

GOOD SAMARITAN LAW ENACTED

On May 17, 1976, Governor Marvin Mandel signed into law new legislation significantly changing the so-called "Good Samaritan Law." Because it was emergency legislation, the changes became effective immediately.

The Division of Emergency Medical Services, with the support of all major organizations in the State committed to improving emergency medical care, worked

very closely with the Maryland State legislature to formulate this new law. The Good Samaritan Law now provides the liability coverage and legal safeguards necessary to support a modern emergency care system in Maryland.

A major provision of the law is the release from liability for physicians and hospitals relaying medical consultation to ambulance attendants via radio and/or telephone

communications. Prior to the new law, protection was provided only to those persons providing treatment at the scene of an emergency. With the statewide communications system soon to be completed, the new provisions allow for full utilization of its capabilities.

The law also extends coverage to the lay person who responds to the aid of someone in an emergency. The previous law dealt only with those persons who normally rendered emergency care such as physicians, nurses, ambulance attendants and police. The new law recognizes the need for all people to assist quickly and effectively in an emergency.

There is very little judicial precedent regarding "Good Samaritan" laws since few claims for damages against their rescuers have ever been initiated by emergency victims.

The intent of the Good Samaritan Law is to provide protection to those persons who, to the best of their ability, act to help someone else without profiting in giving this help. The complete text of the new law follows.

(A) A person licensed by the State of Maryland to provide medical care, who renders medical aid, care, or assistance for which he charges no fee or compensation: (1) at the scene of an emergency; (2) in transit to medical facilities; or (3) through communications with personnel rendering emergency assistance is not liable for any civil damages as the result of any professional act or omission by him not amounting to gross negligence.

(B) A member of any State, County, Municipal or Volunteer Fire Department, Ambulance and Rescue Squad, or Law Enforcement Agency who has completed an American Red Cross Course in

(continued)



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International EMS/Traumatology Symposium held in Baltimore (story page 4)

Advanced First Aid or its equivalent and possesses a current card indicating that status as determined by the Secretary of Health and Mental Hygiene, or is certified by the State of Maryland as an Emergency Medical Technician or Cardiac Rescue Technician has the same immunity provided in subsection (A).

(C) *Members and employees of Federal, State, County, or City Governments, Hospitals, Emergency Medical Service Councils and Agencies which operate as nonprofit groups that provide support to the Emergency Medical Facilities, or consultant support without charging the emergency victim a fee for the service provided are not liable for any civil damages resulting from acts or omissions not amounting to gross negligence.*

(D) *A person not included in the above categories, who without compensation renders emergency assistance at the scene of an emergency, is not liable for acts committed or omitted, provided the person rendering the aid acts in a reasonably prudent manner and relinquishes direction of care of the injured person when a person licensed or certified by the State of Maryland to provide medical care or services is in a position to assume responsibility for care of the injured person.*

**THE MARYLAND FIRE AND
RESCUE INSTITUTE
ANNOUNCES
A NEW
TELEPHONE NUMBER.**

301-454-5966

CPR TRAINING BEGINS IN SCHOOLS



The Division of Emergency Medical Services, the American Heart Association, Maryland Affiliate, and the regional school systems throughout the State are developing plans to include cardiopulmonary resuscitation (CPR) instruction in the health education curriculum of all secondary schools. DEMS is providing the funding for equipment and materials, the Heart Association is training teachers to give CPR instruction, and the community schools are providing educational facilities for this training.

How to implement the CPR training in each region will be determined by local school officials and local Heart Associations. For example, some schools prefer to add CPR at the ninth grade level, while others prefer the tenth grade level. In some cases, the physical education teacher will be the primary instructors; in others, nurses and/or health educators. Some schools will hold training workshops for their teachers; in other schools, teachers will attend CPR classes off campus. Materials and equipment may also vary from school to school depending on the capabilities which exist within any given school. Whatever the unique local arrangements,

however, the objective of the program is to provide schools with the capabilities of including CPR training in their health education programs and to train, on a continuing basis, all secondary school students in CPR.

To date, the response from school officials has been most encouraging, and interest in making this training available to students appears nearly universally favorable.

For further information on this program, contact your Regional EMS Coordinator or your local Heart Association Chapter.

