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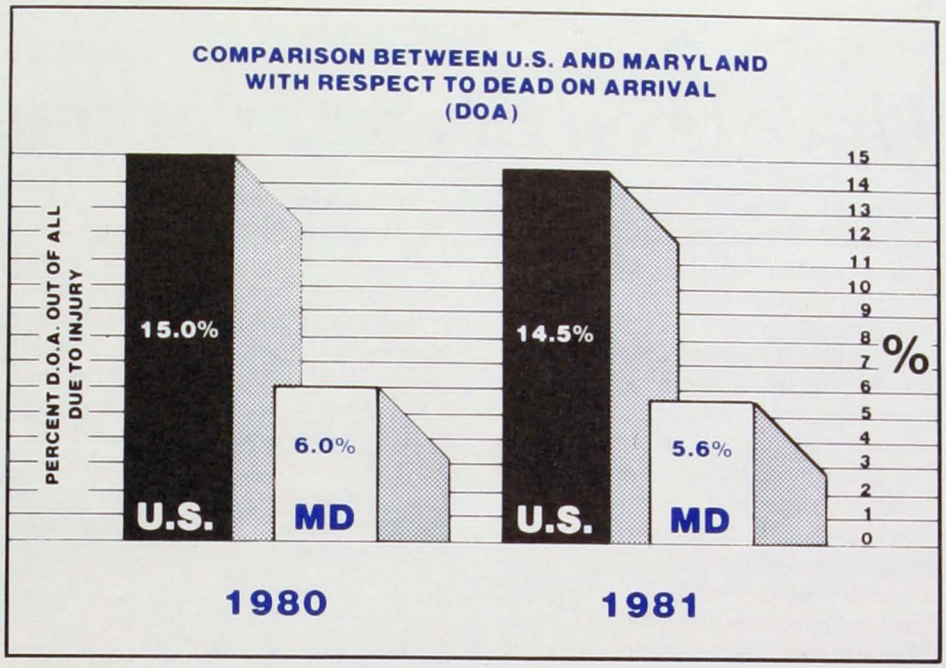

A recent study conducted by MIEMSS Operations Research and Analysis shows that accident victims in Maryland have a better chance of reaching a hospital alive than victims in the United States as a whole.

Study Documents State's EMS Success

We know it works. Prehospital care providers see it work. Hospital personnel see it too. And the citizens of Maryland, whether or not they have ever needed the medical care provided by the state's EMS system, know that high quality care is available when they need it.

Maryland's echelons of care system for treating severely injured people is tremendously successful in saving lives. A recent study conducted by MIEMSS Operations Research and Systems Analysis, under the direction of Belavadi Shankar, ScD, shows that accident victims in Maryland have a better chance of reaching a hospital alive than victims in the United States as a whole. R Adams Cowley, MD, director of MIEMSS, and Dr. Shankar presented the results of the study at the 8th National Trauma Symposium in Baltimore.

Routinely available information from hospital discharge records, vehicular accident reports, and death certificates was used in the study. Analysis of death certificates showed that in 1980, 15 percent of deaths due to injury were classified as dead on arrival (DOA) in the United States, whereas the rate was only 6 percent in Maryland. In the following year, the rates for both groups declined, but the rate of decrease was greater in Maryland (3.3 percent for the country and 6.7 percent in the state).

Looking at all deaths due to injury, Dr. Shankar found that the age-adjusted death rate was 46/100,000 people in Maryland in 1980 and 56/100,000 nationally. By applying the Maryland death rate to the national statistics, it can be calculated that about 20,000 lives could have been saved nationwide. Conversely, if the national death rate is applied to Maryland, the statistics show that the state's regionalized trauma system is saving 385 lives each year above the national average.

Some people claim that it is no surprise that Maryland's survival rates are better than the nation's, because Maryland is a small state with most of the population concentrated in an urban corridor. In response to comments that Maryland's geography and population distribution influence the death rate, Dr. Shankar notes that "even though you might be injured next door to a community hospital, in our system you wouldn't necessarily be taken to that hospital if your injuries required treatment at one of the specialty referral centers. It's not geographic proximity that gives the high injury survival rate in Maryland—it's our statewide, coordinated EMS system."

