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The head-on collision of a Mt. Airy school bus and a car injured 41 children and the driver of the car. Twenty-nine children were taken to Frederick Memorial Hospital causing them to implement their disaster plan. (Photo by Richard T. Meagher; courtesy of the Frederick Post)

Bus Accident Tests Region II's Disaster Plan

A multicasualty disaster drill was scheduled in Region II this spring to apply the lessons learned during a similar drill held last December. Before this planned event could be arranged, however, a real multicasualty accident occurred.

The real accident occurred in April near Mt. Airy. After getting out of the Mt. Airy Middle School for the day, 41 children were traveling home in a school bus to their homes in Carroll County. A car, coming in the opposite direction, crossed the center line on the road and collided with the loaded bus head-on. Both vehicles were totaled.

The bus driver was not hurt, but all 41 of the riders received minor injuries, including cuts, scratches, and minor abrasions. The worst injury was a broken nose. The driver of the car was flown to the Shock Trauma Center in critical condition.

Some of the children on the school bus were taken to Carroll County General Hospital, but most of them were treated at Frederick Memorial Hospital. The hospital was notified of the accident shortly after the shifts had changed. With this advance warning, however, the hospital activated its disaster plan, making it possible to pull sufficient numbers of volunteers, nurses, and physicians into service to handle the sudden, large influx of patients. As a result, the hospital staff was ready and able to treat the patients when they arrived.

Fortunately, the real accident was far less gruesome than was the make-believe accident that was staged in December. The scenario of the drill was that gas-fired boilers and tanks next to the cafetorium in the Myersville Elementary School exploded, injuring 50 men, women, and children. Some of the victims were burned; others had penetrating and blunt wounds, eye and ear injuries, and amputated fingers or limbs.

Following stabilization at the Myersville Elementary School, the victims in the disaster drill were transported to Washington County and Frederick Memorial hospitals. To cope with the demands of a large number of simultaneous admissions, both hospitals implemented their respective disaster plans.

Although the real-life accident was not as complicated a situation as the pretend situation, it showed that disaster preparation enables EMS personnel to respond effectively in actual multicasualty accidents.

— Mike Smith
(301) 791-2366

Region I

(L-R) Willa Auvil, Gary Carpenter, Robert George, and Margaret Barnes. Ms. Auvil and Ms. Barnes are presenting plaques to EMTs Carpenter and George in recognition of their rescue of Daniel Claycomb from the top of his car during a flash flood at DeHaven's Beach, Allegany County. Both EMTs are members of the Corriganville Volunteer Fire Department.

Dealing with "Budget Squeeze"

Ambulance services are confronting the difficult problems of increasing costs and decreasing revenues. Vehicles initially purchased with the assistance of grants are wearing out; replacing these vehicles requires companies to pay 50–75 percent more than their initial outlay.

Two programs sponsored by the Region I EMS Council and MIEMSS have been initiated in Allegany and Garrett counties to reduce the effects of the "budget squeeze." The first is a bulk purchase program where ambulance services combine medical equipment and supply needs and place them out to bid for qualified vendors.

Are there savings in combining purchases? Yes! Ambulance services are realizing a 25- to 30-percent reduction in cost for items ranging from bandaids to scoop stretchers.

Another program recently sponsored by the Region I Council was a special workshop entitled "How to Buy an Ambulance." Speaker Mel Globerman, of the Federal General Services Administration and Laurel Rescue, provided insight on ambulance specification development. Special emphasis was placed on the tendencies of squads to spec vehicles that have unnecessary lights and sirens, causing overloads on the electrical system and subsequent breakdowns. The importance of adhering to the Federal KKK-A-1822 specifications was stressed for the quality and legal protection they offered ambulance services.

For additional information, contact the MIEMSS Region I Office.

— Dave Ramsey
(301) 895-5934

Region V

Charles County MICU

On March 28, 1984, the mobile intensive care unit from Charles County was involved in a serious motor vehicle crash that left the vehicle a total loss and placed both CRTs in the hospital. The driver was not wearing a seat belt; her passenger was. The driver was thrown from the vehicle, causing injury to her passenger.

The crash, which occurred as a result of an error in judgment, resulted in a tractor-trailer colliding with the Medic One Unit, a 1984 Chevrolet Suburban delivery truck type vehicle. The large tractor-trailer struck the emergency vehicle at the right front wheel causing it to spin 180 degrees and again strike the larger vehicle at the right rear.

In the process of the 180-degree spin, the unbelted driver was thrown across the front seat, striking the belted passenger at his left shoulder and continuing out of the vehicle through the right front window. She landed some 30 feet beyond the point of impact and rolled and bounced another 30 feet before coming to rest in the center area of the four-lane highway. Her injuries were amazingly limited to a severe laceration to the right rear of her skull, and bruises to the trunk of her body. After two weeks of hospitalization and four additional weeks of disability, she is on the road to complete recovery.