DIVISION OF EMERGENCY MEDICAL SERVICES

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PROFILE

GEORGE PELLETIER

"By George, he's done it" is probably not an expression of surprise if one is speaking of George Pelletier. For his record of leadership and accomplishment in Maryland's EMS Region III supports the idea that George can not only solve difficult EMS problems but actually thrives on facing the challenges of a regional coordinator.

As a regional coordinator for DEMS, George works with all people involved in the EMS system - assessing regional needs and determining priorities, lending administrative support to the regional EMS council, assisting in scheduling nursing and physician workshops, EMT and CRT training programs, and meeting with EMS providers and consumers to assure that all components of the system in Region III function smoothly.

Although George is not a native Marylander (he hails from New Jersey), he certainly qualifies as a native of Maryland's EMS system. Three years ago while in Philadelphia, he packed up his possessions, and with his wife Phyllis and his sons Scott and Mark, headed for the Free State.

George arrived at Baltimore's Emergency Medical Services Development, Inc. (EMS DI) with 14 years of experience in the health-care field. He had worked with the United States Public Health Service

as Public Health Advisor for Venereal Disease Control, for Emergency Health Services, and for the Immunization Branch in Atlanta, Georgia, before serving in the federal Health, Education and Welfare's Emergency Medical Services regional office in Philadelphia during its infancy stages. He then transferred to Baltimore in the State's Division of Communicable Disease Control under the direction of John Stafford, M.D., now director of Region III. Working with Dr. Stafford, he saw the "opportunities and challenges of emergency medical services" and decided he would make the move to EMS DI.

At that time EMS DI, a non-profit corporation, was under federal contract to install a communications system providing direct contact between ambulance attendants and hospitals. That project materialized into one of the nation's most sophisticated emergency medical communications systems - ambulances and hospitals tied together by Region III's Emergency Medical Resource Center (EMRC) located at Sinai Hospital in Baltimore.

The successful utilization of the EMRC was due in large part to George's efforts as EMS DI's medical resources liaison and to his current efforts as DEMS' Region III coordinator. For he spent months traveling throughout the 2,200 square miles of Region III, explaining the magnitude and projected effects of the regional communications system to the region's 128 ambulance companies. He gained the crucial support and cooperation of the ambulance companies, pointing out how as first-responders they would benefit from a regional communications system. According to George, many ambulance companies now recognize the need for a sophisticated communications network and strongly feel their own contribution to the system.

There were, of course, many problems in establishing the EMRC since no precedent for a communi-

cations system of that magnitude existed. But George observes that for most problems there are "no overnight answers"; they may take many months to solve. In the meantime, however, he continues his troubleshooting in the "field," explaining the multi-faceted aspects of the communications system and other EMS components to educate the people in his Region, trying to emphasize their mutual goal of saving people's lives.

According to George, Region III, supporting 53 percent of the State's population, can be considered a microcosm of the statewide EMS system, complete with many of the problems found in other regions of the State. With this in mind, he notes that "I can never plan ahead for a typical day, because I never know what is going to happen when I arrive in the office. Almost anything is possible, from a complete system breakdown (which I hope never happens) to the malfunctioning of an individual company's radio."

But it is the good days that George emphasizes. "When I see a run sheet or when someone mentions that the communications system was instrumental in assisting to save a person's life - someone who without the system would have died - this is what makes it all worthwhile All I have to do is listen to a tape of the ambulance attendants talking to a hospital and receiving instructions to administer drugs or transmitting an ECG, and I know that I have been a part of developing a system which is working toward saving a life."

And perhaps what is more important, the people of Region III have absorbed some of George's thinking, for they expect an ambulance or rescue squad to be highly trained and professional to increase an emergency victim's chance of survival. George feels his responsibility to meet their expectations and is working to provide Region III with the best overall emergency care possible.

MARYLAND HOSTS SUCCESSFUL SYMPOSIUM

A few minutes after 6:00 p.m. on Monday, May 10th, flying fish were spotted in Baltimore's Inner Harbor, but they were not the only things that were taking flight on what began as a very uneventful day for the majority of Baltimore's citizens.