To further explore the success of Maryland's system, Dr. Shankar evaluated DOA rates in the five regions in the state system. In Region I, for example, the DOA rate was 45 percent in 1980. There was no regional trauma center in the area at that time. The following year, Cumberland Memorial Hospital was designated as an areawide trauma center and was equipped and staffed to provide more sophisticated medical care. The DOA rate dropped to 19 percent in 1981 and 11-1/2 percent in 1982. The system works.

Maryland is the only state in the country with a regionalized, coordinated emergency medical services system. This structure gives uniformity to all aspects of services, including training of prehospital care providers, communications, transportation, and criteria for designation of trauma and specialty centers. The benefits of this structure are demonstrated in the statistics, proving that Maryland's system is a model for the nation.

Dr. Shankar will present the findings of this study in April at the First International Conference on Emergency Medicine in London.

—Linda Kesselring

Update on EMS Malpractice Insurance

In recent years, EMS personnel have come to realize the need for malpractice insurance. The attributes and weaknesses of the Good Samaritan law are generally a topic of discussion in EMT and CRT classes. Most departments, both career and volunteer, have faced the reality that the laws may not be enough to protect field personnel.

While most departments and many individuals have purchased their coverage, most people do not understand the foreign language of insurance. This article is written to provide some basic knowledge of protection available to the EMS provider.

Most policies afford protection for the insured even if the alleged negligence is groundless or fraudulent. Most insurance policies provide legal defense in addition to the limit of coverage. The legal defense coverage alone could save you thousands of dollars, even in a groundless accusation.

Settling Out of Court

In most malpractice policies, the insurance company has the right to settle or defend a lawsuit. Thus, if the insurance company can settle out of the court for a reasonable figure, they have the right to do so, with or without your permission. This clause is in nearly all forms of insurance. You will find similar wording in your automobile and homeowners' policies.

In the event of a potential claim, EMS providers should also notify their personal insurance agent. The wording of most homeowners' policies does not specifically exclude actions of a volunteer EMS provider. In addition, many insurance companies may provide coverage for a volunteer under a personal umbrella policy. Most homeowners' and personal umbrella policies exclude "business pursuits." Thus, coverage for a career EMT or paramedic is probably excluded under these policies.

How Much Insurance

No one can tell you how much insurance to carry. You need only to read the daily paper to see the phenomenal figures being entered into court dockets for attempted recovery. Even more frightening are the amounts of the awards from these suits. It is important to maintain high limits of protection to keep the insurance company involved in the claim. The insurance company's duty to defend usually ends when the policy limits are exhausted.

Malpractice and liability policies are written on either a "claims made" basis or a "per occurrence" basis. This slight wording difference can be critical in determining if coverage is provided. Claims made policies provide coverage if the claim is *made* during the policy period. Per occurrence policies provide coverage if the claim *occurs* during the policy period. Serious gaps in coverage can exist if a policy is changed from a claims made policy to a per occurrence policy. There may be a need to provide special coverage to insure the "tail" of the claims made policy. To be sure of continuous coverage, contact your agent immediately if your policy is changed from one type to the other.

Personal Injury Coverage

The EMT or CRT also has a need for insurance coverages not provided by a malpractice policy. Potential claims such as invasion of privacy, libel, slander, and false arrest are not covered by malpractice. "Personal injury" coverage can be added to the general liability policy of the rescue squad to cover most of these circumstances.

Increased severity of claims, severe underwriting losses, reinsurance restrictions, and decreased investment income combined to make 1984 the worst year in the history of the insurance industry. As a result, many companies are no longer offering EMT/CRT/EMT-P malpractice insurance. As of December 1, 1985, only three carriers offer a malpractice policy designed for the fire and rescue service. Some renewal policies increased by 800 percent this year alone. One of the largest providers of EMT/CRT/EMT-P insurance will no longer write policies for entire counties or individual squads unless they also write all equipment, building, and other related insurance.

Package Policy

It is advisable for the individual ambulance company or rescue squad to purchase a package policy that includes malpractice insurance. This could result in several hundreds of dollars in savings. The malpractice insurance written in conjunction with a package policy is usually much less expensive and is generally broader in coverage. The companies with a package program are also licensed Maryland insurance companies with local agents to service the policies.

For those squads that do purchase separate malpractice policies, a word of caution: most malpractice policies today are issued in a "nonadmitted" insurance company. These companies specialize in unusual or high-risk insurance and are not under the jurisdiction of the Maryland insurance commissioner. As of this writing, individual EMT/CRT/EMT-Ps can still purchase their own malpractice policies from special programs available in most states. However, even the individual policies are being renewed with less coverage provided and premiums that are more than double those for last year's policies.