The belted CRT passenger was able to remove himself from the vehicle on the driver's side and proceeded to attempt to offer aid to the injured driver. He suffered separated muscles of the left shoulder, and a laceration to the right neck above the carotid artery. A sliver of glass penetrated the skin and was surgically removed after it was located lying on top of the artery. After three days of hospitalization and 3-1/2 weeks of disability, he has returned to his career firefighter's position without any disability. It should be noted that his injuries were sustained as a result of the driver's body striking him as she was thrown out of the vehicle.

A very tragic type of accident was averted by sheer luck. Although the emergency vehicle was declared a total loss, the tractor-trailer was able to continue its journey after having its fender pulled away from the left front wheel. It is believed that the truck driver's evasive action — pulling sharply to the right — prevented him from causing more serious injury by striking the emergency vehicle's passenger door. On the other hand, the driver's poor judgment in not wearing a seat belt contributed largely to her injuries and those of her passenger.

Even though more serious injuries were avoided, the majority of those received came as a result of the driver being thrown from the vehicle.

This incident again reinforces the need for the continued use of safety belts by everyone, including emergency vehicle personnel.

— William F. Cooke
Waldorf Volunteer Fire Department

Region IV

Congratulations to all members of the recently completed CRT class at Peninsula General Hospital Medical Center (PGHMC) in Salisbury on the results of the State Board exam. For the second successive year the CRT program at PGHMC experienced a 100 percent pass rate. Congratulations also go out from the Region IV Office, Robert Adkins, MD (regional medical director), and John T. Bulkeley, MD (council chairman) to all of the CRT students, Preston Bounds (CRT instructor), and Susan Greenleaf, RN (EMS nurse coordinator at PGHMC). Their efforts and accomplishments speak for themselves.

The Region IV Office is also pleased to announce that Chuck Barton and Stan Finch have been approved by MIEMSS as CRT instructor candidates from Region IV. Both individuals have already completed many of the requirements necessary for instructor certification. They will be a valuable addition to the advanced life support program in Region IV.

Finally, the regional field office wishes to thank the Maryland State Police Aviation Division for their support in the most recent field training program conducted in Caroline County.

— Marc Bramble, John Barto
(301) 822-1799

Region III

George P. Smith is the new assistant regional administrator for Region III. Most recently he worked as coordinator of volunteers for the MIEMSS neonatal transport program. He also has worked in the emergency department at Montgomery General Hospital and is a volunteer with Montgomery County's Sandy Spring Volunteer Fire Department. In addition, he was head of the EEG department at Howard County General Hospital and was involved in spinal cord injury research at the neurobiology research unit at USUHS.

— George Pelletier, Jr.
(301) 528-3997

'Burnout' May Reflect Serious Problems

In recent years, the concept of burnout has become popular among employees in all professions. However, grouping symptoms of possibly serious psychiatric illnesses under the vague, overgeneralized term of "burnout" may be dangerous, according to Paul McClelland, MD, director of psychiatry at MIEMSS and assistant professor of psychiatry at the University of Maryland School of Medicine.

"When people diagnose themselves or their peers as 'burned out,' they risk letting a serious problem go undiagnosed and untreated," Dr. McClelland said. "The term 'burnout' seems to be much more acceptable to many people than an accurate psychiatric diagnosis."

Generally, burnout is characterized by such symptoms as dissatisfaction with one's job; fatigue, especially on the job; and a harsh and critical attitude toward one's co-workers and self. These same symptoms are characteristic of depression, alcoholism, or substance abuse.

Patients with any of these disorders need to be treated as early as possible for the greatest chance of recovery. According to Dr. McClelland, "the longer that specific treatment is avoided, the longer the problems persist. By the time the depression has subsided on its own, it may have destroyed a job, family, and relationships, leaving a life in shambles."

Trauma center staffs are especially vulnerable to the symptoms of burnout, due to the high levels of stress on the job. Dr. McClelland gathered some statistics together from files of 40 trauma center employees, many referred for burnout. He found 10 with major depressive disorders, 6 with anxiety disorders, 4 with substance abuse problems, 2 with psychoses, and 8 with suicidal tendencies. Five individuals received inpatient psychiatric treatment.

"Because serious psychiatric disturbances can occur, it is crucial to avoid overlooking serious symptoms in our colleagues and yourselves," Dr. McClelland urged. These symptoms include withdrawing from the employee group (although this is not necessarily due to a psychiatric problem, virtually every severe psychiatric problem is preceded by this), absenteeism, and depression.

Although depressed mood is a symptom of depression, it is one of many, according to Dr. McClelland. Other important clues are anhedonia (loss of motivation for things that normally bring pleasure), and changes in thinking that include preoccupation with death, dying, suicide, and bodily decay. In a depression, these thoughts last day after day, and may be so intrusive that the victim cannot concentrate.