A terrific explosion aboard the U.S. Coast Guard Cutter S.S. Primrose, less than one hundred yards from Constellation Pier, sent five of her crew members aloft and into the harbor. Debris and the shock wave from the blast also resulted in death or severe injuries of nearly four hundred school children, sailors on leave and others who were strolling on the newly constructed Inner Harbor promenade. Fortunately the explosion, the deaths, and the injuries were simulated - part of an Emergency Medical Preparedness Exercise coordinated by the Maryland Division of Emergency Medical Services.

After the smoke had cleared, other objects were observed soaring in the air - responding to the pre-planned disaster. A Baltimore City Police Department helicopter landed an air traffic control officer to guide following medevac aircraft in the evacuation of the severely injured to nearby specialty referral centers. The Baltimore City Disaster Plan was thus placed in effect.

Emergency rescue teams and equipment - U.S. Army helicopters, choppers from the Coast Guard, U.S. Park Police and State Police, 30 ambulances, city and Coast Guard fire boats, and an oil spill recovery ship - all rushed to the scene. Ambulances transferred injured victims immediately to five near-by hospitals, while other patients were treated at the scene by medical teams brought in from



... moulaging makes the simulated victims appear real.



... and continuing its supportive role in E



... ambulances and rescue teams responded from the cities and the counties, from the shore and from the mountains.



... almost 400 people were "killed or injured" by the explosion.



... rescue of the "injured" was ca



... role in EMS was the 247th Army Air Medical Units ...



... triaging teamwork "saved" many lives ...



... triage tags were found to be very helpful in sorting and classifying "victims" for transport ...



... and the International EMS/TRAUMATOLOGY Symposium was brought to you by those wonderful people who brought you the Maryland EMS system ...



... was carried out by land, air and sea ...



... adding authenticity, a priest administers last rites to the "dead" and "dying" ...

other Baltimore and nearby community hospitals.

Nearly 1800 spectators watched the "biggest disaster ever to strike the city" from the decks of the U.S.F. Constellation and the S.S. Nobska, moored in a sequestered area, as the City's Office of Disaster Control, the Maryland Port Authority, the Division of Emergency Medical Services, and military forces tested the Baltimore City Disaster Plan. The simulated crisis also served to demonstrate to the spectators - including national and international representatives - how emergencies of such proportions should be planned for and can be handled.

The staged harbor disaster, the largest disaster drill ever undertaken by the City, occurred during a three-day international symposium on emergency medical services - the U.S.A. Bicentennial Emergency Medical Services and Traumatology Conference. The event was co-sponsored by HEW's Division of Emergency Medical Services, the NATO EMS Subcommittee, the Maryland Division of Emergency Medical Services, and the Maryland Institute for Emergency Medicine.

The Emergency Medical Preparedness Exercise, the brainchild of Dr. R Adams Cowley, DEMS Director, was coordinated by Paul Marino, City of Baltimore Mayor's Liaison Officer of Disaster Control and Alexander Gretes, DEMS Disaster Coordinator. It tested Baltimore's ability to handle mass casualties, traffic and crowd control, evacuations and public safety during an actual disaster.

"Although a simulated harbor disaster is not a new idea," according to Dr. Cowley, "in any disaster exercise, like this, you try to see where the flaws are in your attempts to cope with the emergencies, and to see what can be done in the future to correct those problems." And as Mayor Schaefer mentioned: "You never know when something like this is going to happen. You have to be prepared."

Sudden Infant Death Syndrome (SIDS) is a tragic, misunderstood and puzzling disease, whose only symptom is death. Each year, almost one hundred babies die in the State of Maryland from this mysterious killer. SIDS, commonly called "crib death," presently cannot be predicted or prevented. There is no known cause.

An SIDS victim may have been totally healthy or have had a slight "cold." Just a few days prior to his death, the child may have even been seen by a physician for a check-up, or perhaps for treatment of a cold - and absolutely nothing unusual was found. Many of the SIDS fatalities occur in low-income, ethnic-minority families -- the babies of young mothers who have had little or no prenatal care. Deaths most frequently occur in the winter months and between fifty and sixty percent of the babies have had slight colds or other minor illnesses a day or two before their deaths.