The fire and rescue service is beginning to feel the effects of the insurance crisis. Most departments have seen premiums skyrocket; in some cases, insurance has not been renewed. Members of the legislative committee of the Maryland State Firemen's Association, as well as a special governor's task force on liability insurance, are working to bring the situation under control.

Because of recent judicial rulings, malpractice insurance has become a necessity. Every department or squad should take the time to review all insurance policies presently in force. Protecting members from potential financial disaster should be a priority.

—Chip Jewell

Editor's Note: The author is a branch manager for Frederick Underwriters, Inc., and an EMT with the Libertytown Fire Department.

Metcalf Moves to CO

Bill Metcalf, paramedic instructor in the EHS program at UMBC, accepted the position of director of the Division of EMS in the Colorado Health Department, effective January 6. He will coordinate the implementation of the EMS program in Colorado, which is now being expanded into a statewide system.

Mr. Metcalf has had many responsibilities in EMS in Maryland. Before joining the UMBC staff in August 1985, he had been the Region II ALS Coordinator. He was a member of the Anne Arundel County Fire Department for 11 years and has been an EMT-P since 1981. Mr. Metcalf is also a certified EMT and CRT instructor.

— Linda Kesselring

Special Care Needs of Elderly Patients

Do elderly people have different EMS needs than people in younger age groups? What is the effect of the changing American age structure on the delivery of emergency care?

These were two of the questions addressed at the Stress and Behavioral Emergencies Conference by Jeanne Floyd, MS, RN, and Melinda Fitting, PhD, from Johns Hopkins Hospital. In their workshop on family and professional care for the elderly, they discussed their experience in working with older individuals and the result of their research in the use of emergency facilities by elderly clientele.

Despite efforts in American culture to maintain youth, our population is getting older. The number of Americans who are older than 65 years is increasing: from 3.1 million in 1900 to 27 million in 1983 to a projected 65 million in 2030. Women who are born in 1985 have a life expectancy of 70 years; the life expectancy for men is a few years less. If an individual reaches age 65, he or she can expect to live 10 more years.

Most elderly people have at least one physical illness, for example, atherosclerosis or diabetes. Of those older than 65 years, 5–10 percent have some type of major mental illness.

Ms. Floyd, a psychogeriatric clinical nurse specialist, explained several elements of normal aging. "As people age, they try to integrate the life they've had into their current situation. They look at the progress toward their life goals. In general, they do a very good job. There is much flexibility for integration, but there are also many stressors."

Aging people must cope with social, psychological, and biological changes. Socially, the elderly experience bereavement over the deaths of spouses, friends, and family members. They must cope with isolation and with the many life changes that accompany retirement. Psychological influences include our cultural bias in favor of youth and, therefore, against older people. Elderly people must adapt to changes in economic status related to retirement and to changes in roles, particularly in regard to dependency of children and spouses. "Roles are not reversed," stated Ms. Floyd, "but people adopt different roles as dependency needs change." Biological changes involve failing health, differences in the way that medications are or are not absorbed, and alterations in response times.

Dr. Fitting, who is a psychologist, noted that "emergency department personnel may cause problems for the elderly by treating them too aggressively, so there may be iatrogenic causes of illness. It looks like the best way to treat them is to 'keep hands off,' observe, and then decide how to treat them. That is not usually the mode of treatment in emergency departments. It takes a different type of personality to deal with that or the people who would usually intervene need to think about how to change that pattern."

Psychiatric disorders may complicate the presentation of an elderly person in an emergency department. Anxiety is a fear of impending doom, which is constantly belaboring the affected individual. Physical manifestations of anxiety are increased breathing rate and heart rate—the individual is "speeded up" in all body responses.

People with panic disorders often come to emergency departments because their physical symptoms resemble those of a heart attack: shortness of breath, chest pain, cramping extremities. It looks like a condition that needs immediate medical attention.

Ms. Floyd studied 94 elderly patients who came to the Johns Hopkins Hospital emergency department in January 1984. "More than half of those older than 60 were cognitively impaired. About a third of those patients drank alcohol regularly in large amounts—not just one drink per day, but often as much as a pint."