"These symptoms can easily be interpreted as burnout, when, in fact, these people are at high risk for suicide, and at an even greater risk of losing their jobs," Dr. McClelland said. "Many depressions end spontaneously over a 6- to 12-month period. By then, however, the person may have lost his job and alienated friends so that he is more prone to repeat episodes of depression." Thus, persons with symptoms of depression or substance abuse need prompt, appropriate treatment.

To avoid burnout or job-related depressions, Dr. McClelland recommended a careful screening of prospective employees. "If a person has experienced burnout symptoms on a similar previous job, he is at a high risk of experiencing them again," he said.

Additionally, reducing stress on the job can prevent burnout symptoms. "We need to implement training programs with an emphasis on management skills," Dr. McClelland said. "Companies have taken advantage of these tools for years, but generally hospitals have not. There are several other examples of inadequate training that can be identified in most medical settings. It is important to note, however, that employees can also be overtrained for their jobs; in such cases, the resulting boredom is still another stressor."

— Rochelle Cohen

EHS Program News

- At the 1984 Women's Fair held at the University of Maryland Baltimore County, Dorothy L. Gordon, DNSc, chairperson of the emergency health services department, was presented the "Faculty Woman of the Year" award. The award is based on outstanding personal/professional accomplishment, rapport with all levels of the UMBC community, scholarship, personal integrity, and serving as a role model for other campus women.
- Jeffrey T. Mitchell, PhD, assistant professor in the emergency health services department at UMBC, received the "George D. Post Instructor of the Year Award" from the International Society of Fire Service Instructors (ISFSI).

Dr. Mitchell was honored for his assistance in developing curriculum and for his faculty work in the emergency health services department and for his research in and writings about emergency service stress and crisis. In addition, his work as a fire service psychologist who developed a specialized treatment program to lessen the impact of critical incident or disaster stress on emergency workers was noted. Dr. Mitchell was the first nonfirefighter to receive the award in the 60-year history of the ISFSI, which represents over 6,800 fire instructors from many countries.

In a separate ceremony, Dr. Mitchell also received the highest award for valuable educational and service contributions to EMS. This award was presented by the EMS section of the ISFSI.

- Eliane Runion and Tracy Zukowski, students in the emergency health services department, received the EHS/MIEMSS Outstanding Services Awards and checks for $50 from MIEMSS. These awards recognize academic excellence plus outstanding volunteer service to the program and the community. Ms. Runion is also a trauma transport technician at the MIEMSS Shock Trauma Center, and Ms. Zukowski is coordinator of the ACLS program at UMBC.
- Ameen I. Ramzy, MD, surgeon/traumatologist and associate medical director for field operations at MIEMSS, has agreed to be medical director for the paramedic program offered by the emergency health services department.

First-Aid Program

MIEMSS, in conjunction with the American Red Cross, WMAR-TV (Channel 2), the Maryland Army National Guard, and the American Trauma Society, will sponsor the Family First-Aid Saturday, June 30, from 9:30 am to 4:30 pm.

The public will learn basic emergency first-aid techniques and how to prevent accidents at home, work, and recreation. The program, which will be given at sites in the Baltimore Metropolitan area (including Baltimore City and Baltimore, Anne Arundel, Howard, Carroll, and Harford counties), consists of morning lectures and afternoon demonstrations and educational exhibits.

For more information and registration, call (301) 467-9905 or your local county American Red Cross.

Nurses Trying to Prevent Teen Trauma

Editor's Note: MIEMSS is involved in several trauma prevention programs for adolescents. Last issue we discussed its newest program; this issue we are reporting on its oldest continuing program. The Adolescent Trauma Prevention Program, begun in 1978, developed as a result of the concern of Shock Trauma Center nurses over the number of teenage admissions involving life-threatening injuries.

For the past six years, Beverly Dearing, RN, MS, has been bringing groups of teenagers who have been arrested for alcohol-related motor vehicle offenses to the Shock Trauma Center, letting them tour the facility, meet some of the inpatients, and talk to a recovered patient. Then after they leave she hopes . . . . She hopes that what they have seen and heard will make enough of an impact that they won't ever drink alcohol and then drive again; because she doesn't want to see them back at the center as patients.

Ms. Dearing's program began in 1978 when a group from the Nursing Department gathered to set goals. She became chairman of what she still remembers as "Goal Number Eight," or the prevention of trauma. Her small committee met and decided to narrow their focus to adolescents over the age of 14. "The nurses were very upset because we saw so many young people at the center who were badly injured," she says. "We were especially saddened because they had so many years ahead of them, and for most of them it would affect the rest of their lives."

Since the majority of the adolescents were admitted for motor vehicle accidents related to alcohol or drug abuse, this problem was cited as the committee's focal point. Anne Arundel County was chosen as the pilot county for the project since, according to Ms. Dearing, their EMS system is excellent, and most trauma cases are appropriately brought to Shock Trauma. In 1978, 23 percent of Shock Trauma's patients were admitted from Anne Arundel. Many accidents occur there because of the winding country roads; in addition, parts of the county are a well-traveled route to Ocean City. Moreover, county officials had already identified drinking and driving as a major problem, and were open and receptive to the program.