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A striking fact is that death is apparently quiet, without struggle or sound. SIDS kills more infants between the ages of two weeks and twelve months than any other disease; highest-risk infants are second-born children, male, between two and three months old, who may have been either premature or of low birth weight.

A typical autopsy of a crib death shows petechial hemorrhages, pulmonary edema and evidence of mild upper respiratory tract infection, but no pathological condition to explain the death.

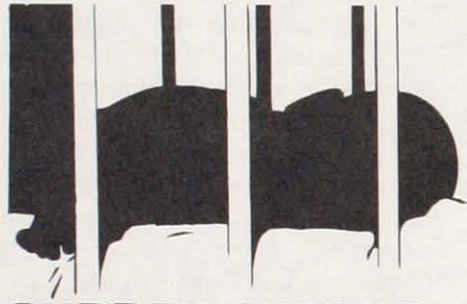
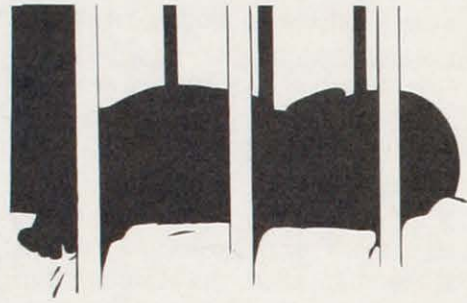
Occurrences of SIDS (although it was not known by that term) can be traced back to Biblical times. Because SIDS most often occurs during sleep, through the many centuries when infants shared their parent's bed, the child's death

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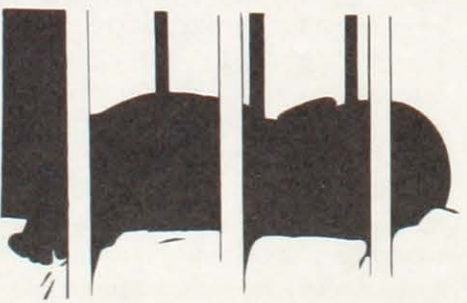
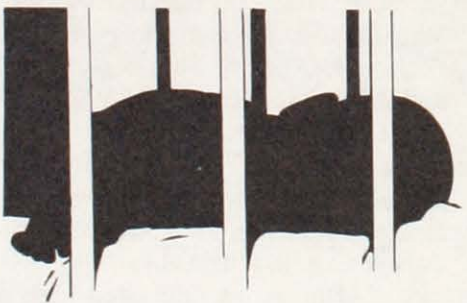
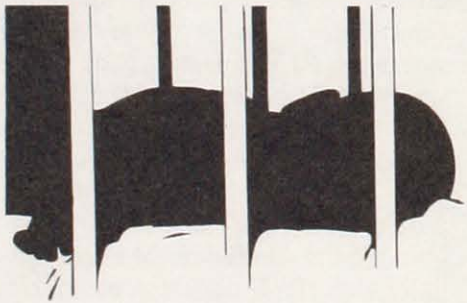
was assumed to be the result of accidental suffocation by the mother's body rolling over the baby. "Overlying" was the traditional term. The classic case is recorded in the Bible story of the famous judgment of Solomon in which a woman's child died in the night "because she overlaid it," and she claimed another woman's child as her own. By ordering that the child be cut in half and shared between the two women, Solomon revealed the true mother to be the one who relinquished her claim so that the child might be spared, and he awarded her the child unharmed. Ancient folklore also warned against allowing a cat in the room with a sleeping baby, in the belief that the cat was capable of "stealing away" the baby's breath.

In later years, when children had their own bedrooms, SIDS was thought to result from suffocation or possible strangulation by pillows and bed clothes, for often the infant was found wedged in a corner under the blankets. However, in most cases no covering, pillow or toy was close enough to interfere with the infant's breathing, and even if the infant was under the bed coverings the supply of oxygen would not be fatally low. In some cases certain postmortem changes, such as the appearance of "bruises," the coldness of the body, or a blood froth around the nose and mouth, led police to accuse parents of criminal neglect or brutality. We now know that these changes are the normal result of an SIDS death.