When taking a patient's history, the health care provider should ask about the patient's consumption of alcohol and use of medications. Some people share their prescription drugs with their spouse or neighbors. Others use outdated medicine that they have stockpiled. Some people are receiving different medications from several doctors who may not be in touch with one another to keep an overall view of the patient's treatment. "The family doctor should consider himself or herself to be the overall care giver, a coordinator of care, and be in touch with the other specialists who are treating the patient," advised Dr. Fitting.

Dr. Fitting stressed the need to specifically identify the behaviors that are being presented by an elderly patient. She described the "Mini Mental Exam" that has been developed at Johns Hopkins Hospital. "It gives a quick glance at a patient's cognitive functioning. It is not a neuropsychological battery, but it can help the health care provider determine what needs to be done.

Dr. Fitting recommended that health care providers involve an elderly patient's family in planning treatment. "Elderly people are usually connected in some way to their families. If they have children, they usually live about an hour away from one of them and have weekly contact with them. Making an alliance with the family establishes a collaborative effort so that medical intervention can be followed through. Even in crisis intervention in emergency de-

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Learning to Cope with Grief & Mourning

"The job of the health care provider is to defeat death. When you can't keep the patient from dying, it creates personal turmoil. How do you handle the family and friends of victims—and how do you handle yourself?" This dilemma faced by EMS providers was addressed at the Stress and Behavioral Emergencies Conference at UMBC, by Thomas Composto, SJ, PhL, MA, MDiv. Professor Composto, adjunct professor in the Weekend College of Notre Dame in Baltimore, and Essex Community College, teaches sociology, psychology, and gerontology. Excerpts from his presentation follow.

"You are faced with making an immediate response to families. Handling physical emergencies is easier; you have the technology behind you. But how do you deal with a mother whose son was killed in a motorcycle accident? It will help to face this type of situation if you know what to expect and what to do.

"The more technology we have as a society, the more we need to touch. John Naisbitt made this impressive observation in a book called *Megatrends*. We could do all our banking by telephone—but we don't; we want to speak to a teller. We could do all our drinking at home, where it's cheaper—but we don't, we go to a bar, so we can be with other people. Hospitals are paragons of technology—but babies are being born at home or in birthing centers, where the families can be near. Shopping by catalog was supposed to be the new wave of the future—but the shopping malls are crowded, and we're building more. People need people.

"When a patient dies, the family wants to talk to you. You were the first and last to be with their loved one. You are dealing with the most powerful event in people's lives. You might not want to talk to them but you talk. What can you expect?

"*Shock:* There has been no preparation. One's whole life changes. It offers solace to the family to talk to you.

"*Babbling, disbelief, denial:* They say, 'Maybe it's a mistake. Can't you try harder?'

"*Questions:* Lots of questions. They will want complete details. The important thing here, is that asking the questions, not their answers, is the beginning of dealing with death.

"*Anger:* At you, at society, at God, at the kid for not wearing his helmet, at the husband for being drunk, at the husband for being dead.

"*Guilt* and *fear.*

"You'll find that people don't want to leave you alone, they want to stay with you. You are their contact. You are going to want to do something. You want your magic words to heal them right away, just like that. Like a psychological IV that will take the hurt away. We don't like to feel helpless.

"The problem is, in a death situation there is a lot of helplessness, powerlessness, and feeling uncomfortable. *That's okay. It's to be expected.*

"What can you do?

"1. Give up the idea that you need a report card to show how effective you are. In a psychological situation, there's no report card, just the belief that you are effective. If you're there, answering the questions, *you are effective.*

"2. The most healing thing you can do—the most difficult, and the most important—is to listen. Think about your own experience. When you're really under stress, doesn't it feel better when you have someone who really listens? Someone who looks at you and listens. Not just being a tape recorder, but actually, seriously, openly, sensitively, uncomfortably if necessary, listening. It works.

"What are you going to hear when you listen?

"*Anger:* It's one of the natural stages to grief. You can't short-circuit it. It can be at the victim: Dumb kid! Lousy husband, you left me in the lurch! Or it could be at God (He's used to it), at themselves, or at you. That's all right. Just listen to it—and let it drain off. They're not angry specifically at you—they're angry at something 'out there.' The thing to realize is, there aren't any answers.

"You can't have a magic way of saying, 'Everything is going to be better.' It's not. They are going to have to go through a process—and you can ease the process.