Initially, the county's Juvenile Services' office would identify candidates for the program and bring them to the Shock Trauma Center. But when that division suffered cutbacks several years ago, the state's attorney's office assumed the responsibility. Now, courtmasters impose the program on first offenders indicted for driving while intoxicated. Generally, the offenders are 15–18 years old and, concurrent with MIEMSS' statistics, 80 percent are males, usually white.

The offenders are driven to Shock Trauma by a representative of the state's attorney's office so discussion is possible while they are in transit.

Once at the center the adolescents are given a tour of patient areas by one of the nurses participating in the program. Patients admitted with drunk-driving related accidents are pointed out, their injuries and the impact on the rest of their lives discussed. Although no personal information is given, nurses stress that many of the patients will never regain their former capabilities.

"The kids have responded well to the program from the very beginning," Ms. Dearing says. "And they respond well because we treat them like adults; we never preach to them or tell them not to drink, and we never force any part of the program on them; we just emphasize their responsibilities to themselves and to others." Interestingly, most of the participants say they had never thought they could hurt anyone else before they attended the program, but that they would definitely consider that now. "Teens characteristically believe that they are indestructible, but we try to give them the perpective that they can get hurt," Ms. Dearing adds.

After the tour, the movie "A Race with Death" is shown and a problem-solving session is held for the five to eight participants in each session. They are asked whether they have ever thought about being in an accident, and how they would act to prevent this from happening. Then the nurse poses more questions such as: "If you drink would you then get into your car and drive?" and "If your friend is drunk would you let him drive?" Since there is a lot of peer pressure at teen parties, a small number of the participants still say they would drink and drive, or drive with a friend who had been drinking. But according to Ms. Dearing, most say they would be different now that they have been through the program.

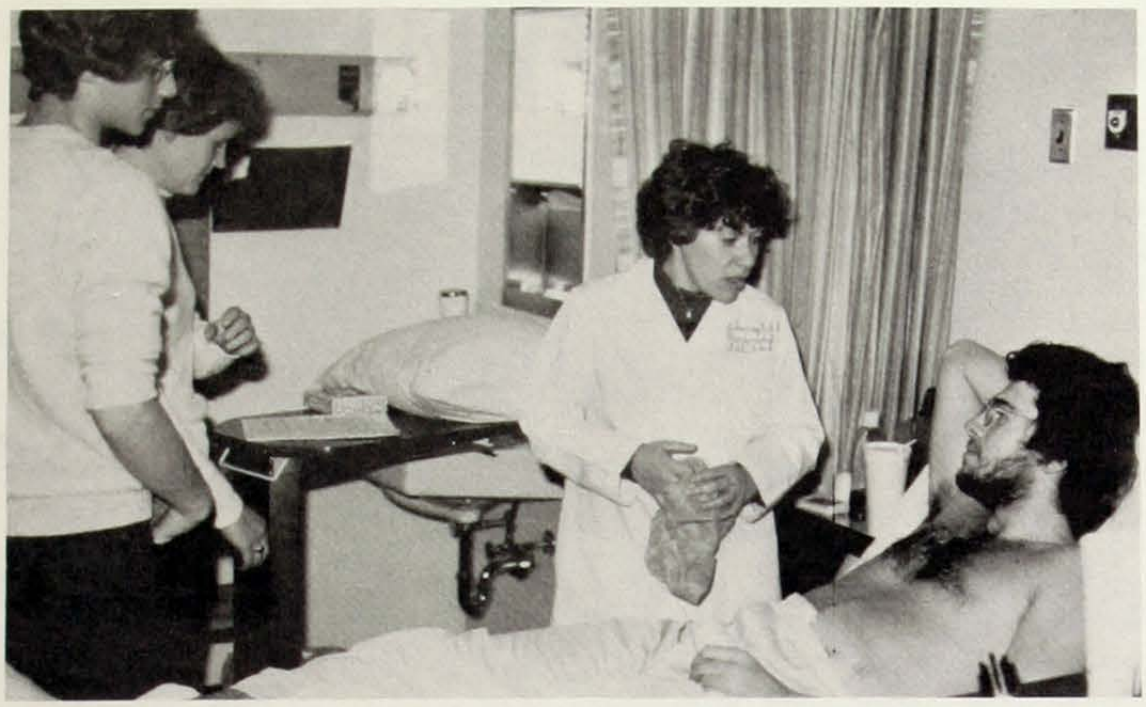
After the problem-solving session, often a recovered patient comes to talk to the group. During the first few years of the program the victim of a drunk driver who had both legs amputated as the result of his accident told about his experience, his pain, and his dependency at home since he could no longer work or function very well. Importantly, he talked about his anger toward the driver who hit him and got a sentence of only six months in jail. Now, several other victims talk to the group. "This seems to be a really important part of the program," Ms. Dearing says. "Many of the groups seem to be especially sensitive to the true stories of people who have come through the system and the limitations they face after discharge."

