seating positions are safely compatible with a child safety seat and the specific manner in which the restraint system must be used. The child safety seat must be very tight when secured with a belt system.

- Of the seven standard types of safety belt systems, three can never be safely used with child safety seats; these are emergency-locking retractors, automatic shoulder seat belts, and seatbelts mounted forward of the seat crease or mounted on the door.
- Manually tightened lap belts are the only seat belts that are ideal in design for child safety seats.
- Other seat belt systems, in *both* the front and rear positions, require additional hardware and/or special child safety seat installation techniques before they can be used. Note: this includes both shoulder and lap belt combinations and lap belts only.
- Some seat belt systems require one or more locking clips. These locking clips are available from car seat manufacturers, automotive dealers, and in some specialty children's stores. (Further information on obtaining locking clips can be obtained from Maryland KISS.) Some seat belt systems require the dealer to install an entire new component.
- Any "automatic" seat belt that moves into position around the passenger/driver seat CANNOT be used to secure a child safety seat.
- In older models of child safety seats, a tethered strap must be installed into the back frame of the vehicle. The directions for installation were included with the safety seat at the time of original purchase. Installation should be done by the automotive dealer.
- Regulations are based on a 30 mph impact with substantial movement of a child being "acceptable."

3. Child safety seats for infants must face rearward until the child is over 20 pounds or can walk. Rearward facing infant seats cannot be placed in a front passenger position if the car is equipped with an airbag for that position.

Guidelines for selecting child safety seats are available from the Maryland KISS [Kids in Safety Seats] at 1-800-370-SEAT.

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Governor William Donald Schaefer

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DATED MATERIAL

Red-Out Day Encourages Safe, Sober Driving

Following the same strategy as the highly successful Smoke-Out Day, Red-Out Day will be observed on December 1, in Maryland, Delaware, District of Columbia, Pennsylvania, Virginia, and West Virginia. These states comprise the National Highway Traffic Safety Administration (NHTSA) Region III, which is sponsoring Red-Out Day.

Residents in the six states are encouraged to wear red articles of clothing on December 1 as part of the campaign. Tying in with red ribbon campaigns from Mothers Against Drunk Driving (MADD) and NHTSA, Red-Out Day is designed to focus public attention on safe and sober driving during the heavy traffic holiday season. The significance of the color is twofold: (1) to stop red ambulance and police cruiser lights from flashing in response to motor vehicle crashes caused by alcohol- and/or drug-impaired drivers and (2) to stop the blood flowing from victims of car crashes involving impaired drivers.

Friends Don't Let Friends Drive Drunk

Red-Out Day will kick off activities for NHTSA's National Drunk and Drugged Driving Month (3D Month) in December. The theme for 3D Month will be "Take a Stand! Friends Don't Let Friends Drive Drunk."

In Memoriam

Raymond M. Curtis, MD, a pioneering hand surgeon and first director of the Hand Center that bears his name at The Union Memorial Hospital, died on October 10 in Mount Vernon, Washington. MIEMSS designated the Hand Center in 1975 as the first hand referral center for the care of hand and upper extremity injuries in Maryland's statewide EMS system. The Hand Center was the first of its kind in the nation.

Before retiring in 1982, Dr. Curtis continued to expand the Hand Center in the areas of physical and occupational therapy.