"You are a very powerful healer just by being there. They want you there; they want to tell you how they feel. That's good. *You can believe in the efficacy of your presence.*

"You can't fix the hurt—it's not like a broken arm. Grieving is a process; it has to be felt. The problem is that in American society, if we can't fix the hurt we squelch it, put the lid on it, clamp it tightly, and don't look at it; maybe it'll go away. That's not good. You can't fix it; what you *can* do is allow it to express itself. Then it will ease; it doesn't go away. There will always be a mark there, but you can help it ease.

"A lot of people have told me that even though they're not supposed to get involved with patients or their families, they do. What can you expect a month, or six months later—and what can you do?

"An important operative element in anything we do, is the meaning. For example, why do we give a birthday cake? The operative element is meaning. It says to the person, 'We love you, we're glad you exist, we're glad you're part of our lives. We're glad for however many years you've been with us, and we hope you'll be here for another birthday.' More than just action, 90 percent of the things we do are because of meaning.

"Death is the same way. What makes it so strong is not the action, but the meaning. It means loss, not freedom. 'You've left me alone, what am I going to do?' 'Didn't he understand all the love and affection we put into his life? And now he's dead.' That's hard. You have to listen to that and let it come out. You are hearing the meaning of that life, not death. That's what you have to listen for.

"That's why you can't say, 'Stop. Don't feel that way.' They feel—and you feel. And everybody's complex of feelings is different. Your meaning is different from my meaning.

"You are going to have to deal with an attitude that says, 'Why go on?' Just let them say it. The grief must be expressed. If you close the pipe, you'll have a pipe bomb some day.

"In America we're macho—we ask, 'How is the person doing?' 'Wonderfully,' we're told. That means he hasn't shown any emotion. Five years later, he turns into an alcoholic, or a suicide, or has cancer. Grief has to come out. It may take two years to be fully expressed. Humor helps.

"One thing that is particularly difficult to deal with is the replaying of

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Physical Therapy Gym Opens

MIEMSS physical therapy staff members at an open house in the department's new gym.

On February 19, the MIEMSS Physical Therapy Department held an open house in its new gym on wing 4A of the University of Maryland Medical System.

The gym provides space for rehabilitative physical therapy, including joint mobilization, ambulation training, and the use of therapeutic modalities such as heat, cold, ultrasound, electrical stimulation, and transcutaneous electrical nerve stimulation for pain management, for subacute care patients. These were formerly done at bedside.

In addition to receiving physical therapy treatment, the patients benefit psychologically in being able to move off the ward to a new environment. An upper extremity group exercise program has been started for orthopedic patients. Patients exercise three times weekly to maintain strength and mobility necessary for ambulation and wheelchair activities after they are cleared orthopedically.

For more information, contact the Physical Therapy Department at 301/528-7667.

Insights into Coping with Grief & Mourning

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mental tapes of the trauma. One thing you can do is to help them to stop replaying the tapes. There comes a time when replaying doesn't heal what hurts. You have to use this method carefully; sometimes you have to do it in follow-ups. How do you know when to do it? That is up to your judgment.

"We can get caught up in the technology of emergency medical services; it's exciting, new, powerful. But we have to remember that human beings are healed by other human beings. Not by miracles, or drugs, or magic, but by one human being reaching out to another human being. All the rest are gimmicks and helps, but technology is not a substitute for human interchange. The hand does more healing than the pill. More healing comes from the concern of the professional.

"How about your own feelings? We're not machines; we have to see the burned baby, or the dead spouse. We're hit by guilt: 'I'm supposed to be the messiah for the world; that's why I wear the uniform, what I get paid for.'

"I say to you—don't take the ER or unit or ambulance home! When you're done, you're done. Take some time for yourself, and live your other life. Then go back and you'll be a much more effective healer. We all need each other. Find yourself a listener. Not the person who says, 'The same thing happened to me,' but a real listener to whom you can speak, but who won't give you remedies, or tell you 'you should . . . .' If you have a listener, it helps you heal. None of us are God. We are the knots in a net, and we're all tied together. The net does the healing."

—Erna Segal

Region III

Congratulations to the Pleasant Valley and Joppa-Magnolia Volunteer Fire Companies, which will represent Region III in the statewide olympics at EMS Care '86. We wish them both luck in the competition.