Although it may be too late to do anything for the SIDS victim, the Emergency Medical Technician can do something for the parents. When dealing with an infant death



SUDDEN INFANT DEATH SYNDROME



where SIDS is suspected, the ambulance personnel should be aware of the variety of responses which parents may express. The parents may be hysterical; they may deny the child is dead; some parents may not appear to be reacting at all. All of these reactions may be considered "normal" to sudden death. Ambulance personnel should be able to handle the parents' reactions without judging them.

... highest-risk infants are second-born children, male, between two and three months old....

Many parents, even after being told the results of the autopsy which had ruled out smothering, strangulation, or infection as a possible cause of death, continued to believe that they or some other member of the family had "done something" to the baby; even a pediatrician, although fully informed on SIDS as a medical problem, has acknowledged that she could not escape feelings of guilt for her own child's mysterious death. One mother who lost an infant son to the syndrome wrote: "The death of any child is heart-breaking, but no other disease leaves in its wake such guilt, self-doubt, incrimination, psychosis, and charges of criminal neglect."

The feelings of guilt by parents for their child's death have contributed to emotional breakdowns, hospitalization for mental illness and the breakup of marriages. Babysitters or relatives caring for the child have been blamed, and physicians who last saw the child and pronounced him well have also been reproached.

The Emergency Medical Technician should quickly check for the postmortem signs....

The appearance of the baby will also need to be dealt with.

Normal postmortem changes should not be confused with signs of neglect or abuse. The child's face may be extremely distorted, and the parents will have strong feelings after seeing such a young, grotesque body.

The Emergency Medical Technician should quickly check for the postmortem signs and ask the parents about any recent illnesses, treatment by a doctor and medicines the child may have been taking. It is important that some attempt to revive the baby is made. If only the baby's pulse is checked, the parents may be haunted by the feeling that if some treatment would have been tried, perhaps the baby would have lived. This does not mean resorting to extreme measures; in addition, any "extra efforts" that might be made should not present the family with a false sense of hope. There is an extremely delicate balance that must be

When dealing with an infant death where SIDS is suspected, the ambulance personnel should be aware of the variety of responses which parents may express.

maintained. Transporting the infant to a hospital is encouraged. Competency in handling the situation and in knowing the routines to be followed is extremely important in aiding the victim's family in dealing with the infant's death.

Of course, many of the problems are beyond the scope of first-contact personnel; however, there is additional help. In 1974, the Sudden Infant Death Syndrome Act was passed. This provided for the establishment of regional centers offering information, parent counseling and the cost of autopsies where state and local authorities did not assume it. An appropriation of \$2 million funded the establishment of 24 centers in 1975. The Central Maryland SIDS Center is one of those agencies. Cooperating in this project are the Office of the

Chief Medical Examiner of Maryland, the University of Maryland Medical School Departments of Pediatrics and Child Psychiatry, and the International Guild for Infant Survival, Inc.

The goals of the Central Maryland SIDS Center are to further study the causes of the Sudden Infant Death Syndrome, to provide counseling for the families of SIDS victims and to develop an educational program for community agencies and the general public. The educational program is developing seminars, lectures and workshops,

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and providing consultation to persons involved with SIDS families as well as disseminating any recent literature regarding the advances in research into the causes of this major infant killer.

Emergency Medical Technicians should be prepared to give basic facts to the family about SIDS, including the phone number of the Maryland SIDS Center, and even call the Center if they feel the family is in need of immediate crisis intervention.

The Center is notified immediately after an autopsy confirms that the child has died of SIDS. The Center then contacts the family to offer assistance consisting of information about the disease, counseling and discussing the results of the autopsy. In most cases this is done in the family's home. Learning the results of the autopsy is an extremely important way to remove the parents' agonizing doubts.

For further information about the Center, you can contact Stanley E. Weinstein, MSW, Project Director, Maryland SIDS Center, Department of Psychiatry, University of Maryland, Baltimore, Maryland 21201, phone (301) 528-6392.

SEEN AROUND THE STATE

The Maryland EMS Mobile Information Center, a 24-foot trailer, enables DEMS to expand its educational and information efforts to increase public awareness of the statewide emergency medical services system. The EMS system components are visually explained on photographic display panels within the information center. In addition, replaceable blank panels are available to tailor a presentation for a specific purpose. Regional panels have already been prepared and are

stored in the trailer to permit instant 'customizing' for regional events.