A questionnaire given to participants at the end of the day's activities suggests that at least 89 percent of the group intends to change their drinking and driving habits after the program; 7 percent may change their habits; and about 4 percent say the program will have no effect on their behavior at all. "From the responses to the program, the attendees seem pleased that they were treated like adults and not like children," Ms. Dearing says. "We stress that this is not punishment but an educational session, and that seems to make them consider what can happen to them or to others."

Warren Davis, a Diversionary Division assistant from the Anne Arundel county state's attorney's office, transports the adolescents to Shock Trauma, leads discussion during transport, and is currently conducting a recidivism study on the program. "Based on our crude data we believe that we have about a 97 percent success rate after one year," he says, "but we're currently conducting our first formal study which we believe will give even more credence to the program."

After the Shock Trauma portion of the program is completed, Mr. Davis receives further input from probation officers, who assign essays to the participants in the program, and lead further discussions on the subject.

Mr. Davis believes his county has made positive progress through the program which can be measured in the decreasing numbers of offending adoles-



Beverly Dearing, coordinator of the Adolescent Trauma Prevention Program, and two teenagers talk with a patient in the Shock Trauma Center. (Staged Photo)

cents. "The kids themselves talk it up and it seems to work to discourage drunk driving," he says.

Ms. Dearing has been approached by nine other counties to implement the adolescent program, and a new grant from the Maryland Department of Transportation and the Maryland Department of Health and Mental Hygiene has already allowed her to expand. In May, Harford county began participating (they had already been in the program briefly until their own grant money ran out), bringing two groups of offenders through the center each month. Two more counties will enter the program in the fall, when the nurses will begin handling eight groups of offenders each month. Under the new grant, training will be offered by health educators in the county before and after the Shock Trauma program.

Additionally, the grant will enable Ms. Dearing to expand the program at a regional trauma center to provide services in another area of Maryland.

Nurses who assist with the adolescent prevention program include Beth Hall, Denise Hargrove, Sharon Bidle, Janet Selway, and Lynn Brick. Others are Sandy Cox, Kathy Meister, Sue Vega, Mitchell Moran, Shirley Wong, and Linda Lashowskie.

—Rochelle Cohen

Call a friend . . .let a non-drinker drive . . .or stay where you are. That's the official advice from Beverly Dearing, coordinator of the adolescent trauma prevention program at MIEMSS, on what to do if you've had too much to drink. Importantly, plan exactly what you will do before you begin to party, since drinking blurs the senses, and unless you have a plan of action, you may decide to drive home.

Another idea for adolescents suggested during Ms. Dearing's program is to make a written contract with their parents. The contract should stipulate that teens may call their parents to drive them home if they get drunk. The contract should also stipulate that parents agree to pick up their teenagers and drive them home with no intimidating questions asked until a later date. This allows the teen to feel comfortable about calling for a safe ride home without the fear of immediate repercussions. "If a teen still doesn't feel comfortable about calling his parents, he should make an arrangement with a relative, neighbor, or friend, and then follow through on the agreement as needed," Ms. Dearing says.

EMRC Breaks Record

The Emergency Medical Resource Center (EMRC), the MIEMSS-operated EMS communications center for Region III, handled a record number of calls in the past year. EMRC handled communications for the transport of 40,055 patients, involving 70,851 telephone calls and 51,541 radio contacts.

For more than one half of the state's population, EMRC, located at Sinai Hospital, is the primary source of emergency medical communications.

Reminder . . .

MD Fire-Rescue Education & Training Commission Meeting, June 16, 1 pm, Ocean City Fire Department Headquarters, Philadelphia & 15th St., Ocean City. CONTACT: Ted Porter (301) 269-2971.

Award Presented To City Paramedic

Linda Sharp was recently honored as the Baltimore City Fire Department's Paramedic of the Year. This is the fourth year that such an award has been given by the Ladies Auxiliary, Box 414 Association, and the first time a woman paramedic has been honored.

A member of Medic Unit 7 at the Oldtown Station on Hillen Street, Ms. Sharp was honored for her "unselfish community involvement exemplified by her more than 250 hours of volunteer service in the field of emergency medicine." She also works as a career paramedic.

Ms. Sharp has been a member of the Baltimore City Fire Department since 1980 and had 10 years previous service as a firefighter and paramedic with the English Consul Volunteer Fire Company. She attained the rank of ambulance captain with that unit.