Woodland Beach Volunteer Fire Company is the most recent company to demonstrate that it holds high standards for service: the company's Ambulance 2 and Reserve Ambulance 2 passed the voluntary ambulance inspection in February. Other units that have met the standards for certification in the past year belong to Fallston, Bel Air, Joppa-Magnolia, Darlington, Fawn Grove, and Aberdeen Volunteer Fire Companies in Harford County; Clarksville Volunteer Fire Company in Howard County; Owings Mills Volunteer Fire Company in Baltimore County; and New Windsor, Pleasant Valley, and Taneytown Volunteer Fire Companies in Carroll County. Any company interested in this program should contact the Region III office.

Rosedale and Owings Mills Volunteer Fire Companies expect to move into new buildings in the near future. Rosedale has already begun to demolish the old Rosedale Elementary School to build its new station. Owings Mills has a large "for sale" sign on its existing building, advertising its intent to move. Best wishes to both companies.

The Baltimore City Fire Department recently purchased four new replacement units. Five new replacement units have been purchased by the Baltimore County Fire Department, which plans to replace nine more units in the next budget year.

—John Donohue
301/528-3997

Update on Wheelchairs

The Trauma Physical Therapy Department of Montebello Rehabilitation Hospital will conduct a course on May 17 for physical therapists, occupational therapists, and others who fit, order, or approve for payment wheelchairs for clients with a variety of disabilities. A selection of the latest wheelchair models and options, with the emphasis on power and sports models, will be discussed and displayed. For further information, contact Mary Salmon, assistant director of trauma physical therapy, at 301/554-5271 or 301/554-5311.

Legal Aspects of Behavioral Emergencies

There must be a prompt, humane, and lawful way to handle individuals with behavioral disturbances who need emergency evaluation and medical or psychiatric care. These problems were addressed at the Legal Aspects of Behavioral Emergencies Conference at Sinai Hospital, which was sponsored by MIEMSS and the Mental Hygiene Administration of the Department of Health and Mental Hygiene (DHMH).

A behavioral disturbance does not mean that a person is "crazy." It can occur as a result of a head injury, seizure disorder, tumor, blood sugar imbalance, or other physical conditions. "Behavioral emergencies are medical problems until shown to be otherwise," says Paul McClelland, MD, director of the division of consultation-liaison psychiatry at the University of Maryland School of Medicine. "Such patients are not taken to community mental health centers, but to hospital emergency departments for evaluation." Dr. McClelland is the director of the statewide Behavioral Emergencies Program.

The Behavioral Emergencies Program was established in 1979 to foster collaboration between different groups of professionals involved in patient care. DHMH provides most of the funds, which are used for training law enforcement, ambulance, and emergency department (ED) personnel; working with collating agencies to establish training standards; and developing standards of care. The focus is on the behaviorally disturbed individual, from identification and petition in the field through triage in the ED.

The Emergency Evaluation Statute is a public health law, not a criminal statute. It concerns a person suffering from a mental disorder who presents a clear and imminent danger of causing bodily harm to himself or someone else. (For the purposes of this law, "mental disorder" does not refer to mental retardation.) Even though a law enforcement officer may take custody of the disturbed individual, that individual is not being arrested, and there will be no criminal record if the individual did not commit a criminal act. The disturbed individual is merely being taken to an appropriate medical facility to be evaluated.

There are three parts to the process by which it is determined whether a person should be committed to a psychiatric facility: the petition, which is the initial request for evaluation; medical clearance in the hospital ED; and the psychiatric evaluation. Each of these parts described at the conference will be explored in a series of articles. Part 1—"The Petition"—follows.

Richard Hann, a Baltimore County police officer and psychologist, who is a consultant in the Behavioral Emergencies Program, describes how the emergency petition procedure can be set in motion. He says it can be started by anyone acting in good faith, including several categories of people: any interested party, such as a lawyer, teacher, or member of the family; a medical doctor of any specialty; a "peace" officer, which includes city, county, or state police, sheriffs, and constables, but not security guards; a licensed psychologist; or a local health officer. There are differing levels of authority. If a medical doctor of any specialty, psychologist, peace officer, or health officer (or designee) signs a petition, it immediately becomes an enforceable document and the disturbed individual is taken to the ED for evaluation. An interested party, however, must appear before a judge who reviews the facts and decides whether the petition should be granted. The serious nature of the procedure is explained, as is the crime of perjury. Every effort is made to protect the rights of the person to be committed.