Also included in the Mobile Information Center are a quiz on medical self-help skills, audio-visual presentations, and a list of suggestions encouraging citizen involvement and support of regional EMS activities.

The Mobile Information Center is an independent, self-contained unit, air-conditioned and with a self-contained power supply requiring no external hook-ups.

If you are interested in scheduling the trailer, please contact your regional EMS coordinator.



CALENDAR STATE

- Sept. 8 - 9 Mid-Atlantic EMS Council Meeting
- Sept. 19 - 25 International Rescue and First Aid Association Conference, Hilton Hotel, Baltimore, MD. Contact: Milton S. Zepp, (301) 825-7310, 800 N. York Road, Towson, MD 21204
- Sept. 23 Medical Management Consultant Group, Governor's Club, 1123 N. Eutaw Street, Baltimore, MD. Contact: Sandy Bond, MIEEM, (301) 528-6846, 22 S. Greene Street, Baltimore, MD 21201.

NATIONAL

- Aug. 23 - 27 Postgraduate Course for Emergency Physicians, Symposium III, University of California, San Diego, School of Medicine, Trauma Research Center, and Emergency Medical Associates. Fee: \$275. Contact: David Allan, M.D., UCSD School of Medicine, LaJolla, CAL. 92093.
- Aug. 25 - 27 Cardiology Program for Non-cardiologists, San Francisco, CAL. American Heart Association Council on Clinical Cardiology, Mount Zion Hospital and Medical Center, and University of Pittsburgh School of Medicine. Fee: \$150/\$175. Contact: Dale Stringfellow, 7320 Greenville Avenue, Dallas, TEX 75231.
- Aug. 28 - 30 Tutorials in the Teton-Cardiac Emergencies, Moran, WYO. University of Nebraska Cardiovascular Center and Northern Rocky Mountain Continuing Education Division of Mountain States, and American College of Cardiology. Contact: Mary Anne McInerney, 9650 Rockville Pike, Bethesda, MD 20014.
- Sept. 17 - 19 American Association for the Surgery of Trauma, Colorado Springs, COLO. Contact: J. A. Boswick, Jr., M.D., University of Colorado Medical Center, 4200 E. Ninth Avenue, Denver, COLO 80220.
- Sept. 23 - 26 Diagnostic Radiology for the Emergency Physician, San Francisco, CAL. Emergency Medical Services Symposia, Inc. Fee: \$300. Contact: J. Clifford Findeiss, M.D., 1200 N.W. 10th Avenue, Miami, FLA 33136.
- Sept. 24 - 26 Trauma, Systems and Management, A National Symposium, Innsbrook Resort and Golf Club, Tarpon Springs, FLA. Co-sponsored by the Florida Chapter of American College of Emergency Physicians. Fees: \$125 physicians, \$50 nurses and EMT's, \$50 residents (with letter from chief of service). Contact: Ms. Charlene H. Taft, Coordinator, Division of Continuing Education, University of Florida, Box J-233/J. H. Miller Health Center, Gainesville, FLA 32610. Tel: (904) 342-3143.
- Sept. 30 Clinical Conference on Emergency Medicine, Salt Fork Lodge State Park, OHIO. Ohio Chapter of ACEP. Contact: Jon E. Starr, M.D., 2425 S. Detroit Avenue, Maumee, OHIO 43537.
- Oct. 11 - 15 American College of Surgeons, Chicago, ILL. Contact: C. Rollins Hanson, M.D., 55 E. Erie Street, Chicago, ILL. 60611.
- Oct. 12 - 14 ACEP/EDNA Scientific Assembly, New Orleans, LA, American College of Emergency Physicians and Emergency Department Nurses Association. Contact: ACEP/EDNA Scientific Assembly, 241 E. Saginaw Street, East Lansing, MICH 48823.
- Oct. 12 - 16 Congress on Emergency Medical Services, Prague, Czechoslovakia. Society for Anesthesiology and Resuscitation and Society for Orthopaedic Surgery and Traumatology. Contact: Secretariat, Sokolska 31, 120 26, Praha 2, Czechoslovakia.



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Address Correction Requested