In her volunteer work during the past year, she has spoken at many schools and to numerous civic and health-related organizations explaining the workings of emergency medical units while encouraging listeners to receive training in CPR and related first aid. She has also taught classes in these subjects, organized the aid stations for the annual Walk-a-thon, and assisted in blood testing at the Baltimore City Health Fair. In her daily work she has received numerous commendatory letters for "prehospital patient care."

(L-R) Mrs. Marjorie Katzenburg (Ladies Auxiliary), Chief Peter J. O'Connor, and Linda Sharp.

Legislature Decides Many EMS Issues

University Hospital Governance Bill

Legislation Passed

University of Maryland Medical System (Senate Bill 481). This bill provides for the creation and organization of the University of Maryland Medical System Corporation. It establishes the UMMS Corporation as a self-supporting entity to which the state may make grants or with which the state may contract. This separation results in the segregation of patient care costs and revenues from unrelated state activities. The separation, however, affects only the clinical portion of MIEMSS — the adult Shock Trauma Center. MIEMSS field operations' functions will continue as they have in the past under the new governance structure.

Of Clinical Interest

Legislation Defeated

Hospital Medical Ethics Advisory Board (House Bill 158). This bill would have required each hospital to have a medical ethics advisory board. An ethics board with the right of consultation would give an advisory opinion to a petitioner, who could be a patient, physician, or family member or guardian, on the provision of life-supporting medication or treatment.

Physical Therapists (Senate Bill 373). This bill would have permitted the State Board of Physical Therapy Examiners to deny a license or discipline a licensee, if the individual shared a remuneration for providing physical therapy services with another person not licensed. MIEMSS supported this bill for three reasons. First, it would remove the incentive for over-utilization of physical therapy services. Second, it would have ensured that hospitals and outpatient physical therapy facilities would continue to receive outpatient referrals. Third, it would have ensured the public the option of choosing physical services based on quality, cost, location, availability, and personal preference.

Legislation Passed

Human Organs — Selling or Buying Prohibited (House Bill 160). This bill provides that a person may not sell or buy human organs, not including blood and plasma, or act as a broker for a profit in the transfer of human organs. Nonprofit organizations which qualify under 501(C)(3) of the Internal Revenue Code, are exempt from the provisions of this law.

Health Insurance — Benefits for Services of Nurse Anesthetists (House Bill 566). This bill requires that after July 1, 1984 any health insurer (including profit, nonprofit, and group and blanket health insurers), who proposes to issue a health insurance policy covering anesthesia in Maryland, shall include benefits arising from the care, treatment, or services rendered by a nurse anesthetist whether or not employed by a physician.

Health Services Cost Review Commission — Rates for Outpatient Services (House Bill 1251). This bill permits the Health Services Cost Review Commission to consider the rates for similar services in nonhospital settings located in the same county as the health care facility. These rates are considered in determining the reasonableness of rates for clinic services of a health care facility. The act takes effect July 1, 1984 and remains in effect for a period of two years, ending on June 30, 1986.

Anatomical Gift Acts — Uniform Donor Cards (House Joint Resolution 10). This resolution encourages health insurance providers and private agencies to issue Uniform Donor Cards to potential organ donors in order to prevent critical time from elapsing when an organ becomes available.

Medical Transplant Study Commission (House Joint Resolution 16). This resolution requests the governor to appoint a commission to study the facilitation of liver and other organ transplants in Maryland.

Infectious Wastes — Disposals in Landfills (Senate Bill 134). This bill prohibits the disposal of infectious wastes in Maryland's landfill systems, referring only to waste from hospitals, clinics, or laboratories that can cause disease or infection in humans.

Insurance Coverage — Profit and Nonprofit Health Plans (Senate Bill 231). This bill clarifies the requirement that for-profit and nonprofit health plans provide reimbursement for any service within the lawful scope of practice of a duly licensed health care provider. The provisions of Senate Bill 231 apply to all such policies, contracts, or certificates issued, renewed, modified, altered, amended, or reissued on or after July 1, 1984.

Of Field Program Interest

Legislation Passed

Emergency Medical Services — Helicopter Transportation (Senate Bill 927). MIEMSS sponsored this legislation in response to the danger resulting from out-of-state helicopters that have flown inter-hospital transfers not coordinated through SYSCOM. Senate Bill 927 allows the director of MIEMSS to adopt rules and regulations to ensure that helicopters transporting patients between hospitals or specialty centers, notify SYSCOM, the hub of the statewide communications system.

Legislation Defeated

Emergency Medical Services Fund (Senate Bill 956). This bill has been referred to summer study. Senate Budget and Taxation Committee members expressed interest in this bill but felt it needed further exploration; hearings on this bill will probably be held during late summer or fall. Senate Bill 956 would establish an Emergency Medical Services Account within the Transportation Trust Fund and authorize the Motor Vehicle Administration to impose an additional $3 on all vehicle registrations, to be credited to the Emergency Medical Services Account. The EMS Fund would be used for the replacement, maintenance, development, and enhancement of the emergency medical services care delivery system in the state. Specifically, the monies provided to the EMS Fund may be used for the purchase of EMS equipment and supplies, training, evaluation, planning, or any other EMS-related activity normally undertaken at the local level of government. MIEMSS will be actively involved in the hearings concerning this bill during the summer months.