According to Mr. Hann, there are frustrations inherent in this system. Courts are open during the day, generally from 9 am to 4 pm. Emergencies usually occur on weekends, after work on payday, or after midnight when the court is not open. Although judges may be called out of bed, usually a police officer is called to the disturbed person's home or to the scene of the disturbance. If the police officer observes the disorder personally, he can become the petitioner and take the disturbed person directly to the appropriate facility for evaluation. However, the unruly person may quiet down at the sight of a police uniform, and the officer may not see anything unusual. Mr. Hann teaches law enforcement officers that it is worthwhile in a case like this to "invest time—behavioral emergencies are the exact opposite of medical emergencies." Mr. Hann says, "Time is crucial in medical emergencies, but mental health emergencies require unhurried observation. The disturbed individual may be able to control his erratic behavior for a short period of time but will eventually lose control, and the officer will witness the disturbance." The officer can become the petitioner *only* if he witnesses the disturbance. (He does not have to see an assault; seeing the injuries is enough.)

Petition forms can be obtained from police departments, mental health centers, and hospital EDs (particularly in rural areas), as well as from the courts. The petition of an interested party has a 5-day life. If the person has not been taken into custody by the sixth day, the petition is returned to the court. A petition from a physician or law enforcement officer has no time limit, but the custody stage should come quickly, Mr. Hann says.

Where do prehospital providers fit into this picture? In this context a prehospital care provider is considered an interested party, as is a social worker. The role of the prehospital provider is to identify behavioral emergencies and to transport the individual or contact a police officer. If a medic unit is called to the scene of a behavioral emergency and the person is violent, the medics should call the police for help. Medics can take an unconscious person who has been mentally disturbed to the appropriate facility, but if the person is violent a police officer may need to follow the ambulance.

It is important that prehospital providers recognize someone with a mental disorder. Mr. Hann describes signs to watch for:

- Lack of orientation (not knowing who or where he is, or having no conception of time)
- Activities indicating delusions (believing he is all-powerful or the reincarnation of a famous person)
- Talking to himself or to a wall or object
- Committing impulsive, destructive acts for no reason
- Speaking in a bizarre language not recognizable as being from a foreign country (gibberish)
- Believing that people are conspiring against him or talking about him

Dr. McClelland emphasizes that law enforcement and prehospital personnel

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should be seen by the ED staff as important sources of data; they are highly trained observers, much more so than the average family member. It is helpful to the ED staff if these trained personnel describe their observations, particularly regarding behavior: what the setting looked like and whether the setting governed the patient's behavior; what the patient said; and whether there were drugs or medicines in the house. It is also helpful if they can provide the name and phone number of a sober, reliable person who knows the patient. First responders are often the only people who can give this type of information.

If the disturbed individual is violent when he reaches the hospital, a physician may request that the police officer stay until a police supervisor is contacted and responds. If the patient becomes violent at any time, the ED staff may call the police.

If the police officer escorting the patient does not have a properly executed petition, a physician in the ED may sign one. In regard to the legal liability of people who petition, evaluate, and treat mental disorders, Robert Fontaine, an attorney with the Offices of the Attorney General, says "the bottom line is good faith. If you believe what you are doing is correct, and you believe that what you see is a valid reason for seeking an involuntary commitment, then you are showing good faith, and are basically covered." In order to prove your good faith, Mr. Fontaine suggests you document your impressions of what you see, so if you are questioned later you can say, "This is what I saw, and this is what I believed was happening." It is important to have something that was written at the time of the incident to show why you acted as you did.

The patient will be evaluated in the ED within six hours of his arrival. The criteria for commitment to a psychiatric facility are the presence of a mental disorder; a need for inpatient treatment or care; presenting a danger to the life or safety of himself or others; unwillingness or the inability to be admitted voluntarily; and the absence of less restrictive forms of intervention consistent with the individual's welfare and safety. Anyone over the age of 65 must receive a geriatric evaluation. Commitment requires examination by two physicians (of any specialty) or one physician and one psychologist; both must sign, and one must write a note describing on what grounds he came to the conclusion that the individual should be committed. According to Elizabeth Eckhardt, an attorney and hearing examiner for the commitment hearings, nothing else is considered but these legal grounds.