Licensing of Freestanding Health Clinics (Senate Bill 738). MIEMSS supported the concept of licensing freestanding health clinics and supported the decision to refer the issue to summer study by the Senate Finance Committee. This bill requires the Department of Health and Mental Hygiene to adopt rules and regulations for the licensing of freestanding health clinics. MIEMSS recognizes the emergence of freestanding health clinics as a major health trend and is concerned that these clinics not mislead the public as to the level of care offered. MIEMSS will be actively involved in the hearings held concerning this bill during the interim.

Motorcycle Helmets (House Bills 41 and 312). MIEMSS actively supported these bills which would have required that all persons operating or riding motorcycles wear protective headgear.

Legislative Issues

Rehabilitation

Legislation Passed

Developmentally Disabled Persons — Respite Care (House Bill 408). This bill provides respite care, short-term care of an individual with a developmental disability provided either within or outside the individual's home, to give temporary relief to the individual or to the family (for a maximum of 24 hours of care, which is provided in periods of less than 10 hours in any 24-hour period, and for a maximum of 14 days of care).

Certificate of Need — Notice (House Bill 948). The purpose of this bill is to require the State Health Resources Planning Commission to notify the following individuals when the Commission receives a Certificate of Need application for a change in bed capacity of a health care facility: members of the General Assembly in whose district the action is planned, executive officers of the county where the action is planned, and interested parties.

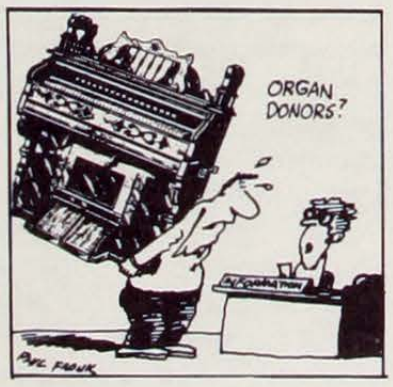
Office of the Governor — Services to the Handicapped (House Bill 684). House Bill 684 provides for the continuation of this office with modifications in responsibility and membership. The next termination date for this office has been set for July 1994.

Certificate of Need—Home Health Agencies (House Bill 1197). This bill requires that after July 1, 1984 all hospitals file a Certificate of Need if they wish to start a home health agency.

Disabled Individuals — Rehabilitation Services (House Bill 487). The purpose of this bill is to establish a disability registry for spinal cord, head-injured, stroke, and amputee patients. The registry will serve a dual function: provide a data bank and serve as a central point of entry for families and patients as they go through the rehabilitation process.

Developmentally Disabled — Definition (Senate Bill 475). This bill will provide head-injured persons, regardless of age, the opportunity to receive respite care under the developmentally disabled program.

— Kevin Anderson and Dennis Evans



Elderly May Need Special Care

As the first EMT responder on the scene of an accident, you find a severely injured 75-year-old man. How do you treat him? Do you use precious time trying to start an IV? Do you refrain from giving certain drugs because you do not know his medication history? Do you take special precautions because of his age? Or do you treat him as any adult trauma patient?

Although current Maryland protocols do not differentiate adult treatment on the basis of age, some care givers now feel that the elderly trauma patient ***does*** differ in some ways from his younger counterpart.

One such care giver is Judy Bobb, critical care nurse coordinator, who cites three possible reasons why older trauma patients should be treated differently. (She stresses, however, that these ideas are only theories and SHOULD NOT be considered as treatment protocol adjuncts until they have been researched and clinically substantiated with controlled data.)

1. The primary difference in the elderly as a separate trauma group is their functional variability. In no other age group are individual "members" so diverse. For example, one 40-year-old patient has approximately the same degree of functional ability/performance, etc. as another. In the elderly group, however, one 75-year-old man may have the physiologic attributes of a 50-year-old, while another 75-year-old may function on the level of an 85-year-old. This difference in functional response can lead to confusion regarding appropriate treatment.

2. Elderly trauma patients are generally "slower to respond" than younger adults. For example, they may react much more slowly to resuscitative measures than would 40-year-olds with the same injuries. Therefore, more time might be required to determine the success of any interventive measure and sometimes drug dosages need to be altered accordingly.

3. Because elderly patients are slower to respond to stress, it is quite likely that they, in fact, do not have a "golden hour." Instead they may have only 45 minutes as the maximum benefit time. Ms. Bobb also suspects that there are more fatalities at the scene among elderly victims, not because of wound severity but because of this smaller "viable" time period. She feels that concern at the scene should center on establishing airways and moving these patients as rapidly as possible to the nearest appropriate facility for further resuscitation, where multiple lines and medications can be given simultaneously if necessary.