—Erna Segal

Trauma & Alcohol

"Trauma and Alcohol: Challenges and Solutions," a conference focusing on a systems approach to the identification, treatment, and rehabilitation of alcohol and drug problems in the trauma population, will be held May 29 and 30 at the Hyatt Regency Hotel in Baltimore. The event is sponsored by MIEMSS and the American Medical Society on Alcoholism and Other Drug Dependencies.

Approximately 50 percent of emergency medicine and trauma patients are under the influence of alcohol or drugs at the time of admission. Alcohol and drugs affect the patient's well-being at every point in the continuum of care, beginning in the acute trauma setting and continuing through rehabilitation.

The conference is designed for physicians and nurses working in the areas of trauma, critical care, emergency medicine, and rehabilitation; social workers; alcoholism counselors; rehabilitation counselors; and clergy.

Application has been made for continuing education credits.

For more information, contact Patricia McAllister at 301/528-2399.

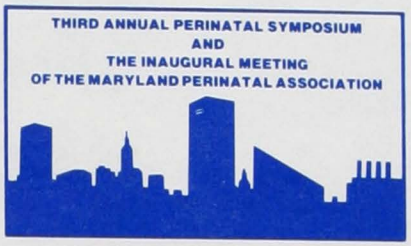
Region IV

The Water Witch Volunteer Fire Department in Port Deposit, Cecil County was the first Region IV ambulance company to have its ambulances reinspected. The Region IV Office encourages other units already certified to contact the Regional Office if they would like their units reinspected.

The Union Hospital of Cecil County, in cooperation with CRT Instructor Frank Muller, began a CRT training program last November. The Region IV Office would like to congratulate all those who succesfully completed the program.

—Marc Bramble, John Barto
301/822-1799

Perinatal Conference



The Third Annual Perinatal Symposium is scheduled for June 12 and 13 at the Baltimore Marriott Hotel. In conjunction with the symposium, the inaugural meeting of the Maryland Perinatal Association will be held at 3:45 pm on June 12 at the same site.

The symposium includes lectures of interest to obstetric and neonatal health providers as well as a choice of workshops on specific topics in perinatology and neonatology. Dr. Edward N. Brandt, chancellor, University of Maryland at Baltimore, will present the keynote lecture, "Prevention as Policy: The Issue of Premature Delivery."

Among the distinguished speakers are Dr. Frank Boehm (Vanderbilt University), who will give a presentation on treatment and prevention of preterm labor, and Dr. Gordon B. Avery, who will speak about future treatment of infants with bronchopulmonary dysplasia. The impact of AIDS on perinatal care as well as the social aspects of the disease will be addressed by Dr. B. Frank Polk of the Johns Hopkins Hospital and Jack B. Stein from the Health Education Resources Organization.

The Maryland Perinatal Association meeting is open to anyone interested in perinatal health care issues. Speakers will include Dr. Rae K. Grad, project director of the Southern Regional Task Force on Infant Mortality, and Dr. Phillip Goldstein, chairman of obstetrics and gynecology at Sinai Hospital and acting president of the Maryland Perinatal Association.

Continuing education units have been granted through the MIEMSS Field Nursing Program, the American College of Obstetrics and Gynecologists, and the American Academy of Pediatrics.

The symposium is sponsored by the Maryland Regional Neonatal Program of MIEMSS and the Maryland Perinatal Association. Co-sponsors are the Johns Hopkins Hospital and the University of Maryland Medical System.

For further information, contact Patricia McAllister at 301/528-2399.

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Care of the Elderly

(Continued from page 3)

partments, families should be involved in treatment because they will be with the patient after they leave the hospital."

The family's methods of coping with previous problems should be considered. Solutions to past problems can be explored, and the effective ones can be applied to the current situation.

Changes in family members' roles in decision-making and other tasks can create problems. An elderly man must make a major adjustment with the realization that he should not drive any more. A depressed woman who cannot put dinner on the table can be devastated by that change because she feels that she is not fulfilling her role.

Family members should be educated about the patient's illness. They should know what to expect during the course of the disease and talk about what they can do as problems arise. Involving the ill person in these discussions helps the family to work together to solve a problem.

Ms. Floyd and Dr. Fitting conclude that more research is needed on elderly patients in emergency medical situations. A multidisciplinary approach will ensure that the treatment fits the patient.

—Linda Kesselring