According to Ms. Bobb, "proving" these differences is difficult because no data bases nor studies specific to this subgroup exist at the present time. Unlike the pediatric trauma group, elderly patients have not been separated statistically from the adult trauma population as a whole.

She recommends keeping one thing in mind, however, when treating the elderly trauma patient. Regardless of the age of the patient, prehospital — and hospital — care should be ***aggressive!*** Too often, she says, there is a tendency to "pull back" because of an underlying feeling of "Oh well, he's already lived a good life." Rather, she says, attitudes should reflect the fact that these elderly patients are ***survivors*** of a lifetime of exposure and risk and that today the life expectancy of a 70-year-old is 16 years — one-fifth of his lifespan yet to be lived. *— Elaine Rice*

New ALS Protocols

Changes in the prehospital ALS protocols are required for two reasons. The first is the paramedic program which will become operational in the field later this year. Maryland has several nationally registered paramedics at this time and it is anticipated that, following approval by the Maryland Board of Medical Examiners, these personnel will be allowed to perform prehospital endotracheal intubation. In addition, paramedics will be allowed to administer all the medications that a CRT can give regardless of the jurisdiction. As many of you know, the number of medications that ALS personnel can administer varies according to jurisdiction; but I feel that the paramedic should be allowed to give all the medications that a CRT can give anywhere in the state.

There is also concern that the CRT protocols are now out of step with the advanced cardiac life support protocols. Changes are being effected to bring these in line.

The new protocols have been circulated in draft form. The advanced life support protocols cover both the CRT level and the EMT-paramedic level. It is anticipated that following further review and approval by the regional medical directors, the protocols can be forwarded to the State Board of Medical Examiners for final approval. For additional information, please contact your EMS regional administrator.

— Alasdair Conn, MD
Medical Director, Field Operations

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Director: R Adams Cowley, MD
Editor: William E. Clark,
(301) 528-7800
Managing Editor: Beverly Sopp,
(301) 528-3248

Address Correction Requested
7215 Rolling Mill Rd., Baltimore, MD 21224

Letter-to-Editor: Handling Intoxicated Patients

After reading the article, "How EMTs Handle Intoxicated Patients" [in the January issue], I would like to ask the following questions.

If a possibly intoxicated person refuses treatment, do we or the police have the authority to overrule him/her using implied consent? If so, then what legal parameters cover us if the refusing patient is further injured by us in resisting his/her aggressiveness and trying to treat him/her. Injury resulting from combativeness very well may be the factor that disables the patient in the future. Do we or do we not follow the implied consent rule, since we don't legally know if the patient is intoxicated? — *Kurt R. Fritsch, EMT-A*
Earleigh Heights VFC
Anne Arundel County

There is no clear-cut answer to that question; prehospital personnel must use their own judgment based on the following guidelines given by Jeffrey Mitchell, PhD. Dr. Mitchell is an assistant professor in the MIEMSS/UMBC emergency health services program who developed and conducts behavioral emergency workshops for ambulance personnel.

The safest course of action for any EMS personnel to take when they have an intoxicated person who refuses treatment and when they believe that person's life would be in jeopardy or serious complications would result without treatment is to call the police for assistance. They should explain the situation to the police and stress how vital the treatment is for the patient. The Emergency Admissions Act gives policemen the legal authority to take patients into protective custody when they are a danger to themselves or to other people due to a mental disorder. (Prehospital personnel do not have this authority.) Prehospital personnel should request that the policeman who provides the protective custody accompany the patient to the hospital in the ambulance or follow the ambulance to the hospital in his squad car. If the policeman decides not to provide protective custody and the patient still refuses treatment, prehospital personnel may withhold treatment and should not be legally responsible for the patient since they have taken every reasonable step to ensure that the person receives treatment. However, prehospital personnel should make sure that the person signs a form saying that he/she refuses treatment, or if he/she refuses to sign a form, this refusal should be noted, along with the day, time, and the signature of a person witnessing the refusal.

Such cases become a problem for prehospital personnel only when a policeman is not available, or cannot get to the scene soon enough to make a judgment about whether the patient needs protective custody. Under these circumstances, prehospital care providers must make judgments about the patient's condition and are responsible for the actions they take based on those judgments. If prehospital personnel believe that the life of the patient, or of any one else involved, is seriously endangered and time is crucial, they must try to intervene because they may be held accountable for the consequences of withholding treatment. Even if the patient refuses treatment, prehospital personnel should make reasonable efforts to transport the patient to the hospital. Prehospital personnel should take the utmost care not to injure the patient.

If prehospital personnel believed that there was no immediate danger of the person endangering himself or others but still felt that treatment was needed, they could act as "interested persons" and fill out a petition for emergency evaluation, have the petition endorsed by the court, and give the person to a police officer who must then take the person into custody.

— *Beverly Sopp*